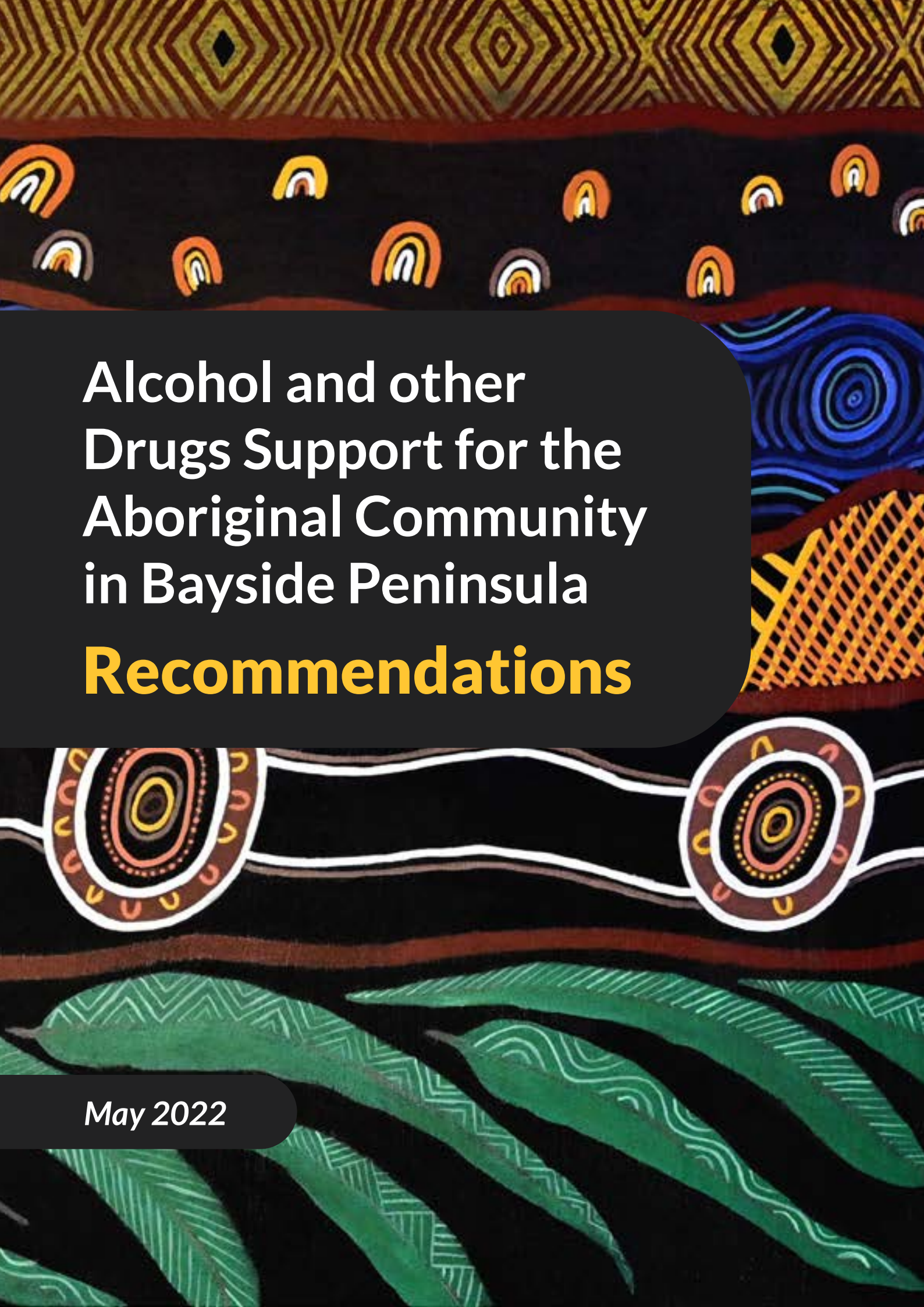
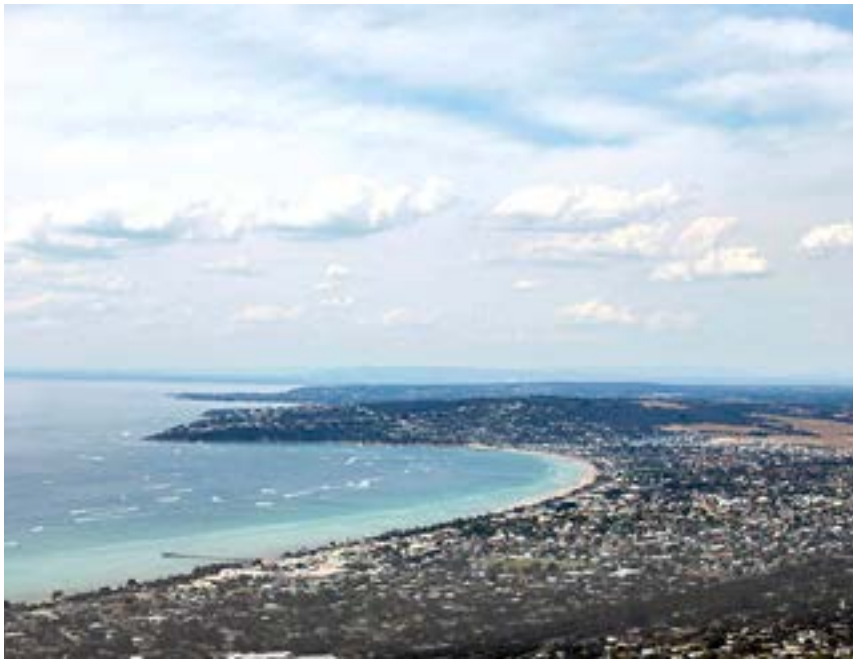


Alcohol and other Drugs Support for the Aboriginal Community in Bayside Peninsula

Recommendations

May 2022

Terminology



We acknowledge the diverse and distinct cultures of Aboriginal people and Torres Strait Islanders. This report is intended for both Aboriginal people and Torres Strait Islanders living in Victoria or accessing Victorian Alcohol and Other Drug (AOD) services. In this report, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koorie' is retained when part of a program name or quotation.

Prepared by Nick Jones
Melbourne Primary Health

Acknowledgements

The project has been guided by a project control group consisting of representatives from:

- Access Health, The Salvation Army AOD Victoria
- Bunjilwarra Koori Youth Alcohol & Drug Healing Service
- Dandenong & District Aborigines Co-operative
- DFFH – Aboriginal Engagement Unit
- DFFH – Agency Performance & System Support
- First People's Health & Wellbeing
- Ngwala Willumbong Aboriginal Corporation
- Orange Door
- Peninsula Health
- Star Health
- Windana

We have also been guided by feedback from the following committees:

- Bayside Peninsula Area Aboriginal Governance Committee
- Bayside Peninsula Area Alcohol and Other Drug Planning Committee

A large number of community members were consulted during the project and shared their stories. The people who chose to be acknowledge are:

- Stacey Morton
- Kenneth Drew
- CLENZ

Artwork

Layers of Country by Sammy Trist

Sammy is a Taungurung woman of the Kulin Nation and is the Cultural Lead (arts and projects) at Willum Warrain gathering place in Hastings.

- First layer - symbols to represent Kulin totems (Waahn and Bunjil)
- Second layer - community/families
- Third layer - waterways, pun pun, turtle pond, Westernport, Port Phillip Bay
- Fourth layer - Kulin line art, diamond or hatch represent fishing/weaving
- The five lines represent the eastern Kulin nations (5 clans)
- Fifth layer - different Aboriginal groups that come and connect and share culture and knowledge
- Sixth layer - gum leaves represent the country that Willum is located on

Service user interviews and thematic analysis by Nyuka Wara consulting.

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Executive summary

Project background

Objective

The Alcohol and other Drugs (AOD) Strategic Planning Project for the Aboriginal Community in the Bayside Peninsula was tasked by the Victorian Department of Families, Fairness and Housing to recommend a service model for the delivery of AOD services to Aboriginal people in the Bayside Peninsula Area.

Deliverables

- A needs analysis of the Aboriginal community in relation to AOD service demand (including consultation with stakeholders) that includes:
  - Prevalence of AOD use amongst Aboriginal people across the Bayside Peninsula Area
  - Existing and emerging social determinants of health, impacting AOD use amongst Aboriginal people, across the Bayside Peninsula Area
  - Current demand and AOD service utilisation amongst Aboriginal people across the Bayside Peninsula Area
  - Current funding of Aboriginal-specific AOD services across the Bayside Peninsula Area
  - Identify existing culturally appropriate evidence-based frameworks for delivery of Aboriginal-specific AOD services
  - Identify gaps in available AOD programs and services appropriate to respond to the needs of Aboriginal people, families and communities across the Bayside Peninsula Area
  - Organisational and workforce development needs amongst Community Controlled organisations and mainstream AOD providers
- Development of an evidence based contemporary alcohol and other drugs strategy and service model for the Bayside Peninsula Area Aboriginal community that identifies a full range of culturally responsive and appropriate programs, including prevention and interventions.

Project team

The project was funded by the Department of Families Fairness and Housing and overseen by the Frankston Mornington Peninsula Primary Care Partnership, with project coordination and data analysis provided by Nick Jones of Melbourne Primary Health.

Eddie Moore from Nyuka Wara conducted the interviews and thematic analysis of the interviews was done by Eddie Moore and Dr Ginny Monteiro.

Overview

What is the challenge?

In the Bayside Peninsula Area, despite Aboriginal people accessing drug and alcohol services (AOD) at 10 times the rate of the general community, only a small number of Aboriginal people are accessing drug and alcohol services that incorporate best practice support for Aboriginal people.

How many people are impacted?

The Bayside Peninsula Area (based on Department of Families Fairness and Housing boundaries) has the:

- largest number of Aboriginal people in Victoria (5,977 people in 2020)[1]
- highest projected number of Aboriginal people in Victoria by 2028 (8,324 people)[2]
- highest estimated number of Aboriginal people with risky AOD usage (594 people)[2]
- highest estimated number of Aboriginal people accessing AOD services (291 people)[2]

What is the imbalance?

Impact of social determinants of health:

- Negative social determinants of health are correlated with higher risk AOD usage[2,3]
- All Aboriginal communities are impacted more negatively by social determinants of health than the mainstream community
- Aboriginal people in the Frankston and Mornington Peninsula Local Government Areas and the suburb of St Kilda have the highest negative social determinants of health in the catchment[5]

Most AOD services for Aboriginal people are being provided by mainstream services:

- Based on the activity data of state funded AOD services[6], only 15 of 253 (6%) Aboriginal people accessing AOD services were supported by Aboriginal Community Controlled Organisations in 2020/21

AOD services for Aboriginal people are not evenly distributed:

- The only Aboriginal Community Controlled Organisation providing state-funded AOD services, Ngwala Willumbong, is a 50 minute drive from the area with the largest need for AOD services (Frankston) and a 1.5 hour drive from the area with the fourth highest need (Hastings)

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[1] Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder. <accessed 20/8/2021>

[2] SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria https://www.parliament.vic.gov.au/images/stories/committees/paec/COVID-19_Inquiry/Submissions/76b._Aboriginal_Executive_Council_AEC.pdf

[3] Commonwealth of Australia. National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017-2023. Canberra: Department of the Prime Minister and Cabinet; February 2017. https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf <accessed 22/2/2022>

[4] Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW; 2015. https://www.aihw.gov.au/reports/indigenous-australians/indigenous-health-welfare-2015/contents/table-of-contents <accessed 22/2/2022>.

[5] Intergovernmental Committee on Drugs. National Aboriginal and Torres Strait Islander peoples' drug strategy 2014 - 2019. A sub-strategy of the National Drug Strategy 2010 - 2015. Canberra: Commonwealth of Australia. https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-peoples-drug-strategy-2014-2019. <accessed 22/2/2022>

[6] Department of Health and Human Services. Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027. Melbourne: State Government of Victoria; October 2017. https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027 <accessed 22/2/2022>

Proposed service model

The proposed service model builds on the existing guidelines that AOD Aboriginal Community Controlled Organisations (ACCOs) already aim to align with:

- Balit Murrup social and emotional wellbeing framework[7]
- Victorian Department of Health AOD program guidelines[8] (where they don't conflict with Balit Murrup recommendations)

The core components of the AOD service model are:

- Promotion of AOD services provided by ACCOs to the community and service providers
- Proactive discussion with Aboriginal people about accessing ACCO AOD services
- More time for yarning
- Culture as treatment
- Focus on the therapeutic relationship between participants and the same small support team
- Active handover within the service and to external services

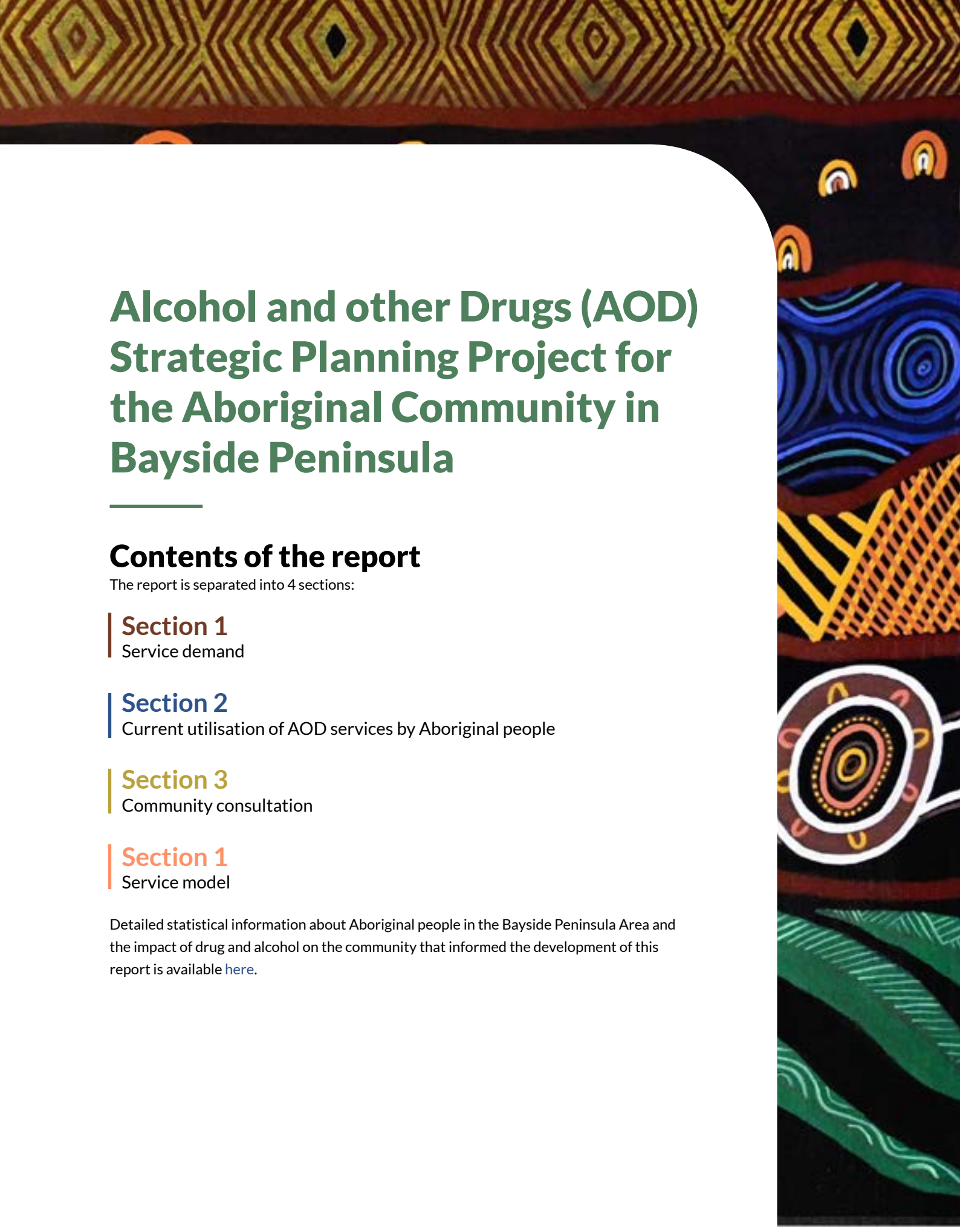
Out of scope

Changes that are needed but are outside the scope of this AOD treatment services project are:

- Social and health supports
- AOD detoxification
- AOD residential rehabilitation
- Pharmacotherapy

[7] Department of Health. Alcohol and Other Drug Program Guidelines. https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines <accessed 22/2/2022>

[8] Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc



Alcohol and other Drugs (AOD) Strategic Planning Project for the Aboriginal Community in Bayside Peninsula

Contents of the report

The report is separated into 4 sections:

Section 1
Service demand

Section 2
Current utilisation of AOD services by Aboriginal people

Section 3
Community consultation

Section 1
Service model

Detailed statistical information about Aboriginal people in the Bayside Peninsula Area and the impact of drug and alcohol on the community that informed the development of this report is available here.

Section 1. Service demand

Service demand can be estimated by understanding:

- The number of Aboriginal people in the catchment
- Social determinants of health
- Current utilisation of AOD services by Aboriginal people
- Number of Aboriginal people experiencing harm related to AOD use

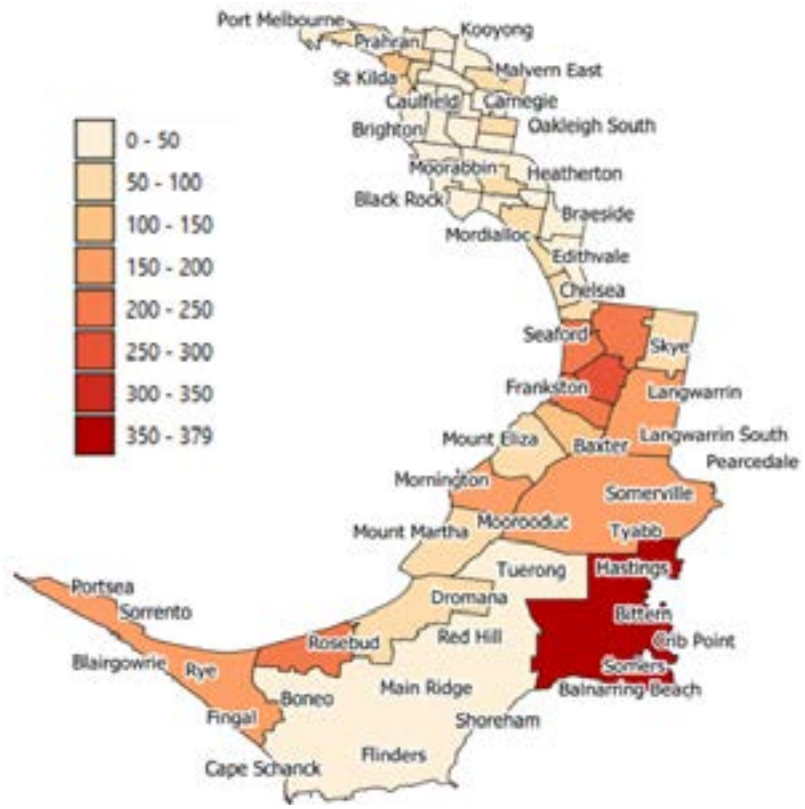
1.1 Bayside Peninsula Demographic Profile

The Bayside Peninsula Area (BPA) includes the local government areas of Frankston, Kingston, Bayside, Stonnington, Glen Eira and Port Phillip, and the Mornington Peninsula.

Figure 1 shows the number of Aboriginal people counted in the 2016 Census. Frankston and the Mornington Peninsula have the top 10 SA2 (suburb sized) areas with the highest Aboriginal populations.

Despite only comprising 16% of the total population, Aboriginal people in the Frankston and Mornington Peninsula Local Government Areas comprise 61% of the BPA Aboriginal population.

St Kilda is the focus of many AOD services supporting Aboriginal people but has fewer Aboriginal people (identified in the 2016 Census) than most suburbs in the Frankston and Mornington Peninsula area. However, this is complicated by evidence that the Census may underestimate the number of Aboriginal people by at least 15%2.



Source: ABS Census 20161

Figure 1. Number of Aboriginal people in BPA 2016

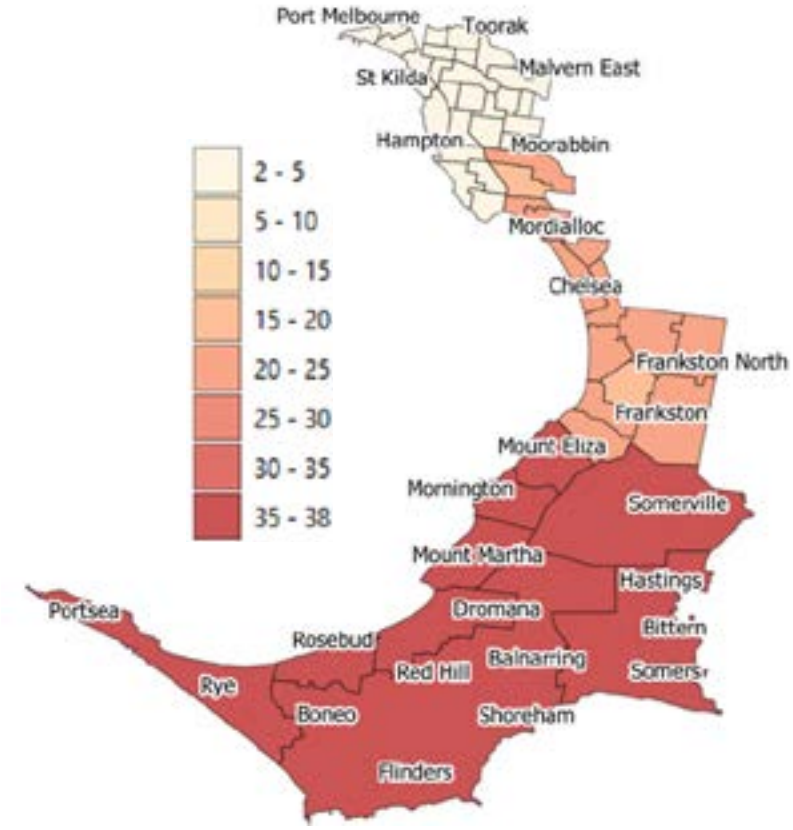
1 .2 Existing and emerging social determinants of health impacting AOD use

Many Aboriginal people in the BPA experience good or excellent health. However, as a group, Aboriginal people continue to experience a greater burden of disease and social and economic disadvantage, compared to non-Aboriginal people.

Figure 2 shows Aboriginal Relative Socioeconomic Outcomes by Aboriginal Areas and highlights the higher disadvantage in the southern part of BPA compared to the northern part.

Aboriginal people in Frankston and the Mornington Peninsula have similar overall socioeconomic outcomes as Aboriginal people in the rest of Greater Melbourne[9].

However, Aboriginal people in all areas of Greater Melbourne are significantly more disadvantaged compared to non-Aboriginal people.



Source: Public Health Information Development Unit9

Figure 2. Aboriginal Relative Socioeconomic Outcomes 2016

1.3 AOD service demand

Bayside Peninsula has the largest number of Aboriginal people in Victoria by Department of Health region and over 8% of all Aboriginal people receiving state funded AOD services live in the BPA.

By 2028, it is expected that there will be over 8000 Aboriginal people living in the BPA region, which is nearly 1000 more people than in the next largest area2.

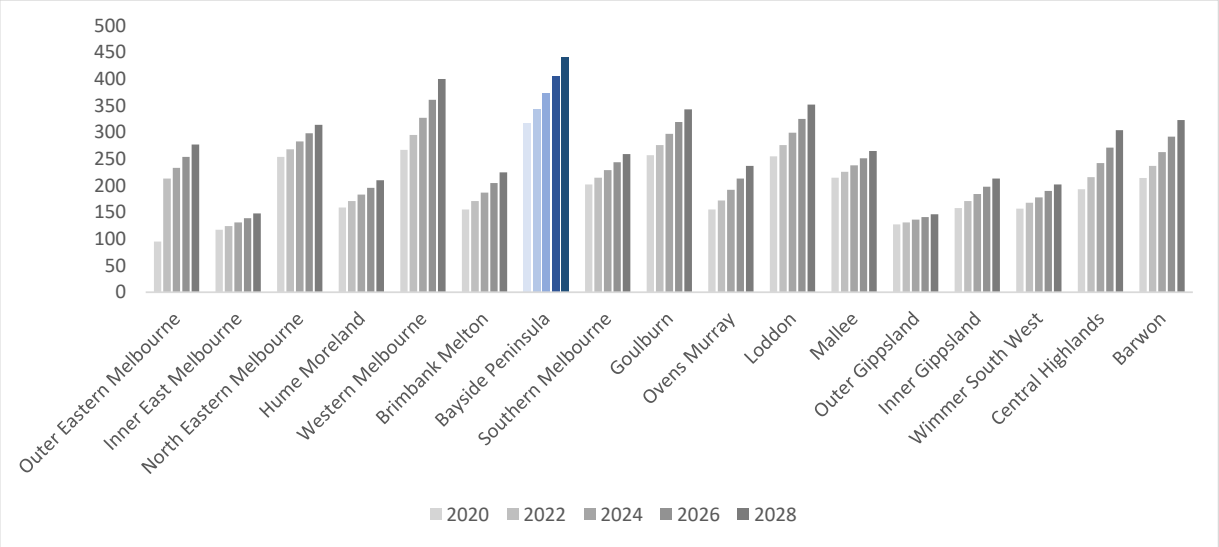
In a 2017 review, Bayside Peninsula area was identified in the top 3 Melbourne metropolitan areas with the highest current and future demand for social services in 8 priority sectors2.

- Education
- Child and family
- Family violence
- Homelessness
- Justice
- Mental health
- Alcohol and other drugs
- Youth

[9] Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 accessed 14/1/2021]. Available from: http://phidu.torrens.edu.au/

Figure 4, adapted from the SVA Consulting report on service demand2, shows the projected demand for Aboriginal people accessing AOD services across Victoria. The estimates of demand for AOD services are calculated by multiplying the proportion of Aboriginal people in Victoria that exceed lifetime risks guidelines for alcohol usage (from previous studies), with the number of Aboriginal people in each area.

The BPA catchment has the highest current and future demand for AOD services for Aboriginal people.



Source: SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria2

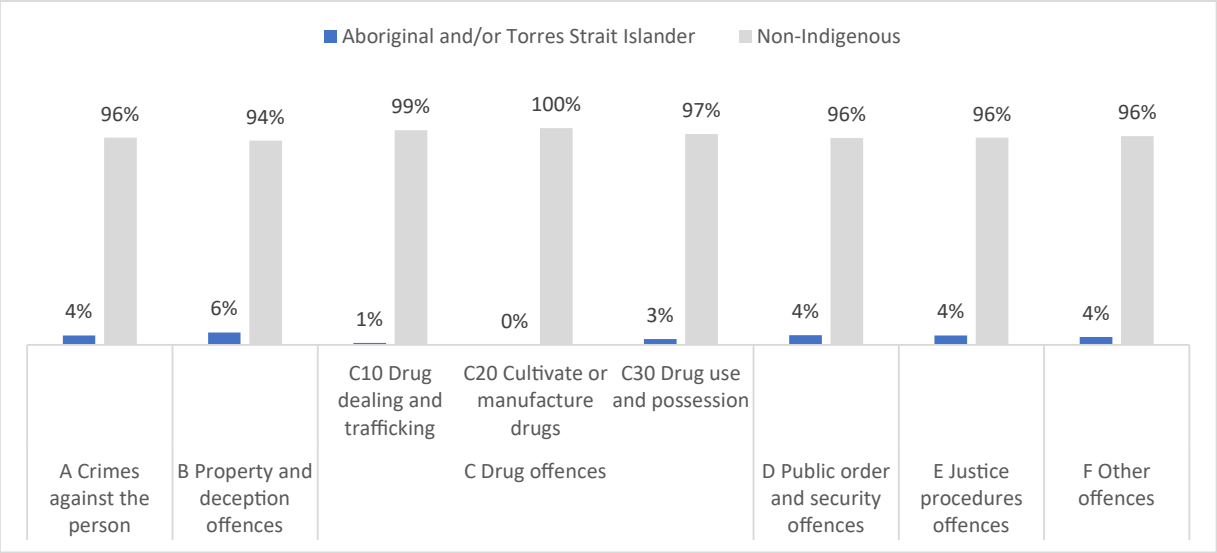
Figure 3. AOD Projected Demand (Individuals) – Community Organisation Support Services, by DHHS Region (2020-2028)

1.3 AOD Harm

There are a variety of sources of harm data linked to AOD use, including hospitalisations and deaths. However, the only publicly available harm data that currently includes Aboriginal status is Victoria Police crime data.

Victoria Police data for 2020/21[10] indicates that the proportion of alleged offences in the BPA involving Aboriginal people is nearly 4%, which is approximately 5 times higher than their proportion in the community.

Figure 3 below shows alleged offender incidents in the Bayside Peninsula Area by type. Of note is that Aboriginal people are very rarely arrested for drug-related crime.



Source: Victoria Police. Crime Statistics Agency[10]

Figure 4. Alleged offender incidents, BPA 2020/21

[10] Victoria Police. Crime Statistics Agency. https://www.crimestatistics.vic.gov.au/ <Accessed 19/11/2021>

Section 2. Current utilisation of AOD services

The Victorian Alcohol and Drug Collection (VADC) records activity for Department of Health Victoria funded AOD treatment providers. In the last financial year, 253 individual Aboriginal people accessed drug and alcohol services.

Aboriginal AOD service users by area

The local government areas with the highest number of Aboriginal people accessing AOD services were Frankston, Mornington Peninsula and Port Philip.

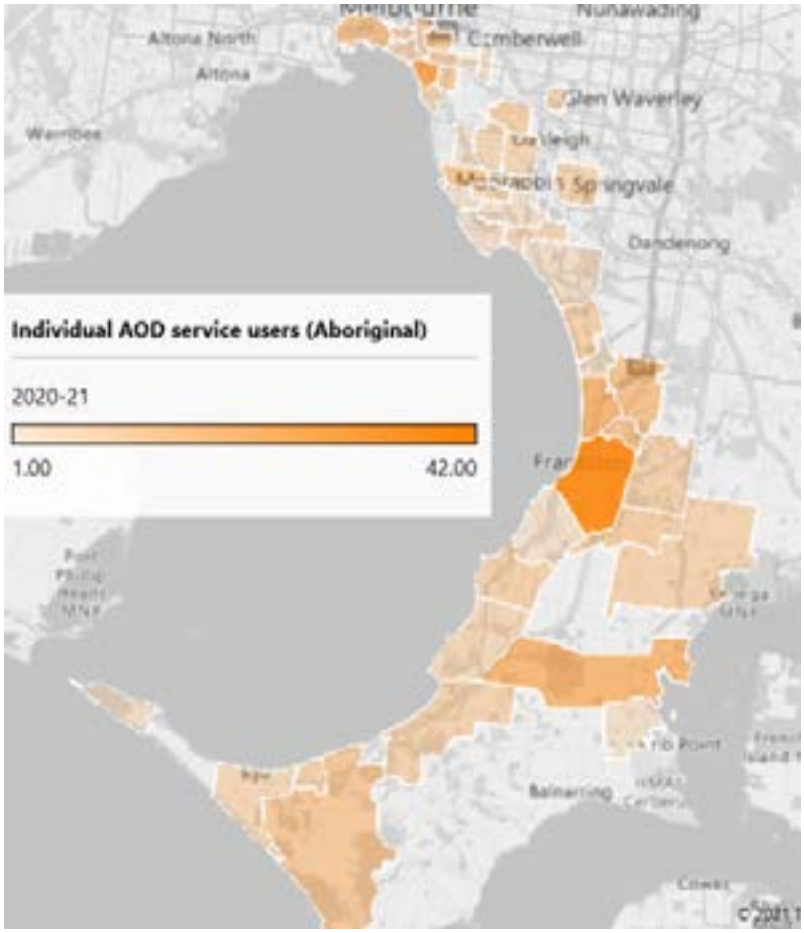
This roughly aligns with the SVA projections cited in section 1 of this report (316 people in 2020).

Compared to mainstream AOD service users, Aboriginal people:

- have similar service contacts per person
- live in similar areas of disadvantage

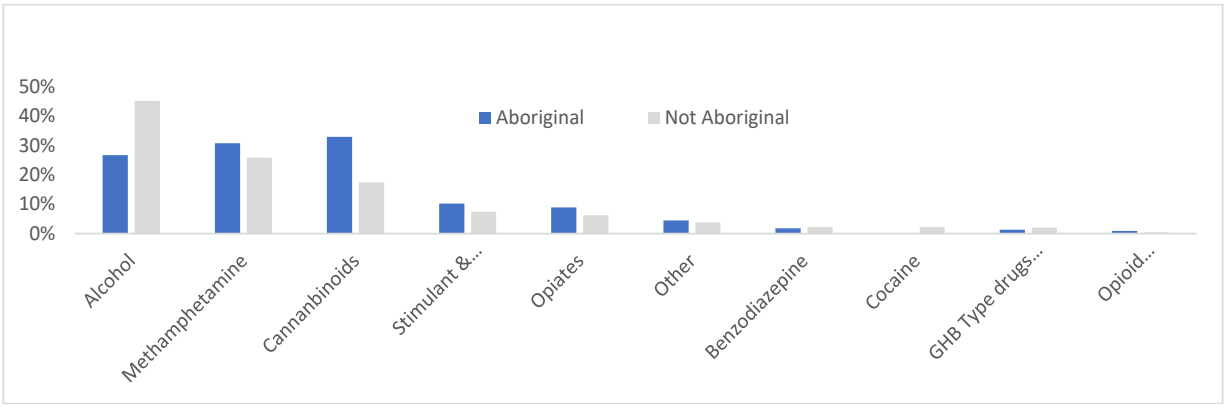
Primary drugs of concern

The Primary Drugs of Concern for Aboriginal people in the BPA are evenly spread between alcohol, cannabis and methamphetamine. This is a different profile to mainstream service users who are more likely to need support for alcohol.



Source: Department of Health. Victorian Alcohol and Drug Collection (VADC)[6].

Figure 5. Aboriginal AOD service users



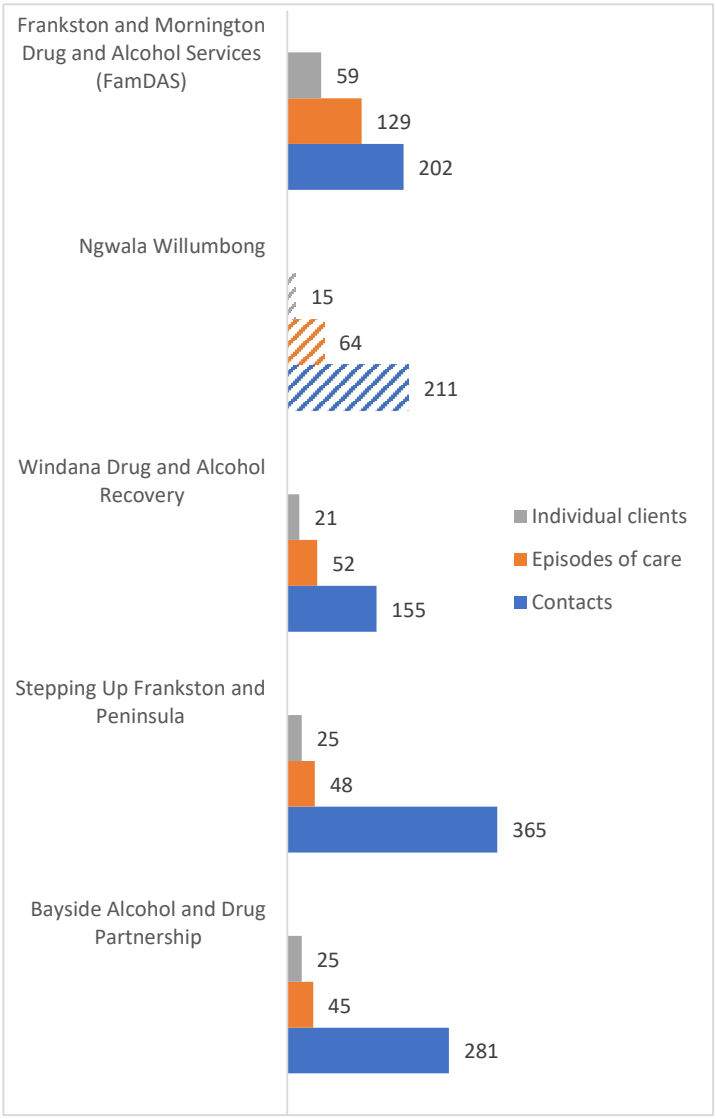
Organisations providing AOD services to Aboriginal people

In 2020/21, most AOD services for Aboriginal people were provided by mainstream services.

Based on the activity data of state funded AOD services[11], only 15 of 253 (6%) Aboriginal people accessing AOD services were supported by the AOD ACCO for the catchment, Ngwala Willumbong.

Figure 6 below shows that most Aboriginal people were supported by mainstream AOD services based in the Frankston Mornington Peninsula (FamDAS and Stepping Up).

The AOD ACCO for the catchment, Ngwala Willumbong, had fewer individual clients than FamDAS but more service contacts.



Source: Department of Health. Victorian Alcohol and Drug Collection (VADC)[11].

Figure 7. Number of Aboriginal AOD episodes of care by service (top 5)

[11] Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Section 3. Service user consultation

Overview of methodology

This study was conducted with Aboriginal people who had used or are currently using AOD services within the Bayside Peninsula Area. A total of 20 participants completed the interviews between August and October 2021.

To ensure cultural safety, a combination of yarning and semi-structured interviews was used.

A Victorian Aboriginal researcher with expertise in health and social research reviewed the research methodology, interview guide and questions for appropriateness of language/terminology, cultural safety, comprehension of questions, and appropriateness of the questionnaire design.

The Aboriginal researcher conducted the yarning semi-structured interviews with the clients. Due to COVID-19 restrictions, all interviews were conducted by video conference or telephone.

The research study adheres to:

- the guiding principles for Aboriginal Evaluation Strategy[12]
- the six core values important to all Aboriginal and Torres Strait Islander Peoples[13]
- the four principles of Australian Institute of Aboriginal and Torres Strait Islander Studies research ethics framework[14]

Ethics approval for the study was obtained from the Peninsula Health Human Research Ethics Committee.

Conventional content thematic analysis was used to analyse the transcripts. Each transcript was independently and sequentially coded by a researcher with over 15 years of Aboriginal health work experience. After completion of coding, discussion and comparison took place with the Aboriginal researcher, and themes were grouped into categories.

Sample characteristics

Seventeen of the 20 Aboriginal participants were from Victoria, and one was from the Northern Territory but living in Victoria. Two participants were from other states. Five of the participants identified as female and 15 as male.

The participants yarned with the interviewer about themselves (provided information about themselves that was important to them) at the commencement at the session. Participants reported working previously in the following occupations:

- cabinet maker
- carpenter
- bakery hand
- shearer
- car detailing
- roof tiler
- mental health peer worker

Results

The results have been divided into 3 major themes:

- Organisational factors
- Staff factors
- Cultural factors

Direct quotations from participants are displayed in blue text boxes

[12] Productivity Commission, Indigenous Evaluation Strategy October (2020), Commonwealth of Australia: Canberra. https://www.pc.gov.au/inquiries/completed/indigenous-evaluation#report <accessed 22/2/2022>

[13] National Health and Medical Research Council. Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders (2018), Commonwealth of Australia: Canberra. https://www.nhmrc.gov.au/about-us/resources/ethical-conduct-research-aboriginal-and-torres-strait-islander-peoples-and-communities <accessed 22/2/2022>.

[14] Australian Institute of Aboriginal and Torres Strait Islander Studies' (AIATSIS) 'Code of Ethics for Aboriginal and Torres Strait Islander Research (2020), Commonwealth of Australia: Canberra. https://aiatsis.gov.au/sites/default/files/2020-10/aiatsis-code-ethics.pdf <accessed 22/2/2022>.

Organisational themes

Holistic approach

Participants reported the need for AOD services that viewed the person as a whole and took the time to get to know them at a personal and cultural level rather than just discussing the addiction.

> *They were absolutely holistic approach to the addiction side of things, and it didn't just attack the addiction they attack everything.*

Insufficient AOD services and long waiting lists

Participants reported that they lost motivation while waiting to find a bed in rehabilitation or get access to support AOD services.

> *Quicker response with the AOD service to talk to someone, not just say, 'Oh hello … we've booked you an appointment for three months from now'.*

Alternative modes of AOD service delivery

Participants reported that they preferred when AOD services explored other service delivery methods to reach them during COVID such as using phone services. However, some participants noted that phone services were insufficiently motivating compared to 'in person' services.

> *I was getting phone calls on a regular basis. But that's not enough you know. Phone calls are nothing when you are in the midst of your addiction, you know, it's really not gonna do anything. Although it's great support, but it's really not physically gonna do anything for ya*

Workforce themes

Aboriginal staff

Participants requested an increase in Aboriginal staff, therapists, Elders and mentors to be a part of the AOD services.

> *Aboriginal worker, working there, it makes it more family orientated, and they just get how we speak and how we interact as people*

> *There's not enough … Indigenous help*

> *Everyone was trying to be sensitive and not say the wrong thing, but whilst doing that, nothing was getting done about what should have been getting done um, yeah and I just, I just I could see that whole situation would have been different if there was a black fella working there*

Staff retention

The high staff turnover within AOD services reduced the ability of Aboriginal clients to form meaningful bonds with their AOD worker. Aboriginal clients also reported a sense of frustration repeating their story whenever a new AOD worker was allocated to them.

> *You're always getting a new worker, 'cause someone leaves the job, it's just not very consistent.*

Acceptanc+e and trust

Participants reported that they felt like shutting down to staff who demonstrate a lack of understanding of their situation. Participants reported that they felt culturally unsafe when staff were inflexible in their perspectives and did not provide person centered care.

> *They've got their mindset on how to be with everyone, you know, they don't treat cases individually, sort of thing, and um, I found some of the workers a bit, like, um, ignorant*

Participants reported that they felt they were connected to the AOD service when they didn't feel like they were going to an appointment but to visit friends and get support rather get counselling. Participants also reported that they would not go back to the AOD service if they did not feel connected to the staff.

> *They make you feel really welcome when you walk in there. You feel like that you've gone to visit people that you know, and you don't feel like you're going to a AOD service. They are very welcoming.*

Cultural support

Cultural space

Participants requested for a designated area on the AOD service grounds where Aboriginal people could sit and yarn and have support sessions conducted with their AOD workers. Aboriginal culture emphasizes the importance of meeting with the mob and being able to have those supports.

> *A special place for Indigenous people to meet.*
>
> *Aboriginal people need sessions outdoors to connect to country and yarn together*

Lived experiences

Participants reported that culturally tailored programs would best be supported by Elders who have lived experiences to share with them and to be surrounded by Elders who are role models of change.

> *Having Elders who support like Aunty and Uncles who can guide the women and men with lived experiences. "*
>
> *These older fellas, they've been there and done it and lived it and survived it, and they're trying to teach me, like, you know, what I'm saying, that's why I listened to them, I really my, you know, sometimes I get a bit complacent and that and you know, drift off to the end of the world, but as soon as one of them old black fellas talk, man, my ears prick up and I'm all ears, I'm listening*

Section 4. Service provider consultation

Consultation occurred with representatives from the following organisations.

Mainstream AOD providers

- Access Health, The Salvation Army, AOD Victoria
- Peninsula Health
- Star Health
- Windana
- Bolton Clarke
- Headspace
- Odyssey House/Uniting Regen
- Wellways

Aboriginal Community Controlled Organisations

- Dandenong District Aborigines Corporation Limited
- First Peoples' Health & Wellbeing
- Ngwala Willumbong
- Bunjilwarra
- Victorian Aboriginal Child Care Agency
- Victorian Aboriginal Community Controlled Health Organisation
- Victorian Aboriginal Health Service/Metro Ice Initiative
- Dardi Munwurro

Support agencies

- Area 4 pharmacotherapy support
- Department of Families Fairness and Housing - Agency Performance & System Support
- Dhelk Dja Southern
- Regional Aboriginal Justice Advisory Committee
- South Eastern Melbourne Primary Health Network
- Southern Melbourne Primary Care Partnership

Intersectoral

- Koorie Education Support
- Chisholm TAFE

Themes from service providers

- Limitation of AOD funding model. No time to build rapport
- Greatest loss of clients from referral to intake
- Importance of 'drop in' service
- Importance of including family support
- Reluctance to engage due to justice or family services risk
- Challenges of recruiting Aboriginal workers
- New models for measuring change (more stories, less spreadsheets)
- Service gaps
  - Connection to appropriate mental health services
  - Intersection with family violence and family services

Cultural support agency consultation

Consultation occurred with representatives from the following organisations:

- Nairm Marr Djambana, gathering place, Frankston
- Willum Warrain – gathering place, Hastings
- Derrimut Weelam – gathering place, Mordialloc
- Bunurong Land Council

Themes from cultural support agencies

Cultural support is a crucial part of successful service delivery

Gathering places and Bunurong Land Council keen to connect people with cultural activities

In general, prefer not to have clinical services on site

Need to slowly build trust and relationships between organisations

Evidence of effective models from academic literature

The following evidence was used by the National Drug and Alcohol Research Centre's service planning model for Aboriginal people[15] and have been incorporated into the proposed model.

Culture as treatment

A qualitative study by Berry and co-workers in 2013 of five residential drug and alcohol rehabilitation services for Aboriginal men in New South Wales examined 'culture as treatment' through different cultural activities. The research involved asking participants what cultural activities they would most like to engage in during treatment. The responses included 'time on Country, learning about culture/heritage/land, traditional art/craft and time with Elders'. Previous research has indicated that re-establishing and promoting traditional culture is an important way of restoring social and emotional wellbeing for Aboriginal Australians.

Individual counselling, while not varied in terms of the time allocation for mainstream services, should be flexibly tailored to be culturally appropriate and to include 'culture as treatment'. This means the time allocated to individual counselling, group sessions and group activities may include taking part in different cultural activities during treatment such as time on country, learning about culture/heritage/land, making traditional items, learning about or making traditional foods and medicines, traditional art/craft, traditional language classes, time with Elders and education regarding history.

When counselling an Aboriginal person, workers should be aware that the concept of family in Aboriginal culture includes immediate and extended family and should include family members in the counselling as much as possible (Williams, Nasir, Smither, & Troon, 2006). The relationship between the Aboriginal social context and patterns of AOD use means that to be effective, programs need to target individuals and their wider family and kinship group (Alati, Madden, & Morton, 1996). Not all Aboriginal clients welcome the involvement of their family in treatment. Research has shown that while some prefer to be away from family influences, others find family separation has a negative effect (Nichols, 2002). The different needs of individual clients necessitate program choices.

[15] Gomez, M., Ritter, A., Gray, D., Gilchrist, D., Harrison, K., Freeburn, B., & Wilson, S., 2014. Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool. Canberra: ACT Health. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/DASPM%20Aboriginal%20care%20and%20resource%20estimation%20FINAL%20REPORT.pdf <accessed 1/11/2021>

Return to country or community

'Return to country or community' involves returning to a place where there is an attachment. This intervention would follow-on after some initial intervention. It needs to be flexible and tailored to the needs of the individual.

This intervention involves firstly establishing connections (where they are from), then co-ordinating and preparing the "return to country or community", which includes contacting the community, making arrangements for support and ongoing care at the specific location to which the person is returning. It may also involve liaising with an Aboriginal Community Controlled Organisation and other workers in the community to which the person is returning. All this needs to be in place before a person can return to their community.

The second step involves ongoing supervision/monitoring as well as counselling and will have been co-ordinated before the person returns to their community. The final step is assertive follow-up. This involves checking on a person's stability rather than provision of treatment and needs to be done weekly for the first month.

Transport

Transport is a structural barrier for Aboriginal people accessing health services. Not all Aboriginal people have access to transport - no license, no vehicle, and/or no cash for transport (Helps & Moller, 2007). Geographical distances and lack of transport (in both urban and non-urban regions) are significant barriers to accessing drug and alcohol treatment (Gray et al., 2010).

Many Aboriginal people require supported referral (that is facilitating / helping/ensuring their attendance) due to their complex needs. Compliance with treatment attendance is enhanced if transport is available or provided (Brett et al., 2014).

A pilot study of community-based education and brief intervention in an urban Aboriginal setting (Conigrave, Freeman, Caroll, Simpson, Lee, Wade, Kiel, Ella, Becker, & Freeburn, 2012) identified transport as the most common barrier stopping participants getting help for their alcohol or drug problem.

Not every client needs transport assistance. The National Drug and Alcohol Research Centre estimate that 70% of clients will require transportation for each element of care.

Section 4. Proposed service model

Background

The proposed service model specifically relates to Aboriginal Community Controlled Organisations providing AOD services to Aboriginal people in the Bayside Peninsula Area. It builds on the existing guidelines that AOD Aboriginal Community Controlled Organisations aim to align with:

- Balit Murrup social and emotional wellbeing framework
- Victorian Department of Health Alcohol and other drug program guidelines (where they don't conflict with Balit Murrup recommendations)

The model also strongly borrows from the work of the National Drug and Alcohol Research Centre's service planning model for Aboriginal people[16].

The proposed model does not recommend that AOD Aboriginal Community Controlled Organisations provide all of the service model's services and capacity building activity themselves. In particular, some services such as cultural support and mental health counselling may be more effectively provided by external agencies.

The core components of the AOD service model are:

- Promotion of AOD services provided by Aboriginal Community Controlled Organisations (ACCOs) to the community and service providers
- Proactive discussion with Aboriginal people about accessing ACCO AOD services
- More time for yarning
- Culture as treatment
- Focus on therapeutic relationship between participants and a small and stable support team
- Active handover within the service and to external services

[16] Gomez, M., Ritter, A., Gray, D., Gilchrist, D., Harrison, K., Freeburn, B., & Wilson, S., 2014. Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool. Canberra: ACT Health. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/DASPM%20Aboriginal%20care%20and%20resource%20estimation%20FINAL%20REPORT.pdf <Accessed 1/11/2021>

Service model recommendations and suggested activities

The service model recommendations are based on services operating within the existing Bayside Peninsula Area service system. There are already existing AOD guidelines for mainstream AOD services, as well as the Balit Murrup guidance for AOD services[17] and Aboriginal cultural safety in health services[18]. The recommendations below incorporate these guidelines and allow for services to identify areas that need additional activity.

The table below identifies recommended practice for each stage of AOD service provision and suggested activities to meet the recommendations. The categories align with the Department of Health AOD Guidelines.

Category	Recommendation	Activities to meet recommendations	Responsibility
Promotion of available services	Promotion of AOD services provided by Aboriginal Community Controlled Organisations (ACCOs) to the community and service providers **Source of recommendations:** BPA AOD service user engagement - wanted more information about available services Provider consultations with Koorie Education Support Officers, TAFEs and Monash University - low awareness of AOD Aboriginal Community Controlled Organisations and how to access them	Provide information to organisations that support Aboriginal people. Follow up visits at team meetings and social occasions. • Mainstream AOD services • TAFE, university, schools • Gathering places • General practices • Other support services – mental health, family violence, housing • Justice	AOD ACCOs BPA AOD catchment planner

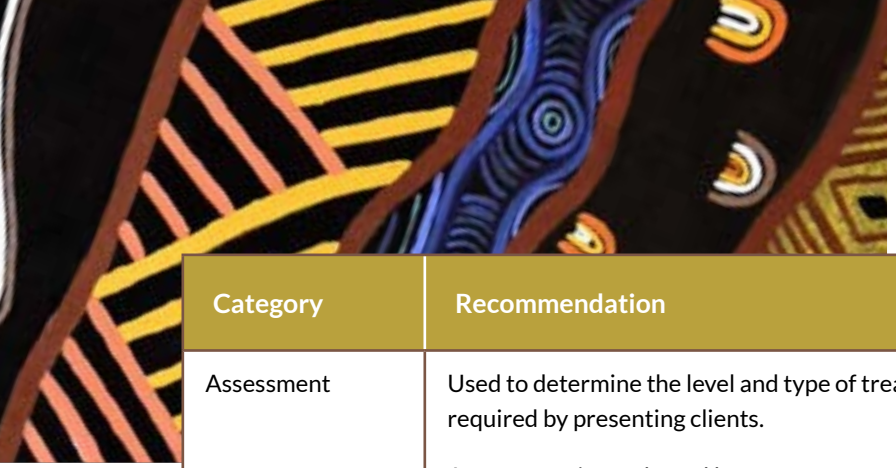
[17] Department of Health and Human Services. Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027. Melbourne: State Government of Victoria; October 2017. https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027 <accessed 22/2/2022>

[18] Department of Health, Victoria. Aboriginal cultural safety fixed grant guidelines Cultural safety planning and reporting 2021-22

Category	Recommendation	Activities to meet recommendations	Responsibility
Culturally responsive service	Specialist mental health services (including AOD services) are culturally responsive and supported by cultural safety frameworks with professional development that supports the use of trauma-informed social and emotional wellbeing models in their treatment of Aboriginal clients (Balit Murrup[7]) Utilise the Aboriginal governance and accountability framework structures and other engagement and co-design processes to enable Aboriginal mental health consumers, families and organisations to inform local, statewide and regional mental health programs, policy and planning (Balit Murrup[7]) BPA AOD service user engagement. **Service should:** • Be free of racism • Support ongoing contact with the same worker **Preference for:** • Aboriginal staff • Consistent worker • Access to culture	Recommendations from Network of Alcohol and Other Drug Agencies (NADA)[19] • Provide training and support in working with transgenerational trauma. • Attend local events such as Sorry Day, NAIDOC, community BBQs • Incorporate community engagement and consultation items on staff meeting agendas and internal communication • Ensure the agency is represented at Aboriginal network or interagency meetings regularly. • Provide training in local history and culture • Provide regular in person communication to community groups about what your organisation is doing • Recommendations from BPA Gathering Places: • Maintain regular connection through open days and shared activities	AOD ACCOs

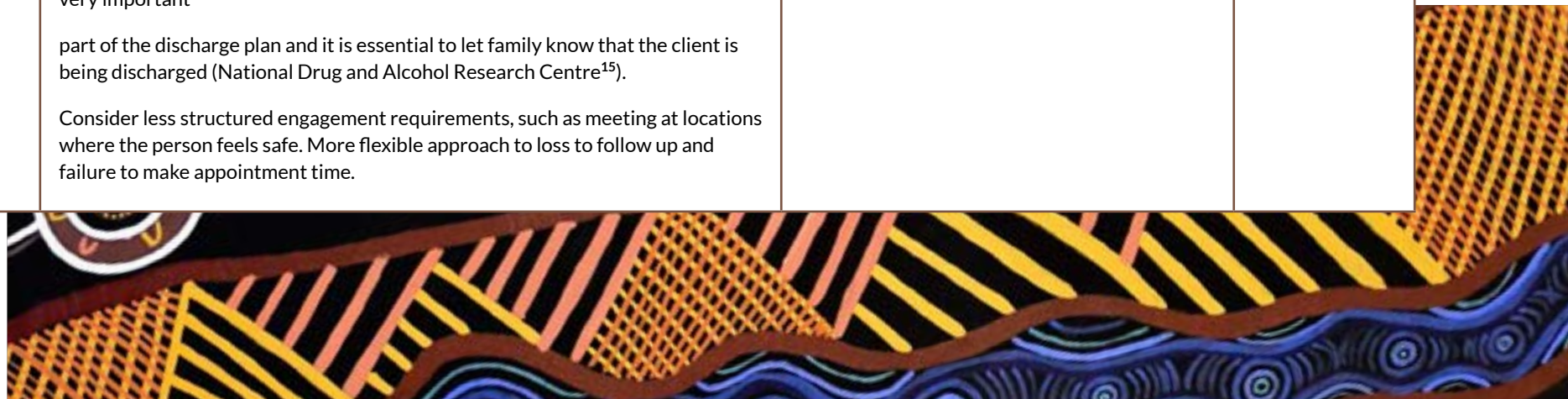
[19] Raechel Wallace and Julaine Allan (2019). NADA Practice Resource: Alcohol & other Drugs Treatment Guidelines for Working with Aboriginal & Torres Strait Islander People in a Non-Aboriginal Setting. Sydney: Network of Alcohol and other Drugs Agencies. <Accessed 22/2/2022>. https://nada.org.au/wp-content/uploads/2021/01/NADA-Aboriginal-Guidelines-Web-2.pdf >

Category	Recommendation	Activities to meet recommendations	Responsibility
Referral in	Self referrals and direct referrals from any agency, including DirectLine, catchment-based intake and Community Offenders Advice and Treatment Services (Department of Health AOD program guidelines[8])	Ensure clear referral pathway for all referrals. Implement electronic system for confidentially receiving and monitoring referrals. No wrong door approach.	AOD ACCO
Screening and brief intervention	• Provide brief interventions in the form of education and advice that aims to achieve a short-term reduction in harm associated with AOD use. • Provide bridging support in the form of regular contact which aims to support client engagement, retention, motivation and stability while clients wait for assessment and treatment. (Department of Health AOD program guidelines[8]) Greater time is required for Aboriginal service users as this first intervention should be seen as a pathway into treatment. More time is also consistent with the complex needs and with the potential need to engage family and kinship members in the process. Brief interventions require the establishment of some level of rapport, it takes time to develop rapport and trust, and this process involves listening to the individual's issues and story as the client wants to tell it. (National Drug and Alcohol Research Centre model[15])	Recommended time allocations (National Drug and Alcohol Research Centre15) • 3 x 30 min screening and brief intervention • 1 x 30 min consultation with primary carer or other family member • 4 x 15 min referral by phone Use screening tools that are suitable for Aboriginal people, including: • Indigenous Risk Impact Screen (IRIS) • AUDIT C • standard drinks charts • Kessler 5 • GEM Implement these tools into client record systems and train staff in their use	



Category	Recommendation	Activities to meet recommendations	Responsibility
Assessment	Used to determine the level and type of treatment and support required by presenting clients. Assessment is conducted by treatment providers to enable therapeutic treatment relationships to begin at the point of assessment. Where possible, the assessment should be conducted by a clinician who is appropriate for the client's ongoing treatment to reduce 'extra steps' in a client's treatment journey and reduce having to retell story/ rebuild rapport/relationship etc and to recognise the importance of relationship and trust. Assessments, combined with clinical judgement is used to identify and respond to a client's treatment and support needs. This work should occur with the support of clinical supervision. (Department of Health AOD program guidelines[8])	Where possible, the assessment should be conducted by a worker who is appropriate for the client's ongoing treatment to reduce 'extra steps' in a client's treatment journey. Use of validated assessment tool appropriate for Aboriginal people. • Average allocation of 3.5 hours for assessment 2 x 75 min assessment • 2 x 30 min case conference Total 3.5 hours (without care coordination) (National Drug and Alcohol Research Centre[15])	

Category	Recommendation	Activities to meet recommendations	Responsibility
Care and recovery coordination Case management and support	Care and recovery coordination seeks to support integrated treatment and care pathways for the highest-need clients within AOD treatment services, who require a coordinated care response by, at a minimum: • coordinating treatment planning and care in accordance with recovery goals • supporting clients' access to other health, human and support services • supporting meaningful involvement by the client and their family in care coordination and goal setting to maximise opportunities for meaningful social and economic participation. • deliver care coordination throughout a client's AOD treatment pathway, and post-exit for up to 12 months from commencement of treatment. • create and sustain strong interagency connections and more integrated service responses to meet the holistic needs of clients. • use peer support • coordinate homeless-specific service responses (Department of Health AOD program guidelines[8]) For Aboriginal and Torres Strait Islander clients there is a need for case coordination across and between multiple services due to the complex needs of clients. More coordination time required, case conferencing, case management time is required due to complex presentations and the need for family involvement. Discharge planning should involve supported referral for Aboriginal clients and more time on transfer of care. Engagement with family is a very important part of the discharge plan and it is essential to let family know that the client is being discharged (National Drug and Alcohol Research Centre[15]). Consider less structured engagement requirements, such as meeting at locations where the person feels safe. More flexible approach to loss to follow up and failure to make appointment time.	Average of 20 hours per client • Investigate options for Peer support • Encourage family and supporter engagement • Strong focus on supported referrals and removal of barriers such as transport and co-payments. • Longer discharge meeting	



Category	Recommendation	Activities to meet recommendations	Responsibility
Assertive follow up	Ongoing assertive follow-up should occur for every client monthly after treatment has concluded. Given the importance of keeping the rapport that has been built with Aboriginal clients, face-to-face appointments (outreach visits) are recommended. This could also involve communicating with the family (rather than the client) and providing them with support. Assertive follow-up should commence immediately after treatment is finished. 12 sessions have been suggested to cover a tapered schedule – where it may be weekly for the first month, then moving to monthly thereafter. Importantly, this clinical time allocation can be flexibly deployed: in some cases, it may involve telephone contact with the client, in others contact with family members. In some cases it is a face-to-face outreach support opportunity, in others a more formal counselling session (National Drug and Alcohol Research Centre[15]).	12 sessions of assertive follow-up after engagement with the AOD Aboriginal Community Controlled Organisations or other AOD treatment service	AOD ACCO

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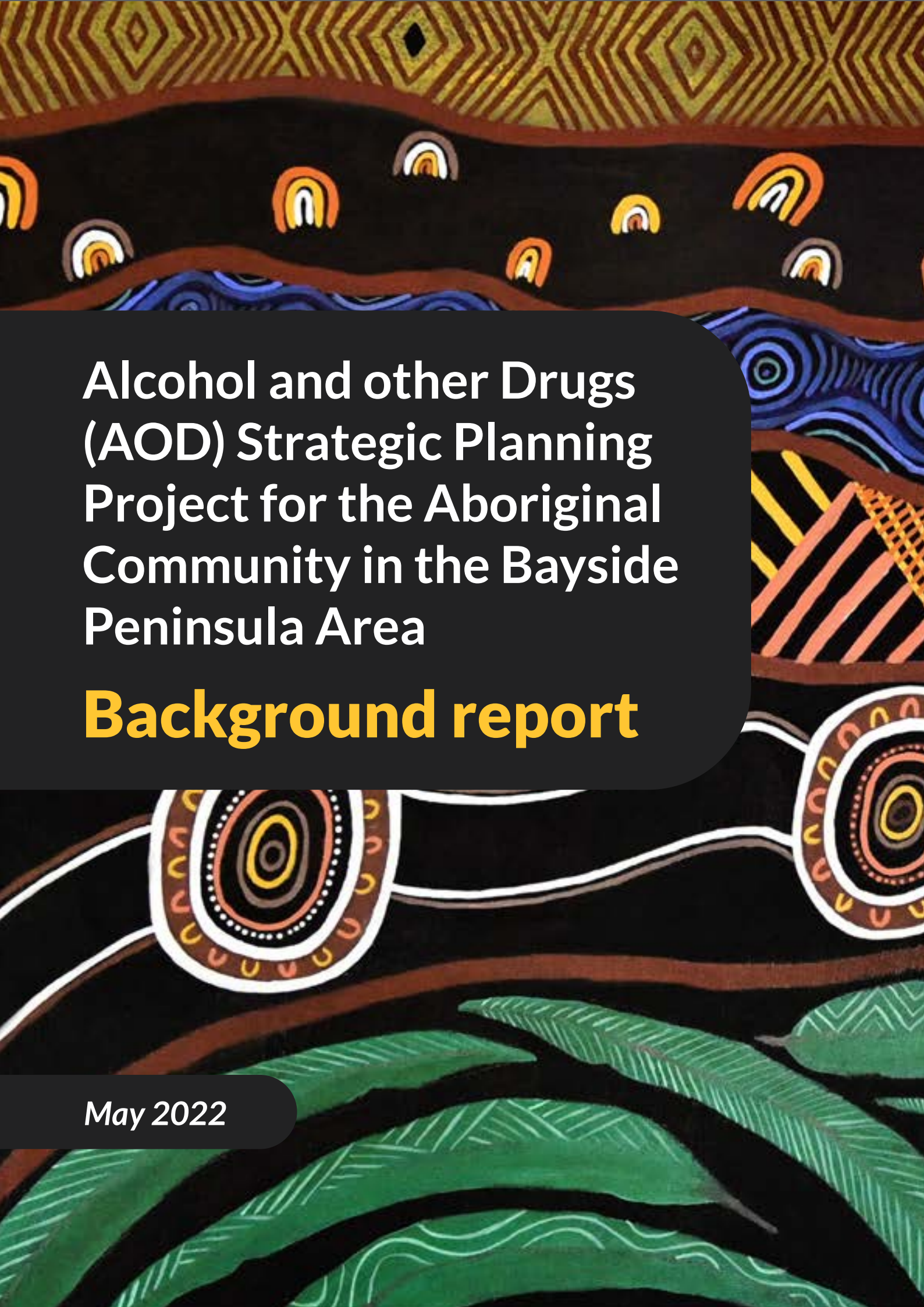


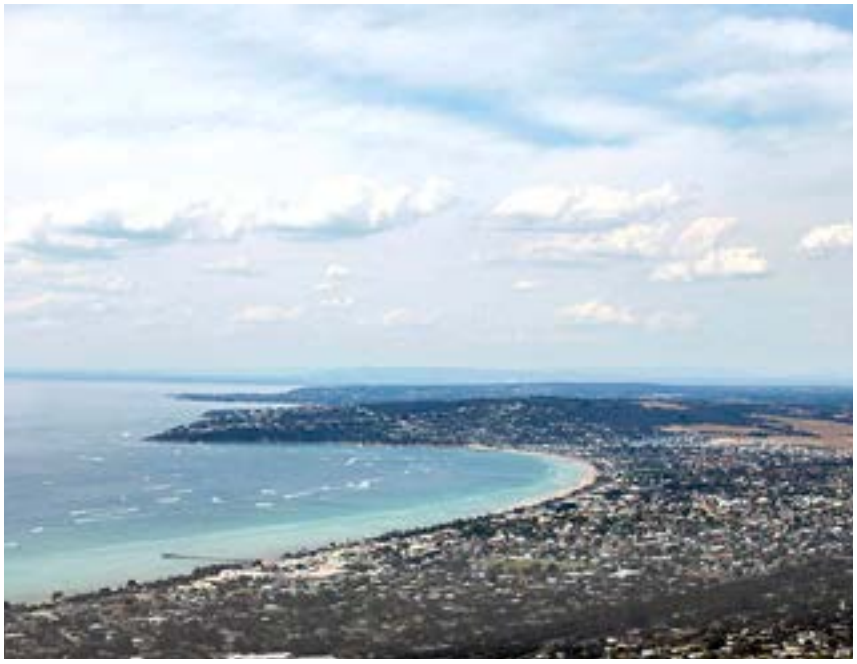
Alcohol and other Drugs (AOD) Strategic Planning Project for the Aboriginal Community in the Bayside Peninsula Area

Background report

May 2022

Background report

Background information that guided the development of the service model



Terminology

We acknowledge the diverse and distinct cultures of Aboriginal people and Torres Strait Islanders. This report is intended for both Aboriginal people and Torres Strait Islanders living in Victoria or accessing Victorian AOD services. In this report, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koorie' is retained when part of a program name or quotation.

MelbournePrimaryHealth

Prepared by Nick Jones
Melbourne Primary Health

Contents

Executive summary

Project background

Objective

The Alcohol and other Drugs (AOD) Strategic Planning Project for the Aboriginal Community in the Bayside Peninsula was tasked by the Victorian Department of Families, Fairness and Housing to recommend a service model for the delivery of AOD services to Aboriginal people in the Bayside Peninsula Area.

Deliverables

- A needs analysis of the Aboriginal and Torres Strait Islander community in relation to alcohol and other drugs service demand (including consultation with stakeholders) that includes:
    - Prevalence of alcohol and other drug use amongst Aboriginal and Torres Strait Islander people across the Bayside Peninsula Area
    - Existing and emerging social determinants impacting alcohol and other drug use amongst Aboriginal and Torres Strait Islander people across the Bayside Peninsula Area
    - Current demand and alcohol and other drugs service utilisation amongst Aboriginal and Torres Strait Islander people across the Bayside Peninsula Area
    - Current funding of Aboriginal and Torres Strait Islander specific alcohol and other drug services across the Bayside Peninsula Area
    - Identify existing culturally appropriate evidence-based frameworks for delivery of Aboriginal -specific alcohol and other drugs services
    - Identify gaps in available alcohol and other drugs programs and services appropriate to respond to the needs of Aboriginal and Torres Strait Islander people, families and communities across the Bayside Peninsula Area
    - Organisational and workforce development needs amongst Community Controlled organisations and alcohol and other drugs services
- Development of an evidence based contemporary alcohol and other drugs strategy and service model for the Bayside Peninsula Area Aboriginal community that identifies a full range of culturally responsive and appropriate programs, including prevention and interventions.
- Capacity building for Aboriginal Controlled Community Organisations to support the implementation of the model and service response across Bayside Peninsula Area including clinical supervision support.

Team

The project was funded by DFFH and overseen by the Frankston Mornington Peninsula Primary Care Partnership, with project coordination and data analysis provided by Nick Jones of Melbourne Primary Health.

Eddie Moore from Nyuka Wara conducted the interviews.

Thematic analysis of the interviews was done by Eddie Moore and Dr Ginny Monteiro.

Nyuka Wara consulting.

Overview

What is the challenge?

In the Bayside Peninsula Area, despite Aboriginal people accessing drug and alcohol services (AOD) at 10 times the rate of the general community, only a small number of Aboriginal people are accessing drug and alcohol services that incorporate best practice support for Aboriginal people.

How many people are impacted?

The Bayside Peninsula Area (based on DFFH boundaries) has the:

- largest number of Aboriginal people in Victoria (5,977 people in 2020)[1]
- highest projected number of Aboriginal people in Victoria by 2028 (8,324 people)[2]
- highest estimated number of Aboriginal people with risky AOD usage (594 people)[2]
- highest estimated number of Aboriginal people accessing AOD services (291 people)[2]

What is the imbalance?

Negative impact of social determinants of health

- Negative social determinants of health are correlated with higher risky AOD usage[3,4],
- All Aboriginal communities are impacted more negatively by social determinants of health than the mainstream community
- Aboriginal people in the Frankston and Mornington Peninsula LGAs and the suburb of St Kilda have the highest negative social determinants of health in the catchment[5]

Most AOD services for Aboriginal people are being provided by mainstream services[6]

- Based on the activity data of state funded AOD services :
  - 17 of 253 (7%) individual Aboriginal people were supported by Aboriginal Community Controlled Organisations

AOD services for Aboriginal people are not evenly distributed

- The only Aboriginal Community Controlled Organisation providing state-funded AOD services, Ngwala Willumbong, is a 50 minute drive from the area with the largest need for AOD services (Frankston) and a 1.5 hour drive from the area with the fourth highest need (Hastings)

[1]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

[2]SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria https://www.parliament.vic.gov.au/images/stories/committees/paec/COVID-19_Inquiry/Submissions/76b._Aboriginal_Executive_Council_AEC.pdf

[3]Commonwealth of Australia. National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017-2023. Canberra: Department of the Prime Minister and Cabinet; February 2017.

[4]Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW; 2015

[5]Intergovernmental Committee on Drugs. National Aboriginal and Torres Strait Islander peoples' drug strategy 2014 - 2019. A sub-strategy of the National Drug Strategy 2010 - 2015. Canberra: Commonwealth of Australia

[6]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Proposed service model

The proposed service model builds on the existing guidelines that AOD Aboriginal Community Controlled Organisations already aim to align with:

- Balit Murrup social and emotional wellbeing framework[7]
- Victorian Department of Health Alcohol and other drug program guidelines[8] (where they don't conflict with Balit Murrup recommendations)

The core components of the AOD service model are

- More time for yarning
- Culture as treatment
- Focus on therapeutic relationship between participants and a small support team
- Active handover within the service and to external services
- Increase awareness and access to services

Out of scope

Changes that are needed but are outside the narrow scope of this AOD treatment services project include improved access to social and health supports for Aboriginal people.

[7]Department of Health and Human Services. Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027. Melbourne: State Government of Victoria; October 2017.

[8]Department of Health. Alcohol and Other Drug Program Guidelines. https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines

Background information that guided the development of the service model

This document provides additional background information that was used to develop the service model. It should be read in conjunction with the full project report, which is available **here**.

Geographical statistics

2016 Census of Population and Housing

Data was drawn from the 2016 Census of Population and Housing using the Australian Bureau of Statistics Table Builder. Cells in this dataset have been randomly adjusted to minimise the risk of identifying individuals. While these adjustments have a negligible impact on the underlying statistical patterns, true values of cells can change by a small amount. Total values included in the ABS data reported hereafter have been drawn directly from the ABS data to minimise the cumulative error that may be introduced by summing the values of individual cells.

Accuracy of Census data

According to a 2019 review of Victorian Aboriginal health data by Social Ventures Australia[9], Census of Aboriginal people and population forecasts are usually inaccurate.

25% of the increase in the Aboriginal population in Victoria between the last two Censuses was not explainable by births, deaths or migration. One reason given for this is an increase in people identifying as Aboriginal.

The ABS estimates that 15.8% of Aboriginal people in Victoria were not counted in the 2016 Census. Independent research conducted in Shepparton identified a Census undercount rate of up to 28%[10].

Statistical areas used in this report

Statistical Areas Level 1 (SA1)

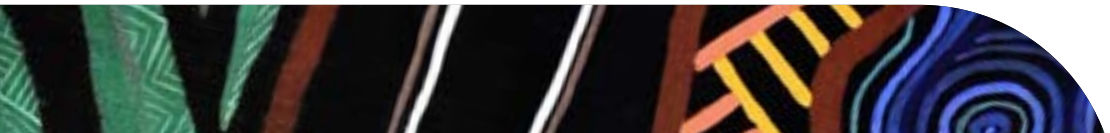
SA1s have an average population of approximately 400 people. This optimises the balance between local detail and the ability to cross classify Census variables without the resulting counts becoming too small for use.

Statistical Areas Level 2 (SA2)

SA2s reflect functional areas that represent a community that interacts together socially and economically. They consider Suburb and Locality boundaries to improve the geographic coding of data to these areas and in major urban areas SA2s often reflect one or more related suburbs. SA2s have an average population of about 10,000 people. SA2s are aggregations of whole SA1s.

[9]Demand for services for Aboriginal and Torres Strait Island people in Victoria. Report prepared for the Aboriginal Executive Council. Accessed 14/12/2021 <https://www.parliament.vic.gov.au/images/stories/committees/rrc/disadvantage_and_inequality/submissions/036_20100331_GreaterShepparton.pdf>

[10]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder



Indigenous Locations (ILOCs)

ILOCs represent small Aboriginal and Torres Strait Islander communities (urban and rural) with a minimum population of 90 Aboriginal and Torres Strait Islander usual residents. An ILOC is an area designed to allow the release of statistics relating to Aboriginal and Torres Strait Islander people with a high level of spatial accuracy whilst maintaining the confidentiality of individuals. ILOCs are aggregates of one or more SA1s.

Indigenous Areas (IAREs)

Medium sized geographical units to facilitate the reporting of data relating to the Aboriginal and Torres Strait Islander population. They combine one or more Indigenous Location (ILOC). There are 430 IAREs in Australia.

The BPA region includes 4 IAREs (See Table 1 below):

- Melbourne – Port Philip
- Melbourne – East
- Frankston
- Mornington Peninsula

IAREs are used as a trade-off between good spatial resolution and population size.

They are particularly useful as they are the smallest published level for Indigenous Relative Socioeconomic Outcomes (IRSEO).

IARE	LGA
Melbourne – Port Phillip	Port Philip (Melbourne) (Yarra)
Melbourne - East	Stonnington Glen Eira Bayside (Boroondara)
Frankston	Kingston Frankston
Mornington Peninsula	Mornington Peninsula

Source: Public Health Information Development Unit[11]

Non-ABS Structures

The Non-ABS Structures comprise eight regions which are not defined or maintained by the ABS, but for which the ABS is committed to providing a range of statistics. They generally represent administrative regions and are approximated by Mesh Blocks, SA1s or SA2s. They are:

Local Government Areas (LGAs)

- Local Government Areas cover incorporated areas of Australia. Incorporated areas are legally designated parts of a State or Territory over which incorporated local governing bodies have responsibility.
- They vary significantly in geographical size and population density.
- These approximated boundaries are constructed from allocations of one or more whole Mesh Blocks.

Postal Areas (POAs)

- An ABS approximation of postcodes

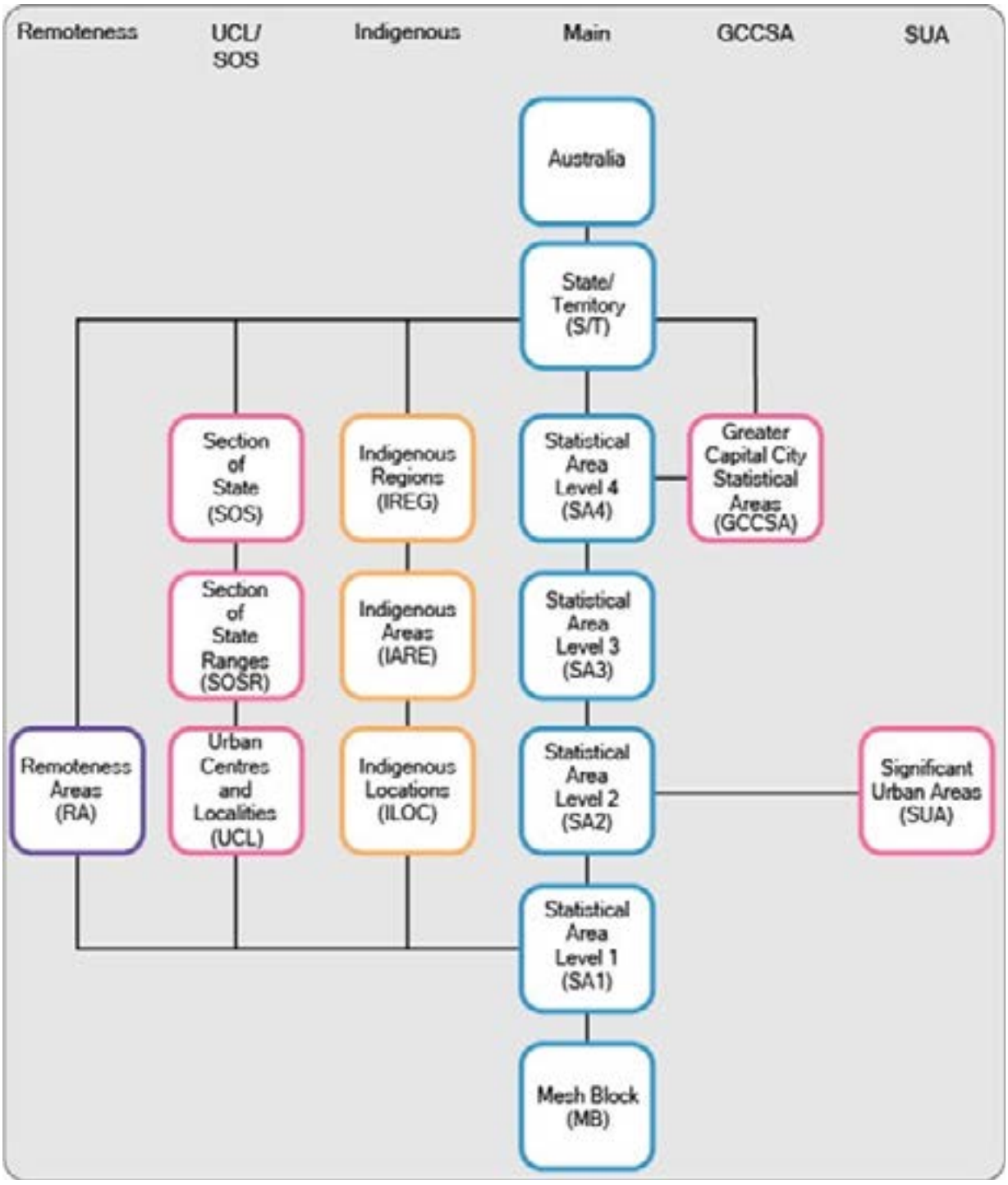
State Suburbs (SSCs)

- An ABS approximation of gazetted localities

[11] Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Statistical areas summary

Figure 1: Statistical areas summary



Source: Australian Bureau of Statistics[12].

[12]Australian Statistical Geography Standard (ASGS) Edition 3. Accessed 14/12/2021 <https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026>

Section 1. Service demand

1.1 Bayside Peninsula Area demographic profile

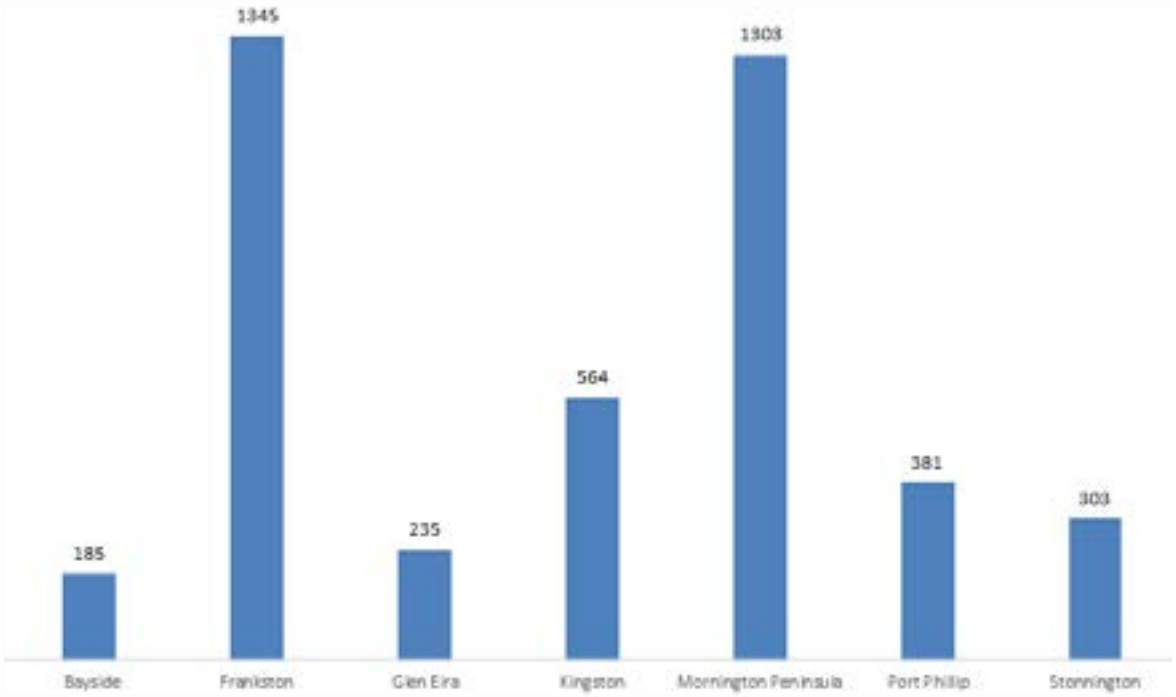
The Bayside Peninsula Area (BPA) includes the local government areas of Frankston, Kingston, Bayside, Stonnington, Glen Eira and Port Phillip, and the Mornington Peninsula.

Despite only comprising 16% of the total population, Aboriginal people in the Frankston and Mornington Peninsula Local Government Areas comprise 61% of the BPA Aboriginal population.

Although St Kilda, which is inside the LGA of Port Phillip has a significant Aboriginal and Torres Strait Islander population, it is still smaller than most suburbs in the Frankston and Mornington Peninsula area.

Even at the SA1 level there are more Aboriginal people living in the population centres in the Frankston and Mornington Peninsula area. However, it is possible that Aboriginal people living in St Kilda were not accurately counted in the 2016 Census .

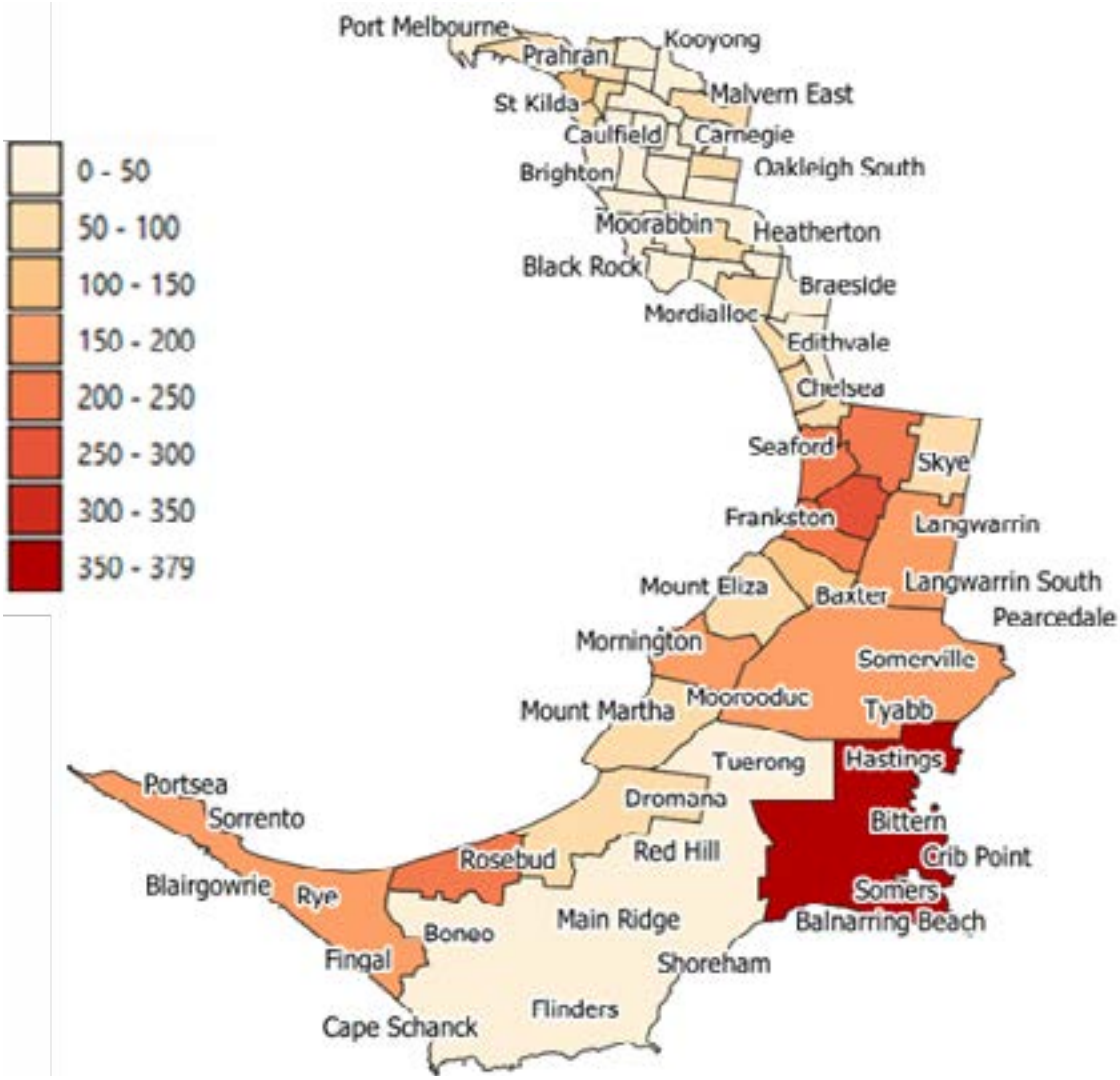
Figure 2: Number of Aboriginal people by LGA 2016



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[13].

[13] Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

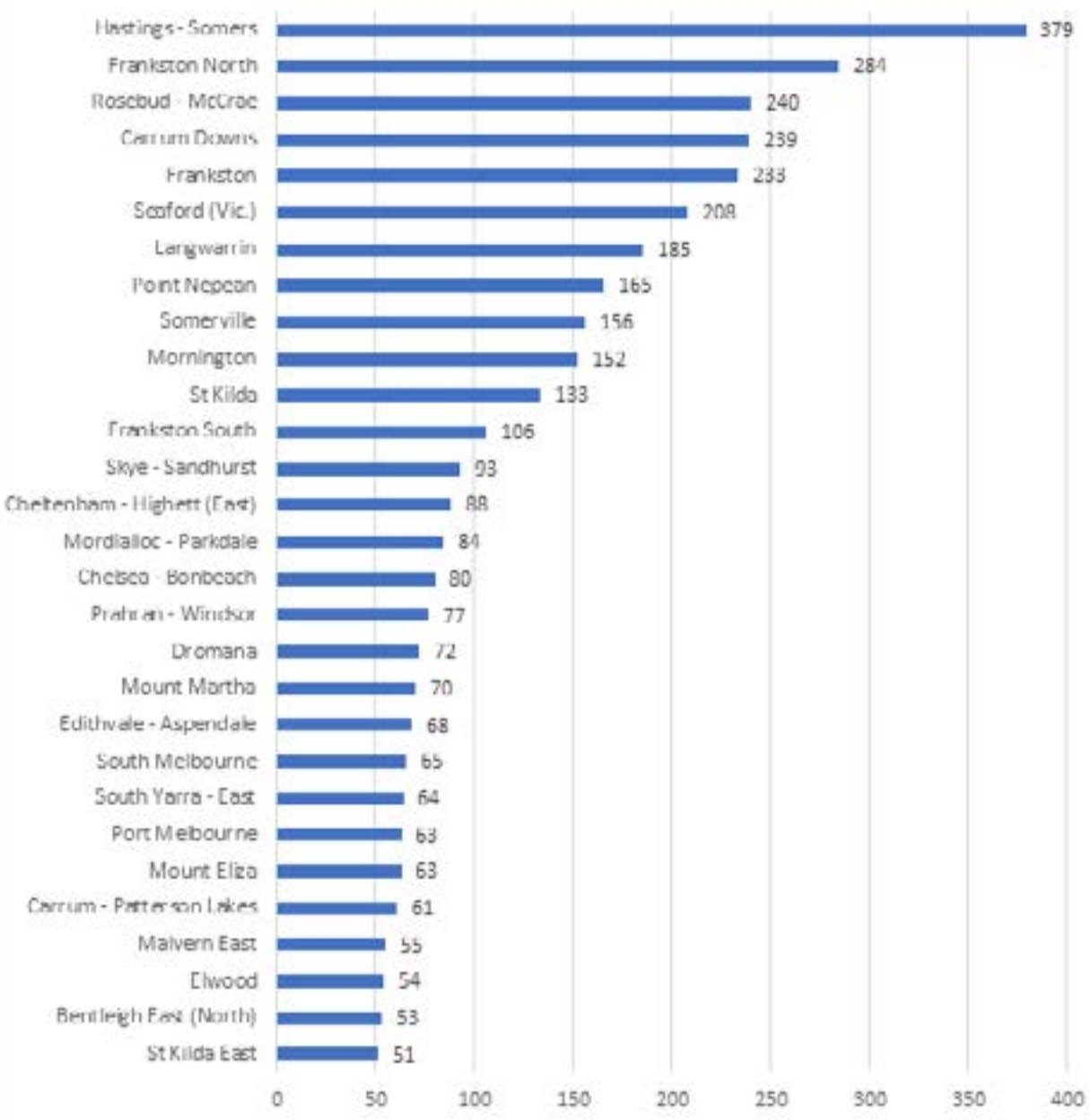
Figure 3: Number of Aboriginal and Torres Strait Islander People in SA2 areas



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[14].

[14]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

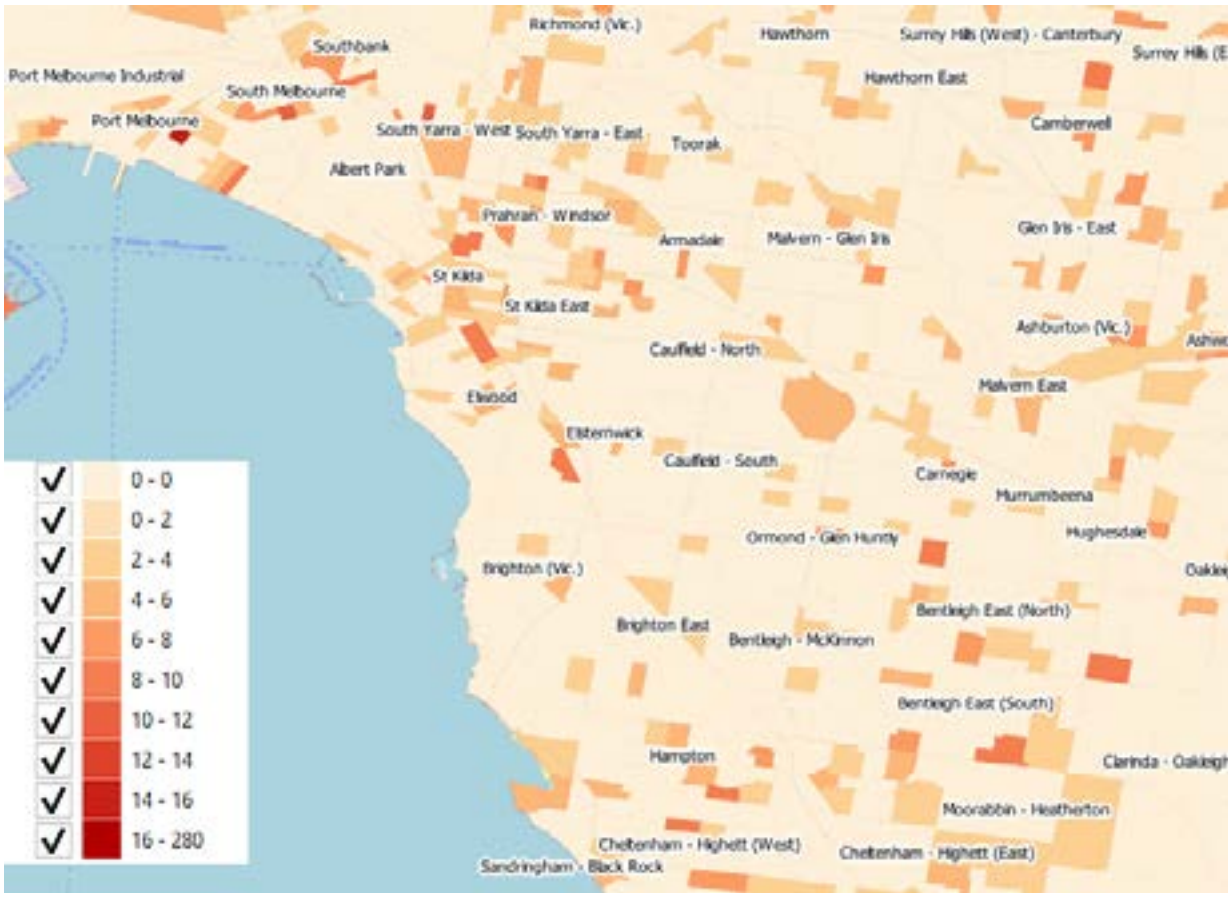
Figure 4: SA2 areas with 50 or more Aboriginal or Torres Strait Islander people - 2016 Census



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[15].

[15]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

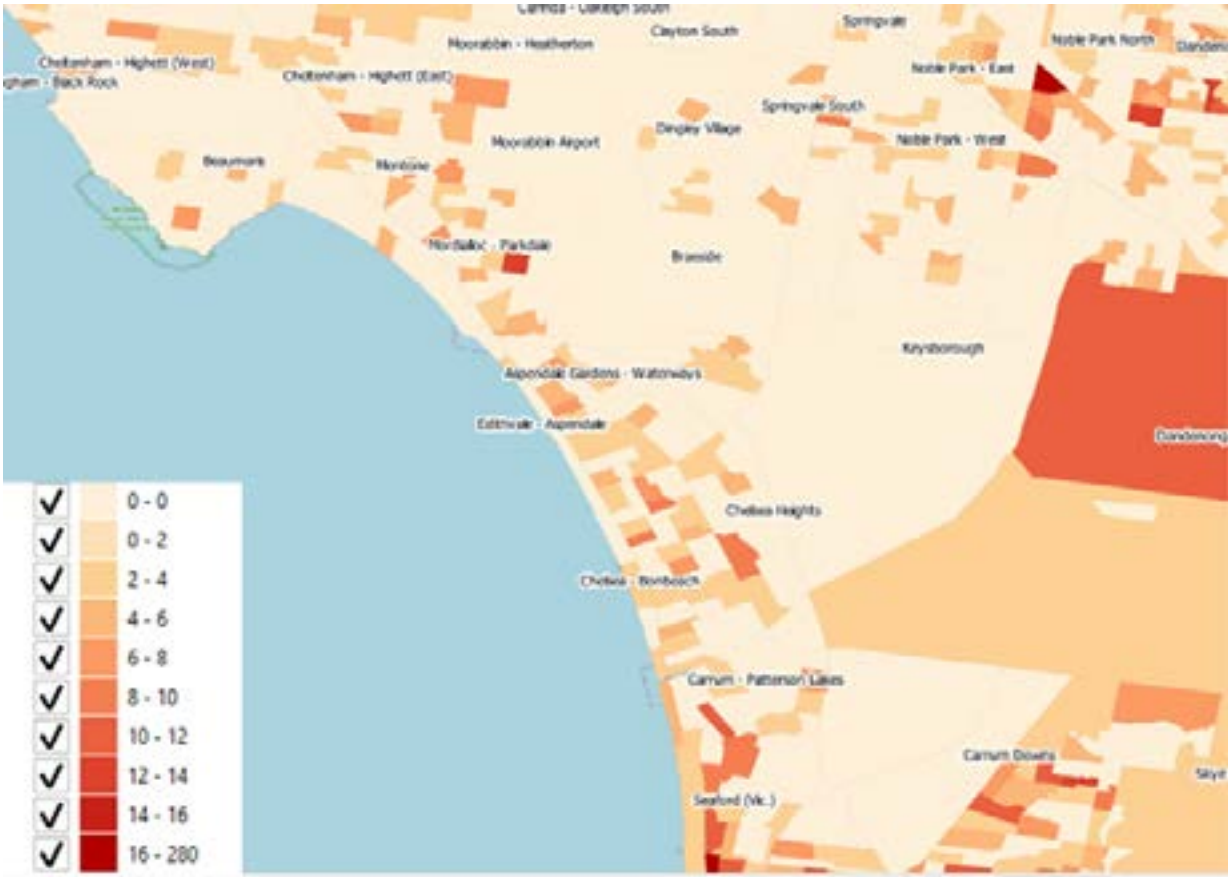
Figure 5: SA1 Number of Aboriginal people BPA catchment (Cheltenham to Port Melbourne)[16]



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[17].

[16]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

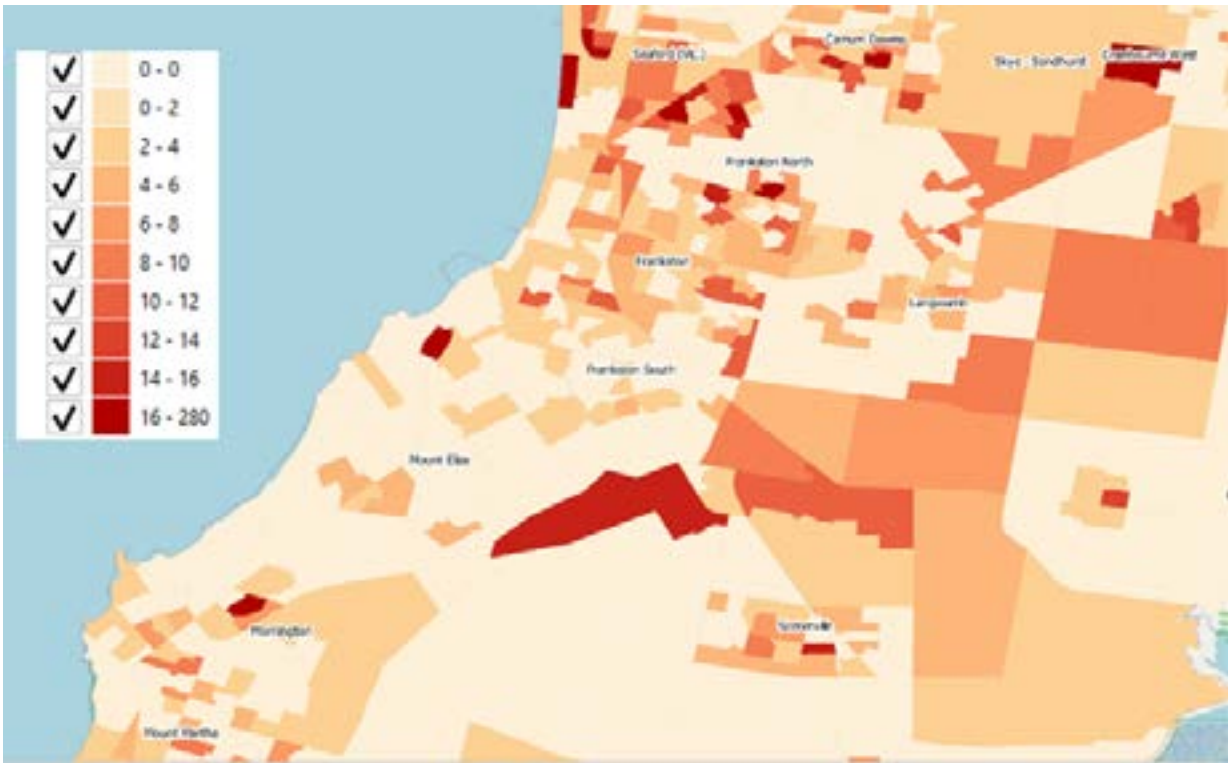
Figure 6: SA1 Number of Aboriginal people BPA catchment (Seaford to Cheltenham)



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[18].

[18]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

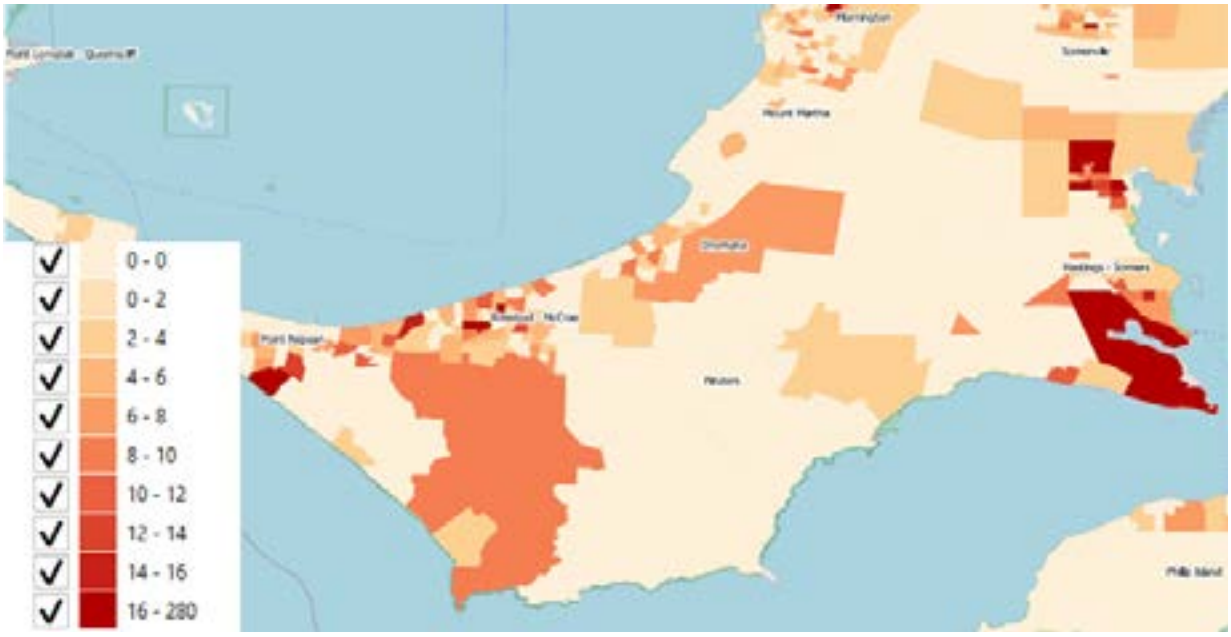
Figure 7: SA1 Number of Aboriginal people BPA catchment (Mount Martha to Seaford)



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[19].

[19]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Figure 8: SA1 Number of Aboriginal people BPA catchment (Portsea to Mornington)

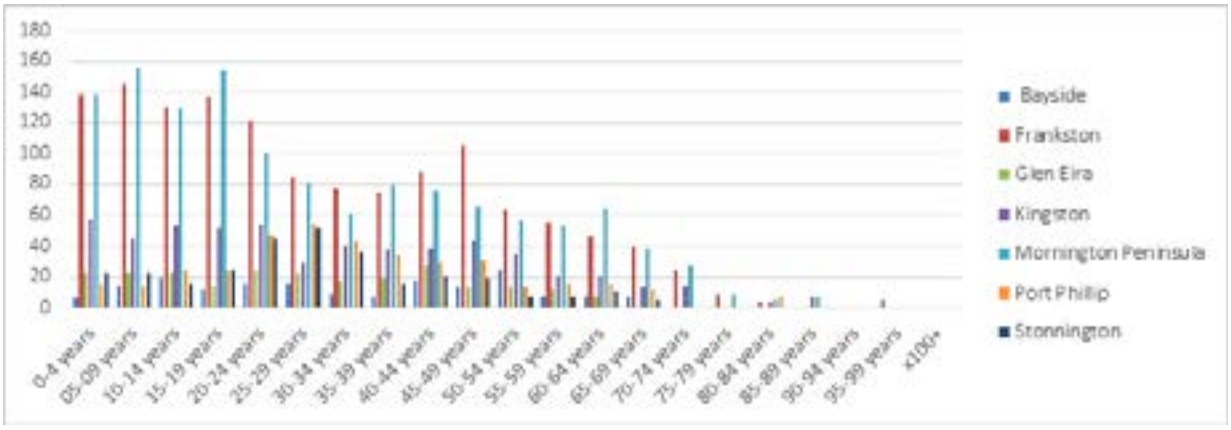


Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[20].

[20]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Age

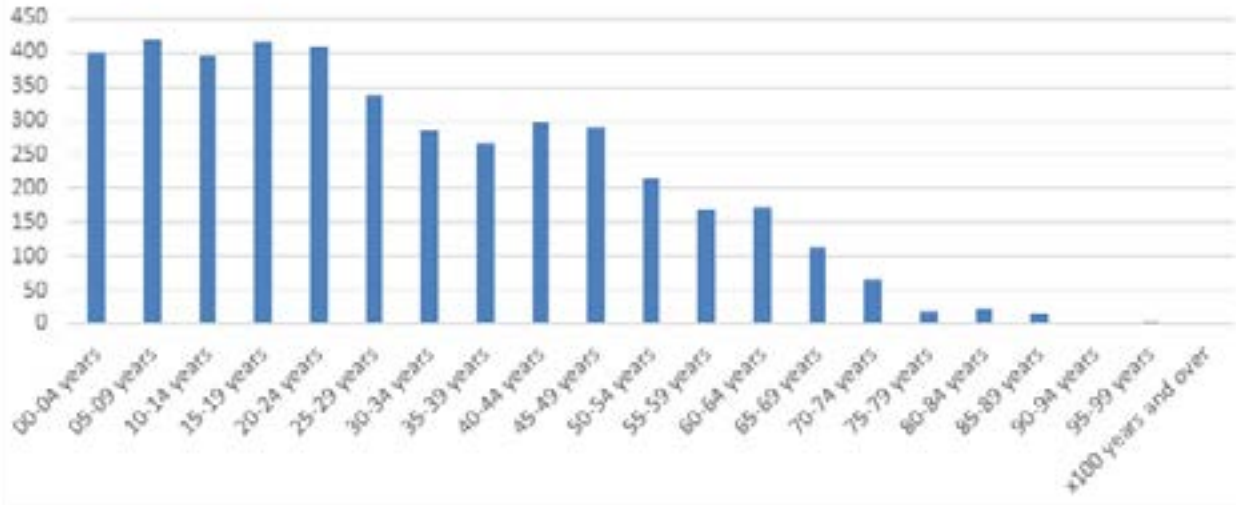
Figure 9: Aboriginal people by age and LGA



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[21].

The largest number of Aboriginal people in the region are aged 0-24 years.
Frankston and Mornington Peninsula area have significantly more people across all aged groups up to 79 years.
The distribution across the LGAs from age 25-65 years is relatively constant.
After 79 years the number of Aboriginal people is very small.

Figure 10: Aboriginal people by age, all LGAs

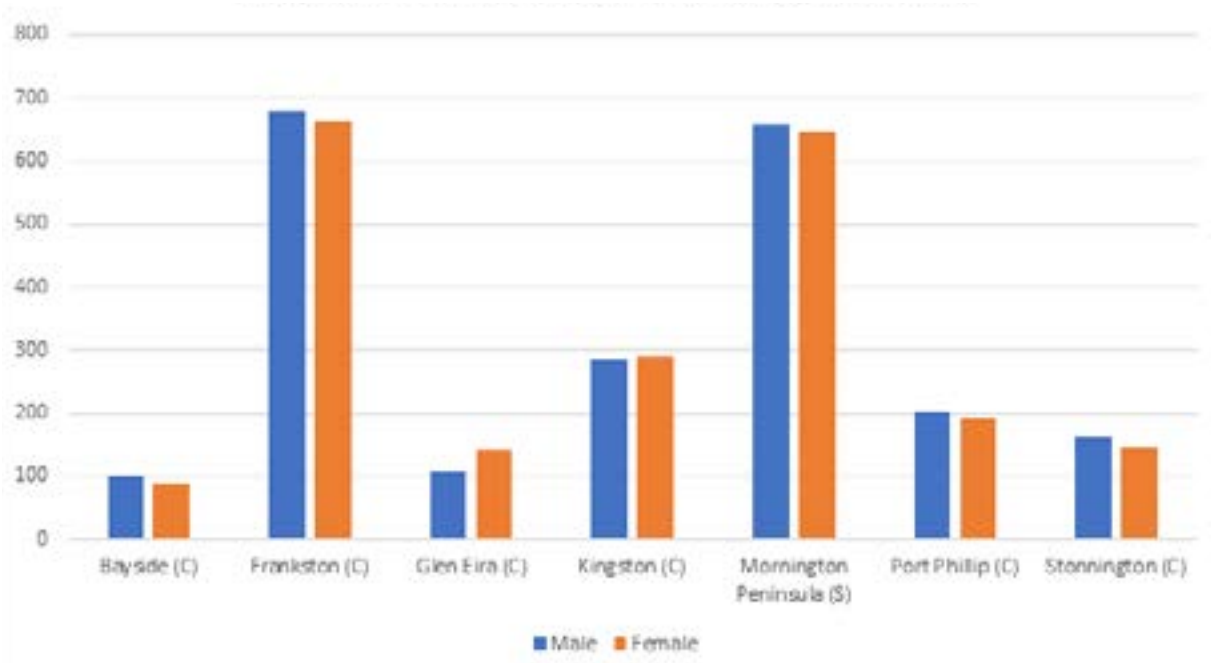


Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[21].

[21]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Gender

Figure 11: Aboriginal status and gender by LGA



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[22].

The proportion of male and female Aboriginal people is similar across the LGAs.

[20]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

1.2 Social determinants of health

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing[23] identifies the Social Determinants of Health as a key dimension of social and emotional wellbeing that must be addressed to adequately respond to the health and wellbeing needs of Aboriginal and Torres Strait Islander People.

The Social Determinants of Health encompass socioeconomic status, education, employment, housing, racism and social inclusion or exclusion. Examples of factors that protect and enable the Social Determinants of Health are identified in the Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework and include:

- enhancing opportunities to access education
- access to community resources (e.g. housing, welfare, family and children's services)
- enabling achievement in education and employment
- ensuring continuity in service support

The Social Determinants of Health can be estimated by indicators that reflect an individual's own personal situation - such as their income, education, employment, levels of social support and social inclusion, early life experiences, housing conditions, transportation and access to health services; or their external natural environment - such as the levels of air pollution and hazardous materials they are exposed to in the areas they live in (AIHW)[24]. Most of these social determinants are closely related; for example, higher levels of education usually lead to better employment prospects and higher incomes, and that leads to healthier housing conditions.

The higher level of disease (including harmful AOD use) that is seen among Aboriginal and Torres Strait Islander people is linked to deep and entrenched disadvantage, social exclusion and the high rate of exposure to life stressors such as racism, that many Aboriginal individuals and populations face . The higher degree of AOD use seen amongst this population has also been identified as a key contributor to the social gradient in health and to exacerbating health inequalities[26].

There is not consensus about which specific indicators should be used to measure the Social Determinants of Health for mainstream or Aboriginal communities. For this analysis, we focus on indicators that are included in the Aboriginal and Torres Strait Islander Social Health Atlas of Australia.

[23]Commonwealth of Australia. National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017-2023. Canberra: Department of the Prime Minister and Cabinet; February 2017.
[24]Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW; 2015
[25]Intergovernmental Committee on Drugs. National Aboriginal and Torres Strait Islander peoples' drug strategy 2014 - 2019. A sub-strategy of the National Drug Strategy 2010 - 2015. Canberra: Commonwealth of Australia
[26]Wilkinson R, Marmot M, editors. Social determinants of health: the solid facts. 2nd ed. Copenhagen: World Health Organization, Regional Office for Europe; 2003

Indigenous Relative Socioeconomic Outcomes index (IRSEO)

The Indigenous Relative Socioeconomic Outcomes index (IRSEO) was created by the Centre for Aboriginal Economic Policy Research (CAEPR). The main difference between the IRSEO index and the SEIFA published by the ABS is that it was calculated separately for the Aboriginal population in each Indigenous Region in Australia, as well as each Indigenous Area. It uses a reduced set of nine socio-economic outcomes of the usual resident population of an area. These are:

- Population 15 years and over employed
- Population 15 years and over employed as a manager or professional
- Population 15 years and over employed full-time in the private sector
- Population 15 years and over who have completed Year 12
- Population 15 years and over who have completed a qualification
- Population 15 to 24 years old attending an educational institution
- Population 15 years and over with an individual income above half the Australian median
- Population who live in a house that is owned or being purchased
- Population who live in a house with at least one bedroom per usual resident

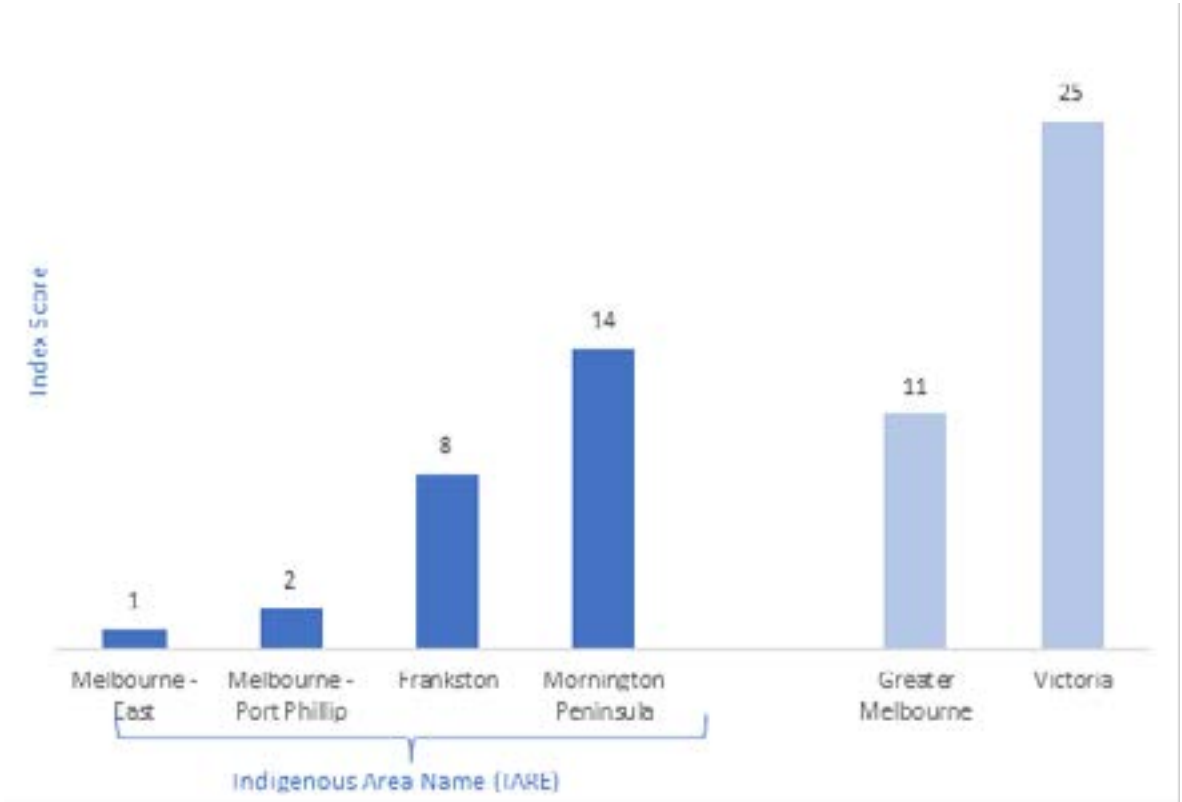
The IRSEO does not incorporate outcomes that measure health, language or other cultural factors. It is also important to note that it focuses mainly on outcome measurement in the adult population. Nonetheless, it offers a comparable measurement of relative social advantage or disadvantage at the IARE level, with each IARE being assigned a national percentile rank, resulting in a measurement scale of 1 (the most advantaged areas) to 100 (the most disadvantaged areas)[27, 28].

Although it is useful to compare between Aboriginal Areas, there is not an exact alignment with the BPA catchment. The 2 Melbourne Aboriginal areas also include a large number of suburbs outside BPA.

[27]Biddle. N and Markham. F. Area Level Socioeconomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016. Area Level Socioecononomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016 - Austaxpolicy: The Tax and Transfer Policy Blog

[28]Biddle. N. CAEPR Indigenous Population Project 2011 Census Papers. CAEPR Indigenous Population Project 2011 Census Papers (core.ac.uk)

Figure 12: Indigenous Relative Socioeconomic Outcomes Percentile by Indigenous Area (IARE), 2016[29]



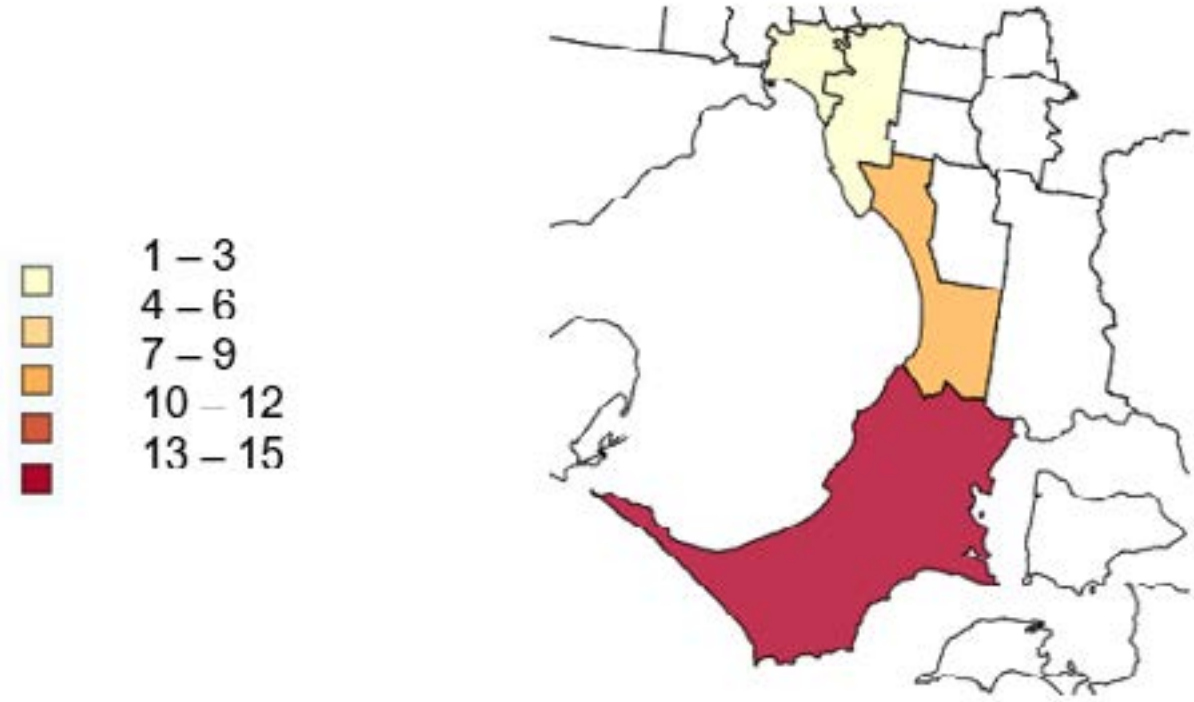
Source: Public Health Information Development Unit[30].

Melbourne-East is one of the most advantaged Indigenous Areas in Victoria with an IRSEO index of 1. This is closely followed by Melbourne-Port Philip with an IRSEO index of 2. The Frankston area is comparably more disadvantaged, (IRSEO index = 8) although it is still below the average value for Greater Melbourne (IRSEO index = 11). The Mornington Peninsula Indigenous Area shows an IRSEO index of 14, which is the highest of the 4 areas in BPA investigated and is higher than the average value for Greater Melbourne yet is still well below the average IRSEO index value for Victoria (IRSEO index = 25)[29].

[29]Biddle. N and Markham. F. Area Level Socioeconomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016. Area Level Socioecononomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016 - Austaxpolicy: The Tax and Transfer Policy Blog

[30]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 13: Below depicts these comparisons according to severity of disadvantage on a map.
Indigenous Relative Socioeconomic Outcomes by IARE, 2016[31]

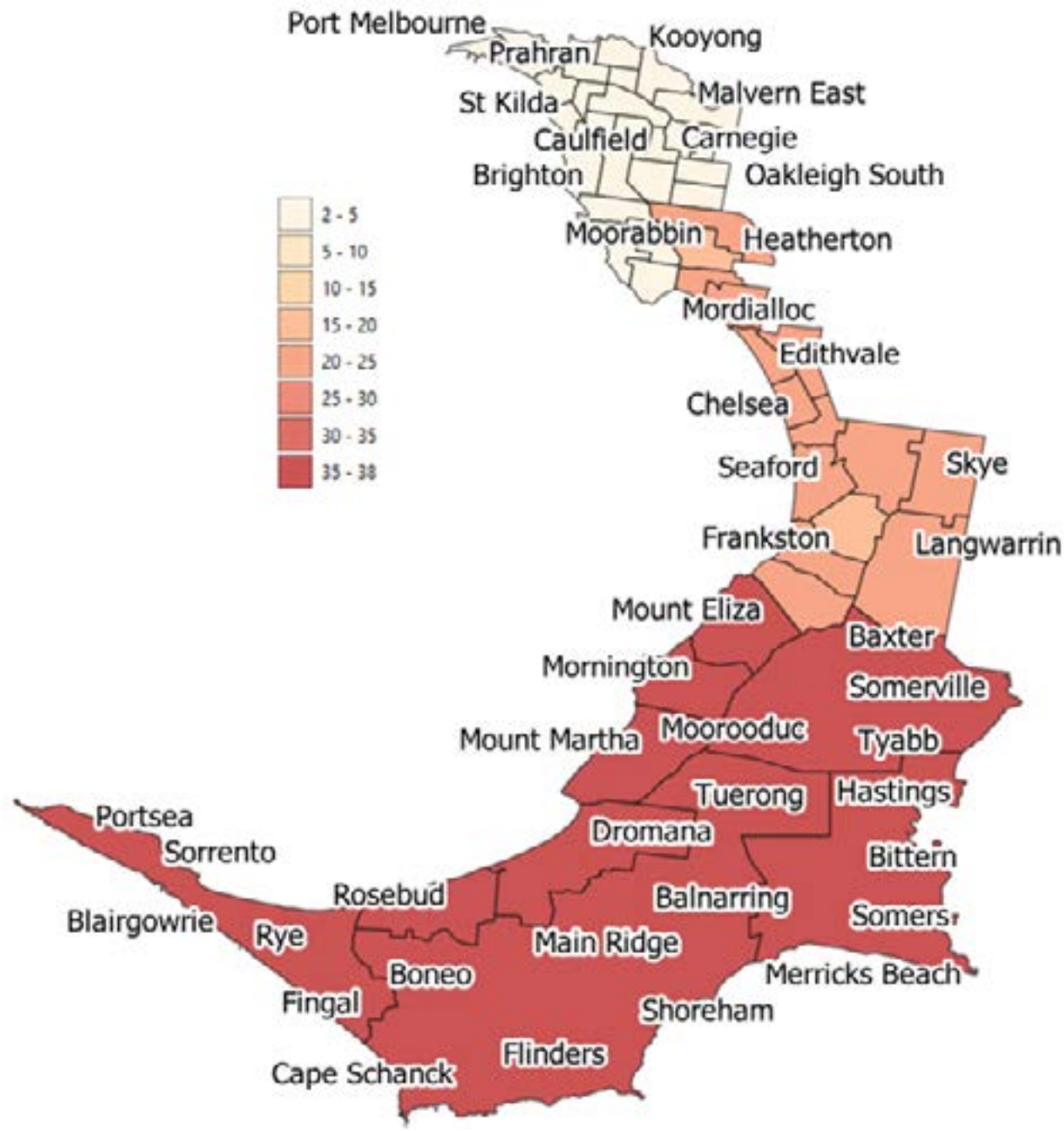


Source: Public Health Information Development Unit[32]

[31]Biddle. N and Markham. F. Area Level Socioeconomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016. Area Level Socioecononomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016 - Austaxpolicy: The Tax and Transfer Policy Blog

[32]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 14: BIRSEO by SA2[33]



Source: Public Health Information Development Unit[34]

[33]Biddle. N and Markham. F. Area Level Socioeconomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016. Area Level Socioecononomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016 - Austaxpolicy: The Tax and Transfer Policy Blog

[34]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Comparing mainstream and Aboriginal socioeconomic disadvantage

Across Australia, the relationship between the Aboriginal socioeconomic status and the non- Aboriginal socioeconomic status is quite weak (correlation coefficient of 0.12). There are some areas with relatively advantaged Aboriginal and non- Aboriginal populations, as well as others where both populations are relatively disadvantaged. On balance though, the socioeconomic status of the non- Aboriginal population in an area is not a good indication of the socioeconomic status of the Aboriginal population. Given the numerical dominance of the non- Aboriginal population in almost all parts of Australia, this means that indices based on the total Australian population are not a good proxy for the distribution of Aboriginal socioeconomic outcomes[35].

PINI RSEO

The PINI RSEO index is based on the same nine variables as the IRSEO index and allows comparison between Aboriginal and non-Aboriginal populations. The index is constructed for 368 Aboriginal Areas with a population count of at least 100 Aboriginal and 100 non- Aboriginal usual residents of age 15 years and over. It is created by pooling Aboriginal and non- Aboriginal area outcomes ranked into percentiles with 1 the most advantaged area and 100 the most disadvantaged.

Table 2: Comparison of disadvantage between Aboriginal and non- Aboriginal people 2016 (high number means more disadvantage)

Aboriginal area	IRSEO score - Aboriginal	IRSEO score - non Aboriginal	Difference between IRSEO scores
Mornington Peninsula	56	24	32
Frankston	54	17	37
Melbourne- Port Phillip	27	4	23
Melbourne-East	17	4	13

Source: Public Health Information Development Unit[36]

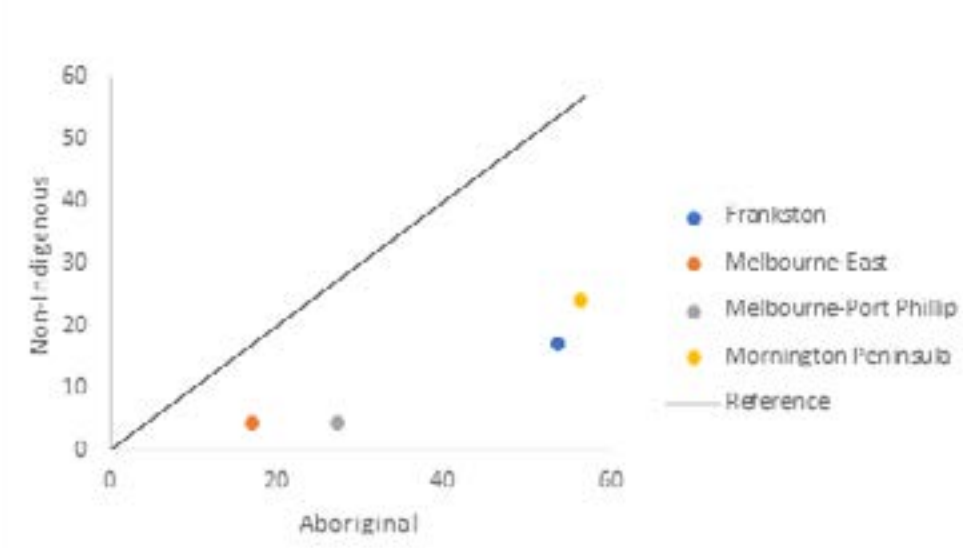
Of the Aboriginal areas in Australia, the Mornington Peninsula is ranked 351 out of 408 most disadvantaged and the Melbourne-East is 405th most disadvantaged.

The difference in disadvantage between Aboriginal and non- Aboriginal people is also higher for Mornington Peninsula and very small for Melbourne East.

[35]Biddle, N. Area Level Socioecononomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016 https://www.austaxpolicy.com/area-level-socioecononomic-outcomes-aboriginal-torres-strait-islander-australians-2016/

[36]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 15: Comparison of disadvantage between Aboriginal and non- Aboriginal people 2016



Source: Public Health Information Development Unit[37]

If the outcomes of the Aboriginal population were better than the non- Aboriginal population, then the area would be plotted above the black 45° line. If the outcomes were the same, then it would be on the line, and if the outcomes were worse amongst the Aboriginal population, then the dot would be below the line. The distance from the line represents the within-area gap between Aboriginal and non- Aboriginal outcomes.

Like in previous Censuses, there was no area in Australia where the Aboriginal population had better or equal outcomes to the non- Aboriginal population. Compared to 2011, the average difference between Aboriginal and non-Aboriginal outcomes was almost exactly the same.

Melbourne-East has the third lowest difference in socioeconomic outcomes between Aboriginal and non- Aboriginal residents in Australia. On balance, differences were smallest in City Areas; Regional Rural Areas; Large Regional Towns; and Small Regional Towns and Localities (in that order)[38].

[37]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

[38]Biddle, N and Markham, F. Area Level Socioeconomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016. Area Level Socioecononomic Outcomes for Aboriginal and Torres Strait Islander Australians, 2016 - Austaxpolicy: The Tax and Transfer Policy Blog

Other measures of Social Determinants of Health

Data from the 2016 Census of Population and Housing[39] for homelessness operational groups is reported at SA3 level based on enumeration. Table 3 below shows the sum of the number of Aboriginal persons living in improvised dwellings, tents, or sleeping out; in supported accommodation for the homeless; staying temporarily with other households; living in boarding houses or in other temporary lodgings. This is also shown as a percentage of the total number of Aboriginal people in that area and is depicted in Figure 14 below.

Table 2: Aboriginal persons living in improvised, supported, boarding or temporary accommodation in each Statistical Area Level 3 (SA3), 2016

SA3	Number of Aboriginal persons living in improvised, supported, boarding or temporary accommodation	% Aboriginal persons living in improvised, supported, boarding or temporary accommodation
Port Phillip	32	7.6%
Stonnington – West	0	0.0%
Stonnington – East	4	4.3%
Glen Eira	0	0.0%
Bayside	4	2.1%
Kingston	10	1.9%
Frankston	4	0.3%
Mornington Peninsula	16	1.2%
% non- Aboriginal persons across the above-listed SA3 areas living in improvised, supported, boarding or temporary accommodation = 0.26%		

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[39].

Stonnington – West and Glen Eira did not report any Aboriginal persons living in improvised, supported, boarding or temporary accommodation. The area of Frankston also showed a relatively low percentage of Aboriginal persons living in the listed categories of compromised accommodation. Each of the other listed SA3 areas showed percentages much higher than the 0.26% shown for non- Aboriginal persons across these areas, with the area of Port Phillip again showing the greatest level of disadvantage with respect to housing.

[39]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Figure 16: Percentage of Aboriginal persons living in improvised, supported, boarding or temporary accommodation by Statistical Area Level 3 (SA3), 2016

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[40].

Mental health

A 2004 study identified Aboriginal people were up to twice as likely to be admitted to hospital for mental health related conditions in comparison to non- Aboriginal Australians[41]. The Aboriginal population is exposed to higher levels of chronic stress compared to the non- Aboriginal population as a consequence of racism, stigma and socioeconomic disadvantage. This has been linked to higher rates of mental health related conditions. The National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017-2023[42] acknowledges the link between mental health and the harmful use of alcohol and other drugs.

The data presented in Table 4 below has been compiled by Public Health Information Development Unit[43] using data from the Australian Institute of Health and Welfare[44]. The 2016 estimated resident population (ERP) for each IARE was calculated by Public Health Information Development Unit43 using ABS data for Statistical Areas Level 2 (SA2). The data is presented as an indirectly age-standardised rate (ASR) per 100,000 (respective population)[40].

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[40]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

[41]Calma. T. Dick. D. Social determinants and the health of Indigenous peoples in Australia – a human rights based approach. Workshop paper [electronic article]. 2007. Available from: https://humanrights.gov.au/about/news/speeches/social-determinants-and-health-indigenous-peoples-australia-human-rights-based

[42]Commonwealth of Australia. National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017-2023. Canberra: Department of the Prime Minister and Cabinet; February 2017.

[43]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

[44]Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW; 2015

Table 4: Admissions for mental health related conditions in Aboriginal persons, by Indigenous Area (IARE), 2015/16 to 2017/18

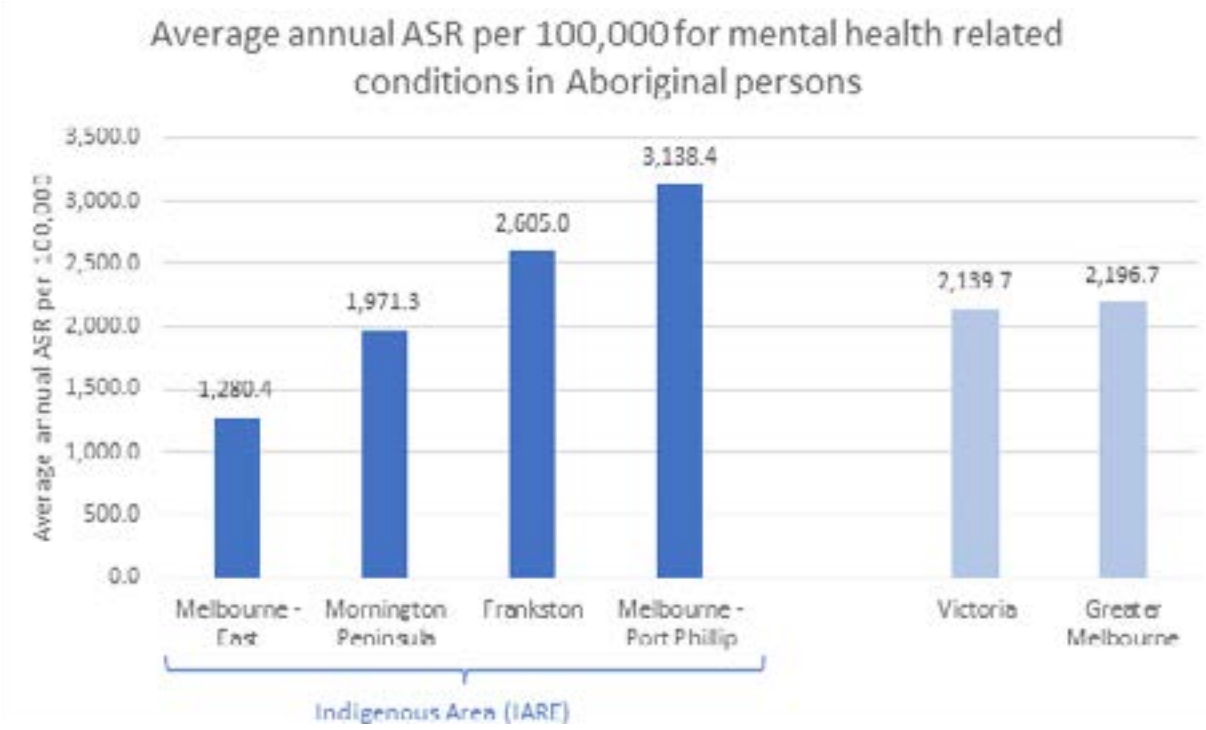
IARE/ Region	Number of admissions for mental health related conditions, Aboriginal persons (ICD-10 codes F00-F99)	Average annual age-standardised rate (ASR) percentage
Melbourne - Port Phillip	224	3.1%
Melbourne - East	60	1.3%
Frankston	190	2.6%
Mornington Peninsula	91	2.0%
Greater Melbourne	2,035	2.2%
Victoria	3,666	2.1%

Source: Adapted from Public Health Information Development Unit[45]

From the data presented in Table 4 above and Figures 15 and 16 below, it is clear that Melbourne-Port Phillip reports a much higher rate of mental health related hospital admissions for Aboriginal persons compared to the other areas included in this report and in comparison to the average rate shown in the larger geographical regions of Greater Melbourne and Victoria. Frankston also reports a rate that is higher than the average rate for the whole of Victoria. Conversely, Melbourne - East and Mornington Peninsula report comparatively low rates, with the rate shown for Melbourne - East standing out as much lower than the other areas reported here.

[45]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 17: Average annual age-standardised rate (ASR) per 100,000 for admissions for mental health related conditions in Aboriginal persons, by Indigenous Area (IARE), 2015/16 to 2017/18



Source: Public Health Information Development Unit[46]

[46]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Learning or earning

Education and employment are key enablers for overcoming social and economic disadvantage. In addition to fostering income capacity, education and employment also encourage the development of social connections, which are protective of mental health.

Table 5 below shows the number of Aboriginal persons aged 15 to 24 years of age who are engaged in school, work or further education/training and express these numbers as a percentage of all Aboriginal people of the same age group in that same area. The data presented was compiled by Public Health Information Development Unit[47] and is based on the ABS Census of Population and Housing, August 2016[48].

Table 5: Aboriginal persons Learning or Earning at ages 15 to 24 by Indigenous Area (IARE), 2016

IARE/ Region	Aboriginal persons Learning or Earning at ages 15 to 24	Aboriginal people aged 15 to 24	% Aboriginal Learning or Earning at ages 15 to 24
Melbourne - Port Phillip	262	296	88.5
Melbourne - East	193	222	86.9
Frankston	280	357	78.4
Mornington Peninsula	203	246	82.5
Greater Melbourne	3,713	4,685	79.3
Rest of Vic.	3,141	4,347	72.3
Victoria	6,874	9,075	75.7

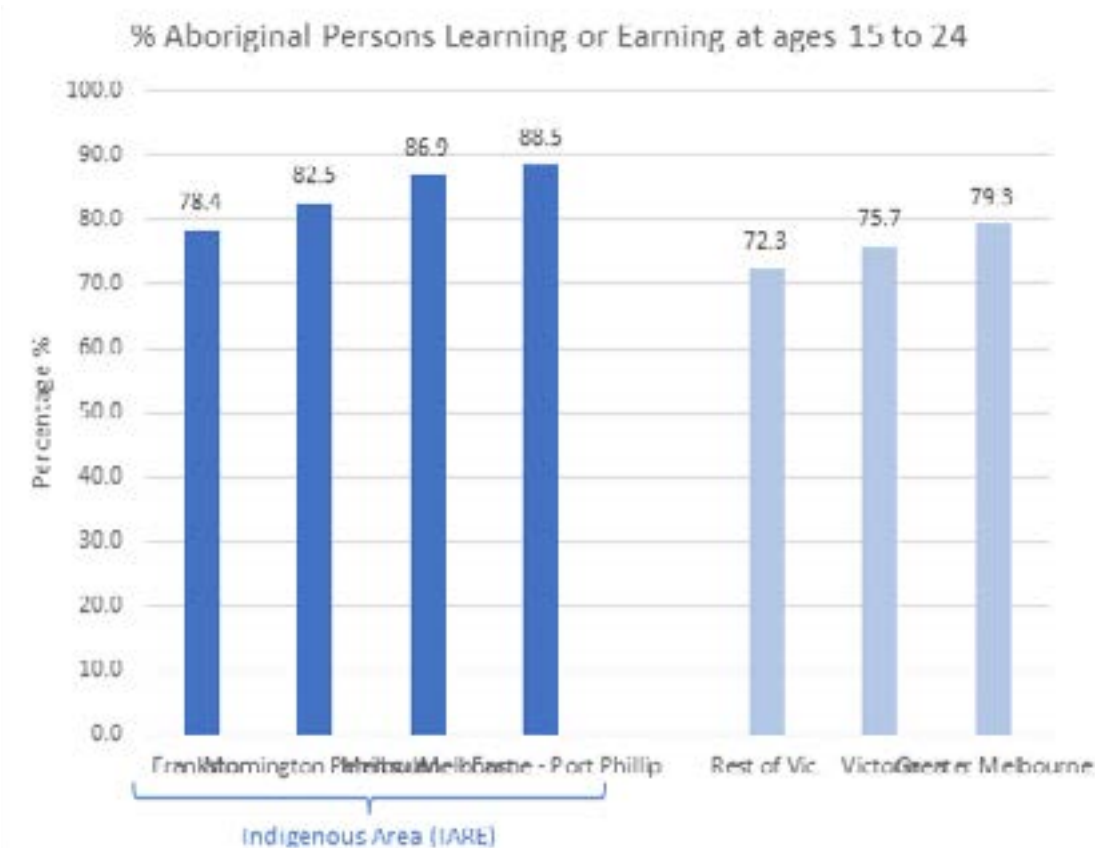
Source: Public Health Information Development Unit[47]

Figure 16 and 17 below clearly show that Melbourne - Port Phillip has the greatest advantage among the target IAREs in respect of this indicator, with 88.5% of Aboriginal persons aged 15 to 24 either 'learning or earning'. All four of the investigated IAREs exceed the Victorian average, with Frankston being the only IARE that has a percentage that is marginally lower than the average for Greater Melbourne (78.4% versus 79.3%).

[47]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

[48]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

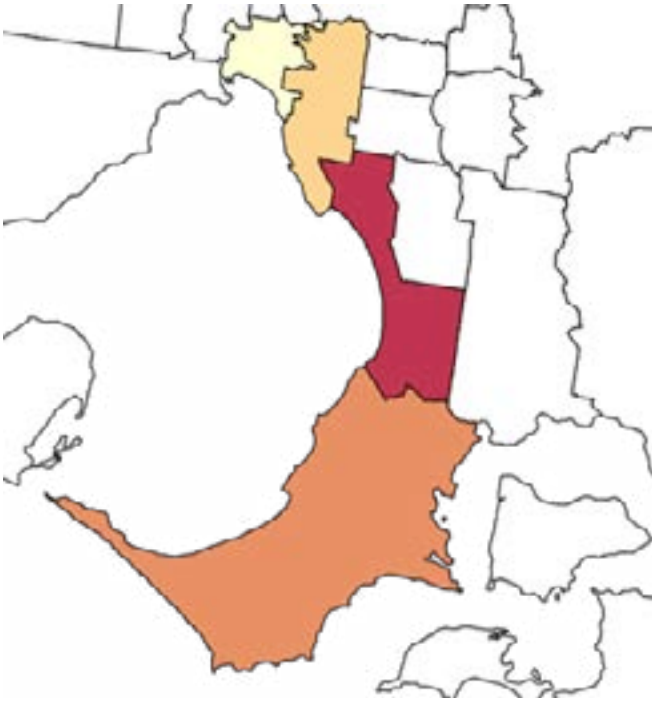
Figure 18: Percentage of Aboriginal persons Learning or Earning at ages 15 to 24 by Indigenous Area (IARE), 2016



Source: Public Health Information Development Unit[49]

[49]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 19: IARE map showing the percentage of Aboriginal persons Learning or Earning at ages 15 to 24 by Indigenous Area (IARE), 2016



Source: Public Health Information Development Unit[50]

The 2016 Census of Population and Housing[51] reports on the highest year of school completed by individuals. Since educational attainment is a key enabler for overcoming socioeconomic disadvantage, areas with a high percentage of the Aboriginal population who have completed Year 12 or equivalent may indicate a smaller degree of disadvantage.

The percentage of Aboriginal persons who have completed year 12 or equivalent in each LGA are shown in Table 6 and Figure 18 below. Each of the seven LGAs report a percentage less than that reported for non- Aboriginal persons across these LGAs. Stonnington shows the least level of disadvantage with a percentage (53.6%) that is only very slightly less than that which is reported for non- Aboriginal persons across these areas (54.2%). Frankston and the Mornington Peninsula areas show the greatest degree of disadvantage among these seven LGAs for this indicator with percentages of 24.8% and 26.3% respectively.

[50]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

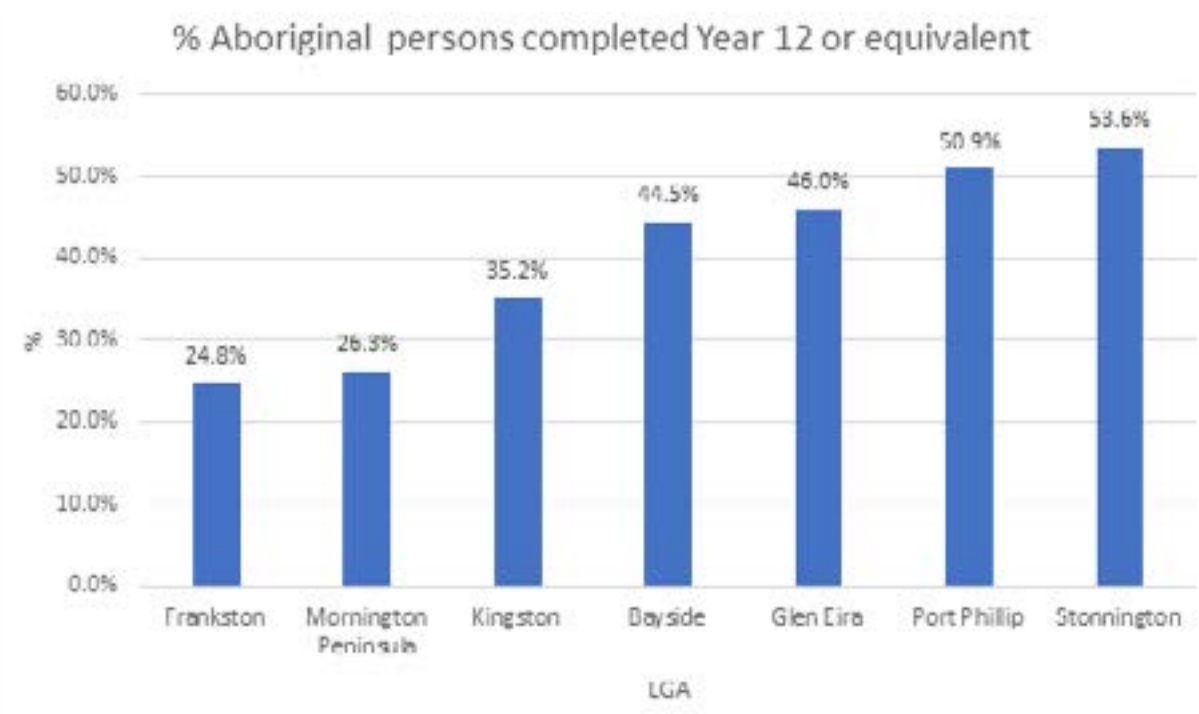
[51]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Table 6: Aboriginal persons who have completed Year 12 or equivalent in each Local Government Area (LGA)

LGA	Number of Aboriginal persons completed Year 12 or equivalent	% Aboriginal persons completed Year 12 or equivalent
Port Phillip	199	50.9
Stonnington	165	53.6
Glen Eira	115	46.0
Bayside	85	44.5
Kingston	205	35.2
Frankston	334	24.8
Mornington Peninsula	343	26.3
% non- Aboriginal persons across the above-listed LGAs with a need for assistance with core activities = 54.2%		

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[52].

Figure 19: Percentage of Aboriginal persons who have completed Year 12 or equivalent in each Local Government Area (LGA), 2016



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[52].

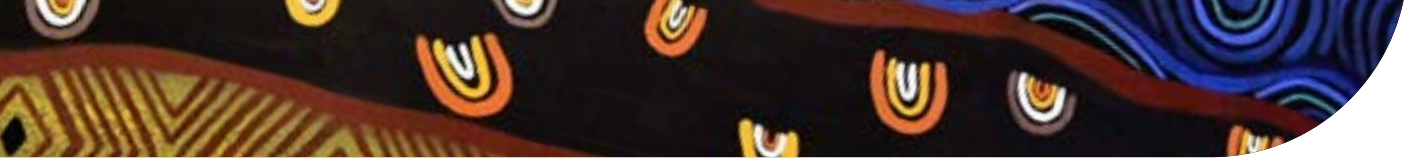
Data for Aboriginal persons who have completed Year 12 or equivalent is also available at the SA2 level and is shown below in Table 7.

[52]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Table 7: SA2 level data on Aboriginal persons who have completed Year 12 or equivalent, 2016.

(NB: N/A replaces percentage values where the number of Aboriginal persons in the area equals zero.)

SA2	Total Aboriginal Persons Completed Year 12 or Equivalent	% Aboriginal Population Completed Year 12 or Equivalent
Total	1426	33.2%
Hastings - Somers	114	30.3%
St Kilda	71	50.0%
Carrum Downs	60	24.3%
Frankston North	59	20.8%
Seaford (Vic.)	59	26.3%
Frankston	54	23.6%
Rosebud - McCrae	52	22.6%
Prahran - Windsor	46	54.8%
Somerville	44	27.7%
Point Nepean	40	24.4%
Langwarrin	38	21.5%
Mornington	37	23.1%
Cheltenham - Highett (East)	35	37.2%
Frankston South	35	34.0%
South Yarra - East	34	49.3%
Mordialloc - Parkdale	30	40.0%
Skye - Sandhurst	29	30.2%
St Kilda East	28	56.0%
Malvern East	28	46.7%
Elwood	27	47.4%
Edithvale - Aspendale	27	38.6%
Toorak	26	81.3%
Chelsea - Bonbeach	25	29.4%
Mount Eliza	24	33.3%
Caulfield - North	22	45.8%
Mount Martha	22	34.4%
Albert Park	21	87.5%
Bentleigh East (North)	20	41.7%
Port Melbourne	19	32.2%
South Melbourne	19	29.2%



SA2	Total Aboriginal Persons Completed Year 12 or Equivalent	% Aboriginal Population Completed Year 12 or Equivalent
Sandringham - Black Rock	19	48.7%
Carrum - Patterson Lakes	19	32.2%
Armadale	17	70.8%
Hampton	17	44.7%
Bentleigh East (South)	17	48.6%
Mentone	17	43.6%
Moorabbin - Heatherton	16	43.2%
Brighton (Vic.)	15	42.9%
Brighton East	15	65.2%
Bentleigh - McKinnon	15	75.0%
Malvern - Glen Iris	15	55.6%
Aspendale Gardens - Waterways	14	50.0%
Dromana	14	17.1%
Beaumaris	13	68.4%
Carnegie	13	33.3%
Elsternwick	11	44.0%
Chelsea Heights	7	25.9%
Caulfield - South	6	66.7%
Ormond - Glen Huntly	6	66.7%
Murrumbeena	5	55.6%
Cheltenham - Highett (West)	4	30.8%
Flinders	3	27.3%
Hughesdale	0	0.0%
Port Melbourne Industrial	0	N/A
Braeside	0	N/A
Moorabbin Airport	0	N/A

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[53].

[53]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Early childhood development

The Australian Early Development Census (AEDC)[54] gathers data on the learning and development needs of young children in their first year of full-time school. Children are assessed over five domains:

1. physical health and wellbeing
2. social competence
3. emotional maturity
4. language and cognitive skills (school-based)
5. communication skills and general knowledge

The AEDC[54] domains have been identified as predictors of health, wellbeing and educational achievement in later life.

The results are reported according to the number of children who score in the following percentile ranges:

- 0 to 10th percentile (developmentally vulnerable)
- 11th to 25th percentile (developmentally at risk)
- > 25th percentile (developmentally on track)

The information presented below in Table 9 shows the number of Aboriginal children in an IARE who were assessed as being developmentally vulnerable on one or more domains. Public Health Information Development Unit[55] has compiled this data using data from the 2018 Australian Early Development Censuses[56]. It should be noted that the suppression rules have been applied to the data to preserve confidentiality (see below). Consequently, no data was able to be reported for the Melbourne - East area.

Data is not reported where:

- ≤3 children had been assessed
- < 15 children had valid AEDC56 scores
- < 2 teachers had completed the AEDC56 instrument for children in that location
- the AEDC56 instrument was completed for <80% of all non-special needs children
- the number of vulnerable/at-risk children represented at least 90% of valid AEDC56 scores
- additional minor suppressions were considered necessary to preserve confidentiality

[54]Australian Early Development Census (AEDC). Australian Early Development Census national report 2015 (A snapshot of early childhood development in Australia). Canberra: Department of Education and Training; 2016.
[55]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/
[56]Australian Early Development Census (AEDC). Australian Early Development Census national report 2015 (A snapshot of early childhood development in Australia). Canberra: Department of Education and Training; 2016.

Table 8: Aboriginal children developmentally vulnerable on one or more domains of the Australian Early Development Census (AEDC)[57] by Indigenous Area (IARE), 2018

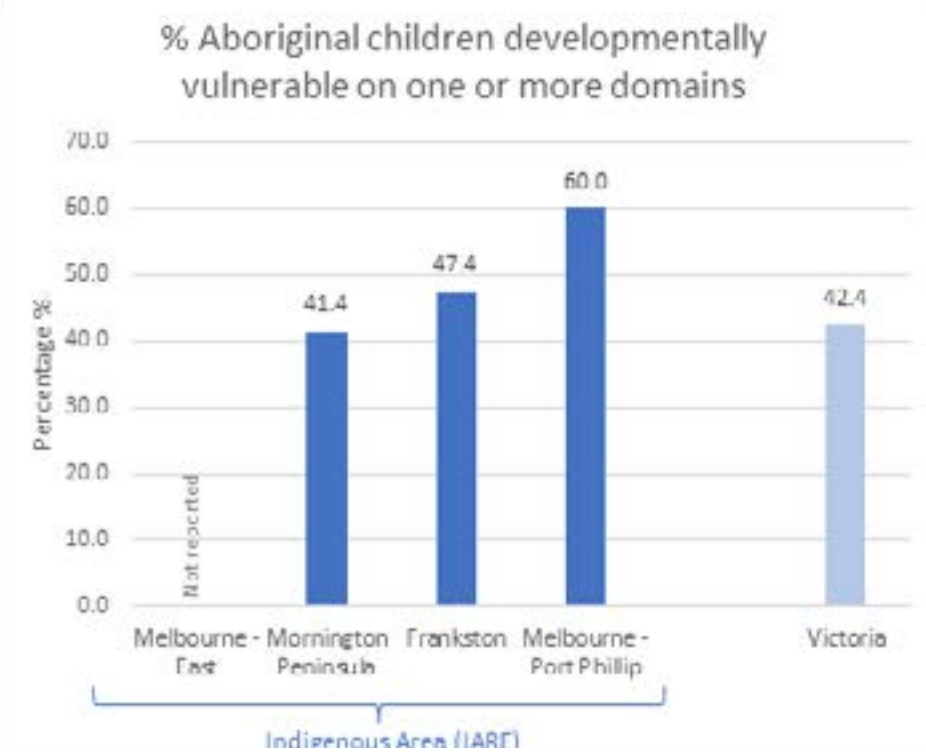
IARE/ Region	Aboriginal children developmentally vulnerable on one or more domains	Aboriginal children assessed in AEDC[57] (first year of school)	% Aboriginal children developmentally vulnerable on one or more domains
Melbourne - Port Phillip	9	15	60.0
Melbourne - East	not reported	not reported	-
Frankston	18	38	47.4
Mornington Peninsula	12	29	41.4
Victoria	547	1,289	42.4

Source: Public Health Information Development Unit[58]

The area of Melbourne - Port Phillip shows the greatest disadvantage in terms of this indicator, with 60% of Aboriginal children assessed in this area being assessed as developmentally vulnerable on one or more domains of the AEDC57. This value is far greater than the percentages seen in the Mornington Peninsula or Frankston areas (41.4% and 47.4% respectively) and is also far greater than the overall percentage seen in Victoria (42.4%). These comparisons are depicted graphically in Figures 19 and 20 below. It should also be noted that the percentage of all Australian children who were assessed as developmentally vulnerable in the AEDC57 on one or more domains was 21.7%.

[57]Australian Early Development Census (AEDC). Australian Early Development Census national report 2015 (A snapshot of early childhood development in Australia). Canberra: Department of Education and Training; 2016.
[58]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 21: Percentage of Aboriginal children developmentally vulnerable on one or more domains of the Australian Early Development Census (AEDC)[59] by Indigenous Area (IARE), 2018.



Source: Public Health Information Development Unit[60]

Figure 22: IARE map showing the percentage of Aboriginal children developmentally vulnerable on one or more domains of the Australian Early Development Census (AEDC)[59], 2018

Source: Public Health Information Development Unit[60]

[59]Australian Early Development Census (AEDC). Australian Early Development Census national report 2015 (A snapshot of early childhood development in Australia). Canberra: Department of Education and Training; 2016.
[60]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Internet access

Although use of the Internet can produce both beneficial and harmful health outcomes, it is reasonable to assume that enhanced access to this tool within deprived communities is likely to have a positive effect.

The data shown in Table 10 below is based on the ABS Census of Population and Housing (August 2016)[61] and describes Internet access among Aboriginal households where at least one usual resident is an Aboriginal or Torres Strait Islander person. In this context, a private dwelling can be described as a house, flat, room, caravan, houseboat, tent, house attached to an office, or a room above a shop. The data shows whether any member of the household has access to the Internet through any type of connection, whether access is via a computer, smart phone, tablet, music or video player, gaming console, smart TV or any other device.

Table 10: Aboriginal households with children aged under 15 years with no access to the Internet at dwelling, by Indigenous Area (IARE), 2016

IARE/ Region	Private dwellings with Aboriginal households with children aged less than 15 years, where internet was not accessed	Total private dwellings with Aboriginal households with children aged less than 15 years	% private dwellings with Aboriginal households with children, where Internet was not accessed
Melbourne - Port Phillip	23	122	18.9
Melbourne - East	10	168	6.0
Frankston	27	397	6.8
Mornington Peninsula	28	277	10.1
Greater Melbourne	459	4,965	9.2
Rest of Vic.	812	5,139	15.8
Victoria	1,270	10,103	12.6

Source: Public Health Information Development Unit[62]

Figure 21 and 22 below make it clear that Melbourne – Port Phillip shows the highest degree of deprivation according to Internet access among these four IAREs, with nearly 19% of the investigated households not having access to the internet. The percentages shown for all of Victoria (12.6%) and Greater Melbourne (9.2%) are well below this percentage. Conversely, Melbourne – East and Frankston fare relatively well in this indicator, with between 6 to 7% of households assessed describing no access to the Internet. This is well below the percentage shown in Victoria and Greater Melbourne. The rest of Victoria shows a higher percentage than Greater Melbourne or Victoria in general, indicating that Internet access is less common within this population when residing outside of the metropolitan area.

[61]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

[62]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

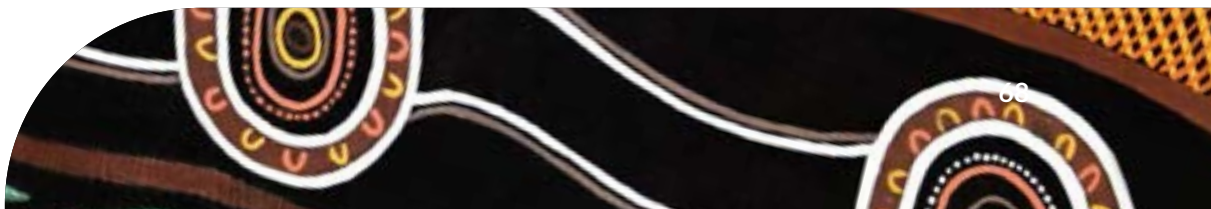
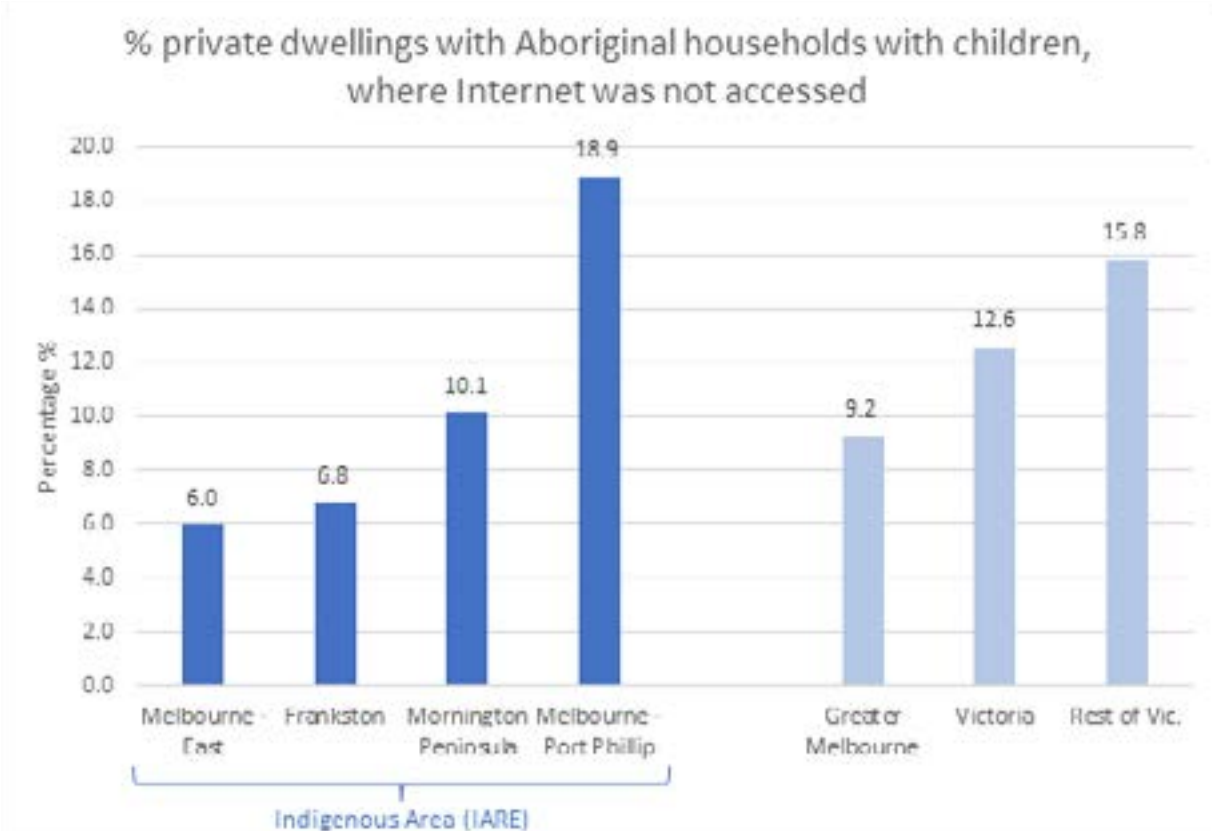


Figure 23: Percentage of private dwellings with Aboriginal households with children aged under 15 years with no access to Internet at dwelling, by Indigenous Area (IARE), 2016



Source: Public Health Information Development Unit[63]

[63]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 24: Percentage of private dwellings with Aboriginal households with children aged under 15 years with no access to Internet at dwelling, by Indigenous Area (IARE), 2016

Source: Public Health Information Development Unit[64]

Data from the 2016 Census of Population and Housing also reports on the number of Aboriginal households within each LGA where Internet is or is not accessed. The figures for households that do not have access to the Internet are shown in Table 11 and Figure 23 below.

Table 11: Aboriginal households with children aged under 15 years with no access to the Internet at dwelling, by Indigenous Area (IARE), 2016

LGA	Aboriginal households where Internet was not accessed from dwelling	% Aboriginal households where Internet was not accessed from dwelling
Mornington Peninsula	109	16.9%
Frankston	105	15.1%
Port Phillip	48	17.3%
Kingston	38	11.7%
Stonnington	17	8.7%
Glen Eira	13	8.2%
Bayside	12	10.2%
% non- Aboriginal households across the above-listed LGAs who do not have Internet access = 11.4%		

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[65].

[64]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

[65]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

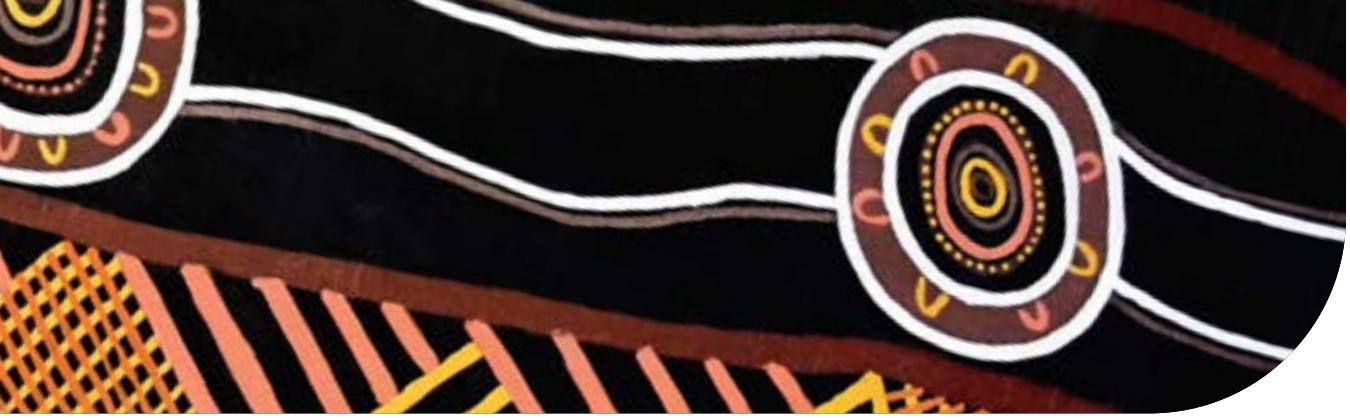
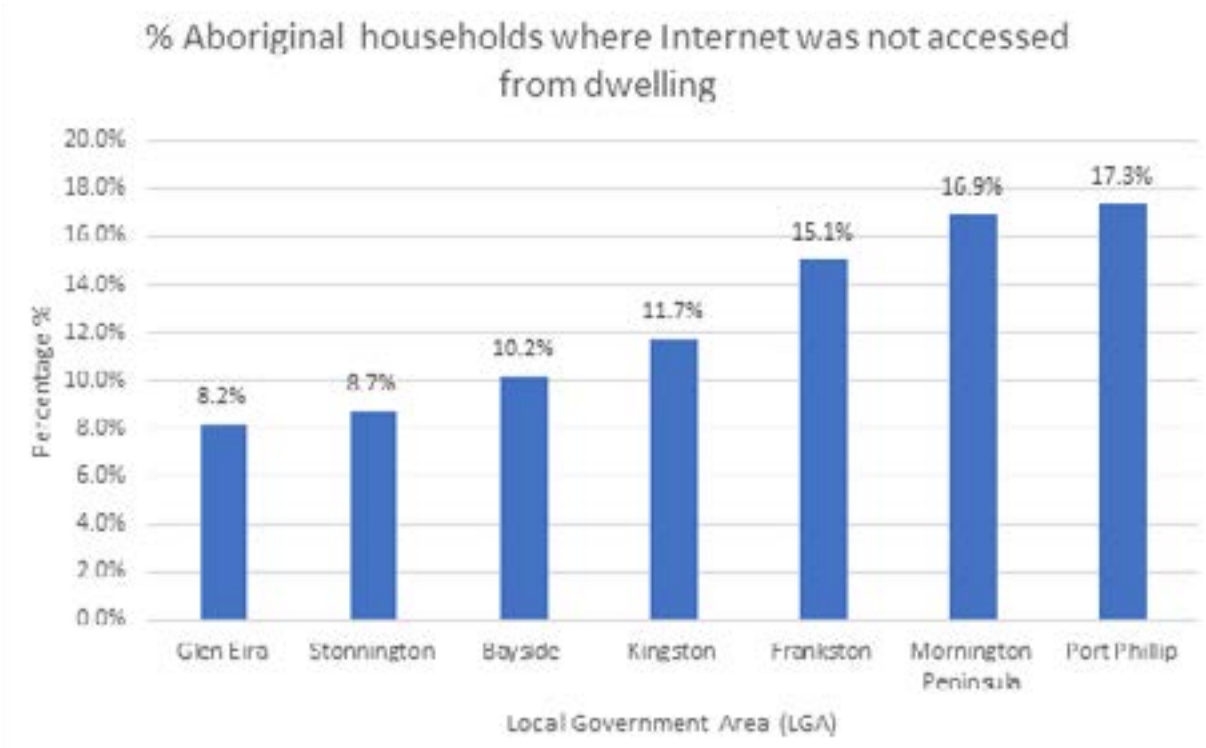


Figure 25: The percentage of In Aboriginal households in each Local Government Area (LGA) where Internet is not accessed from the dwelling



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[66].

The data presented in Table 11 and Figure 23 above show that the Local Government Area of Port Phillip has the highest degree of deprivation with respect to Internet access with 17.3% of Aboriginal households in this area not accessing the Internet. This is much higher than the rate of 11.4% shown in non- Aboriginal households across these seven LGAs. The LGA of Glen Eira showed the highest level of advantage in this indicator (8.2%) and was one of three LGAs (Glen Eira, Stonnington and Bayside) among those reported that showed less disadvantage with respect to Internet access in comparison to the non- Aboriginal households in the Bayside Peninsula Area.

Data for Aboriginal households who do not have an Internet connection is also available at the SA2 level from the Census of Population and Housing 2016[66] and is shown below in Table 12.

[66]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

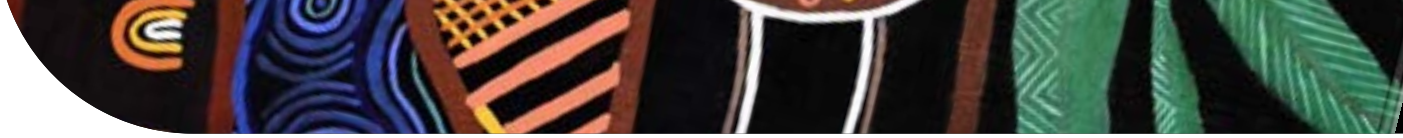


Table 12: SA2 level data on Aboriginal Households where Internet is not accessed from the dwelling, 2016

(NB: N/A replaces percentage values where the number of Aboriginal persons in the area equals zero.)

SA2	Number of Aboriginal Households where Internet is not accessed from the dwelling	% Aboriginal Households where Internet is not accessed from the dwelling
Total	337	14.1%
Seaford (Vic.)	26	21.1%
Rosebud - McCrae	26	19.8%
Frankston	25	19.7%
Frankston North	25	17.0%
Hastings - Somers	25	14.8%
South Melbourne	16	36.4%
Carrum Downs	15	13.4%
St Kilda	13	14.6%
Dromana	13	28.3%
Point Nepean	13	18.3%
Prahran - Windsor	10	17.9%
Somerville	10	12.2%
Edithvale - Aspendale	9	22.5%
Mentone	9	29.0%
Langwarrin	9	10.0%
Mornington	9	11.3%
Cheltenham - Highett (East)	8	16.0%
Frankston South	8	14.8%
Mount Eliza	8	32.0%
St Kilda East	7	15.2%
Mount Martha	7	19.4%
Port Melbourne	6	12.2%
South Yarra - East	6	11.3%
Chelsea - Bonbeach	6	12.0%
Cheltenham - Highett (West)	5	38.5%
Bentleigh - McKinnon	5	26.3%
Elwood	4	9.8%
Hampton	4	13.8%
Carnegie	4	16.7%

SA2	Number of Aboriginal Households where Internet is not accessed from the dwelling	% Aboriginal Households where Internet is not accessed from the dwelling
Mordialloc - Parkdale	4	8.3%
Albert Park	3	15.8%
Malvern - Glen Iris	3	11.5%
Skye - Sandhurst	3	7.0%
Armadale	0	0.0%
Toorak	0	0.0%
Beaumaris	0	0.0%
Brighton (Vic.)	0	0.0%
Brighton East	0	0.0%
Sandringham - Black Rock	0	0.0%
Caulfield - North	0	0.0%
Caulfield - South	0	0.0%
Elsternwick	0	0.0%
Hughesdale	0	0.0%
Murrumbeena	0	0.0%
Ormond - Glen Huntly	0	0.0%
Bentleigh East (North)	0	0.0%
Bentleigh East (South)	0	0.0%
Aspendale Gardens - Waterways	0	0.0%
Carrum - Patterson Lakes	0	0.0%
Chelsea Heights	0	0.0%
Moorabbin - Heatherton	0	0.0%
Malvern East	0	0.0%
Flinders	0	0.0%
Braeside	0	N/A
Moorabbin Airport	0	N/A
Port Melbourne Industrial	0	N/A

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[67].

[67]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Employment

Aboriginal people experience an unemployment rate that is three times that of non- Aboriginal people[68]. For some people poor health status leads to unemployment, but for many people poor health status is a consequence of their inability to gain adequate employment and the psychological and financial stress that this imparts[69]. The reduced capacity to produce income, limited opportunity to create social connections and the feeling of insecurity that unemployment creates (to name a but few consequences) can have a detrimental effect on a person's social and emotional wellbeing. Australia's Health 2016[70] also cites that unemployed people are also more likely to use cannabis, methamphetamines and ecstasy compared to those who are employed.

Table 13: Aboriginal unemployment according to Indigenous Area (IARE), 2016

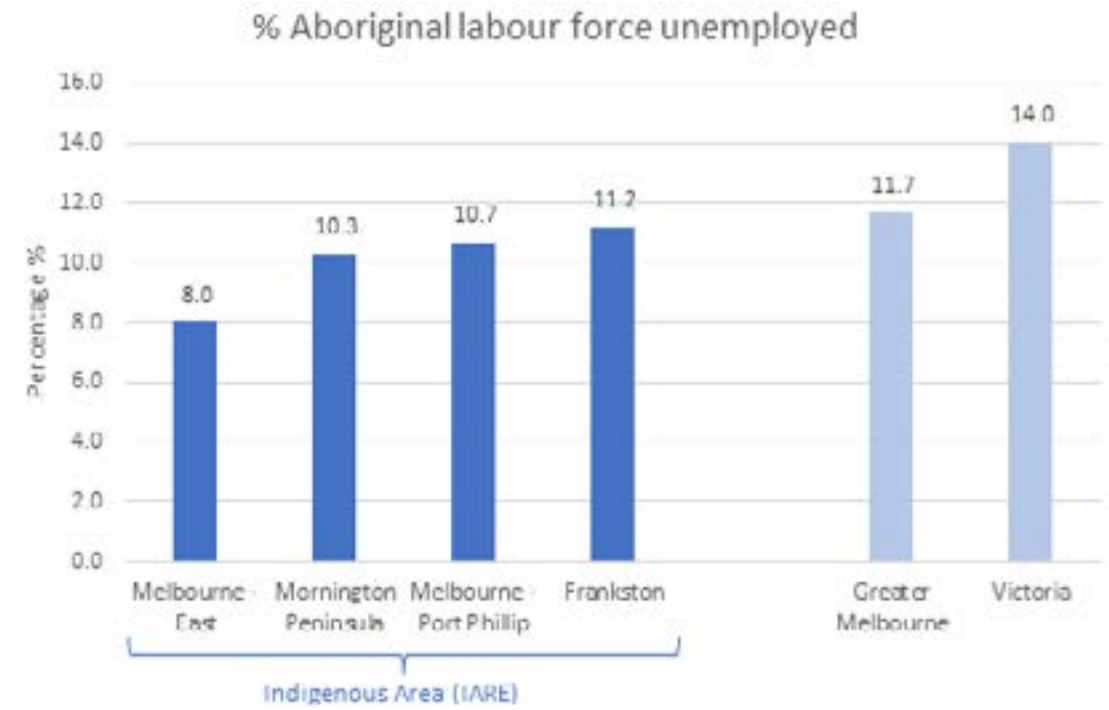
IARE/ Region	Aboriginal unemployed	Total Aboriginal labour force	% Aboriginal labour force unemployed
Melbourne - Port Phillip	73	684	10.7
Melbourne - East	46	575	8.0
Frankston	90	806	11.2
Mornington Peninsula	54	525	10.3
Greater Melbourne	1,192	10,197	11.7
Victoria	2,508	17,874	14.0

Source: Public Health Information Development Unit[71]

Table 13 above shows the percentage of the Aboriginal labour force that is unemployed within each of the target IAREs. Each of the four IAREs investigated show an unemployment rate that is lower than the overall rate for both Greater Melbourne (11.7) and Victoria (14%). Melbourne - East shows the most positive outcome for this indicator (8%), while Frankston fares least favourably (11.2%) among the four IAREs evaluated. Figure 48 and Figure 49 below show these figures in a graphical and geographical manner.

[68]Department of Health and Human Services. Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027. Melbourne: State Government of Victoria; October 2017.
[69]Australian Institute of Health and Welfare. 4.1 Social determinants of health. In: Australia's health 2016. Canberra: AIHW; 2016.
[70]Australian Institute of Health and Welfare. Australia's health 2016. Australia's health series no. 15. Canberra: AIHW; 2016.
[71]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 26: Percentage of Aboriginal labour force unemployed according to Indigenous Area (IARE), 2016



Source: Public Health Information Development Unit[72]

The Census of Population and Housing 2016[73] reports the number of persons who participate in the labour force and are either employed or unemployed. These numbers can be broken down according to Aboriginal status. Table 27 below shows the number of Aboriginal persons in each LGA who are unemployed and reports this as a percentage of the Aboriginal labour force in each area.

[72]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

[73]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

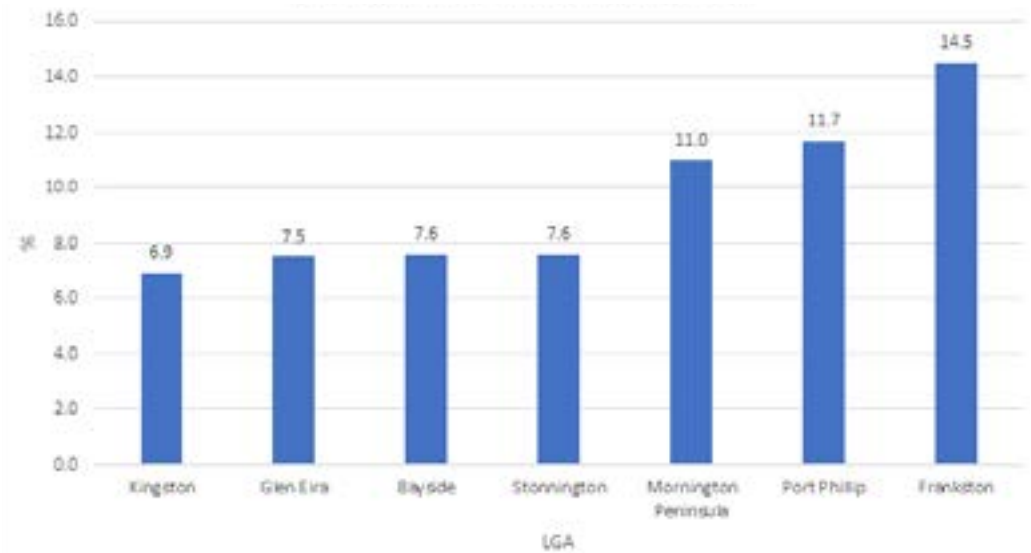
Table 14: Aboriginal unemployment by Local Government Area (LGA), 2016

LGA	Aboriginal unemployed	% Aboriginal labour force unemployed
Frankston	80	14.5%
Mornington Peninsula	58	11.0%
Port Phillip	25	11.7%
Kingston	18	6.9%
Stonnington	14	7.6%
Glen Eira	10	7.5%
Bayside	7	7.6%
% non- Aboriginal labour force across the above-listed LGAs who are unemployed = 5.4%		

Source: Public Health Information Development Unit[74]

Table 14 above shows that unemployment is far more pronounced in the Aboriginal population compared to the non-Aboriginal labour force. Each of the listed LGAs reported a higher rate of unemployment in the Indigenous population compared to the non- Aboriginal population. Mornington Peninsula, Port Phillip and Frankston LGAs each reported a rate of unemployment more than twice the rate shown in the non- Aboriginal population. Figure 50 below highlights the much higher rate of disadvantage in terms of unemployment among Aboriginal residents in the Mornington Peninsula, Port Phillip and Frankston LGAs.

Figure 28: Percentage of Aboriginal labour force unemployed in each Local Government Area (LGA), 2016



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[75].

The 2016 Census of Population and Housing[75] also reports unemployment status at SA2 level. Table 24 below details the percentage of Aboriginal labour force who are unemployed within each SA2 area.

[74]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

[75]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Table 15: SA2 level data for Ab original unemployment, 2016

(NB: N/A replaces percentage values where the total Aboriginal labour force in the area equals zero.)

SA2 area	Aboriginal unemployed	% Aboriginal Labour Force Unemployed
Total	219	11.2%
Frankston North	21	20.2%
Frankston	18	17.8%
Carrum Downs	18	17.1%
Hastings - Somers	13	7.4%
Seaford (Vic.)	12	14.8%
Rosebud - McCrae	12	14.8%
St Kilda	11	13.6%
Somerville	10	13.3%
Langwarrin	9	12.5%
Mornington	8	16.7%
Caulfield - North	6	25.0%
Mount Eliza	6	19.4%
Point Nepean	6	10.0%
Mount Martha	5	17.2%
Dromana	5	14.7%
Cheltenham - Highett (East)	5	14.3%
South Yarra - East	5	10.6%
Brighton (Vic.)	4	23.5%
Armadale	4	22.2%
South Melbourne	4	16.0%
Malvern East	4	14.8%
Elwood	4	10.8%
Skye - Sandhurst	4	9.3%
Ormond - Glen Huntly	3	27.3%
Sandringham - Black Rock	3	12.5%
Carrum - Patterson Lakes	3	11.1%
Edithvale - Aspendale	3	9.7%
Albert Park	0	0.0%
Port Melbourne	0	0.0%
St Kilda East	0	0.0%

SA2 area	Aboriginal unemployed	% Aboriginal Labour Force Unemployed
Prahran - Windsor	0	0.0%
Toorak	0	0.0%
Beaumaris	0	0.0%
Brighton East	0	0.0%
Cheltenham - Highett (West)	0	0.0%
Hampton	0	0.0%
Bentleigh - McKinnon	0	0.0%
Carnegie	0	0.0%
Caulfield - South	0	0.0%
Elsternwick	0	0.0%
Hughesdale	0	0.0%
Murrumbeena	0	0.0%
Bentleigh East (North)	0	0.0%
Bentleigh East (South)	0	0.0%
Aspendale Gardens - Waterways	0	0.0%
Chelsea - Bonbeach	0	0.0%
Chelsea Heights	0	0.0%
Mentone	0	0.0%
Moorabbin - Heatherton	0	0.0%
Mordialloc - Parkdale	0	0.0%
Malvern - Glen Iris	0	0.0%
Frankston South	0	0.0%
Flinders	0	0.0%
Port Melbourne Industrial	0	N/A
Braeside	0	N/A
Moorabbin Airport	0	N/A

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[76].

[76]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Income

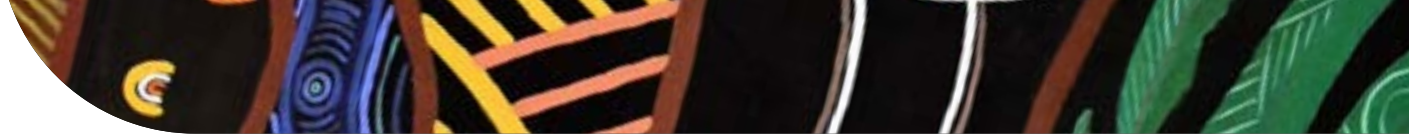
Although national data shows the income gap between Aboriginal and Torres Strait Islander persons and non-Aboriginal persons is narrowing, income inequality persists. Aboriginal and Torres Strait Islander persons continue to report significantly lower incomes than non- Aboriginal Australians, and the income gap continues to widen in very remote areas. Given that alcohol and other drug-related harm can be linked to socioeconomic disadvantage[77,78,79] an individual's capacity to produce sufficient income (or lack thereof) can influence the health outcomes linked to such consumption. It should, however, be noted that the relationship between income and problem drug and alcohol use is complex[80,81], and that level of income alone is not a reliable indicator for health outcomes linked to consumption of alcohol and other drugs79 80.

In 2016, the median weekly personal income for people aged 15 years and over in Victoria was $644[82]. Table 29 below reports the number of Indigenous people in each SA2 area with an income above the Victorian median income and reports this value as a percentage of the total Aboriginal population in each area. It is noted, however, that a degree of caution is required when interpreting these figures since 3.9% of the Aboriginal population across these areas did not state an answer to this question on the census and 28.2% responded N/A.

Table 16: Aboriginal persons with a total personal income above the Victorian median income (Victorian median income for 2016 was $644 ($33,488 annual)), 2016
(NB: N/A replaces percentage values where the total Aboriginal population in the area equals zero.)

SA2 area	Aboriginal people with an income >$650/week	% Aboriginal people with an income >$650/week
Port Melbourne Industrial	0	N/A
Braeside	0	N/A
Moorabbin Airport	0	N/A
Hughesdale	0	0.0%
Aspendale Gardens - Waterways	0	0.0%
Flinders	0	0.0%
Sandringham - Black Rock	4	9.5%
South Melbourne	7	10.8%
Hampton	6	12.8%
Chelsea Heights	3	14.3%
Bentleigh East (North)	9	17.0%
Mentone	7	17.9%
Malvern East	10	18.2%
Rosebud - McCrae	47	19.6%
Frankston North	57	20.1%

[77]Goux D, Maurin E. The effect of overcrowded housing on children's performance at school. Journal of Public Economics 2005;89(5):797-819.
[78]Chatterji P. Illicit drug use and educational attainment. Health Econ 2006;15(5):489-511.
[79]Boffa J, Tilton E, Ah Chee D. Preventing alcohol-related harm in Aboriginal and Torres Strait Islander communities: The experience of an Aboriginal Community Controlled Health Service in Central Australia. Aust J Gen Pract 2018;47(12):851-4.
[80]Bjarnason T, Andersson B, Choquet M, Elekes Z, Morgan M, Rapinett G. Alcohol culture, family structure and adolescent alcohol use: multilevel modelling of frequency of heavy drinking among 15-16 year old students in 11 European countries. J Stud Alcohol 2003;64(2):200-8.
[81]Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW; 2015.
[82]The Social Research Centre. Findings from the AEDC. Melbourne: Commonwealth of Australia; 2019 [cited 2021 January 19]. Available from: https://www.aedc.gov.au/parents/findings-from-the-aedc



SA2 area	Aboriginal people with an income >$650/week	% Aboriginal people with an income >$650/week
Brighton (Vic.)	7	21.2%
Carrum Downs	52	21.8%
Seaford (Vic.)	48	23.1%
St Kilda East	12	23.5%
Carnegie	8	23.5%
Point Nepean	39	23.6%
Dromana	17	23.6%
Cheltenham - Highett (East)	21	23.9%
Mornington	38	25.0%
Caulfield - North	11	25.0%
Frankston	60	25.8%
Carrum - Patterson Lakes	16	26.2%
Somerville	43	27.6%
Hastings - Somers	111	29.3%
Edithvale - Aspendale	20	29.4%
Moorabbin - Heatherton	12	30.0%
Skye - Sandhurst	29	31.2%
Murrumbeena	6	31.6%
Mount Eliza	20	31.7%
Langwarrin	59	31.9%
Cheltenham - Highett (West)	10	33.3%
Mount Martha	25	35.7%
St Kilda	48	36.1%
Chelsea - Bonbeach	29	36.3%
Malvern - Glen Iris	13	38.2%
Bentleigh East (South)	12	40.0%
Elsternwick	10	40.0%
Caulfield - South	5	41.7%
Mordialloc - Parkdale	36	42.9%
Port Melbourne	27	42.9%
Frankston South	47	44.3%
Elwood	24	44.4%
Ormond - Glen Huntly	5	45.5%
Beaumaris	10	47.6%
Bentleigh - McKinnon	11	52.4%
Brighton East	9	52.9%
South Yarra - East	38	59.4%
Prahran - Windsor	51	66.2%
Toorak	22	66.7%
Armadale	18	66.7%
Albert Park	17	68.0%

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[83].

[83]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Housing

1 in 5 Aboriginal Australians were living in overcrowded conditions in 2016 compared to around 7% of non- Aboriginal Australians[84]. Researchers have shown a connection between household crowding and adverse health and wellbeing outcomes including mental health problems[85], and poor educational attainment – both of which are associated with higher rates of alcohol consumption and problem drug use.

Table 17 below shows the number of Aboriginal persons in a given IARE who live in a crowded dwelling and expresses this as a percentage of the total number of Aboriginal persons living in a private dwelling in the same IARE. Here, a dwelling is assessed as crowded according to the Canadian National Occupancy Standard, which evaluates household size and composition and assesses appropriate bedroom requirements, specifying:

- ≤ 2 persons per bedroom
- children <5 years of age of different sexes may reasonably share a bedroom
- children < 18 years of age and of same sex may reasonably share a bedroom
- single household members ≥18 years should have a separate bedroom (as should parents or couples)
- a lone person household may reasonably occupy a bed-sitter.

The data is based on the ABS Census of Population and Housing, August 2016.

Table 17: Aboriginal persons living in crowded dwellings by Indigenous Area (IARE), 2016

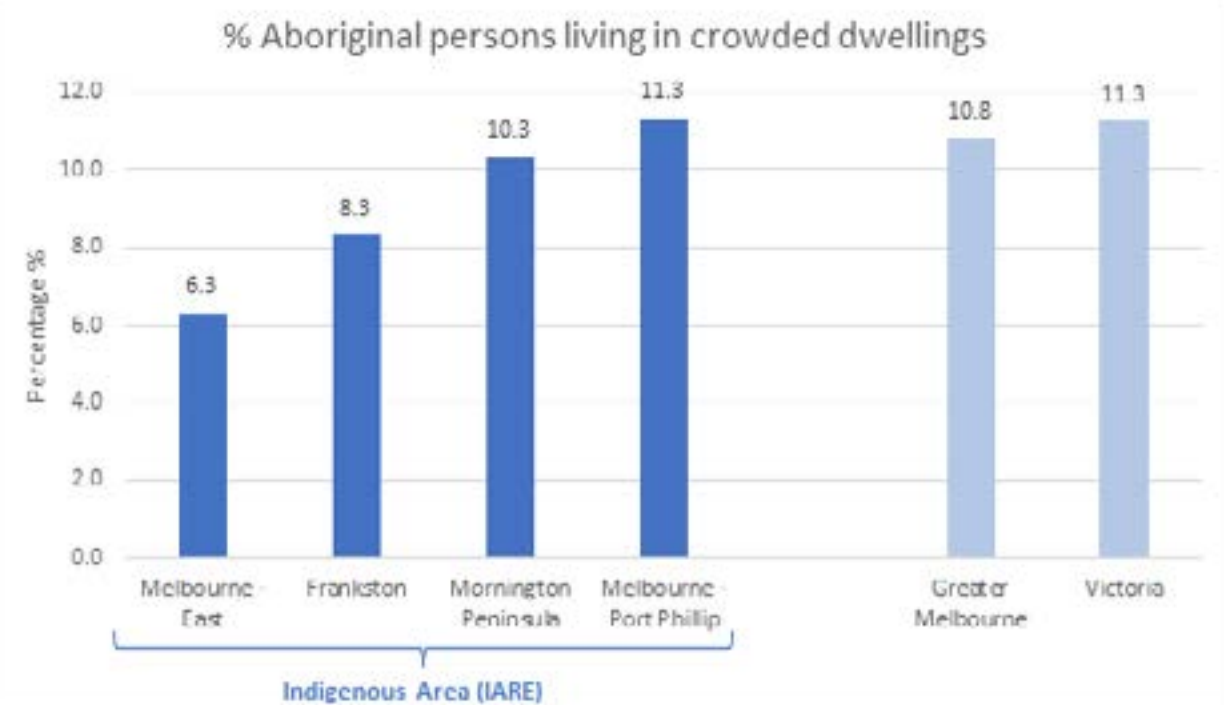
IARE/ Region	Aboriginal persons living in crowded dwellings	Total Aboriginal persons in private dwellings	% Aboriginal persons living in crowded dwellings
Melbourne - Port Phillip	119	1,049	11.3
Melbourne - East	64	1,012	6.3
Frankston	155	1,864	8.3
Mornington Peninsula	127	1,229	10.3
Greater Melbourne	2,488	23023.0	10.8
Victoria	5,123	45479.0	11.3

Source: Public Health Information Development Unit[86]

Melbourne – East and Frankton fare reasonably well in this indicator in comparison to Greater Melbourne and Victoria. Melbourne – Port Phillip shows the same degree of household crowding as Victoria in general, with 11.3% of Aboriginal persons living in crowded conditions. Approximately 10% of Aboriginal persons in the Mornington Peninsula area live in crowded conditions, which lies marginally below the percentage seen in Greater Melbourne in general. These percentages are represented graphically and geographically in Figures 12 and 13 below.

[84]Australian Institute of Health and Welfare. Indigenous housing. Canberra: AIHW; 2019 [updated 2020 November 25; cited 2021 January 18]. Available from: https://www.aihw.gov.au/reports/australias-welfare/indigenous-housing
[85] World Health Organization. WHO housing and health guidelines. Geneva: WHO; 2018.
[86] Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 29: Percentage of Aboriginal persons living in crowded dwellings as a percentage of total Aboriginal persons in private dwellings in an Indigenous Area (IARE), 2016



Source: Public Health Information Development Unit[87]

Figure 30: IARE map showing the percentage of Aboriginal persons living in crowded dwellings as a percentage of total Aboriginal persons in private dwellings in an Indigenous Area (IARE), 2016

Source: Public Health Information Development Unit[88]

[87]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

[88]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Disability

Disability can adversely impact an individual's capacity to gain adequate employment and produce income and can also lead to social exclusion[89]. These factors contribute to socioeconomic disadvantage.

Disability is more prevalent in relatively disadvantaged areas and Aboriginal and Torres Strait Islander people are more than twice as likely to need assistance with core activities of daily living as a consequence of disability in comparison to non- Aboriginal Australians[90]. It should also be noted that chronic and/or inappropriate use of alcohol and other drugs has the potential to cause disability, although data on drug-associated disability is largely unavailable[91].

The data presented in Table 3 shows the number of Aboriginal persons of any age who are living in the community with a profound or severe disability. These figures exclude those who reside in nursing homes, retirement or aged accommodation (not self-contained), hostels for the disabled and psychiatric hospitals. The data was compiled by Public Health Information Development Unit[92] based on unpublished data from the ABS Census 2011.

Table 18: Aboriginal persons with a profound or severe disability living in the community, by Indigenous Area (IARE), 2011

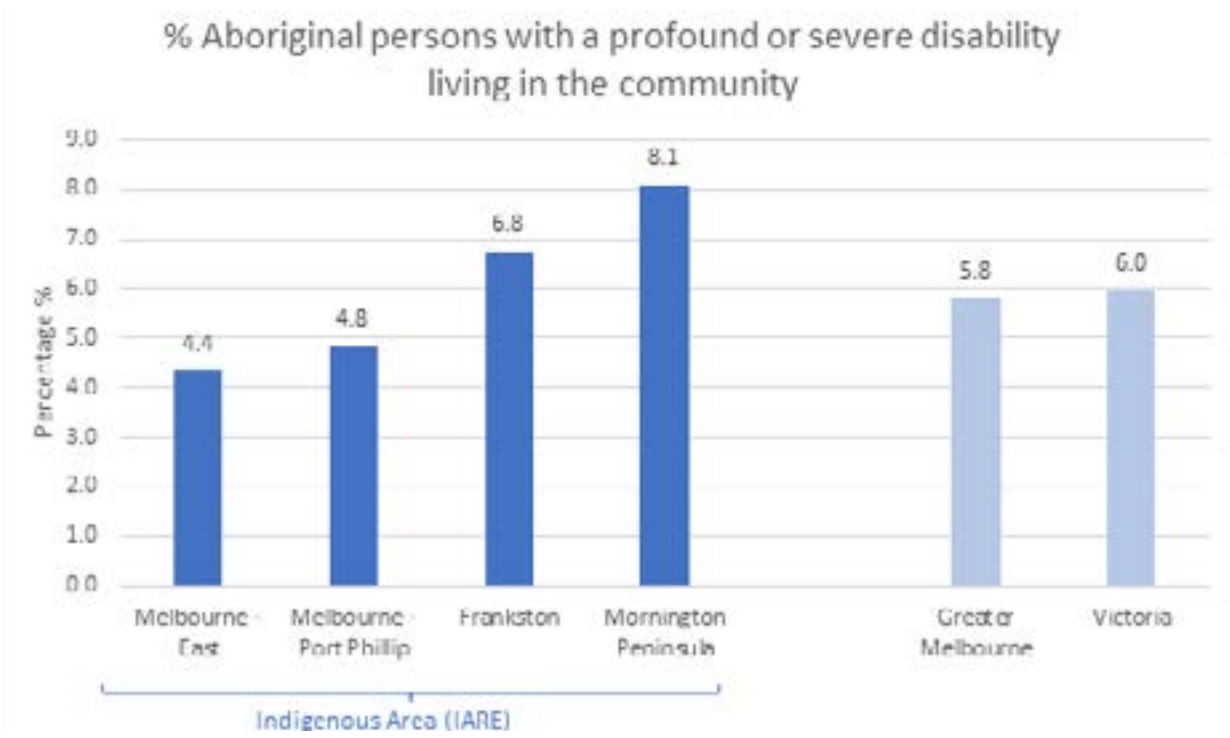
IARE/ Region	Estimated Aboriginal persons with a profound or severe disability living in the community	Total Aboriginal population (PoE)	% Aboriginal persons with a profound or severe disability living in the community
Melbourne - Port Phillip	54	1,117	4.8
Melbourne - East	35	804	4.4
Frankston	93	1,375	6.8
Mornington Peninsula	78	963	8.1
Greater Melbourne	1,066	18,312	5.8
Victoria	2,273	38,061	6.0

Source: Public Health Information Development Unit[92]

Among the IAREs reported here, Mornington Peninsula exhibits the highest percentage of disabled Aboriginal persons who reside in the community (8.1%). This percentage outweighs the overall percentage shown in Greater Melbourne and Victoria (5.8% and 6% respectively). The areas of Melbourne - East and Melbourne - Port Phillip fare relatively well in this indicator with percentages of 4.4% and 4.8% respectively. These comparisons are shown graphically in Figure 6 below and are represented geographically in Figure 7.

[89]Australian Institute of Health and Welfare. Australia's health 2016. Australia's health series no. 15. Canberra: AIHW; 2016.
[90]Australian Institute of Health and Welfare. Australia's welfare 2009. Australia's welfare series no. 9. Canberra: AIHW; 2009.
[90]Australian Institute of Health and Welfare. Drug use among Aboriginal and Torres Strait Islander peoples: an assessment of data sources. Drug statistics series no. 17. Canberra: AIHW; 2006.
[91] Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia.
[92]Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 31: Percentage of Aboriginal persons with a profound or severe disability living in the community, by Indigenous Area (IARE), 2011



Source: Public Health Information Development Unit[93]

Figure 32: IARE map showing the percentage of Aboriginal persons with a profound or severe disability living in the community, 2011

Source: Public Health Information Development Unit[94]

[93]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

[94]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

At the Local Government Area level, the 2016 Census of Population and Housing reports on Core Activity Need for Assistance (ASSNP) within a population, which is a measure of the number of people with a profound or severe disability. These people are defined as needing help or assistance in at least one of the three core activity areas (self-care, mobility and communication) as a consequence of disability, a long-term health condition (≥6 months) or old age. Table32 below shows the percentage of Aboriginal persons who need assistance with core activities in each LGA. These numbers are also shown graphically in Figure 55 below.

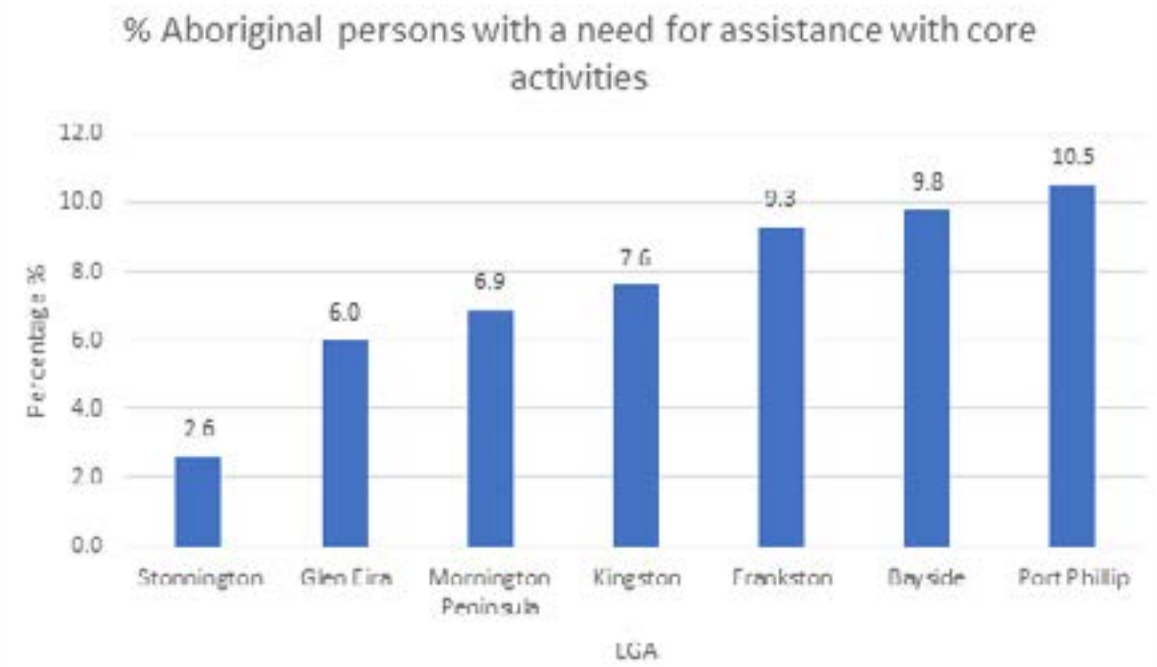
Table 19: Aboriginal persons with a need for assistance with core activities by Local Government Area (LGA), 2016

LGA	Number of Aboriginal persons with a need for assistance with core activities	% Aboriginal persons with a need for assistance with core activities
Frankston	124	9.3%
Mornington Peninsula	90	6.9%
Kingston	44	7.6%
Port Phillip	42	10.5%
Bayside	18	9.8%
Glen Eira	15	6.0%
Stonnington	8	2.6%
% non- Aboriginal persons across the above-listed LGAs with a need for assistance with core activities = 4.8%		

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[95].

[95]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Figure 33: Percentage of Aboriginal persons with a need for assistance with core activities, by Local Government Area (LGA), 2016



Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[96].

The data presented in Table 32 and Figure 55 above shows that Aboriginal people within these areas are more likely to show a need for assistance with core activities than non- Aboriginal persons across these areas. The exception to this among the areas described in this report is in Stonnington, which reported 2.6% of Aboriginal persons with a severe or profound level of disability compared to 4.8% for non- Aboriginal persons across these areas. Each of the other LGAs reported percentages greater than this, with Port Phillip showing the largest level of disadvantage in the area of disability at a percentage of 10.5%. Interestingly, prior analysis of 2006 Census data revealed that disability is more prevalent in relatively disadvantaged areas and that Aboriginal people are more than twice as likely to need assistance with core activities of daily living as a consequence of disability in comparison to non- Aboriginal Australians[97].

Data from the 2016 Census of Population and Housing for the Core Activity Need for Assistance (ASSNP) within a population is also available at SA2 level. Table 33 below details the percentage of Aboriginal persons with a need for assistance with core activities in each SA2 area.

[96]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

[97]Aboriginal and Torres Strait Islander people with disability: wellbeing, participation and support. https://www.aihw.gov.au/reports/indigenous-australians/aboriginal-and-torres-strait-islander-people-with/contents/summary

Table 17: SA2 level data on Aboriginal persons with a need for assistance with core activities, 2016

(NB: N/A replaces percentage values where the number of Aboriginal persons in the area equals zero.)

SA2 area	Number of Aboriginal persons with a need for assistance with core activities	% Aboriginal persons with a need for assistance with core activities
Total	334	7.8%
Frankston North	37	13.2%
Hastings - Somers	26	7.0%
Rosebud - McCrae	22	9.5%
Seaford (Vic.)	20	9.3%
Frankston	19	8.3%
Carrum Downs	17	7.1%
Mornington	13	8.9%
Point Nepean	12	7.5%
Sandringham - Black Rock	11	22.4%
St Kilda	10	7.5%
Chelsea - Bonbeach	9	11.5%
Cheltenham - Highett (East)	9	9.7%
Frankston South	9	9.2%
Somerville	8	5.2%
Langwarrin	7	3.9%
Port Melbourne	5	8.3%
Mount Eliza	5	7.1%
Skye - Sandhurst	5	6.0%
Carnegie	4	11.4%
Hampton	4	9.1%
St Kilda East	4	8.2%
Bentleigh East (North)	4	7.8%
Malvern East	4	7.7%
Elwood	4	7.3%
Edithvale - Aspendale	4	6.1%
Aspendale Gardens - Waterways	3	18.8%
Cheltenham - Highett (West)	3	11.5%
Chelsea Heights	3	10.0%
South Melbourne	3	4.8%
Dromana	3	4.1%

SA2 area	Number of Aboriginal persons with a need for assistance with core activities	% Aboriginal persons with a need for assistance with core activities
Albert Park	0	0.0%
Armadale	0	0.0%
Prahran - Windsor	0	0.0%
South Yarra - East	0	0.0%
Toorak	0	0.0%
Beaumaris	0	0.0%
Brighton (Vic.)	0	0.0%
Brighton East	0	0.0%
Bentleigh - McKinnon	0	0.0%
Caulfield - North	0	0.0%
Caulfield - South	0	0.0%
Elsternwick	0	0.0%
Hughesdale	0	0.0%
Murrumbeena	0	0.0%
Ormond - Glen Huntly	0	0.0%
Bentleigh East (South)	0	0.0%
Carrum - Patterson Lakes	0	0.0%
Mentone	0	0.0%
Moorabbin - Heatherton	0	0.0%
Mordialloc - Parkdale	0	0.0%
Malvern - Glen Iris	0	0.0%
Flinders	0	0.0%
Mount Martha	0	0.0%
Port Melbourne Industrial	0	N/A
Braeside	0	N/A
Moorabbin Airport	0	N/A

Source: Australian Bureau of Statistics. 2016 Census of Population and Housing[98].

[98]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Aboriginal single parent families with children aged less than 15 years

Single parent families are more likely to experience a higher level of disadvantage with respect to income, employment, housing and social connection. Children living with a single parent have been shown to experience higher rates of excessive alcohol consumption[99] and substance abuse[99] in comparison to those living with two parents, and Aboriginal families are more likely than the general population to be sole-parent families[100].

The data presented in Table 34 below shows the number of single parent families with children under 15 years of age where at least one family member is an Aboriginal or Torres Strait Islander person, expressed as a percentage of the total number of Aboriginal families with children under 15 years of age within an area. The figures are based on data obtained from the ABS Census of Population and Housing, 2016.

Table 18: Aboriginal persons with a need for assistance with core activities by Local Government Area (LGA), 2016

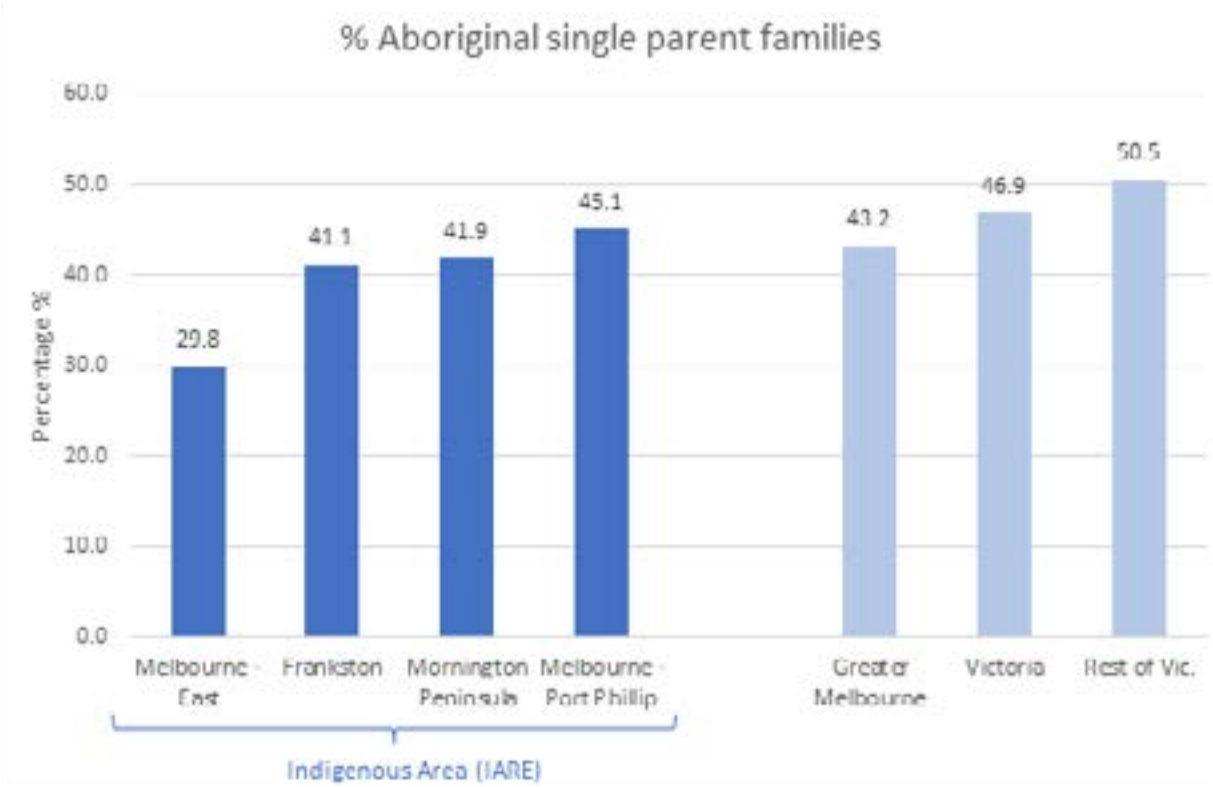
IARE	Aboriginal single parent families with children under 15 years	Total Aboriginal families with children under 15 years	% Aboriginal single parent families
Frankston	163	397	41.1
Melbourne - East	50	168	29.8
Melbourne - Port Phillip	55	122	45.1
Mornington Peninsula	116	277	41.9
Victoria	4,741	10,103	46.9
Greater Melbourne	2,143	4,965	43.2
Rest of Vic.	2,594	5,139	50.5

Source: Public Health Information Development Unit[101]

Melbourne- East appears to be significantly less disadvantaged compared to the other target IAREs with respect to this indicator, with approximately 30% of Aboriginal families being sole-parent families. This is well below the average of approximately 43% for Greater Melbourne and approximately 50% for the remainder of Victoria. The Mornington Peninsula and Frankston areas exhibit percentages that are marginally below the state average, while Melbourne Port Phillip exhibits the highest percentage of single parent Aboriginal families within the target area. Nonetheless, the value for Melbourne - Port Phillip remains below the state average. Figure 56 below shows these percentages and allows for easy comparison to the average percentages shown in Greater Melbourne, the rest of Victoria and the whole of Victoria.

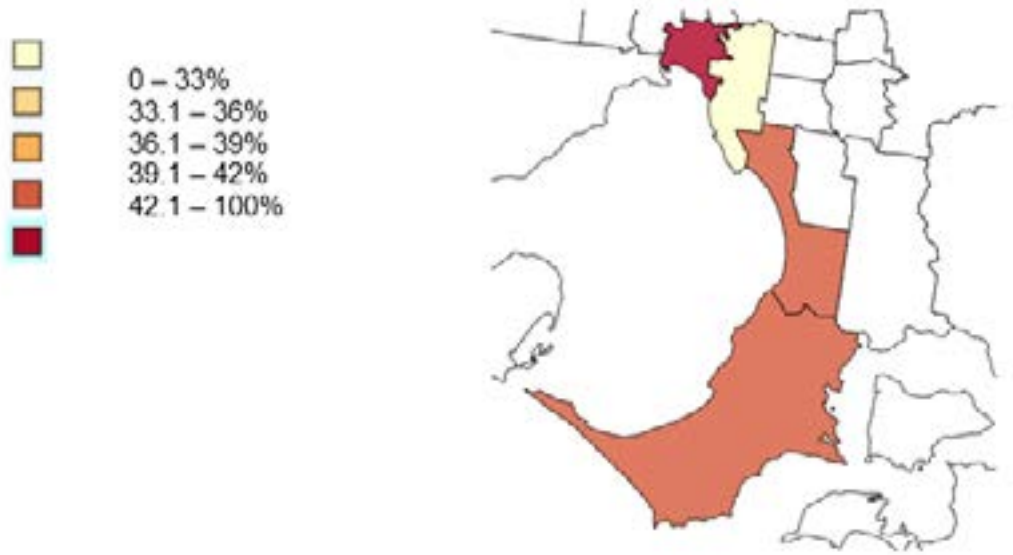
[99]Australian Institute of Health and Welfare. Australia's health 2016. Australia's health series no. 15. Canberra: AIHW; 2016.
[100]Australian Institute of Health and Welfare. Australia's welfare 2009. Australia's welfare series no. 9. Canberra: AIHW; 2009.
[101]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: http://phidu.torrens.edu.au/

Figure 34: Percentage of Aboriginal single parent families with children aged less than 15 years as a percentage of total Aboriginal families within an Indigenous Area (IARE), 2016



Source: Public Health Information Development Unit[102]

Figure 35: IARE map showing the percentage of Aboriginal single parent families with children aged less than 15 years as a percentage of total Aboriginal families, 2016



Source: Public Health Information Development Unit[102]

[102]Public Health Information Development Unit. Aboriginal and Torres Strait Islander social health atlas of Australia. Adelaide: Torrens University Australia; 2020 [updated 2020 August; cited 2021 January 14]. Available from: whttp://phidu.torrens.edu.au/

1.3 AOD harms

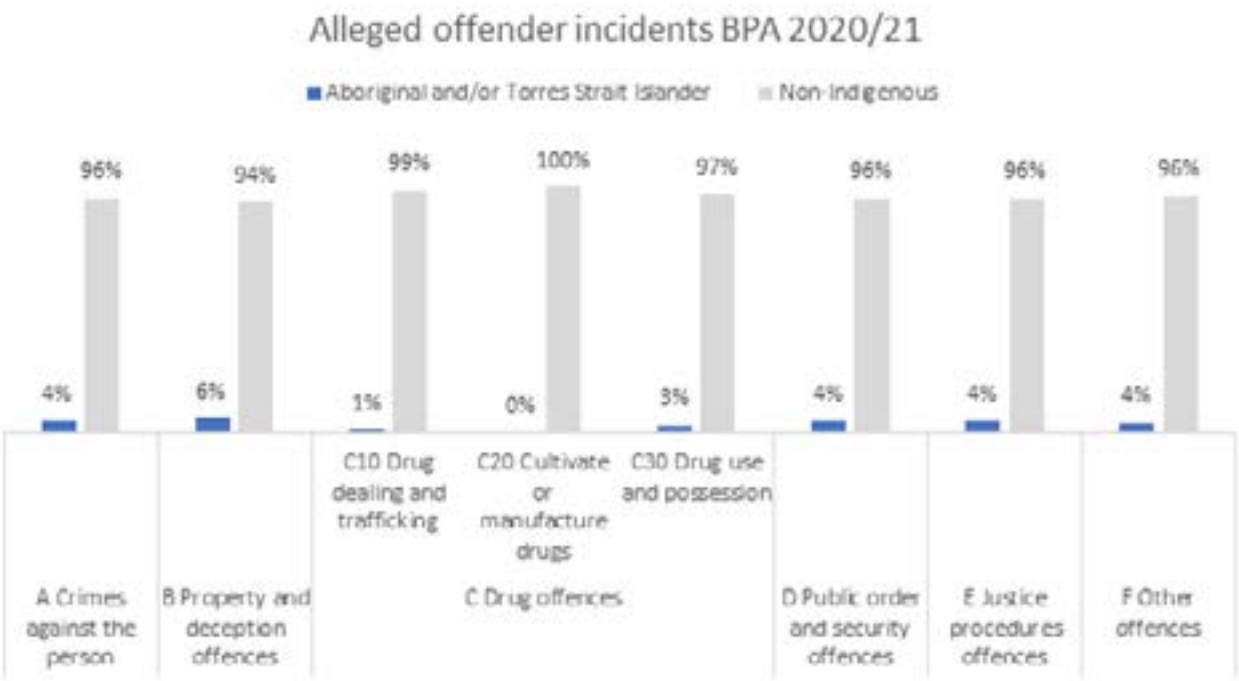
Note. Hospitalisation and ambulance usage will be available in December 2021.

Alleged offender incidents

Aboriginal people are very rarely arrested for drug-related crime.

The percentage of all alleged offences involving Aboriginal people is approximately 4%, which is significantly higher than their prevalence in the community. This proportion is similar to the proportion of Aboriginal people in the community accessing drug and alcohol services.

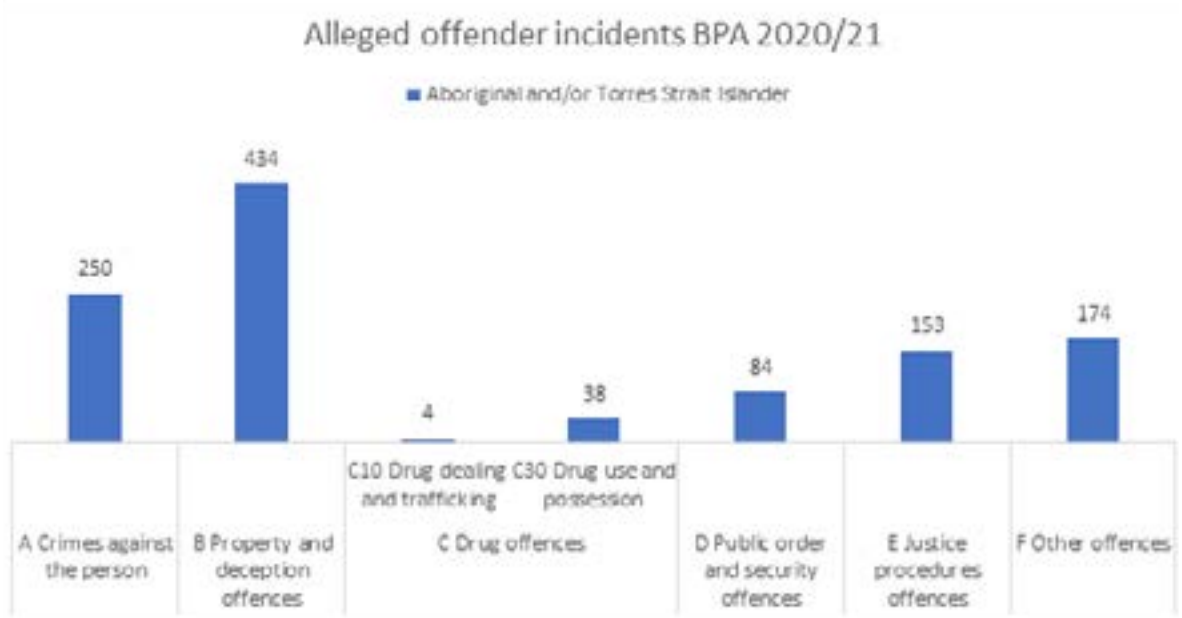
Figure 36: Victoria Police alleged offender incidents - all



Source: Victoria Police. Crime Statistics Agency[103].

[103]Victoria Police. Crime Statistics Agency. Accessed 19/11/2021

Figure 37: Victoria Police alleged offender incidents - Aboriginal offenders



Source: Victoria Police. Crime Statistics Agency[104].

Figure 38: Alleged offender incidents (Aboriginal people) by LGA where the offence occurred

Source: Victoria Police. Crime Statistics Agency[104].

[104]Victoria Police. Crime Statistics Agency. Accessed 19/11/2021

Table 19: Alleged offender incidents (Aboriginal people) BPA

LGA	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Bayside	7	4	15	9	24	24	32	23	29	54	221
Frankston	97	115	189	188	270	201	240	220	251	221	1992
Glen Eira	10	16	26	17	48	43	41	34	31	64	330
Kingston	19	35	22	48	68	86	106	74	87	68	613
Mornington Peninsula	117	77	113	129	135	94	113	101	147	132	1158
Port Phillip	120	111	115	147	214	213	251	249	240	320	1980
Stonnington	40	42	68	75	116	134	121	106	152	278	1132
Total	410	400	548	613	875	795	904	807	937	1137	7426

Source: Victoria Police. Crime Statistics Agency[105].

[105]Victoria Police. Crime Statistics Agency. Accessed 19/11/2021

1.4 Demand for services for Aboriginal and Torres Strait Islander people in Victoria

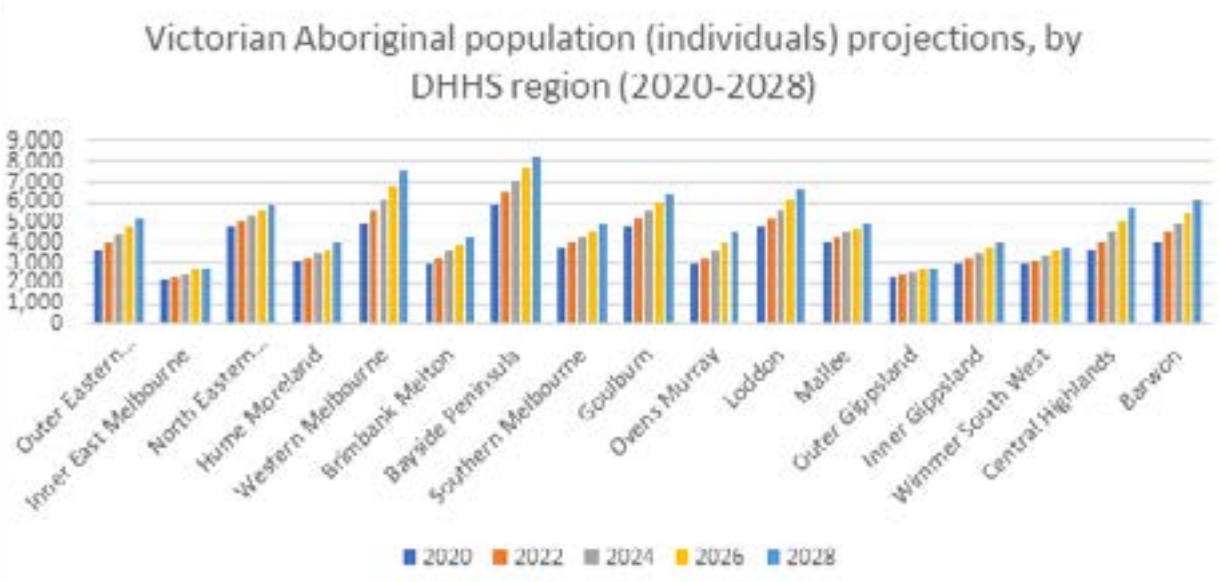
In 2019 the Aboriginal Executive Council commissioned Social Ventures Australia to project future demand for social services in 8 priority sectors :

- Education
- Child and family
- Family violence
- Homelessness
- Justice
- Mental health
- Alcohol and other drugs
- Youth

In all sectors, the Bayside Peninsula area was identified in the top 3 Metro areas with highest demand.

By 2028, Bayside Peninsula is expected to have the largest number of Aboriginal people (8,324) by DHHS region, which is nearly 1000 more people than in the next largest area.

Figure 39: Victorian Aboriginal Population (Individuals) Projections by DHHS Region (2020-2028)



Source: SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria[106]

[106]SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria https://www.parliament.vic.gov.au/images/stories/committees/paec/COVID-19_Inquiry/Submissions/76b._Aboriginal_Executive_Council_AEC.pdf

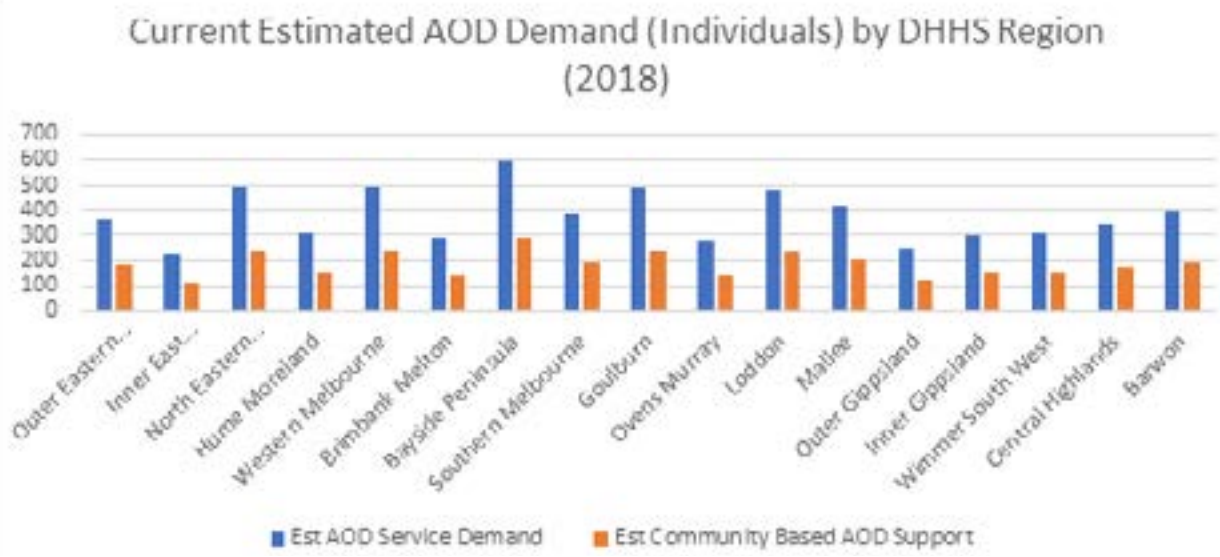
AOD services

Bayside Peninsula and North Eastern Melbourne are predicted to have the highest demand for AOD services.

The model currently projects the demand for Alcohol and other drug (AOD) services using an estimate of demand that is the proportion of Aboriginal people in Victoria that exceed lifetime risks guidelines for alcohol usage, and applying this proportion at the level of DHHS area. This proxy has been selected due to a lack of available data in this sector, but will be reviewed as data requests are completed.

The estimated demand for community based AOD services is based on service utilisation data from AIHW[107] that identifies 49% of AOD service users receive counselling and case management (services typically delivered by organisations operating within the community). This assumption was tested and approved by the Victorian Drug and Alcohol Association (VAADA).

Figure 40: Current Estimated AOD Demand (Individuals) by DHHS Region (2018)



Source: SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria[108]

Note. The blue column is total demand and the orange column is the part of that demand managed in the community. The numbers should not be combined.

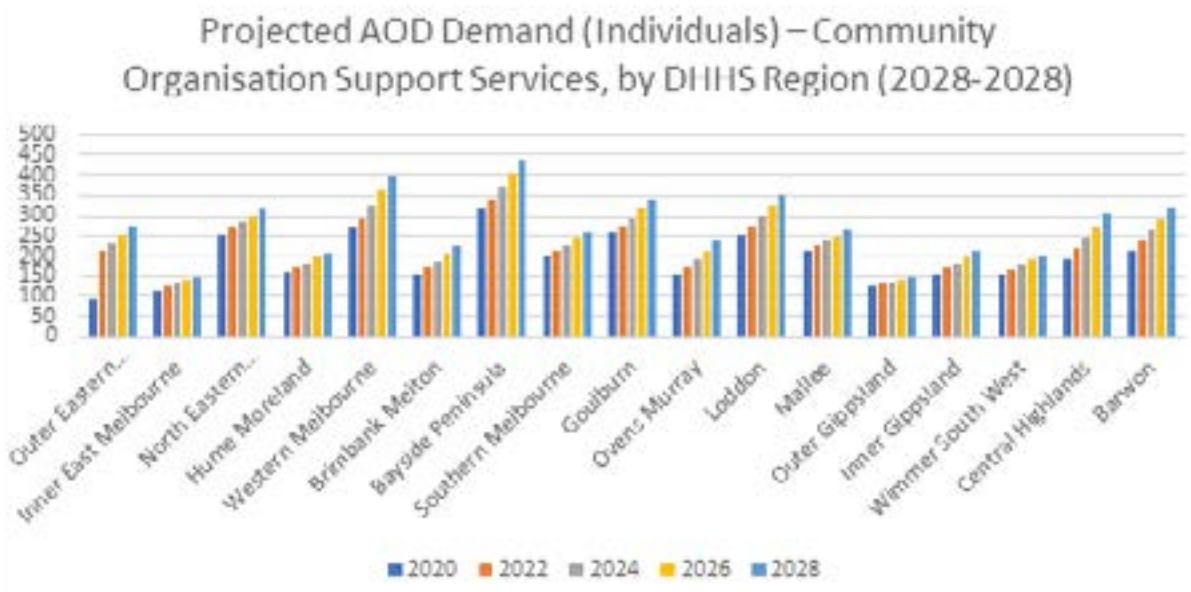
The numbers match well with actual activity from VADC data.

Financial year	2018-19	2019-20	2020-21
Individual Aboriginal clients	219	317	253
Projected	291	316	

Source: SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria[108]

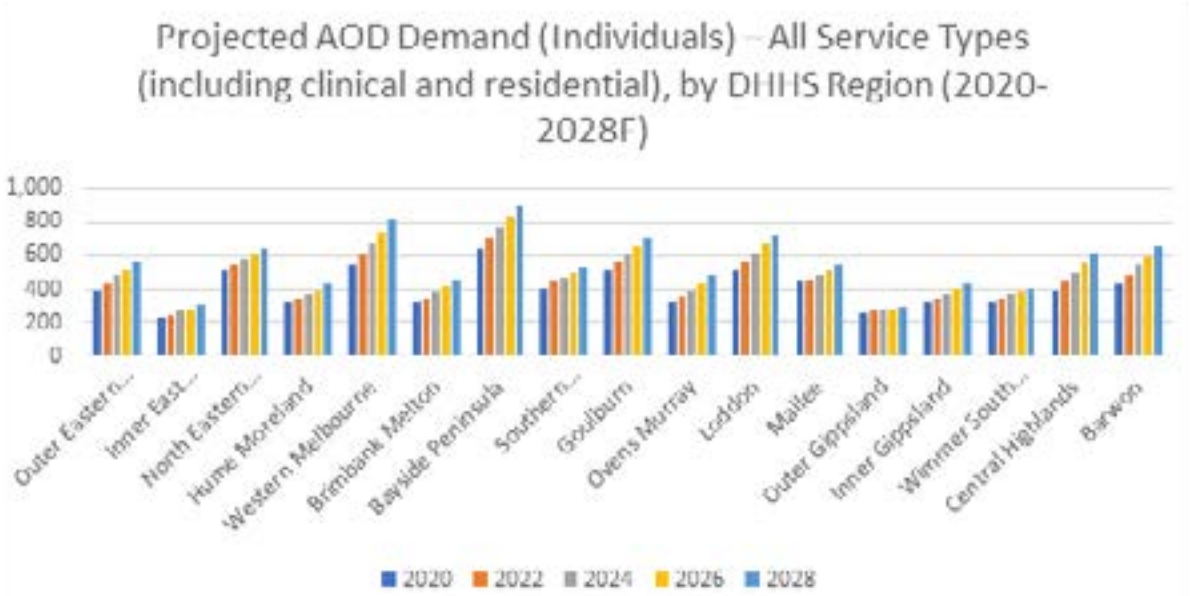
[107]Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW; 2015.
[108]SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria https://www.parliament.vic.gov.au/images/stories/committees/paec/COVID-19_Inquiry/Submissions/76b._Aboriginal_Executive_Council_AEC.pdf

Figure 41: Projected AOD Demand (Individuals) – Community Organisation Support Services, by DHHS Region (2028-2028)



Source: SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria[109]

Figure 42: Projected AOD Demand (Individuals) – All Service Types (including clinical and residential), by DHHS Region (2020-2028)



Source: SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria[109]

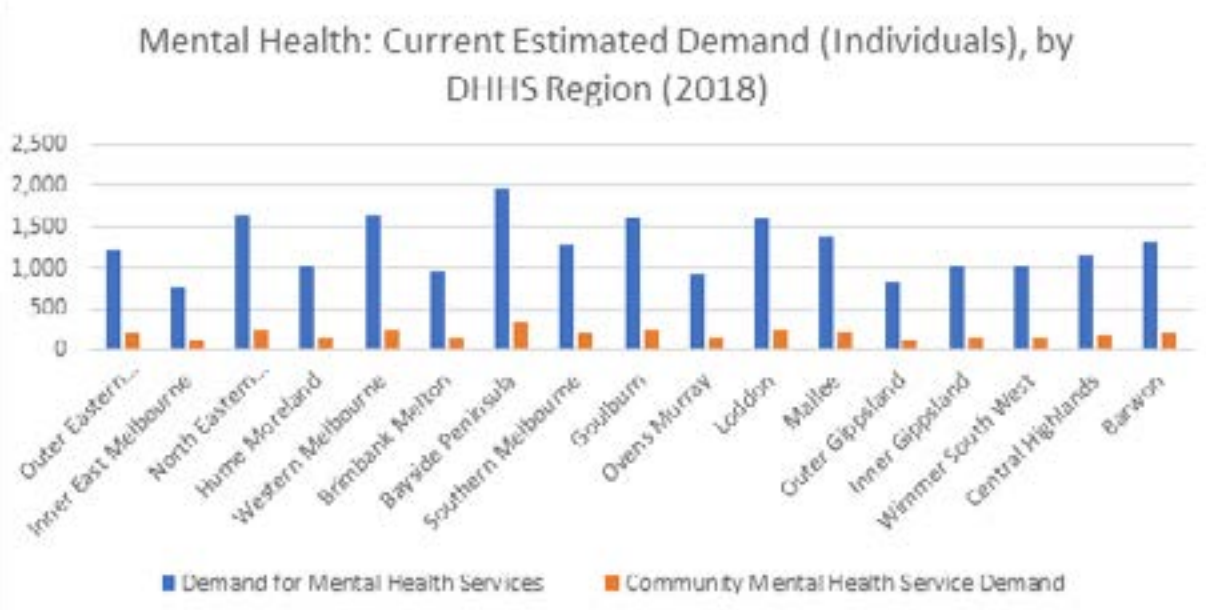
[109]SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria https://www.parliament.vic.gov.au/images/stories/committees/paec/COVID-19_Inquiry/Submissions/76b._Aboriginal_Executive_Council_AEC.pdf

Analysis commissioned by DHHS in 2017[110] offers a number of insights, including:

- Utilisation of services has remained steady since 2013, whilst the population has grown significantly
- 43% of Aboriginal clients accessed an alcohol and drug service via an Aboriginal organisation
- Primary drugs of concern are alcohol (31% of clients), cannabinoids (31.5%) and amphetamines (37%)
- Service utilisation varies significantly across local government areas – Mildura, Greater Shepparton, Campaspe and Darebin have high numbers and Frankston, Melton and Yarra Ranges are significantly lower
- Methamphetamine use by Aboriginal people is higher among Aboriginal people, and users tend to be younger than non-Aboriginal people, with several studies identifying an increase in use
- A lack of Aboriginal-specific AOD services in the outer south eastern corridor of Frankston, Mornington Peninsula, Casey, Cardinia and Greater Dandenong

Mental health

Figure 43: Mental Health: Current Estimated Demand (Individuals), by DHHS Region (2018)



Source: SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria[112]

Half of all demand for family violence services in Victoria will be in Bayside Peninsula, Mallee and North Eastern Melbourne.

The impact of colonisation, intergenerational trauma and ongoing social, cultural and political marginalisation in Australia has driven experiences of poor mental ill-health for many Aboriginal people in Victoria, with 36% of Aboriginal Victorians reporting high or very high levels of psychological distress (an estimated 21,000 people in 2018) .

[110]Frizzell. J. December 2017. Aboriginal Alcohol and Other Drug and Mental Health Mapping Project, prepared for DHHS
[111]Snijder. M. Kershaw. S. (2019). Review of methamphetamine use among Aboriginal and Torres Strait Islander people. Australian Indigenous HealthBulletin 19(3)
[112]SVA. Demand for services for Aboriginal and Torres Strait Islander people in Victoria https://www.parliament.vic.gov.au/images/stories/committees/paec/COVID-19_Inquiry/Submissions/76b._Aboriginal_Executive_Council_AEC.pdf
[113]Victoria State Government. Victorian Government Aboriginal Affairs Report 2018. https://www.firstpeoplesrelations.vic.gov.au/sites/default/files/2019-12/Victorian-Government-Aboriginal-Affairs-Report-2018.pdf

Section 2. Current utilisation of AOD services

The Victorian Alcohol and Drug Collection (VADC) is the data collection specification for all Department of Health Victoria funded AOD treatment providers. The VADC is a list of data elements (or types of information) that AOD treatment providers are required to report from their own client management systems to the Department.

Relevant AOD data excluded from this activity report includes:

- PHN funded AOD services
- Pharmacotherapy services provided by general practice

Table 20: Service users by LGA

LGA 2020/21	Individual service users
Bayside	17
Frankston	86
Glen Eira	10
Kingston	14
Mornington Peninsula	57
Port Phillip	58
Stonnington	17
Total	253

Source: Victorian alcohol and drug collection (VADC)[114].

[114]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

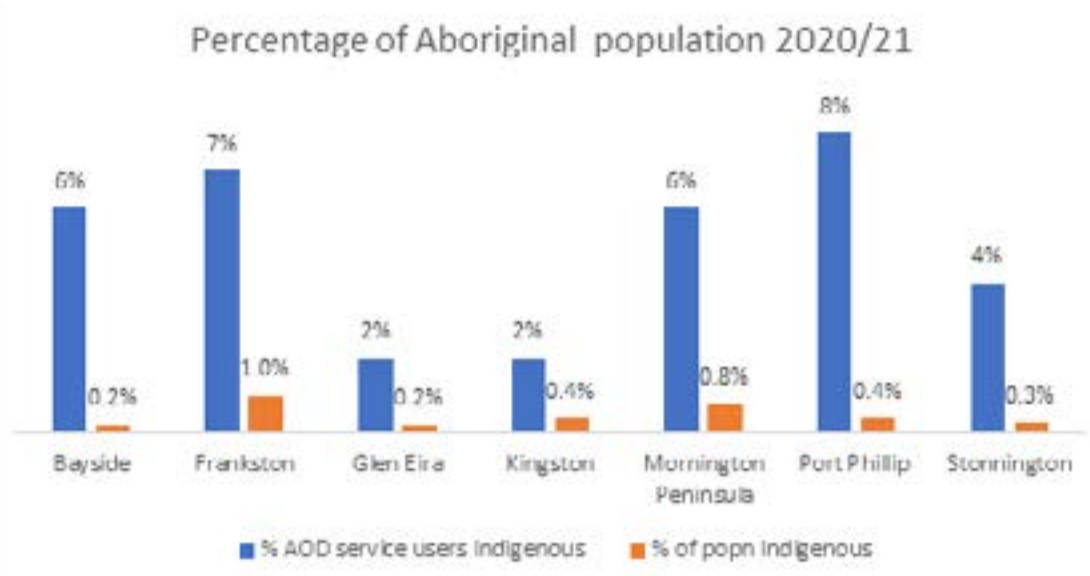
In addition, Access Health, The Salvation Army AOD Victoria, supports 150 individual non-residential clients in Port Phillip.

Table 21: Comparison of Aboriginal and non-Aboriginal service users by LGA

LGA	% AOD service users Aboriginal 2020/21	% of population Aboriginal	Multiplier
Bayside	6%	0.2%	30x
Frankston	7%	1.0%	7x
Glen Eira	2%	0.2%	10x
Kingston	2%	0.4%	5x
Mornington Peninsula	6%	0.8%	
Port Phillip	8%	0.4%	20x
Stonnington	4%	0.3%	
All BPA	5%		
Metro Melbourne	7%		
Victoria	10%		

Source: Source: 2020/21 VADC Data, 2016 Census[115].

Figure 44: Percentage of Aboriginal Population 2020/21

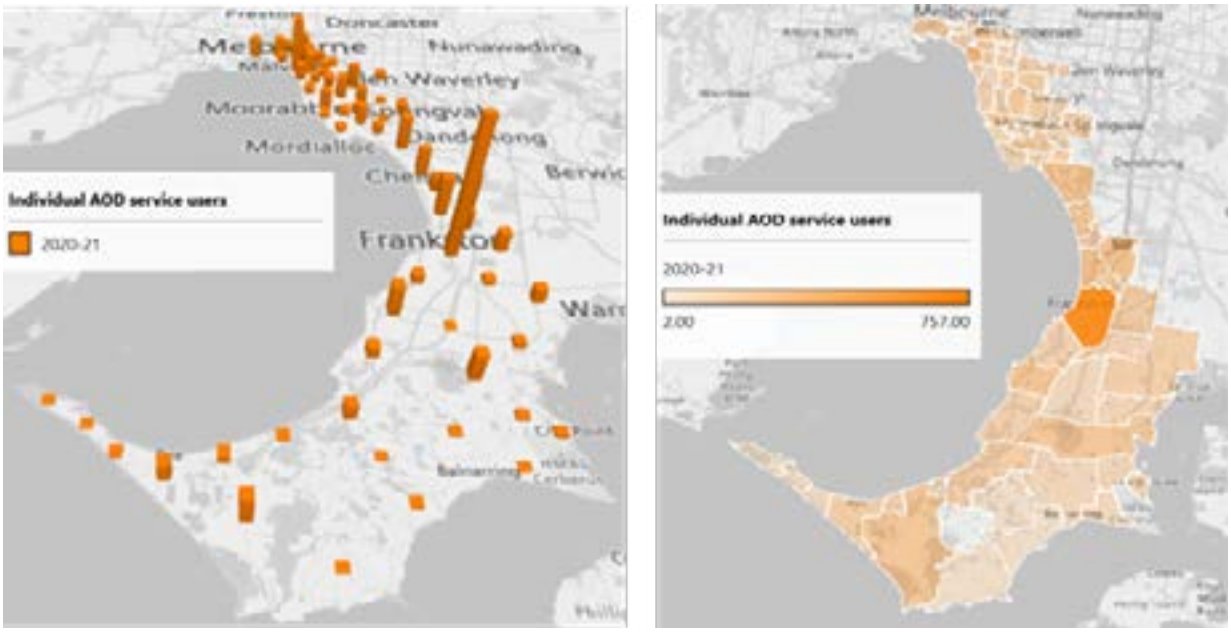


Source: Source: 2020/21 VADC Data, 2016 Census[115].

People receiving AOD services are generally spread across the catchment, with the exception of a dense concentration in Frankston, which has over twice the number of clients of any other postcode. Other popular areas are St Kilda, Seaford and Rosebud.

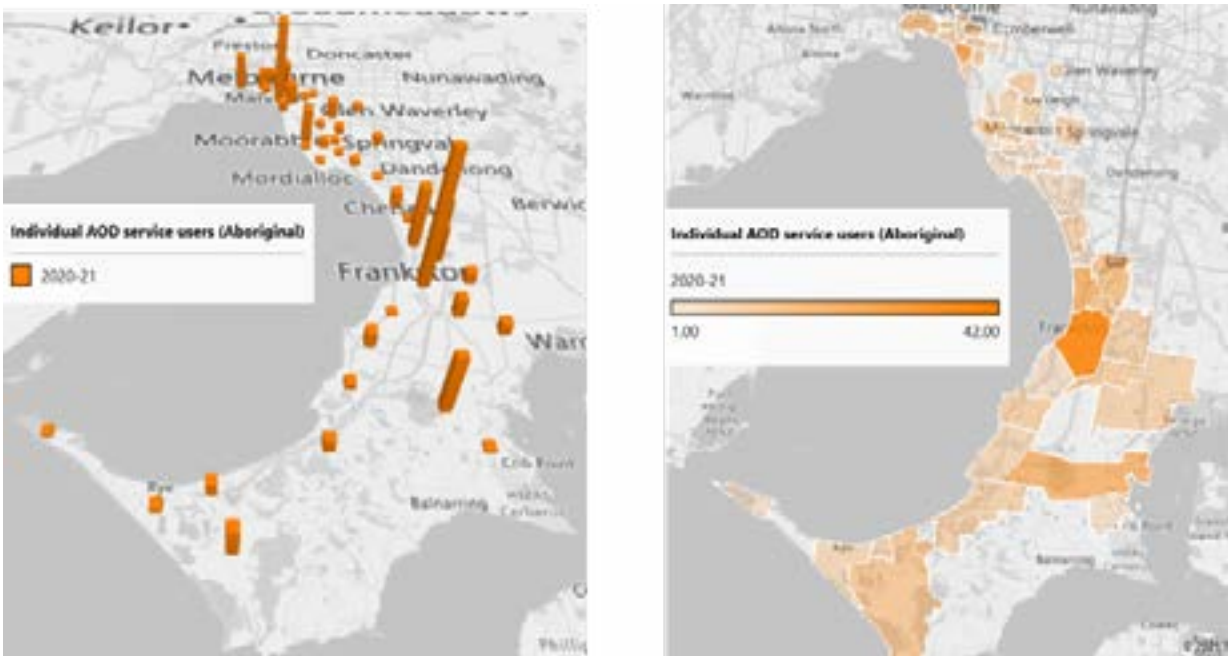
[115]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Figure 45: Individual AOD service users (all) by LGA



Source: 2020/21 VADC Data[116], 2016 Census[117]

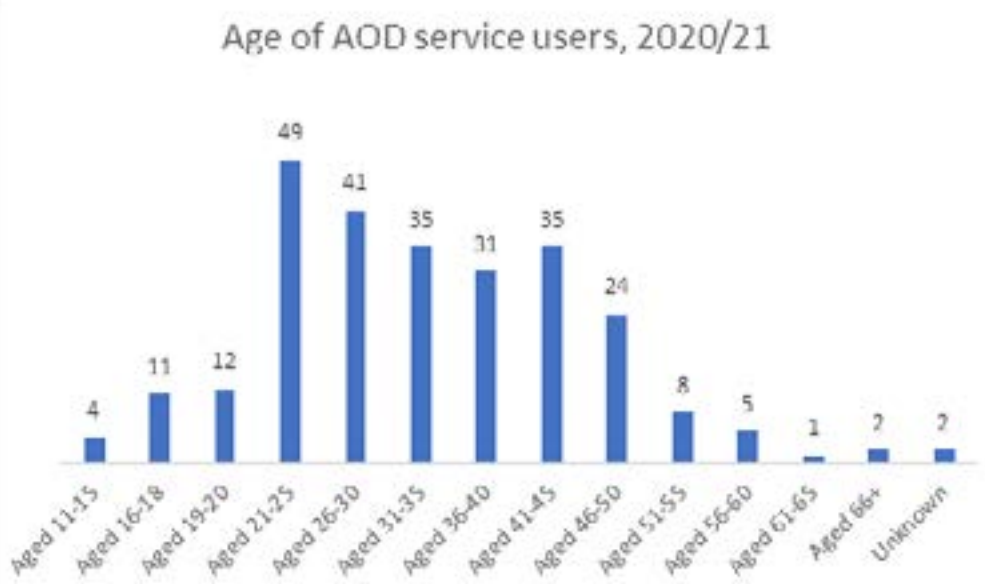
Figure 46: Individual AOD Service Users (Aboriginal) by LGA



Source: 2020/21 VADC Data[118], 2016 Census[119]

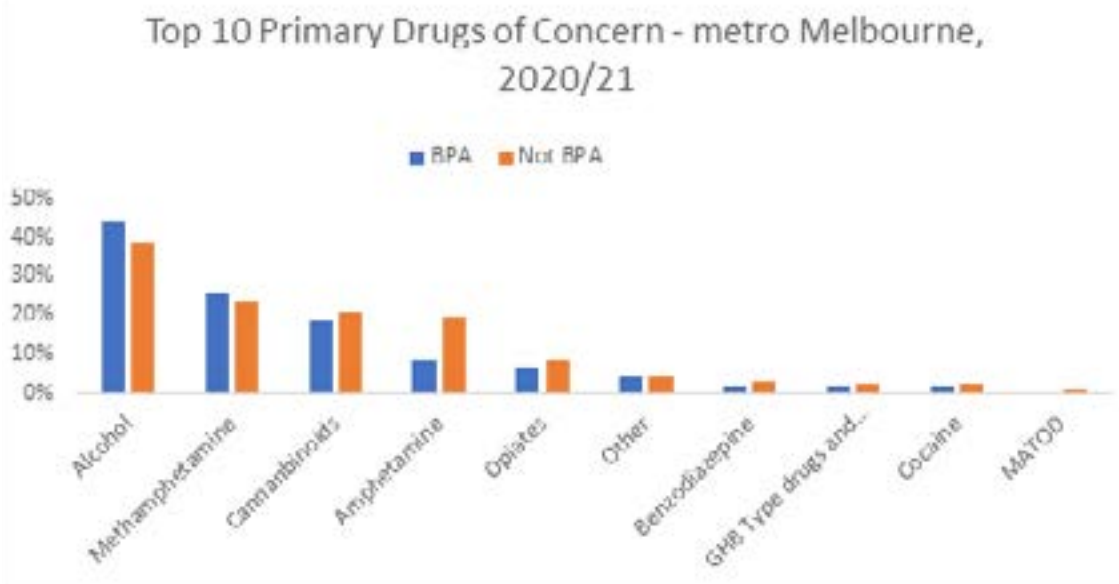
[116]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc
[117] Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder
[118] Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc
[119]Australian Bureau of Statistics. 2016 Census of Population and Housing. Accessed using TableBuilder. https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Figure 47: Age of Aboriginal AOD Service Users 2020/21



Source: Source: Source: 2020/21 VADC Data[118], 2016 Census[119]

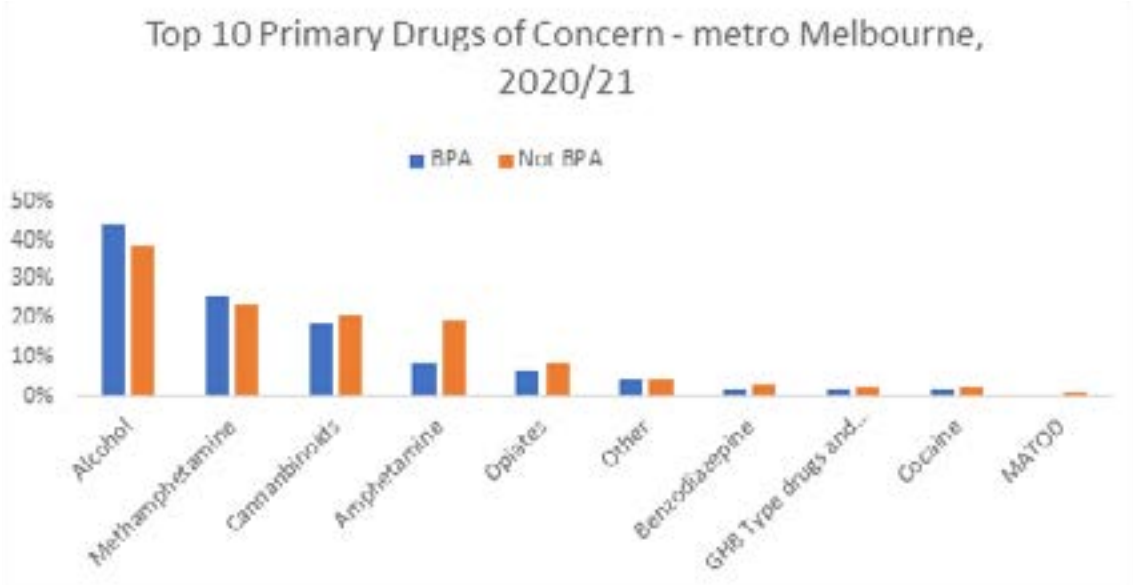
Figure 48:Primary drugs of concern 2020/21 (all)



Source: Victorian alcohol and drug collection (VADC)[120].

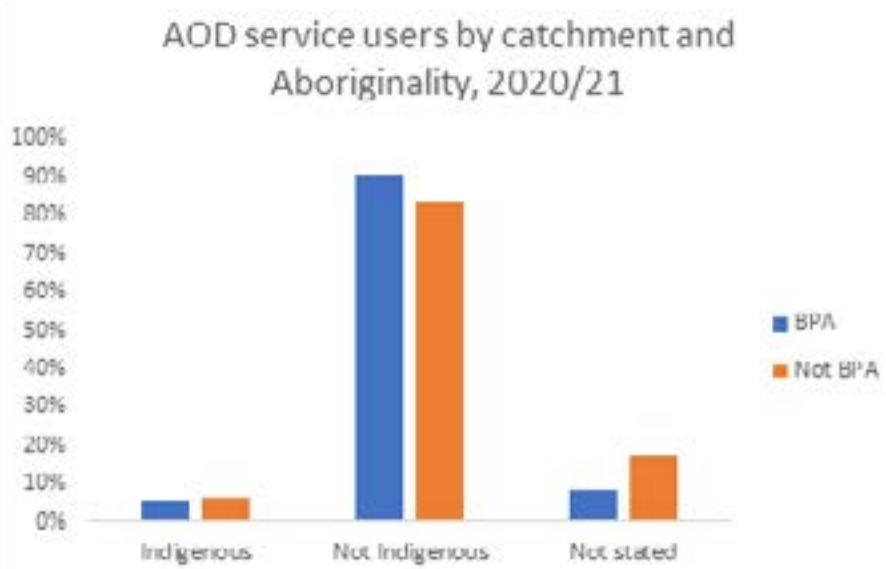
[120] Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Figure 49: Top 10 Primary drugs of concern (Aboriginal)



Source: Victorian alcohol and drug collection (VADC)[120].

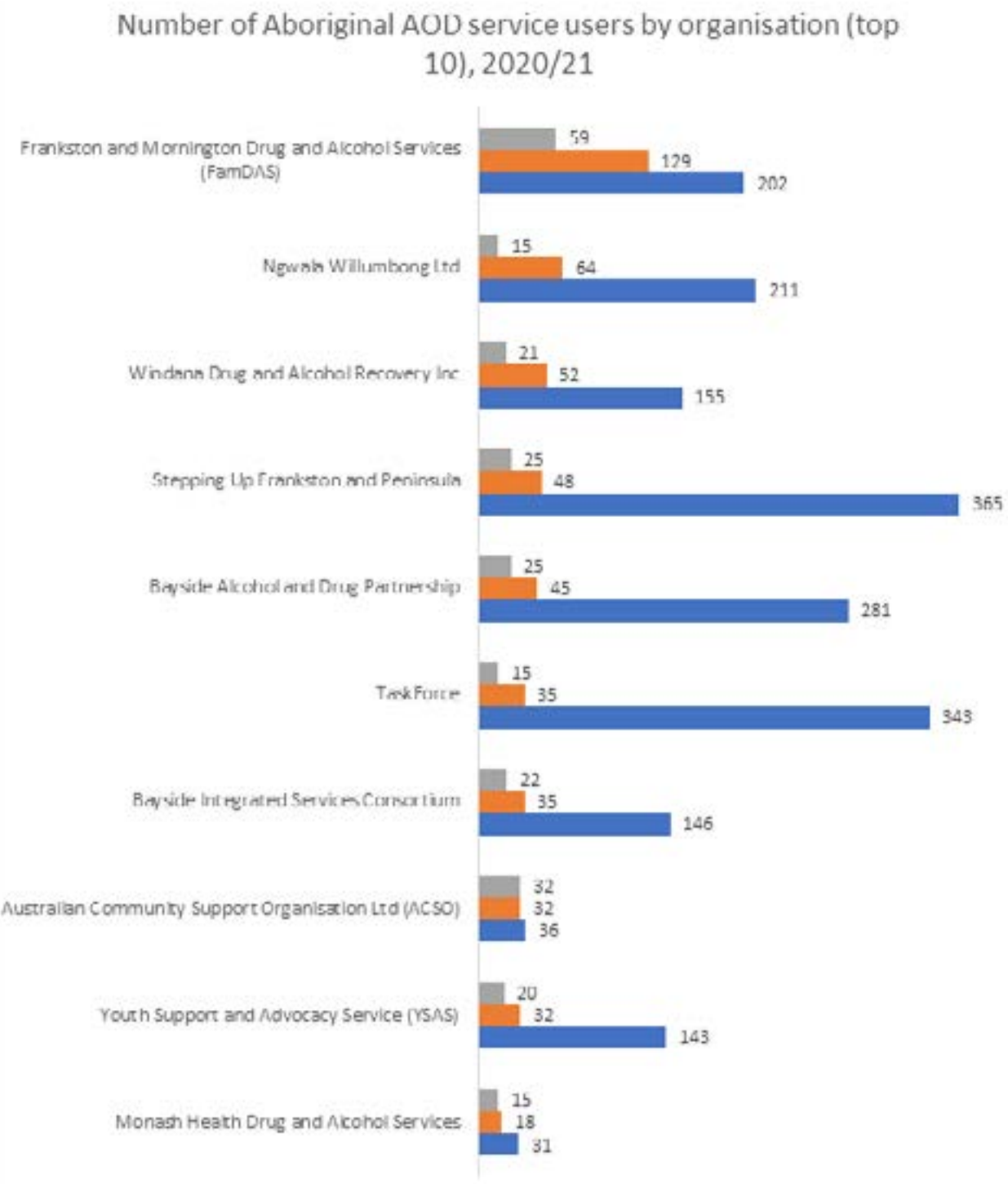
Figure 50: AOD service users by catchment and Aboriginality



Source: Victorian alcohol and drug collection (VADC)[121].

[121]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Figure 51: Number of Aboriginal AOD services by organisation



Source: Victorian alcohol and drug collection (VADC)[122].

[121] Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

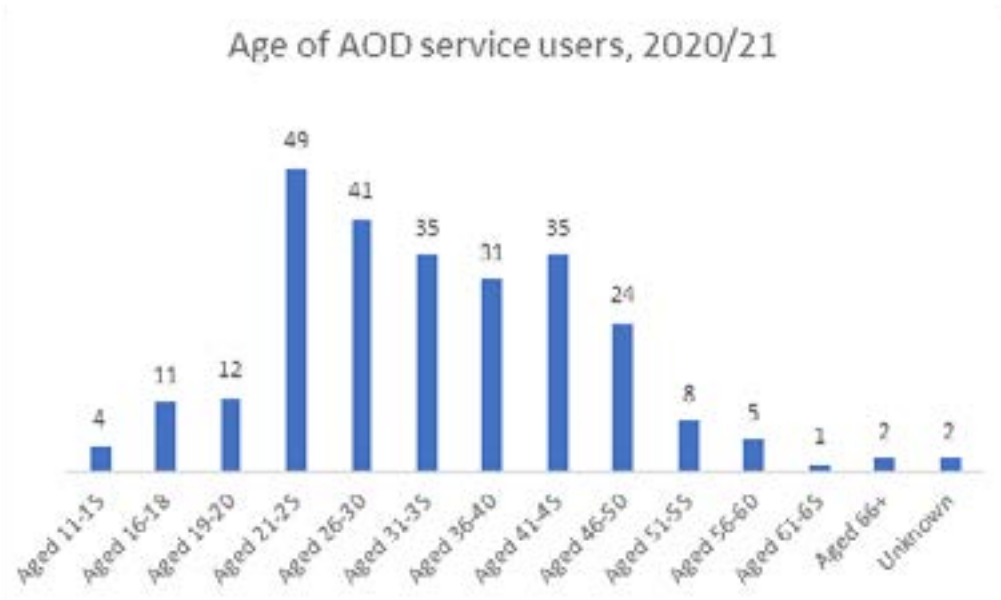
Table 22: AOD services by clients, episodes of care and number of contacts

Service type 2020/21	Individual clients	Episodes of care	Service contacts	Contacts per episode
Comprehensive assessment	75	76	92	1.2
Intake	70	72	70	1.0
Counselling	64	86	759	8.8
Bridging support	60	73	164	2.2
Pre-admission client engagement	38	59	233	3.9
Care & recovery coordination	27	30	125	4.2
Youth outreach	24	51	404	7.9
Residential withdrawal	18	21	0	0.0
Aboriginal Metro Ice Program - counselling	16	19	189	9.9
ACCHO AoD treatment - worker	12	29	169	5.8
ACCHO AoD treatment - worker assessment	10	10	38	3.8
ACCHO AoD treatment - worker brief intervention	10	21	50	2.4
Non-residential withdrawal	9	12	52	4.3
Residential rehabilitation	9	11	0	0.0
Brief intervention	9	9	6	0.7
Warning, invalid funding/target/stream combination	4	4	9	2.3
Youth residential withdrawal	3	5	0	0.0
Youth counselling, consultancy and continuing care	2	2	12	6.0
Outdoor therapy	2	3	9	3.0
Day rehabilitation	2	2	14	7.0
DDAL intervention	2	2	4	2.0
Slow stream pharmacotherapy	1	1	0	0.0
Ante & post-natal support	1	1	7	7.0
Specialist pharmacotherapy	1	1	1	1.0
Counselling kickstart	1	1	3	3.0
Youth day program	1	2	6	3.0
Total	253	603	2416	4.0

Source: 2020/21 VADC Data[123]

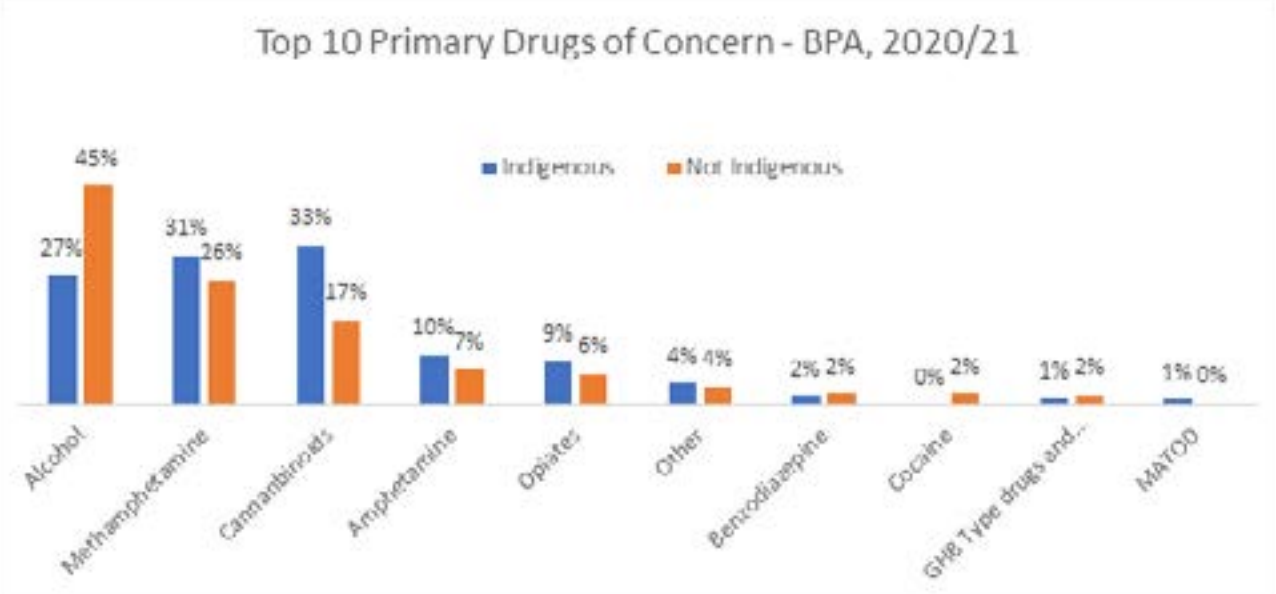
[123]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Figure 52: Age of AOD Service Users (all) 2020/21



Source: 2020/21 VADC Data[124].

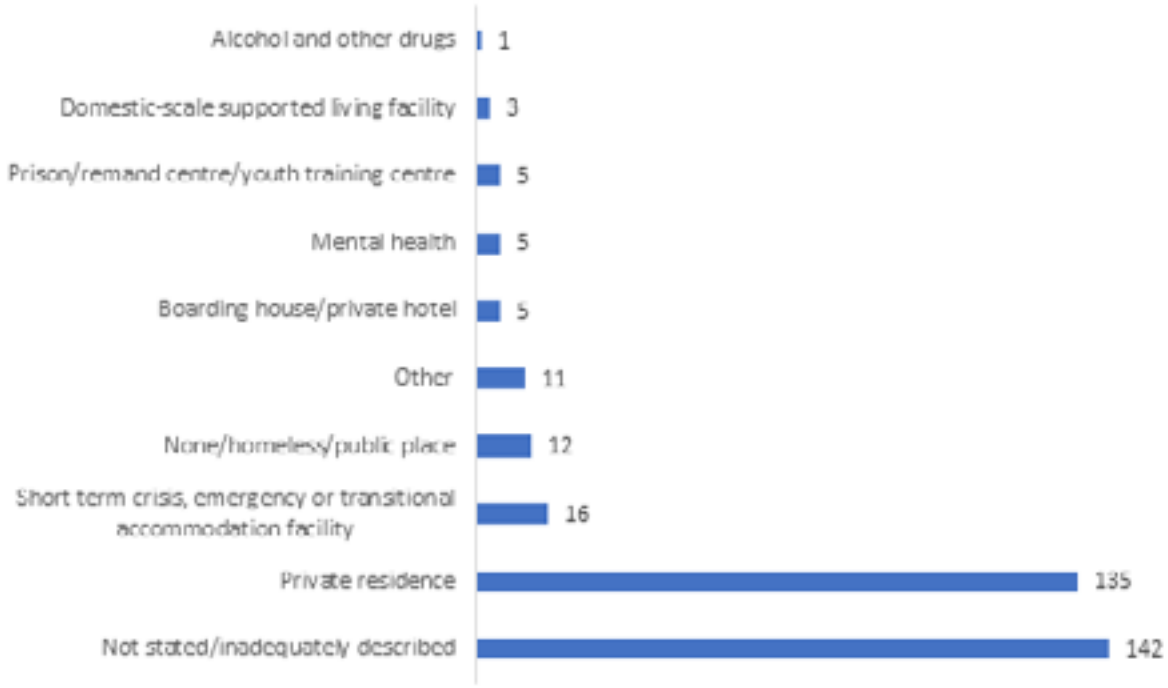
Figure 53: Top Primary Drugs of Concern (Aboriginal and non-Aboriginal) – BPA 2020/21



Source: 2020/21 VADC Data[124].

[124]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Figure 54: Accommodation at the time of AOD service 2020/21



Source: 2020/21 VADC Data[125].

[125]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Access Health, The Salvation Army AOD Victoria - activity data for Aboriginal clients

The Access Health, The Salvation Army AOD Victoria in St Kilda provides primary health care for people who are marginalised and injecting drugs, street sex working and/or experiencing homelessness. Approximately 15% of their clients are Aboriginal.

This data is not captured by VADC[125].

Table 23: TSA Access Health service users for 20219/20 financial year

Service type	Number of people
Aboriginal people accessing non-residential services who live in the City of Port Phillip	150
Aboriginal people from local residential recovery programs from City of Port Phillip	71
Aboriginal people accessing non-residential services who live outside the City of Port Phillip	71
Total	292

Table 24: TSA Access Health Registered Aboriginal Clients

Financial year	Registered Aboriginal clients
2014-2015	87
2015-2016	93
2016-2017	123
2017-2018	151
2019-2020	292

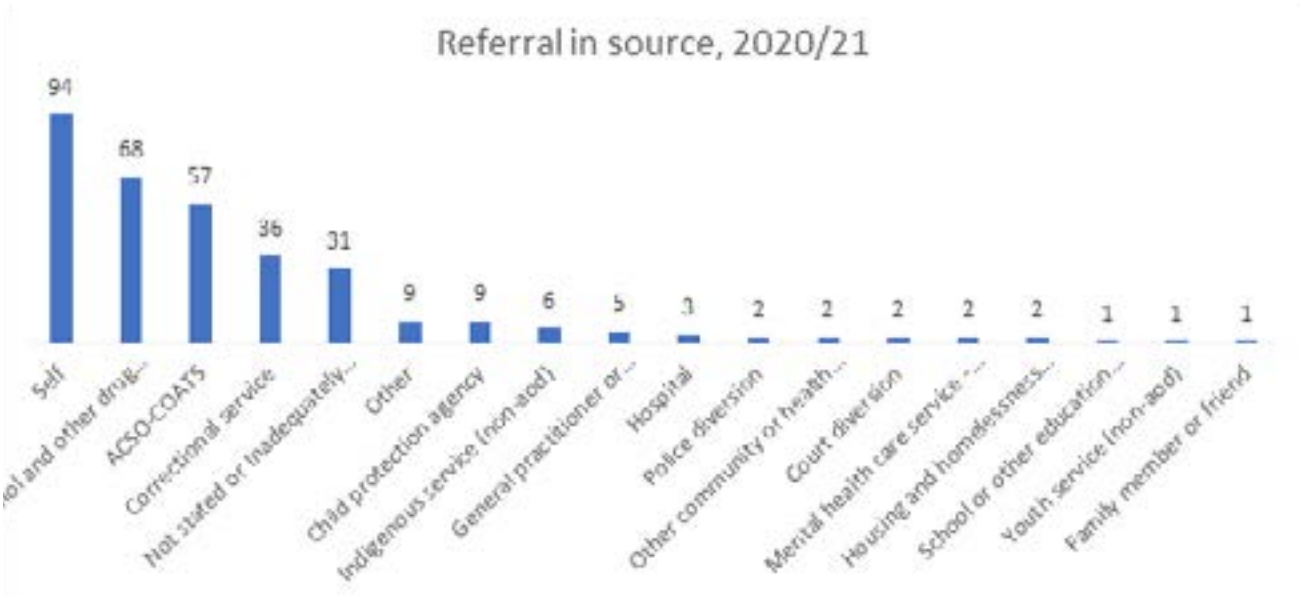
Source: Report for The Salvation Army on the Characteristics and Needs of Aboriginal Clients at Access Health[125]

Does not include 24/7 NSP data.

Does include people with no fixed address or local service addresses which are often used for people who sleep rough or do not have a permanent residential address.

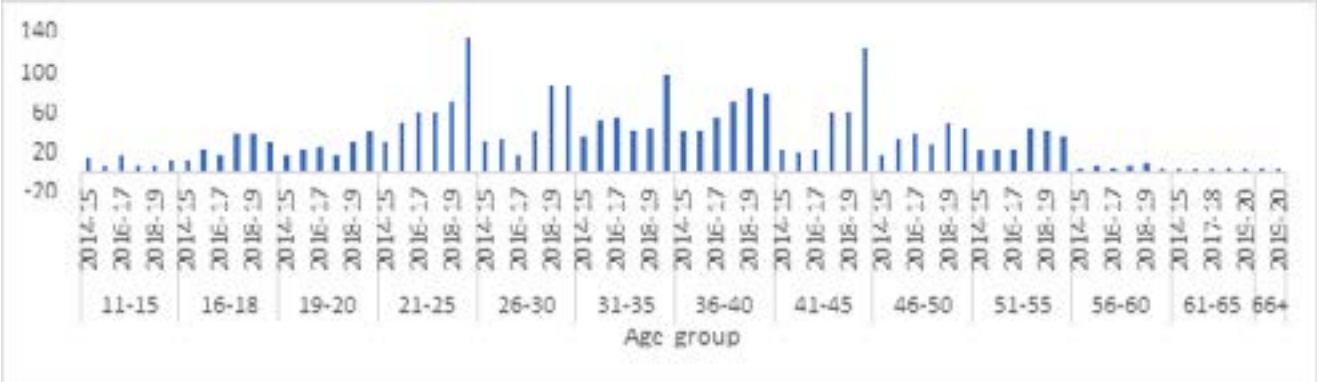
[125]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Figure 55: Referral in source to AOD services 2020/21



Source: 2020/21 VADC Data[126].

Figure 56: Trends since 2014



Source: 2020/21 VADC Data[126].

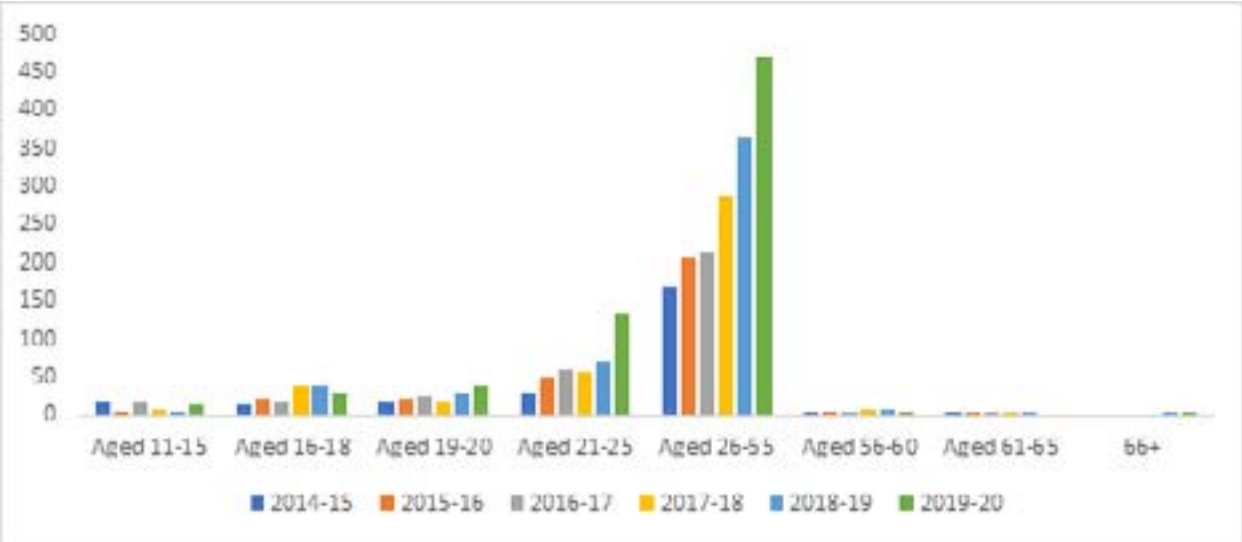
The distribution of AOD service users since 2014 has been relatively consistent.

Most clients continue to be aged from 21 to 55 years.

The chart below shows significant growth since 2017 in people aged 26-55 years.

[126]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc

Figure 56: Trends since 2014



Source: 2020/21 VADC Data[127].

Opioid replacement therapy

AIHW[128] publishes data on Opioid Replacement Therapy users through national Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) at State level. Victoria is the only state that doesn't provide any Aboriginal data https://www.aihw.gov.au/about-our-data/our-data-collections/nopsad-collection.

[127]Department of Health. Victorian Alcohol and Drug Collection (VADC). https://www.health.vic.gov.au/funding-and-reporting-aod-services/victorian-alcohol-and-drug-collection-vadc
[128]Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW; 2015.

Section 3. Community consultation

Previous client consultation

3.1 Talking up Strong – Voices of Our Mob[129]

Access Health, The Salvation Army AOD Victoria in St Kilda provides primary health care for people who are marginalised and injecting drugs, street sex working and/or experiencing homelessness. In 2014 they commissioned a report into 'The Characteristics and Needs of Aboriginal Clients at Access Health'. At the time of the study, Aboriginal clients comprised approximately 13% of the total number of clients represented.

Staff survey

TSA Access Health staff were surveyed to explore their knowledge about, and responses to, Aboriginal clients.

Individual staff responses to working with Aboriginal communities included:

- "Almost entirely positive, clients are usually respectful"
- "I have had some experience working with Indigenous clients but have found that they are often amongst some of the most marginalised clients who experience some of the most significant health issues and chronic diseases."
- "Positive – especially with the support and secondary consultations with Aboriginal Access Worker."
- "Limited experience. Overflow of current Aboriginal worker."

All but one staff member indicated that they were confident in working with or supporting Aboriginal clients. One respondent illustrated that their individual confidence has risen since working in partnership with an Aboriginal organisation.

[129]Report for The Salvation Army on the Characteristics and Needs of Aboriginal Clients at Access Health, St Kilda, Victoria. 2014. https://www.sarmy.org.au/Global/State%20pages/Victoria/Crisis%20Services/Talking%20Up%20Strong%20Report.pdf

Two staff recognised the benefit of, and had confidence in, having a designated Aboriginal staff member within the team providing a direct service to Aboriginal clients.

Staff confidence improved when there was a healthy two-way respect between Aboriginal culture and TSA Access Health, when there are partnerships with Aboriginal Medical Services, when there is support from the Aboriginal Access Worker, and when there are extra education, cultural awareness and cultural safety programs on offer.

Four respondents recommended that TSA Access Health consider providing cultural awareness training on a regular basis, and that TSA Access Health increase its access to, and brokerage with, Aboriginal organisations such as the Victorian Aboriginal Health Service.

Staff view further expansion of TSA Access Health's partnerships and brokerage as an important step in fostering positive working relationships with organisations that provide services to the Aboriginal community. It is clear that developing partnerships and relationships like this will heighten the confidence levels of TSA Access Health staff to work more closely with the Aboriginal community.

Most staff agreed throughout the survey that the Aboriginal Access Worker is very effective and offers support, education and training to non Aboriginal staff when working with Aboriginal clients.

The majority of staff (nine out of 13) had participated in cultural awareness training either in previous employment or at TSA Access Health. However, throughout the survey it was clear that staff recommend the incorporation of ongoing cultural awareness training as a preferred professional development opportunity and that this training is important both to their role and to TSA Access Health.

TSA Access Health staff have a high level of awareness about the range of services provided to Aboriginal people. However, there is a great deal of emphasis placed on the Aboriginal Access Worker by many staff, a positive sign that they are engaging with this position. Unfortunately, this places increased pressure on the worker to support both the community and the staff, including running individual training for non Aboriginal staff so as to provide more appropriate services to TSA Access Health's Aboriginal clients.

Internal processes appear to be working well, e.g. referrals for clients, etc. and the majority of staff are aware of the key Aboriginal services, such as Ngwala Willumbong.

When asked about the types of support TSA Access Health provide for staff to meet the needs of Aboriginal people in the community, respondents identified the following areas:

- Outreach work – more flexibility in the service scope to do outreach work
- Participation in community events – encourage staff to engage with the community through participating in appropriate events
- Orientation and Performance Development – becoming inclusive of cultural awareness training and include this training in orientation and induction programs as well as introducing staff to key members of the Aboriginal community and those involved in relevant services

Service user survey

40 Aboriginal clients from TSA Access Health were interviewed by University of Melbourne staff.

- 48% male, 52% female
- Aged 18-69 years
- Large number of different countries they identify with

This section is a compilation of information generated from clients' interviews conducted over a five-week period on site at TSA Access Health, Grey Street, St Kilda.

It is thought that the growth in service access has occurred because of the increase in case contact with the Aboriginal Access Worker whose position has increased from one day to four days per week.

The majority of the referrals to the research program were made by the Aboriginal Access Worker on site. While the 40 people interviewed represent approximately 25 per cent of the total Aboriginal client population of TSA Access Health, the Reference Group agreed that this number, and their diversity, provided a representative cross section of the Aboriginal client group.

Referral source:

- 21 referred to TSA Access Health
- 7 word of mouth
- 6 Aboriginal access worker

Use of traditional healer or medicine for health concern:

- Bush tucker 29
- Bush medicine 8
- Traditional healer 6
- No response 9

Best services provided by TSA Access Health:

- General practitioners 20
- Aboriginal Access Worker 9
- Social events/BBQ 7
- Counselling 4

A number of clients identified that if they had a bad experience, particularly if related to racism, they would not return to the service.

Table 25: Client Knowledge about and Use of Referral Services

	Aware		Used	
Service	**Yes**	**No**	**Yes**	**No**
Galiamble	30	4	9	25
Alfred Hospital	28	6	19	15
Homeground	28	6	11	23
Aboriginal Medical Services	27	7	16	18
Sacred Heart Mission	26	8	13	21
Emergency Rooms and Hospitals	25	9	14	20
Salvation Army Crisis Services	25	9	12	22
Winja Ulupna (Women's Recovery Centre)	24	10	9	25
Odyssey House	24	10	5	29
St Vinnies Hospital	22	12	10	24
Inner South Community Services (Prahran)	22	12	10	24
Inner South Community Health Service (S Melbourne)	21	13	9	25
General Practice	20	14	8	26
Inner South Community Health Services (St Kilda)	18	16	8	26
Hanover Family Services	22	12	7	27
Salvation Army Bridge Centre	20	14	6	28
St Kilda Legal Service	16	18	6	28
101 Chapel	12	22	6	28
City of Port Phillip Services	17	17	5	29
Good Shepherd Youth and Family Services	16	18	4	30
Sacred Heart Women's House	14	20	4	30
Maya Centre	13	21	4	30
Child and Maternal Health Services	9	25	4	30
Living Room	6	28	4	30
Gladys Nicols Family and Community Services	16	18	2	32
Elizabeth Hoffman House	12	22	2	32
The First Step Program	10	24	2	32
St Kilda Youth Service	9	25	2	32
Open Family Australia	7	27	2	32
Barkly Street Medical Clinic	14	20	1	33
Dandenong AMS	11	23	1	33
St Kilda Gatehouse	7	27	1	33
Bert Williams Hostel	10	24	0	34
Resourcing Health and Education in the Sex Industry (RhED)	6	28	0	34
Buoyancy Foundation	3	31	0	34

Source: Report for The Salvation Army on the Characteristics and Needs of Aboriginal Clients at Access Health[129]

Table 26: Identify from a list some of the barriers around access to health services

Barrier	Number who identified barrier
Distance	21
Time services available	16
Money	15
Public transport	12
Racism	9
All	5

Source: Report for The Salvation Army on the Characteristics and Needs of Aboriginal Clients at Access Health[129]

Table 27: Identify an unmet service need

Unmet need	Number identified
None	8
Eye care	4
Physiotherapy	4
Housing	3
Dietician	3
Podiatrist	3

Source: Report for The Salvation Army on the Characteristics and Needs of Aboriginal Clients at Access Health[129]

Recommendations

- Consider creating an advisory group and a well-regarded quality improvement procedure that allows for Aboriginal clients and key community people to have input into strategies for TSA Access Health services to better meet client need. Communicate information about any new measures, such as these, with clients and referral agencies.
- Mental health issues are prevalent in the Aboriginal client group so better referral mechanisms to psychiatric and other key services are needed. In developing these mechanisms, put in place strategies to deal with institutional racism and heighten health-seeking behaviour among clients.
- Develop systems that support clients with limited organisational skills to access TSA Access Health services by addressing lengthy waiting times and low staffing numbers especially in the clinic.
- Develop a plan to address issues in the workplace. The plan could incorporate the recruitment of additional staff – especially General Practitioners (i.e. increase hours of second GP), GP registrars (work with universities), Aboriginal support officers (male support for male clients), counsellors and nurses/nurse practitioners – and expanding currently available services.
- Invest in brokerage and extending the range of services available to Aboriginal clients by strategically partnering with other health and wellbeing services to provide more holistic treatment, care and support. These services might address dental, physiotherapy, alcohol and drug (AOD) counselling, and financial and social work needs – thereby creating more of an allied health professional strategy.
- Establish a discrete budget for funding community/staff engagement though orientation, professional development and cultural awareness and induction programs, and enable staff participation at local, relevant events with community people.
- Ensure all continuous quality improvement strategies incorporate and address the specific needs of Aboriginal clients with regard to clinical access, diagnostic equipment, referral, professional development (PD), orientation and brokerage with other agencies. Ensure there is adequate reflection of these activities in the annual report, and feedback to the Aboriginal community on the scaling up of services.
- Establish cultural awareness/cultural safety training as the preferred PD training in this and referral agencies and meet on an annual basis with other services in the region to address issues that impact on Aboriginal clients.

Service user consultation

This study was conducted with Aboriginal people who had used or are currently using AOD services within the Bayside Peninsula Area. A total of 20 participants completed the interviews between August and October 2021.

Holistic approach

Participants reported the need for AOD services that viewed the person as a whole and took the time to get to know them at a personal and cultural level rather than just discussing he addiction.

> ***"They were absolutely holistic approach to the addiction and side of things, and it didn't just attack the addiction they attack everything and what I said, I took home some of those things, they taught me like meditation and curiosity for you know acupuncture and all them other alternative things that are out there."***

Participants reported that holistic health is supporting the clients to be able to have the basics before giving them the freedom to receive additional supports or leaving such as having a shower and eating some food.

> ***"They'll walk them back in when they're starving and homeless and let them have a shower and give them a nice clean towel and, you know, and give them a loaf of bread and some fruit and muesli bars and a drink you know what I mean, like, yeah that's awesome man really you know"***

One participant explained that Aboriginal classified AOD services were different to mainstream AOD services as they focused on the family, mental health and other circumstantial issues which allowed the engagement with the AOD service.

> ***"I think the holistic way in the Koori sector ….. they are more focussed on where you've been, what you are doing and family issues, um, mental health. Mental health is a big one … and the homelessness and all of that, like that all plays a really key, key role in where you are and where you've come from…"***

One participant reported that there were youth AOD services that supported cultural activities but there were a lack of adult support AOD services that included cultural activities.

> ***"It would be nice to go to a um, detox, or a rehab or a drug and alcohol meeting where you can sit back with other mob and just do either painting or you're sitting there and you got the guys doing the didgeridoo and the girls doing something else kicking black painting, talking about things. They've got youth ones, they don't have many adult ones"***

Aboriginal artwork

Participants reported that the display of Aboriginal posters and artwork demonstrated a culturally supportive environment.

> ***"Encouraged Aboriginal, um, culture, they had, you know, they had the pictures of everything, but, it was just more, for me it's just more energy"***

Welcome to Country and Acknowledgement of Country

Participants reported that doing smoking ceremony, Welcome to Country and Acknowledgement of Country ceremony before meetings made them feel respected and the history acknowledged.

> ***"before any big meetings, but I found with um, with YSAS and stuff and Table House like I didn't' see any Welcome to Country anywhere"***

Awareness of Aboriginal AOD services

Participants reported mainstream AOD services do not inform Aboriginal clients of Aboriginal AOD services or programs that could fit better with their cultural needs.

> ***"No, no, I've never been pointed to one, which I really would like to go to one"***
>
> ***"I did not know there were Aboriginal organisations providing this AOD service."***

Developmental stage supports

Participants reported the need for programs that met their needs at each developmental stage of their life. The programs that were tailored supported participants to feel comfortable to return to the AOD service.

> ***"I used them when I was like sixteen going through some trouble with the police and then when I had a young family, about twenty-one and then again about ten years, oh sorry, about four years ago when I went through my divorce, I, um, yeah, they're just a really good AOD service, um, cause I know they're always there and they're there to support, if you want the support they'll help you, if you don't want the support they'll just put you through the motions as well"***

Participants reported the need for AOD services that acknowledged or made allowances for the level of maturity of the client rather than the age of the client. One participant reflected that he was a teenager when he first went to the service but he had lived through many life experiences which made him not fit in with the other teenagers in group.

> ***"I went there as a teen man but I mean because of the things I've been through and whatnot, and you know, like I was fourteen bro, but I felt like I was in my twenties sort of thing"***

Insufficient AOD services and long waiting lists

Participants reported that more AOD services are required for Aboriginal clients especially when the client are ready for change. Having AOD services that are ready to accept a client when they were ready for rehabilitation or other support AOD services was critical to the ongoing engagement with the AOD service.

> ***"..they do say um, one in ten people will you know, have a positive experience and won't go back to the way they were. Um, I can honestly say, I'm probably that one percent ha, … yeah I just think there needs to be more help out there for people. I mean like, I know it's a hard issue to address but, it's an issue that isn't addressed enough you know. …. You've gotta give the best of a bad situation I suppose, and it's entirely up to the individual at that time in their life, you know"***

Participants reported that they lost motivating while waiting to find a bed in rehabilitation or get access to support AOD services.

> ***"I haven't been able to get a hold of one for a while. I've been trying to ring and they've all been booked because of COVID and, that"***
>
> ***"Quicker response with the AOD service to talk to someone, not just say, Oh hello … we've booked you an appointment for three months from now."***

Participants reported the need for support AOD services between long waiting periods to get into rehabilitation or into counselling AOD services. One participant described how the AOD services provided fortnightly phone contact support him during his wait for a rehabilitation bed.

> ***"He rings me at least once a fortnight and then he says, look, if you need to call me any sooner or if you're having, um, a bad day or really bad panic or anxiety attack…"***

Frequent AOD support sessions

Participants reported that they would like more AOD services sessions rather than weekly or monthly sessions when they were ready for change.

> *".. it's only like a couple of days a week or something"*

Alternative modes of AOD service delivery

Participants reported that they preferred if AOD services explored other service delivery methods to reach the clients during COVID such as using phone services. However, some participants noted that phone services were insufficient when a person was attempting to quit or reduce intake as they physically feel incapable of stopping as the supports are not face to face.

> *"I was getting phone calls on a regular basis. But that's not enough you know. Phone calls are nothing when you are in the midst of your addiction, you know, it's really not gonna do anything. Although it's great support, but, it's really not physically gonna do anything for ya"*

> *"It's all like over the phone ...The truth is I could be sitting here drinking right now and you wouldn't' even know"*

Participants reported that they wanted services that understood the history of Aboriginal people such as trauma informed services. Some rehabilitation services restricted the use of phones and other personal freedoms. However, such practices could be triggers for past government policies which led to atrocities in the Aboriginal community.

Homeless AOD services

Participants reported that the AOD services do not reach homeless clients who may be searching for AOD services. Participants also reported that services had stringent intake criteria.

> *"When I was homeless I couldn't find many Aboriginal AOD services at all but when I was in that desperate state I found it really hard to find, to find anything, at that point."*

After-hours AOD services

Participants reported the need for support AOD services that were after-hours where they could have access to the staff they bonded with at the AOD services. One participant explained that one of the staff members responded to his texts at night when he was feeling like he had a relapse.

> *"I text him sometimes at night, and he text me back...which helps"*

> *"I'm allowed to contact him if I need to"*

Workforce

Participants requested for Aboriginal staff to be employed and an increase in Aboriginal staff, therapists, Elders and mentors to be a part of the AOD services.

> *"Aboriginal worker, working there, it makes it more family orientated, and they just get how we speak and how we interact as people"*

> *"not one Aboriginal person..."*

> *"Having Aunty and Uncle, Elders who have lived experience who support and guide"*

> *"There's not enough ... Indigenous help"*

Aboriginal liaison officers

Participants requested that Aboriginal people to be employed such that they could support both, the non-Aboriginal staff and the Aboriginal clients. The Aboriginal liaison officers can support non-Aboriginal people on how to support Aboriginal people during different periods of their lives to ensure the treatment was not compromised due to sensitivities to Aboriginal culture. Elders can also support Aboriginal people who visit AOD services and build relationships and connections.

> *"Everyone was trying to be sensitive and not say the wrong thing, but whilst doing that, nothing was getting done about what should have been getting done um, yeah and I just, I just I could see that whole situation would have been different if there was a black fella working there"*

> *"they'd open the door for us and they'd welcome us in we'd go and sit around the side bit, the side bit and had a lady um Aunty just and um, she's not long passed away there just a beautiful soul, just a beautiful lady, she's always coming and bringing some fruit or something and she'd sit down and have a yarn with all the boys.."*

Multicultural staff

Participants requested for multicultural staff to be a part of the AOD services as they felt that multicultural people recognised the importance of culture and family. Participants also reported that multi-cultural people are connected to culture in their own and this awareness is important to connecting to the Aboriginal people.

> ***"More people from other cultures… they connect with us mob"***
>
> ***"… they were all white but they didn't want to say anything to upset anyone and yeah it just felt weird, but I thought, I thought in this day and age you'd think they'd have one staff member of um, that was not white, you know"***
>
> ***"Non-Indigenous men working there, but they're really culturally connected in their own way so they know a bit about your culture you know and they're culturally, they've got that awareness as well"***

Staff retention

The high staff turnover within AOD services reduced the ability of Aboriginal clients to form meaningful bonds with their AOD worker. Aboriginal clients also reported a sense of frustration repeating their story every couple of sessions whenever a new AOD worker was allocated their case. Furthermore, participants reported that high staff turnover resulted in them feeling rejected and devalued.

> ***"your always getting a new worker, cause someone leaves the job, it's just not very consistent, so, you I hadn't had a very good, um, a very good time on the outside with drug and alcohol workers,…. understanding mental health it is about consistency, it's important to be consistent and its important to have, if you have a worker, that worker be to be there for you, you know over a long period of time"***

Acceptance and trust

Participants reported that staff who accepted clients without judgement or stereotyping Aboriginal people was important to cultural safety. Participants felt more accepted when staff verbalized their acceptance.

> ***"…listened like your story is being listened to and taken seriously and being like, you are accepted as a part of, you know, everybody else in society and things like that… when you tell them you do identify as Aboriginal or Torres Strait Islander"***
>
> ***"..they just told me …whatever you say is all good.."***

Participants reported that they did not feel engaged with the AOD service when the staff did not believe in the client's capacity to change, to attend appointments and keep their word. One participant reported that she felt like the staff had preconceived ideas that she would not attend the appointments or follow through on commitments.

> ***"Sometimes I feel like …, they'll do all the work and I just won't turn up and stuff, like I feel like there's not trust in me to do what I say I'm gonna do"***
>
> ***"Sometimes I feel that they think I'm an alcoholic and I won't go all the way through with it, you know. I feel like sometimes they feel like that I'm, just gonna, I'm just blowing smoke up their arse"***

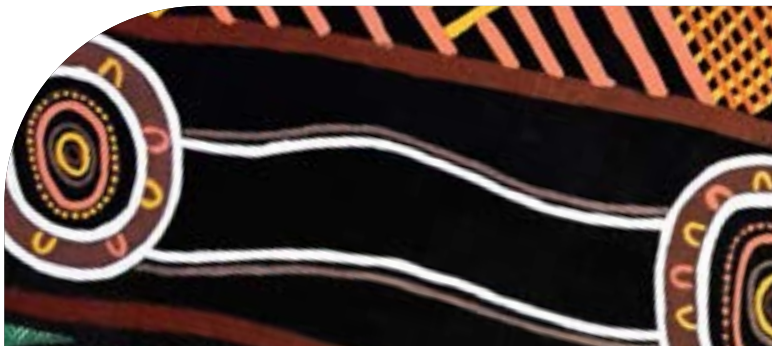
Bonding

Participants reported that they needed to feel a bond with the AOD service by ensuring consistency of staff so that they felt culturally safe and progress on their mental health improvement journey. Building the bond required trust in the person and when participants consistently saw new workers each week then never felt like the bond had developed to support their wellbeing.

> ***"You're always getting a new worker, cause someone leaves the job, it's just not very consistent, …., it's important to be consistent and it's important to have, if you have a worker, that worker be to be there for you, you know over a long period of time"***
>
> ***"It's kind of hard to trust someone that you see for a week or two. …I haven't had a very good consistent worker that you can, you barely know, so you can barely trust em' sort of thing, like it takes a long time for that to just happen and if they leave every week sort of thing, or if you're getting new workers every fortnight, it's just, it's not gonna really happen"***

Participants reported that they connected better with staff who were calm towards them.

> ***"It was her voice, she had a really calming voice…, you could tell she wanted to help me. But yeah, as soon as I heard her voice I was like you're the one"***



Listening to the client's story with an open mind

Participants reported that staff who listen to them allow them to feel connected and adhere to the staff requests even if it may be tough and they recognized that it was for their long-term wellbeing.

> ***"There was one staff member that really heard me, he started caring and was concerned even though he used harsh words on me, I needed to listen.. I needed to hear it, you know, I needed to hear it and um, when I realised those words that he said to me um, it made me realise you know, that I needed to come and get help, so, I couldn't do this for the rest of my life just drinking and being a miserable person, you know"***

Participants reported that staff did not discriminate and were open to having a yarn with the client.

> ***"like no discrimination really, like, you know, you can have a yarn with them …"***

Participants reported that staff demonstrated openness and a wish to learn more about the clients which supported the client to be culturally safe.

> ***"I think a lot of it's missed … what really goes on for us …I feel the openness from them like, I feel like they want to be educated and they want to know more."***

Participants reported that staff's patience towards clients helps as the client may not be able to articulate their needs clearly.

> ***"With trying to get connected to these places … the people you deal with … it's a bit frustrating sometimes, they can be a bit rude or not understand what you're trying to get from them"***

Participants reported that they found it hard to work with staff who would did not respect them because of their past actions such as criminal activities.

> ***"Just treat me differently cause of my past and you know, going to jail and stuff, um, not giving you that same respect that everyone else gets, sort of thing, um, so yeah, I found that very hard"***

Participants reported that they felt like shutting down to staff who demonstrate ignorance to their situation. Participants reported that they felt culturally unsafe when staff were inflexible in their perspectives and did not provide person centered care.

> ***"They've got their mindset on how to be with everyone, you know, they don't treat cases individually, sort of thing, and um, I found some of the workers a bit, like, um, ignorant"***
>
> ***"I feel like people can be ignorant, you know the ones that don't want to know, then I can sort of shut off and I don't want to tell them like"***

Caring and able to make a connection

Participants reported that AOD services demonstrate care when the staff get to know the client at an individual level, when the staff speak to the client at a personal level, and when the staff would connect with the client at their level. Participants also reported that they felt the AOD service cared when staff responds immediately during a crisis situation.

> *"I had a big break down about three and a half years ago. Um, I was on death's door um, yeah and they, they sprung into action and um, I was in rehab within like five months, you know"*
>
> *"they know me very well, they know everything about me, even the receptionist um, they ask me how I've been if they haven't seen me for a couple of weeks um, and they really talk to you and you can see they actually really care "*
>
> *"I could trust more if they would come down to more of a personal level and get to know people more on a personal level in their home, or cultural environment… understood and listened a little bit more"*
>
> *"and it just feels like your someone like from, like a family member, so anyway, it's easy, like, someone looking at you, and then like, you can tell they care like, you know"*
>
> *"I am now considered part of their (staff) family"*

Participants reported that they felt they were connected to the AOD service when they didn't feel like they were going to an appointment but to visit friends and get support rather get counselling. Participants also reported that they would not go back to the AOD service if they did not connect with the staff.

> *"They make you feel really welcome when you walk in there. You feel like that you've gone to visit people that you know and you don't feel like you're going to a AOD service. they are very welcoming."*
>
> *"They've been very community based, or even if they're been Aboriginal or not …they fit right in, I don't know, they feel, they feel sort of Koori-really, more than a counselling visit, it's more support, you know"*
>
> *"It was just easy to speak to someone that like kind of seems familiar instead of like just some random person… it was good you know, feeling like I'm connected with someone."*
>
> *"Those ones you just don't connect with you don't go back and you find ones that you do connect with"*
>
> *"She's more like a friend than a worker"*

Participants reported that staff were considerate of their needs and vulnerabilities.

> *"They were fairly helpful, …. would always have a pretty positive outcome ….it just comes down to whether you really want the help or not, I think"*
>
> *"I was in a very very vulnerable state and um, I felt that they felt very considerate of that… they were lovely people and they made me feel good"*

Participants reported that staff were encouraging and motivating clients to achieve their goals despite the challenges.

> *"..really encouraging, um and supportive with me um, whilst I was there, I must admit, you know I had a few meltdowns and a few moments where I wanted to leave um, and they were pretty good with me, like counselling me through those moments I guess you could say. That was a good thing"*
>
> *Participants reported that if staff were friendly then they would return to the AOD service.*
>
> *"Things sort of stood out for you when I went first time…just how open and um, how friendly the staff were"*

Participants reported that staff should demonstrate their disappointment with the client's relapse and participants saw this as honest behaviour. This could potentially be the client's previous behaviours that could be projected onto the staff and the staff may be using an alternative technique to support the client.

Participants reported that staff who shared their own lived experiences helped them.

> ***"…telling the truth and whatnot. Opening up about what I've done in the past and instead of sitting there lying and saying oh, you know, it's not that bad"***
>
> ***"Staff share their own lived experience…I could see my life"***

Participants reported the having trust with the staff allowed them to be themselves, say their truth openly and thereby being able to get better treatment.

> ***"It made me feel um, it made me feel like a person. Um, it made me feel like there was someone out there you know, um. Because if you, you don't have, if you don't have that trust that's in ah, partnership or relationship, its, you're gonna be missing out on a lot of things and holding back ah. …"***
>
> ***" trust is a big thing. Ah, if I don't get trust well, um, you know um, if I don't trust or feel a little bit of acceptance in someone's views, you know, it's gonna limit what I actually say. It (trust) was a good opportunity for me to um, to tell my 100%,"***

Helpful and communicative

Participants reported that staff were helpful and would provide support outside the assigned counselling role, such as visiting the client in hospital.

> ***"She goes above and beyond her, her work sometimes um, she um, knows my doctors and communicates with my doctors for me and um, if I need anything … AOD services like for detox and stuff like that she goes above and beyond her work. "***
>
> ***"She's even taken me to the hospital and visited me, you know. Like I said, she goes, above and beyond her duties sometimes"***

Participants reported that staff are appreciated when they keep them informed of the process and provided sufficient information about the next steps during the session. This allows the participants to feel in control of the outcome.

> ***"..to be honest with me and keep me involved, ….because when I feel like running is when I'm not educated in what I'm doing"***

Understanding Aboriginal culture and history

Participants reported that staff may not always know what to say or do in all situations where Aboriginal people are concerned and should acknowledge if they need assistance from other Aboriginal people on potential solutions to support them.

> ***"sometimes that barrier between …I don't know, what you call it…maybe like them not knowing a hundred percent what to say or what to do"***

Participants reported that the Aboriginal AOD services should support staff with training on cultural competency and cultural respect, trauma informed conversations and cultural identity conversations.

> ***"it doesn't matter if you're black or white, have that training then, so that if you are a white fella with a black fella client they feel safe enough to engage with you because you have that respect for their culture, you are there trying to help and they can see that, but until they actually start proving it to the client that's when the wall starts coming up"***

Participants reported that staff that take an interest and know about the culture support their cultural safety.

> ***"Organisations to be mindful … of the different cultural groups that come in and different mob, you know, um"***
>
> ***"I'm not, I'm not Koori, you know, I'm, you know, Waltbury and stuff like that, you know, it's not really one thing that, like one thing that kind of fits all, it's just, you know, our cultures are different"***

Help to discover Aboriginal heritage

Participants requested for support AOD services to find out more about their Aboriginal heritage. A few of the participants reported not being able to learn about their tribe because the family had abandoned them at a young age. These participants wanted the AOD services to support them to link with Aboriginal Heritage AOD services that could give provide them more information on their tribe so they would know where they belong and who their tribe is.

> ***"Only one thing really, because obviously like I don't have much contact with my Aboriginal heritage (mother abandoned him when he was a baby and father brought him up), just like maybe help me get information or try and help me get in touch with my Aboriginal heritage. That's really the only thing"***
>
> ***"I mean there should be a AOD service out here that can, you know, so if people that are lost then they can know where they belong"***

Art and artefacts

Participants reported that Elders teaching art and doing paintings everyday was therapeutic.

> ***"do art therapy"***
>
> ***"doing paintings every day"***

Participants reported working with their hands such as making artefacts like spears and other woodwork and weaving also helped feel culturally connected.

> ***"Making artefacts, spears"***
>
> ***"doing woodwork"***
>
> ***"learning to weave and learning you know, like learning a lot of things that our people have missed out on"***

Connection to Country

Participants reported the need for connection to Country by respecting the Indigenous holistic health and wellbeing concepts.

Participants reported that they wanted to go fishing, sit by the campfire, and sit by the river so they could connect with country.

> ***"I don't mind sitting by the, by the river with a campfire and a fishing rod"***

Participants reported that they wanted to cook Aboriginal foods at the rehabilitation centers.

> ***", yep all the dinners we have.. made of plants and fruit, fruit and veggies and they um, we cook it up in meals, we made desserts from um, ah long fingers um, macadamia nuts I've called to have turtle and guna, and witchetty grubs, and goana"***
>
> ***"if I could've been in charge of doing a feed, you know, like I could've got some roos, some buffalos"***
>
> ***"Aboriginal people need to feel connected to Country and you know with their mobs and things like that, and I think maybe that that's not in there with that whole holistic way that AOD services"***

On Country based AOD services

Participants reported that AOD services on Country were preferred as a way to feel culturally connected and heal.

> ***"In the community (Country), like, not, not the NT but like Melbourne community (Country) sort of thing, you know, yeah that's where I would like it"***

Cultural outdoor space

Participants requested for a designated area on the AOD service grounds where Aboriginal people could sit and yarn and have support sessions conducted with their AOD workers. Aboriginal culture emphasizes the importance of meeting with the mob and being able to have those supports.

> ***"a special place for Indigenous people to meet"***
>
> ***"Aboriginal people need sessions outdoors to connect to country and yarn together"***

Physical activities

Participants reported that physical activities such as being outdoors and going for walks in the bush supported their cultural connection.

> *"Outdoors"*
>
> *"Going for a walk"*

Working on the land

Participants reported being out in the garden supported them to feel like they were connecting with their culture.

> *"we do gardening, so we have the gardening which is really um, amazing, um, like the first couple of weeks we're here, we're in the garden and doing herbs and planting plants and like connecting with culture, like with land, but I still find it's ah therapeutic for me to be able to walk out in my bare feet"*

Cultural treatment options

Participants reported that they wanted to have cultural treatment options such as connecting with Country and going on the land and working in the soil that supported the connection to Country.

> *"you know like detoxing and it sounds funny but, like the white way, you know like, here's some valium, watch some tv, eat some food. You know, like that kind of stuff where in my detox like when I did the home detox, I was going for walks every day, going camping that kind of stuff like connecting to Country, being out with mob and community…. So I could start being strong again"*
>
> *"it's got cultural aspects to it and it's not a, it's not a clinical rehab"*
>
> *"we can't have no shoes on and that sometimes that is a little bit annoying to me cause I just want to go outside scram my feet in the grass or the floor (we can't use, not wear shoes outside because we were on a farm) "*

Dreamtime stories

Participants reported sharing Dreamtime stories helped feel culturally connected.

> *"we read some dreamtime stories and that, like we were doing dreamtimes stories of a night, me and a couple of other fellas here"*

Aboriginal meditation

Participants reported that learning and doing Aboriginal meditation allowed them to feel stronger and culturally connected.

> *"Aboriginal meditation…that would keep Aboriginal people and non Aboriginal people grounded if they're, you know stressed and that"*

Lived experiences

Participants reported that culturally tailored programs would best be supported by Elders who have lived experiences to share with them and to be surrounded by Elders who are role models of change.

> *"Having Elders who support like Aunty and Uncles who can guide the women and men with lived experiences"*
>
> *"the older blokes, you know, they're just the older men for me personally, like um and I shut up and listened when it's an older fella that's been there and done it before me and knows all about it and, you know, I look at them and their life and they've come through it and they've, they break that cycle, they're not these, you know, drug addicts and bloody um, criminals anymore"*
>
> *"for us black fellas, man, you need Indigenous men and women helping ya, you know, like, like I said before these older blokes, these older men that have been there and done it and lived and survived and doing, and they're finished with it, I've said that, you need, I need men like that around me"*
>
> *"these older fellas, they've been there and done it and lived it and survived it, and they're trying to teach me, like, you know, what I'm saying, that's why I listened to them, I really my, you know, sometimes I get a bit complacent and that and you know, drift off to the end of the world, but as soon as one of them old black fellas talk, man, my ears prick up and I'm all ears, I'm listening"*

Men's and Women's Business

Participants reported having Men's and Women's Business cultural activities as they had not grown up with it.

> *"… it's more cultural, more stuff to do with Men's Business"*

Yarning

Participants reported that yarning allowed them to feel connected with each other and supported by each other.

> *"Yarning- a group where Aboriginal people can meet together and plan stuff or just have a um, a yarn, you know"*
>
> *"going to mob meetings and stuff like that"*
>
> *"there's six of us at a time, um, I got them together and push their identity away because of their white skin and blue eyes and um, they recognise they are Indigenous ..meet up once a week and organise the community to get together in some Indigenous areas"*

3.2 Supporting Aboriginal young people to live self-determining lives in the Bayside Peninsula and Southern Melbourne Areas project

PwC's Indigenous Consulting were engaged by the Department of Health and Human Services[120] to better understand the needs and aspirations of Aboriginal young people aged 10 to 25 years in the Bayside Peninsula and Southern Melbourne area in order to better inform appropriate priority actions that:

- Support cultural connection and identity for Aboriginal young people
- Support Aboriginal young people to live self-determining lives

The project engaged with 62 Aboriginal young people at workshops and received 48 surveys from Aboriginal young people.

Aspirations identified by participants:

- Improve mental and physical health
- Finish school
- Access higher education and obtain the job they desire
- Learn more about Aboriginal culture
- Participate in sports

In order to achieve these aspirations, the following high-level themes were identified by participants:

- Improved mental and physical health
- Culture being taught in schools and culturally safe places
- Elders to teach youth about language, traditional dance and art
- More opportunities to be around Aboriginal community

Workshop participants were asked to identify the key issues that are commonly faced by other Aboriginal youth in the local area. Workshop participants identified:

- Drugs and alcohol issues - use of drugs and alcohol by Aboriginal youth and/or by their parents/ guardians/carers. Some youth reported drug use and/or drug dealing as occurring in the home environment
- Mental health issues - including depression and anxiety caused by abuse and neglect. Some youth felt anxious about their younger siblings' exposure to abusive carers and felt extreme hurt due to racist attitudes from non- Aboriginal people
- Crime - primarily for violent offending against other youth within the community in response to insults or other perceived wrongdoing by other youth. It is important to note that youth did not specify whether instances of violent offending occurs primarily amongst Aboriginal youth - only that it occurs and that Aboriginal youth generally (either referring to themselves or other Aboriginal youth that they know) have some degree of experience with it across the Bayside Peninsula and Southern Melbourne areas
- Racism - experiences of verbal abuse and subtle forms of racism including exclusion and insensitive remarks and attitudes about Aboriginal culture from non- Aboriginal people

[130]Department of Health and Human Services. Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027. Melbourne: State Government of Victoria; October 2017.

Existing models and frameworks

Balit Murrup social and emotional wellbeing framework

Balit Murrup was developed as a Victorian Government framework with the shared knowledge and wisdom of leaders and experts from the Aboriginal Social and Emotional Reference Group[131]. The reference group was made up of Aboriginal people with support from non-Aboriginal representatives from across local and statewide Aboriginal community-controlled organisations, mental health services and government.

Balit Murrup's[131] objective is to reduce the health gap attributed to suicide, mental illness and psychological distress between Aboriginal Victorians and the general population.

Aboriginal people using alcohol and other drugs a a priority group of the Balit Murrup[131] Social and Emotional Wellbeing Framework.

Figure 1 presents the dimensions of Aboriginal sc and emotional wellbeing described in Balit Murru

- connection to spirit, spirituality and ancestors
- connection to land
- connection to culture
- connection to community
- connection to family and kinship
- connection to mind and emotions
- connection to body

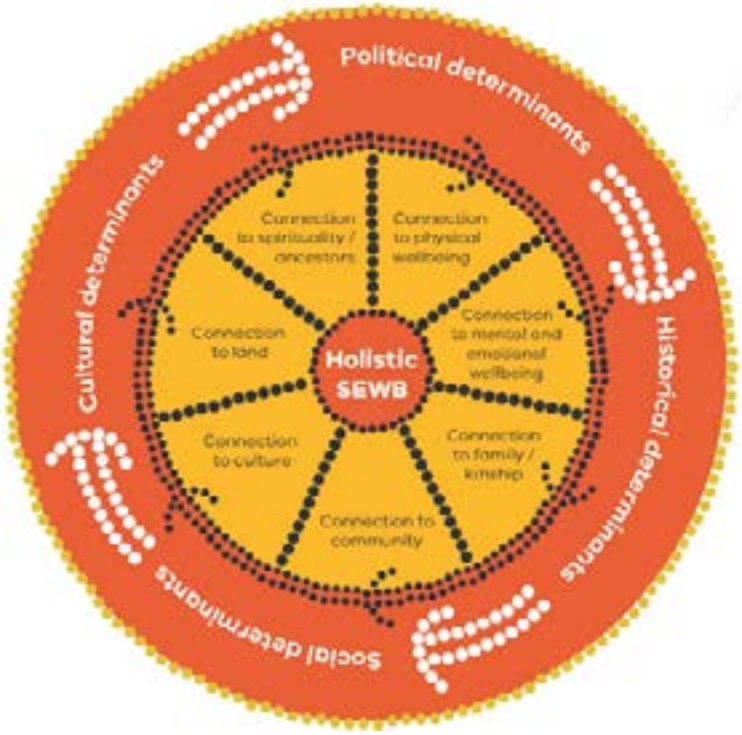
The outer ring shows the determining influence o social, political, historical and cultural factors on s and emotional wellbeing.

Artist: Tristian Schultz,

RelativeCreative. Reference: Gee,

Dudgeon, Schultz, Hart & Kelly, 2013 on behalf of the Australian Indigenous Psychologists Association

The framework is based on four domains. The activities of each domain relevant to the AOD service model are described below.



[131]Department of Health and Human Services. Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027. Melbourne: State Government of Victoria; October 2017.

Domain 1: Improving access to culturally responsive services

Activities relevant to the AOD service model

Specialist mental health services need to be culturally responsive and supported by cultural safety frameworks with professional development that supports the use of trauma-informed social and emotional wellbeing models in their treatment of Aboriginal clients

Relevant AOD service model activity:

- ensure implementation and monitoring of cultural safety framework

Responsibility in AOD service model:

- AOD ACCOs

Domain 2: Supporting resilience, healing and trauma recovery

Activities relevant to the AOD service model

Healing is a culturally informed therapeutic approach to promote Aboriginal social and emotional wellbeing.

Healing is one of the most common ways of understanding Aboriginal peoples' experiences of recovery from trauma and other mental health and social and emotional wellbeing difficulties, including transgenerational trauma, unresolved grief and loss (Phillips & O'Brien 2009; Atkinson 2002; Caruana 2010). Often recovery is understood to be implicit in healing, although healing can also refer to aspects of personal growth and renewal that have been argued to extend beyond concepts of recovery (Milroy in Mackean 2009).

Healing involves growth and recovery across many dimensions. It can be used with individuals, groups and families – young people, men, women, Elders and whole communities. The common denominator in healing programs is the incorporation of the protective factors of connection to land, culture, spirituality, ancestry, family and community (Healing Foundation 2016).

Healing involves the application of existing cultural knowledge to address trauma and post-generational trauma using traditional and contemporary practices. Healing programs and services focus on gaining and sustaining hope and achieving a sense of identity and belonging, wellbeing, empowerment, control and renewal. The common denominator in all healing programs and services is the incorporation of the protective factors of connection to land, culture, spirituality, ancestry, family and community (Healing Foundation 2016).

Relevant AOD service model activity:

- ensure access to internal and external cultural support and healing opportunities

Responsibility in the AOD service model:

- gathering places, land councils

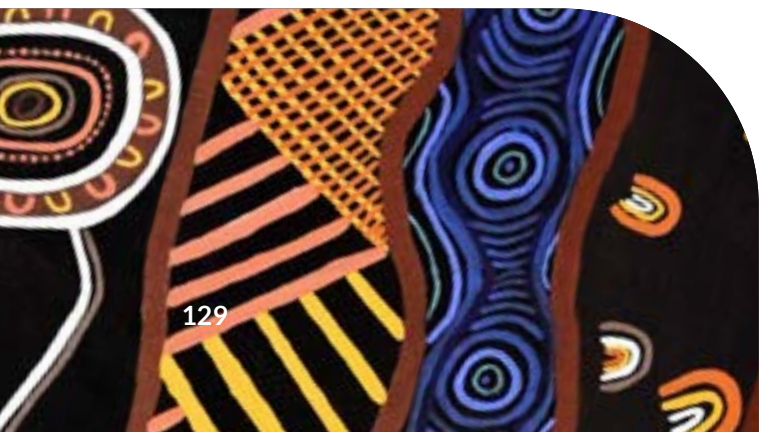
Royal Commission into Victoria's Mental Health System.

The AOD service system is not static and while it is not possible to anticipate all changes to funding and service models, many key changes effecting the sector over the next 5 years are connected to the recommendations of the Royal Commission into Victoria's Mental Health System.

Royal Commission into Victoria's Mental Health System – final report, relevant recommendations

Recommendation 33: Supporting Aboriginal social and emotional wellbeing

- Build on the interim report's recommendation 4 (see below) to support Aboriginal social and emotional wellbeing and resource the Social and Emotional Wellbeing Centre to establish two co-designed healing centres
- Fund Infant, Child and Youth Area Mental Health and Wellbeing Services to support Aboriginal Community Controlled Health Organisations by providing primary consultation, secondary consultation and shared care
- Fund Aboriginal Community Controlled Health Organisations to commission the delivery of culturally appropriate, family-oriented, social and emotional wellbeing services to children and young people
- Fund the Victorian Aboriginal Community Controlled Health Organisation, in partnership with an Infant, Child and Youth Area Mental Health and Wellbeing Service, to design and establish a culturally appropriate, family-oriented service for infants and children who require intensive social and emotional wellbeing supports



Interim Report Recommendation 4

Expand social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:

- dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal community-controlled health organisations, with statewide coverage within five years
- scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five years
- recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:
  - clinical, organisational and cultural governance planning and development - workforce development - including by enabling the recommended scholarships
  - guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment
  - developing and disseminating research and evidence for social and emotional wellbeing models and convening associated communities of practice

Relevant AOD service model activity:

- Awareness that additional capacity building support for Aboriginal workers is likely
- Additional access to SEWB programs

Drug and Alcohol Service Planning Model for Australia[132]

The National Drug and Alcohol Research Centre at UNSW was commissioned by the Commonwealth Ministerial Council on Drug Strategy and undertaken by the NSW Ministry of Health to develop a resource planning tool for use by health planners in relation to alcohol, and other drug treatment for Aboriginal and Torres Strait Islander people.

The researchers identified variances from usual care when providing AOD services to Aboriginal people. We have used their identification of differences in usual care to quantify any changes required in the proposed model.

The care elements for appropriate and evidence-based clinical care for Aboriginal clients they identified include:

- attention to kinship and family relationships
- greater time and flexibility in providing immersion in cultural activities
- the need for transport
- greater time in counselling to address complex issues, needs and comorbidities
- additional ongoing care and assertive follow-up
- return to country/community

Only a proportion of Aboriginal clients will require some of these – for example not every client will require transport to every appointment.

There are additional costs associated with providing the AOD care required for Aboriginal clients. These costs are about two to three times as much as for non-Aboriginal clients receiving AOD care.

[132]Gomez, M., Ritter, A., Gray, D., Gilchrist, D., Harrison, K., Freeburn, B., & Wilson, S., 2014. Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool. Canberra: ACT Health. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/DASPM%20Aboriginal%20care%20and%20resource%20estimation%20FINAL%20REPORT.pdf