WA Network of Alcohol and Other Drug Agencies

Feb 2023

# ‘Nothing about us without us’

## Aboriginal alcohol and other drug sector leadership project report

## Acknowledgement

We acknowledge the traditional custodians of the land on which we live and work, and recognise their strength in connection to the land, sea, and community. We pay our respect to their Elders past and present.

We acknowledge the widespread and intergenerational effects of colonisation. The policy and actions of dispossession established long-lasting barriers between peoples, land, and culture. Furthermore, we acknowledge that this trauma has a systemic presence in Western Australian society, policy, and the alcohol and other drug system. We acknowledge the need to address this issue by re-evaluating the systems in place that affect the cultural, social, and economic matters of Aboriginal people.

WANADA is committed to advancing conciliation/reconciliation and fostering the valuable contributions that Aboriginal people make in the alcohol and other drug service sector to deliver meaningful, lasting outcomes for Aboriginal people, families, and communities.

## About WANADA

The Western Australian Network of Alcohol and other Drug Agencies (WANADA) is the peak body for the alcohol and other drug education, prevention, treatment, and support sector in Western Australia. WANADA is an independent, membership-driven not-for-profit association.

WANADA is driven by the passion and hard work of its member services, which include community alcohol and other drug counselling; therapeutic communities; residential rehabilitation; intoxication management and harm reduction services; peer based; prevention; and community development services.

This report is the product of a WANADA project funded by Mental Health Commission (WA).

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## Summary of Recommendations

### Recommendation 1

Develop a Western Australian Aboriginal-specific AOD Strategy informed by the needs of Aboriginal people and communities throughout Western Australia.

### Recommendation 2

Conduct a comprehensive Western Australian Aboriginal planning process, that identifies current service gaps and service expansion needs to meet future demand for Aboriginal individuals, families and communities.

### Recommendation 3

Support Aboriginal leadership and engagement in decision-making throughout all policy, planning, and commissioning processes that is proportionate to the level of harm and need in the community.

### Recommendation 4

Develop and implement cultural competencies that ensure culturally safe service provision and workplaces for Aboriginal peoples. This would require whole-of-organisation cultural security development to apply:

- local protocols, procedures, and practices.
- understanding of Aboriginal worldview and wellbeing.
- awareness of the spirit of reconciliation and self-determination.
- cultural awareness informed by local Aboriginal history and experiences.

### Recommendation 5

Establish, support, and resource the development of routine monitoring and evaluation of sector data in collaboration with the AOD sector and community members. This is to inform the ongoing planning and support of the workforce and service delivery. The process should be led by both principles of Aboriginal data sovereignty and research methodologies.

### Recommendation 6

Support and resource AOD organisations/service providers to implement culturally safe recruitment and retention approaches, including a minimum benchmark of Aboriginal staff, supporting participation beyond entry level positions.

### Recommendation 7

Resource organisations to establish and maintain culturally safe and accountable relationships with the local Aboriginal community and Elders.

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## Introduction

> *If you put self-determination as the ultimate of what we want to achieve, we have to be in control. It means control of procurement (commissioning of services), what happens in policy level, workforce and beyond. You can't have true self-determination if you aren't in control … Otherwise, it's all just warm and fuzzy words.* [Reference group planning day]

Self-determination emerged as a central theme of the 2019 WA Aboriginal Alcohol and other Drug Workers Forum (the Forum). Aboriginal[1] alcohol and other drug workers, managers, executives, and board members identified the central role of self-determination in the provision of culturally responsive services.

By promoting a systems-based approach to self-determination, this report aims to contribute to improved health and social wellbeing outcomes for Aboriginal peoples in Western Australia. This paper recommends actions that can be taken by government, organisations, and workers to embed the principles and practice of Aboriginal peoples' right to self-determination within the alcohol and other drug sector.

This report provides a summary of the:

- consultations across the alcohol and other drug services sector in Western Australia.
- contextualisation of these themes.
- recommendations on what is needed to develop culturally secure capacity across the alcohol and other drug services sector in Western Australia.

## Background

WANADA frequently hears from Aboriginal people working in the alcohol and other drug (AOD) sector about their lack of voice and agency, and opportunities to provide culturally responsive solutions. This exclusion throughout the sector continues the trauma and harms of the past, not only for the clients of services. This results in a sense of fatigue, distrust, anger and frustration with both organisations and funders responsible for AOD services. It is recognised that this is a multi-faceted issue, linked to the AOD workforce, organisational capacity, and the policy, planning, and commissioning of services in WA. A different or reformed approach to service delivery to meet the needs of Western Australia's Aboriginal community is needed.

The participants in the Forum called for translation of the principles and rights of Aboriginal peoples' self-determination into meaningful action. This was voiced from all levels of the workforce: including Aboriginal CEOs, AOD workers, organisational board members and community members. Consistent with research on effective engagement,[2,3] Aboriginal leadership and voice within sector policy, planning, and service delivery

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[1] While WANADA recognises that peoples from many of First Nations live throughout Western Australia, as WANADAs focus is within Western Australia the term Aboriginal is used unless referring to a specific language group.

[2] Thorpe, A., Arabena, K., Sullivan, K. and Rowley, K. 2016. *Engaging First Peoples: A Review of Government Engagement Methods for Developing Health Policy*, The Lowitja Institute, Melbourne.

[3] Hunt, J., (October 2013). *Engaging with Indigenous Australia – Exploring the Conditions for Effective Relationships with Aboriginal and Torres Strait Islander Communities*, Australian Institute of Health and Welfare, Canberra.

was seen as essential. As identified in a literature review on elements necessary for effective relationship with Aboriginal and Torres Strait Islander communities:

> *Effective engagement is a sustained process that provides Indigenous people with the opportunity to actively participate in decision making from the earliest stage of defining the problem to be solved. Indigenous participation continues during the development of policies—and the programs and projects designed to implement them—and the evaluation of outcomes.*[4]

Participants in the 2019 Forum voiced an expectation of WANADA to advocate for Aboriginal leadership, voice and self-determination for the WA AOD sector. On this basis a WANADA working position paper[5] was developed, which included expectations regarding roles and responsibilities for Aboriginal inclusion and engagement in:

- government policy, planning, and commissioning processes.
- organisational governance, policies and practices.
- developing and supporting the Aboriginal AOD workforce.

*Meeting community needs must be the priority.* [Aboriginal alcohol and other drug service worker]

[4] Above: page 3

[5] Western Australian Network for Alcohol and Other Drug Agencies. (2019). *Self-determination Active involvement in the alcohol and other drug service system to support Aboriginal community self-determination* (2019 WANADA Position Paper). Western Australian Network for Alcohol and Other Drug Agencies.

## Aboriginal AOD Sector Leadership project

This mandate provided WANADA with the backing to propose the Aboriginal AOD Sector Leadership project. The proposed project was to contribute to the achievement of the Mental Health Commission's (MHC) *Mental Health, Alcohol and other Drug Workforce Strategic Framework: 2020–2025* (Strategic Framework).[6] The Strategic Framework identified a number of strategies and suggested actions to better meet the needs of the Western Australian community (i.e. based on the endorsement we received, the alcohol and other drug service needs of the WA Aboriginal community).

### Purpose and objectives

The aim of the WANADA AOD Sector Aboriginal Leadership project is to:

- identify strategies that will enhance access and improve outcomes for Aboriginal service users, families and the community within a systemic workforce development model.
- identify ways to build culturally secure capacity across the AOD services sector.
- recommend ways forward to develop culturally secure capacity across WA's AOD services.

### Approach

> *The reference group endorses WANADA to present our views and voice as Aboriginal peoples, to move forward with alcohol and other drug sector development in WA.* [Reference group chair]

WANADA is an advocacy organisation for the alcohol and other drug sector in Western Australia. As a non-Aboriginal organisation, WANADA looked to apply elements of effective engagement. A number of stages were used to ensure state-wide views were sought.

Firstly, WANADA employed an Aboriginal AOD coordinator to lead this scoping research, with the plan to enhance WANADA's sector development team. Karina Clarkson was employed as the Project coordinator. Karina brought a wealth of experience in the AOD sector, including Aboriginal workforce development. The role included facilitating Reference Group engagement, consultation with relevant stakeholders, sector workers and community members. Annalee Stearne, Research Associate/ PhD Candidate at Curtin University's National Drug Research Institute, was engaged as a consultant to assist with the analysis and finalisation of this report.

Secondly, a project Reference Group was established, to guide the direction of the project (Table 1). The Reference Group members were individuals and representatives (via proxies) from the Aboriginal community controlled AOD treatment services in WA, as well as Aboriginal elders, MHC staff and the chair of the AOD advisory board. The reference group were diverse in age, genders, roles and responsibilities, experience in the AOD sector, and included representation from both regional, and urban services.

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[6] Mental Health Commission (2020). *Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020–2025.* Mental Health Commission, Government of Western Australia.

**Table 1**: Reference group membership

| | |
|---|---|
| Stanley Nangala (Chair) | CEO, Ngnowar Aerwah Aboriginal Corporation |
| Aunty Oriel Green | WANADA's Aboriginal Elders |
| Aunty Moya Newman | WANADA's Aboriginal Elders |
| Daniel Morrison<br>Proxy(s): Celine Thomson, Awhiora Nia Nia & Michael Winton | CEO, Wungening Aboriginal Corporation |
| Andrew Amor | CEO, Milliya Rumurra Aboriginal Corporation |
| Cliff Collard<br>Proxy: Alira Palmieri (Kelly) | Program Manager, Mental Health Commission<br>Strong Spirit Strong Mind Aboriginal Programs |
| Professor Colleen Hayward | Chair WA AOD Advisory Board (former) |

Thirdly, based on the guidance of the reference group a number of strategies were used to seek sector and community views for this report. Following planning with the reference group, an online survey of CEOs across the AOD Sector was developed. This was then complemented with two site visits to regional locations for interviews with both AOD workers and community members in each location.

### *Limitations*

The WANADA Aboriginal AOD sector Leadership project was resourced as a scoping study for 12-months, and while the investment outcome informs ways forward, it was not viable to provide a definitive solution. Fundamentally the project outputs were to identify 'sector needs to, and strategies that would enhance, access and improved outcomes for Aboriginal service users, families and community.' The proposed recommendations contribute towards that intent.

The time and resource limitations of this project would not allow comprehensive consultations, given the diversity and scale of Western Australia's geography. As such, some yarning/consultations with Aboriginal workers and community members were held to gather a sample of Aboriginal lived experience stories related to the alcohol and other drug issues and concerns.

It should also be noted that this work was conducted in Western Australia in 2021, with the analysis and report writing conducted throughout 2022. During this period Western Australians had significant restrictions due to COVID-19; including sporadic lockdowns (state-wide and Perth metropolitan region), limits on number of people in venues depending on size of the venue; and restrictions on travel across regions within the state.[7] These measures, and restrictions had significant impact on the methods used in this scoping study, with some changes applied within hours.

[7] Website: https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Western_Australia#Timeline

## Project timeline

| **March – April 2021** | Project establishment | |
|---|---|---|
| **May 2021** | Reference group meeting 1 | |
| **June 2021** | Reference group meeting 2 | |
| **August 2021** | Reference group planning day | |
| **October 2021** | CEO survey | |
| **November 2021** | | Community consultations – Site 1 |
| **December 2021** | Reference group planning day | Community consultations – Site 2 |
| **April – December 2022** | Report analysis and writing | |
| **January 2023** | Presentation to reference group and WANADA board for endorsement | |

## Report structure

The WANADA Aboriginal AOD sector Leadership report has been structured to provide relevant context for the recommendations (summarised on page 3). Specific recommendations are also listed throughout the report.

- Introduction to the WANADA Aboriginal AOD sector Leadership project.
- Western Australian specific context.
- Summary of the consultations with the sector:
  - Aboriginal AOD workforce issues.
  - Aboriginal community needs and AOD organisational capacity to respond.
  - Organisational perspectives.
  - Aboriginal community connection, guidance, and leadership.
  - Government policy, planning, and commissioning of services.

### *Aboriginal self-determination*

The importance of allowing Aboriginal people to exercise their right to self-determination was prominent throughout the discussions. However, what is self-determination, and what does Aboriginal (or First Nations Australian) self-determination mean? Within the Australian health and AOD context most of the discussion of self-determination is focused on autonomy over service delivery.[8] In the context of health policy Ian Anderson (2008) discussed how there was not a singular approach for self-determination but emphasised it is '…integral to the development of [health] strategy and service delivery.'[9] The most commonly observed method of exercising self-determination in the Australian context has been through the inclusion of First Nations Australians in decision-making processes on issues directly affecting them.[10]

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[8] Mazel, O. (2016). Self-Determination and the right to health: Australian Aboriginal community-controlled health services. *Human Rights Law Review*, 16 (2), 323-355.

[9] Anderson, I. (2008). Indigenous Australia and health rights. *Journal of Law and Medicine*, 15 (5), 760-772. (p. 772)

[10] Behrendt, L., & Vivian, A. (2010). *Indigenous self-determination and the Charter of Human Rights and Responsibilities: A framework for discussion*. Occasional paper. Melbourne: Victorian Equal Opportunity and Human Rights Commission.

Self-determination is complex and difficult to define, as it is unique in each and every context. Stearne's (2021) definition of self-determination has five elements, it is: a right, decision-making powers, an ongoing process, collective in nature (not individual), and defined by Aboriginal people.[11] Even though Stearne's work focused on self-determination in alcohol policy development, the findings have wider relevance. Self-determination in policy development and service provision requires multiple approaches at many levels. Aboriginal people's self-determination in WA's AOD services is multi-faceted, with there being the need for self-determination to be exercised at multiple levels:

- within organisations,
- externally by the local community, and
- in those bodies (such as the MHC) that have influence over the decisions, directions, and priorities.

Further to this, the nature of representation and participation is likely to be different at each of these levels, though they will not be mutually exclusive. It is important to note that exercising of Aboriginal peoples' self-determination has the potential to be contradictory within existing governance structures. The purpose of the support and facilitating Aboriginal self-determination is to address the legacy of colonisation. The way in which this is done is important as it could reproduce 'the colonial relations of dominance that Indigenous self-determination has sought to overcome.'[12] Ways to exercise self-determination need to be defined by the Aboriginal community, thus a blanket approach is not possible.

[11] Stearne, A. E., Allsop, S., Shakeshaft, A., Symons, M., & Wright, M. (2021). *Identifying how the principles of self-determination could be applied to create effective alcohol policy for First Nations Australians: Synthesising the lessons from the development of general public policy*. International Journal of Drug Policy, 93 (July), Article 103260.

[12] Above: Page 10

## Western Australian context

### Population

Firstly, 4% of the Western Australian population identifies as Aboriginal, slightly higher that the national proportion (3.3%). However, approximately 12.5% of all Aboriginal and Torres Strait Islanders live in Western Australia. The population is not evenly distributed, with higher proportions in regional and remote areas. It should be recognised that 40% of the Western Australian Aboriginal population reside within the Perth-metro area.

**Table 2:** Western Australia's Aboriginal Population[13]

| | Aboriginal & Torres Strait Islander | % | Non-Indigenous |
|---|---|---|---|
| National | 798,365 | 3.3% | 23,392,542 |
| Western Australia | 100,512 | 4.0% | 2,455,466 |
| Urban (Major cities) | 40,433 | 2.0% | 1,951,121 |
| Regional (Inner and outer regional) | 21,894 | 5.6% | 393,866 |
| Remote (and very remote) | 38,185 | 32.0% | 118,192 |

### WA AOD Service use

According to the national minimum dataset, in Western Australia (Table 3), of those accessing AOD services for their own use, 23.5% are Aboriginal; while 21% accessing services because of a family member's AOD use, identify as Aboriginal. This is higher than the national figures of 17% and 11%, respectively; and significantly higher than the population rates.[14] These data are not able to be broken down by Aboriginal-specific service providers verses mainstream service providers. It should also be recognised that non-Indigenous-specific services are also funded for Aboriginal service provision.

**Table 3**: Percentage of clients engaging in AOD services by Aboriginal status WA, 2019–2020[15]

| | Own drug use | Other's drug use | Total |
|---|---|---|---|
| Aboriginal | 23.54 | 21.16 | 23.35 |
| Non-Aboriginal | 76.41 | 78.84 | 76.6 |
| Not stated | 0.05 | 0 | 0.05 |
| Total | 100.00 | 100.00 | 100.00 |

[13] Australian Institute of Health and Welfare. (2021). *Profile of Indigenous Australians*, AIHW, Australian Government, accessed 21 May 2022.
[14] Australian Institute of Health and Welfare. (2022). *Alcohol and other drug treatment services in Australia: early insights*, AIHW, Australian Government, accessed 21 May 2022. (Table SC WA 3)
[15] Above

### *Summary of AOD service availability*

The main types of treatment are similar for Aboriginal and non-Aboriginal clients. However accordingly there are some types of treatment that non-Aboriginal clients are receiving at higher rates than Aboriginal clients: withdrawal management; support and case management; and pharmacotherapy. Similarly Aboriginal clients are given the following at higher rates: counselling; assessment only; and information and education.

**Table 4:** Percentage of main treatment type accessed by Aboriginal status, Western Australia, 2019–2020[16]

| | **Aboriginal** | **Non-Aboriginal** | **Total** |
|---|---|---|---|
| Counselling | *80.78* | 73.53 | 75.21 |
| Withdrawal management | 2.14 | *4.42* | 3.90 |
| Assessment only | *5.87* | 3.46 | 4.04 |
| Support and case management | 3.08 | *7.31* | 6.32 |
| Rehabilitation | 2.12 | 2.33 | 2.28 |
| Pharmacotherapy | 3.01 | *7.14* | 6.16 |
| Information and education | *2.98* | 1.79 | 2.07 |
| Other | 0.02 | 0.02 | 0.02 |

### *Service demand and capacity*

The 2014 New Horizons report examined the funding, service capacity, and demand for AOD services across Australia.[17] Though dated, the report estimates that just 26–48% of demand for services are being met based on services available in Australia. Since this time, the funding for AOD treatment services has not increased, even by indexation.[18] It is then safe to assume that capacity to meet demand has likely decreased further. Further to this, the New Horizons report noted that for Aboriginal clients, there is a greater demand for services AND that considerations of the approachability of the service is also necessary.[19]

[16] Australian Institute of Health and Welfare. (2022). Alcohol and other drug treatment services in Australia: early insights, AIHW, Australian Government, accessed 21 May 2022. (Table SC WA 15)

[17] Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K. and Gomez, M. (2014). *New Horizons: The review of alcohol and other drug treatment services in Australia*. Drug Policy Modelling Program, National Drug and Alcohol Research Centre UNSW.

[18] Above

[19] Above

### *Funding*

While all services are accessible and available for Aboriginal clients, additional funding for Aboriginal-specific AOD programs and services is intended to address intergenerational grief and trauma, resulting for past policies. Funding for Aboriginal-specific programs and services comes from both the Australian and Western Australian governments. The definitive funding allocated to and expended on Aboriginal-specific AOD services in Western Australia is not readily available to those outside of the funding bodies The former ANCD and NIDAC committees commissioned reviews of the funding allocations (and expenditures) for Aboriginal-specific AOD services in 1999[20] and 2007;[21] however there have been no assessments since then. These reviews also identified the absence of Aboriginal-specific residential AOD treatment services in the south-west of Western Australia. Despite being recommended in the 10 Year Plan; no actions toward development have commenced.[22]

## Historical policies have created (and continue to) disadvantage

> *… the past is not the past, it is still central today and will be the future too.* [Reference group planning day]

Aboriginal peoples' inclusion in Australian society is recent. Aboriginal people were controlled, families destroyed and separated, practicing culture and speaking traditional languages were prohibited, and people were moved from their traditional lands.[23,24] It is only recently (1970s) that Aboriginal people have been able to engage fully in Australian society – employment with equitable pay, unrestricted access to education and having access to social security payments. However, the inter-generational effects of these policies remain evident in the lives of many Aboriginal people.

The impacts of these policies, and the relationship to increased alcohol and other drug-related harms have been acknowledged and recognised extensively. These have been well documented in Royal Commission into Aboriginal Deaths in Custody[25] (1991) that documented and recognised the relationship of intergenerational trauma to increased harms related to alcohol and other drug use, and the contribution of these to increased rates of incarceration. Further to this, the intergenerational trauma caused by the systematic removal of Aboriginal children from their families was documented in the 1997 Bringing Them Home report.[26]

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[20] Gray, D., Sputore, B., Stearne, A., Bourbon, D. & Strempel, P. (2002). *Indigenous Drug and Alcohol Projects: 1999–2000.* Canberra: Australian National Council on Drugs.

[21] Gray, D., Stearne, A. E., Wilson, M., & Doyle, M. (2010). *Indigenous-specific Alcohol and Other Drug Interventions: Continuities, Changes, and Areas of Greatest Need.* ANCD Research Paper 20. Australian National Council on Drugs.

[22] Gomez, M., Ritter, A., Gray, D., Gilchrist, D., Harrison, K., Freeburn, B., and 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. Drug Policy Modelling Program National Drug and Alcohol Research Centre UNSW.

[23] Haebich, A. (1988). *For Their Own Good: Aborigines and Government in the Southwest of Western Australia, 1900–1940.* University of Western Australia Press.

[24] Haebich, A. (2000). *Broken circles: Fragmenting Indigenous families, 1800–2000.* Fremantle Arts Press.

[25] Royal Commission into Aboriginal Deaths in Custody

[26] Human Rights and Equal Opportunity Commission. (1997). Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children and Their Families. Human Rights and Equal Opportunity Commission.

**Table 5:** Some significant dates in WA's Aboriginal peoples' rights

| | |
|---|---|
| 1910 | Aboriginal people become wards of the state. Permission was required from the Protector of Aborigines to spend money, visit family, and movement and travel. |
| 1936–1972 | WA government quarantined portion of Aboriginal peoples' wages. |
| 1960 | Aboriginal people successfully awarded equal pay rather than rations for work. |
| 1970 | The Western Australian government ceased the removal of Aboriginal children from their families based on race. |
| 1972 | Aboriginal people now permitted to purchase and consume alcohol. |
| 1991 | Royal Commission into Aboriginal Deaths in Custody released. |
| 1997 | Bringing Them Home: Australian Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families. |

## *Aboriginal worldview*

> *Aboriginal health does not mean the physical wellbeing of an individual, but [also] refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view.*[27]

Aboriginal peoples' world view and understanding of wellbeing is integral to understanding the inter-related nature of community expectations. Aboriginal peoples' understanding of health and wellbeing highlights the inter-connectedness of individuals within their communities. This understanding of wellbeing is necessary for the development and provision of culturally secure services.

## *Relationship of harms related to AOD and need for culturally secure systems development and service provision*

One recognised consideration of AOD issues is the role of historical and current trauma, both at an individual and community level. In their work on the social determinants of health, Marmot (2011) identified that Indigenous Peoples also have the ongoing trauma of dispossession, and colonisation impacting their health and wellbeing.[28] These cannot be addressed without a service model that addresses all intersecting issues, and the resultant accumulative weight on communities. Communities are trying to address many of the additional harms related to harmful AOD use – including domestic violence, youth suicide, and the related trauma.

The ultimate goal of the AOD sector – funders and service providers – is how it can work to support individuals and communities to address the harms of alcohol and other drug use. Given the high engagement of Aboriginal people with services across the sector, the provision of culturally secure services is vital.

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[27] Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2014). Aboriginal and Torres Strait Islander social and emotional wellbeing. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (2nd ed., pp. 25-42). Australian Government Department of Health and Ageing.

[28] Marmot, M. (2011). Social determinants and the health of Indigenous Australians. *Medical Journal of Australia.* 194 (10): 512-513.

The Western Australian AOD sector has made significant efforts to the cultural security of services. There has been investment in several key areas:

- Aboriginal specific programs and services.
- Aboriginal-specific places/beds in residential treatment services.
- Development and maintenance of Aboriginal AOD workforce, through training and supports.
- Development of the cultural secure framework – increasing cultural safety of services.

In Western Australia Aboriginal people are accessing both Aboriginal-specific and mainstream AOD treatment services at higher rates than non-Aboriginal people. Highlighting the need for all services to be accessible, culturally safe, and culturally secure for Aboriginal clients.

Despite this, Aboriginal AOD workers, AOD services, and Aboriginal community members still see a need for systemic change in facilitate Aboriginal leadership across the sector. The consultations show that further enquiry is necessary to ensure culturally secure service provision across the Western Australian AOD services sector. These consultations highlighted the need for structural and systemic changes to develop and increase cultural security within the AOD service sector.

## Reference group guidance and direction

The WANADA Aboriginal AOD Sector Leadership reference group was formed with the purpose of guiding the development of Aboriginal AOD sector leadership and WANADA's role in advocating for self-determination principles and practices. The reference group met virtually to discuss the direction of the project terms of reference, and an additional two face-to-face planning days (August and December 2021). Input at these events guided the direction of the project consultation. The Reference Group identified three key areas of focus for the sector-level consultation.

*Policy, planning, and commissioning processes:*

- There is a need for a policy, planning, and commissioning framework that reflects the principles of Aboriginal self-determination and includes targets and areas for focused investment.

*Meeting community needs through organisational application of self-determination.*

- Aboriginal communities experience ongoing trauma and harm that can be linked to AOD use, The reference group advocated for approaches that enhance the application of self-determination within service organisations. It is recommended that service solutions guide and are directed by Aboriginal people.

*Aboriginal AOD Workforce:*

- There is a need for robust strategies to support and develop the Aboriginal AOD workforce, across the sector as well as within organisations, services, and programs. These strategies should work to balance both the capacity and capability of sector and organisational needs.

**Figure 1:** Inter-related nature of factors

## Consultation with the sector

Based on the three priorities identified by the reference group, an online survey of WA AOD sector CEOs was undertaken. The survey had 19 questions that were focused on the priorities of the reference group and sent to CEOs of sector organisations. The time and resource limitations of this project would not allow for more comprehensive consultations, given the diversity and scale of Western Australia's geography. As such, some yarning/consultations with Aboriginal workers and community members were held to gather a sample of Aboriginal lived experience stories related to alcohol and other drug issues and concerns. Comments made during these yarning sessions are incorporated within this report.

Overall, data collected through these consultations has helped enabled the identification of possible next steps needed to inform or establish strategies for improved alcohol and other drug service access and outcomes for Aboriginal people. The CEO survey was complemented with focus groups with AOD workers in the Pilbara, and community members in the Pilbara and Goldfields.

### *CEO surveys*

Both the CEO survey and focus groups with the workforce identified some strengths and barriers in the recruitment and retention of the Aboriginal AOD workforce. Responses were received from 16 CEOs of organisations, including five Aboriginal community-controlled organisations, providing a combined total of 41 alcohol and other drug treatment and support service responses. The organisations – and services – covered all of the state; with 10 of the organisations being based in the Perth metropolitan and south-west region. The organisations vary in size from seven to 208 employees (mean= 92.6) and had between 0% and 97% Aboriginal staff (mean= 26%).

In terms of Aboriginal staffing in these organisations, the roles varied significantly. These have been grouped into eight categories: volunteers; advisory roles (including cultural advisors); administration staff (including bookkeepers and receptionists); governance (primarily board members, and elders-in-residence); officers/ workers/ co-ordinators (including Aboriginal support workers, counsellors, and patrollers); managers (including cultural lead); and CEOs (four). The majority of positions listed as filled by Aboriginal staff, were for the officer/workers/ co-ordinator positions (n=87/112, 78%).

### *Focus groups*

The focus groups with workers, concentrated on workforce issues, including training, and supports needed to recruit and retain specifically Aboriginal AOD workers. The AOD workers who participated ranged in experience from two months to seven years, with some coming into the sector with significant experience in other areas such as mental health, education, and housing.

**Table 6:** Focus group consultations with AOD workers

| | Aboriginal | non-Aboriginal | Grand Total |
|---|---|---|---|
| Female | 6 | 3 | 9 |
| Male | 2 | 1 | 3 |
| *Grand Total* | *8* | *4* | *12* |

## Aboriginal AOD Workforce

The experience of the Aboriginal AOD Workforce in the sector is diverse. Even those that have only recently joined the sector, come with vast experience in related fields.

> *I only started working with [service name] … but had a varied background in education, mental health, women's refuge and DCP. Most of these jobs required a level of AOD support and I had a passion for wanting to work in the AOD sector*. [Female., Aboriginal, AOD worker, regional]

Focus group participants spoke of wanting to give back to their local communities and wanting to support those people (in their communities) experiencing the harms of AOD use.

> *I grew up in Port Hedland and I wanted to work in a job where I could give back to the community and I wanted to see change.* [Male, non-Aboriginal, AOD worker, regional]

> *I wanted to work in Aboriginal communities, I wanted to learn about respect for working in Aboriginal communities*. [Female, Aboriginal, AOD worker, regional]

> *I always wanted to work in communities to help communities. I came from a time when there wasn't much help at all. Things need to be community-led at a local level.* [Female, Aboriginal, AOD worker, regional]

### *Recruitment and retention of the Aboriginal AOD workforce*

While some organisations acknowledged that they did not implement any targeted strategies for the recruitment and retention of Aboriginal staff, others have implemented a range of strategies. Some organisations have proactively addressed issues of recruiting Aboriginal staff through several ways: engaging and including Aboriginal staff in the advertising and dissemination of vacancies, and on the interview panel; and flexible and staged approaches to the recruitment process to develop relationships.

Consultations identified that potential staff, especially those with lived experience, may have a police record that inhibit them seeking employment in AOD services. Some organisations have made allowances to ensure that this is not a barrier their employment. The employment of inexperienced and unqualified staff is often required, particularly in regional areas. Some organisations have invested significantly to support these staff to gain relevant and related qualifications, additional skills, and extraordinary driver's licences. Other life skills and knowledge – in particular cultural knowledge and connection – that Aboriginal people hold are valuable for organisations.

*Lived (living) experience matters; qualifications and knowledge around frameworks matter; understanding the complexity of clients and issues they present with matter. These are all [interrelated].* [Sector worker]

*You need good staff who know the community and can work in the community.* [Community elder]

*Mainstream metropolitan alcohol and other drug services need to incorporate positive recruitment approaches to enhance their cultural responsiveness, which in turn will enable Aboriginal leadership.* [Sector CEO]

*Being familiar with the community creates a sense of meaning for the job.* [Sector Survey Response]

### *Retaining Aboriginal workers*

The focus group participants spoke of factors affecting staff retention in their organisations. Most of these are linked to remuneration and affect those workers in the lower end of the remuneration scale. Across the sector one of the greatest difficulties is competing with the allowances and salary rates in the government sector.

*Salaries also aren't competitive, again especially compared with government salaries.* [Sector Survey Response]

This is even more pronounced in regional areas where regional allowances, housing and sometimes vehicles are part of employment packages. The non-government sector is not able to compete with such packages, especially in areas where housing is limited, and cost of living is high. These are difficult to address, as the funding for services has not been indexed for many years;[29] effectively services and organisations are operating with less funding.

Two participants highlighted barriers to the retention of Aboriginal AOD workers and identify the complexities faced by the workforce, especially in regional areas. These factors are also, to some extent within the capacity of organisations to address. One participant spoke of how some staff struggle with limitations of what the organisation can provide for clients, with them expecting more.

*Some staff struggle with understanding the limitations of what services Organisation can/can't offer.* [Sector Survey Response].

[29] Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K. and Gomez, M. (2014). New Horizons: The review of alcohol and other drug treatment services in Australia. Drug Policy Modelling Program, National Drug and Alcohol Research Centre UNSW.

Another factor one participant highlighted was the tension experienced by Aboriginal staff with being in positions of confidence, while also being members of the local Aboriginal community. This tension was described as almost impossible to navigate, especially for those in smaller regional communities.

> *Conflicts of interest with staff and service users, sometimes there are family relationships that need to be managed* [Sector Survey Response].

The survey respondents also identified many factors influencing the long-term retention of the Aboriginal AOD workforce. Some organisations have instigated additional measures to support the retention of Aboriginal staff. Organisation-wide strategies include:

- accreditation;
- Aboriginal staff-led practice and support groups;
- Aboriginal members on the board;
- the development and implementation of Reconciliation Action Plan (RAP); and
- having an organisational strategic plan that integrates the RAP.

One agency described some of the clear supports that they have put in place that seem to counteract and mitigate these conflicts. These included: peer-support initiatives; facilitating workers to work across programs; clinical and cultural supervision; and flexible cultural leave provisions (lore, sorry business, NAIDOC day leave). One organisation has said it is essentially 3–6 months of intensive supervision and support required to onboard someone new into the AOD workforce. Such an intense recruitment process places a heavy burden on the organisation and other service providers, and likely unsustainable in the long term.

### *Workforce training*

Most organisations mentioned 'active steps to be inclusive, equitable'. One organisation spoke of the efforts across the organisation:

> *All staff are training in cultural awareness and sensitivity. Our workplace environment has been intentionally designed in recognition of Aboriginal heritage.* [Sector Survey Response].

This highlights an important factor in the recruitment and retention of an Aboriginal workforce, as well as the cultural safety for Aboriginal staff and clients. There has been significant work and effort in order to ensure culturally secure service provision with the focus on the Aboriginal AOD workforce. Workforce is repeatedly identified as a key factor for the achievement of a responsive service model. Within a culturally responsive service model, Aboriginal workers play an essential role. A strong Aboriginal workforce informing the response to community contributes to service accessibility for Aboriginal people who seek information and treatment when it is needed as well as the relevance to meet the Aboriginal community's needs. Aboriginal leadership, evident within organisations, is needed to enhance the confidence of the community in the culturally secure practice of an organisation.

This is important, as it highlights the diverse experience of the current AOD workforce. Even those that have only recently joined the sector, come with a passion or desire to help and support those in their local

community. Such factors are important in the recruitment and retention of a workforce, as is continuous professional development.

AOD workers spoke of three different types of training that they had completed. Firstly, most spoke of the Certificates III and IV provided by the Mental Health Commission (Strong Spirits, Strong Minds), as well as the diploma-level courses such as one in narrative therapy. The workers also identified general skills training that has relevance in the AOD sector. This training focused on: blood borne virus awareness, applied suicide intervention skills, trauma-informed care and practice, FASD awareness, alternative to violence, de-escalation, and first aid. In addition to these, there is also training that is appropriate for those working with Aboriginal clients, with training in: suicide prevention in Aboriginal communities, culturally informed development, and Aboriginal mental health first aid.

One CEO, spoke of need the multi-skilling needed in regional and remote areas, as the range of support services, and referral services are not available. They highlighted while the focus on psycho-social treatment this is only possible when the full range of services are close by for referrals, this is not possible in many regional and remote areas.

> *They need to be able to see the signs of withdrawal, manage co-occurring conditions, and case management. We even have to help them learn how to sleep well again. We can't refer to other sector services, it's a big ask and alcohol and drug issues often get worse ... 40% of our clients have diagnosed anxiety, and 30% have depression. Our staff have to be skilled in mental health as well.* [Sector CEO].

*What has been done*

Extensive efforts have been made to develop the Aboriginal AOD workforce in WA, most notable is the Strong Spirits, Strong Minds (SSSM) program. Beginning as a workforce development program, SSSM has been integral to developing the Aboriginal AOD workforce through the provision of two nationally accredited certificates (Certificate III in Community Services and Certificate IV in Alcohol and other Drugs).[30] Further to this they also offer cultural awareness training for non-Aboriginal people in the sector, and accessible resources for the community.

*What needs to be done*

There are several actions highlighted in the consultations that would assist in the attraction, retention, and development of the Aboriginal workforce in alcohol and other drug service sector.

There is a need for workforce and service planning informed and developed with Western Australia's Aboriginal communities. Further to this, development and expansion of service needs should meet demand and support culturally secure service models that are informed by the needs of the local Aboriginal communities. [Recommendation 2]

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[30] Website: https://strongspiritstrongmind.com.au/training/

Across the board there is a significant lack of evidence preventing sector advocacy, including the impacts of the ongoing development and retention of the Aboriginal AOD workforce. There is a need to resource, establish and support the development of routine monitoring of sector data to inform ongoing planning and support of the workforce and service provision [Recommendation 5].

The consultations highlighted that there was significant variation in the portion of Aboriginal staff employed across organisations in the sector, with some organisations not having any Aboriginal staff members. The policy, planning, and commissioning process has capacity to address this through supporting and resourcing AOD organisations/service providers to implement culturally safe recruitment and retention approaches that support them to achieve, and improve upon the number of Aboriginal staff employed, and increasing the numbers beyond entry level positions. [Recommendation 6]

## Community needs and organisational ability to respond

> *Mental health is not just affecting people on drugs, but it (mental health) is affecting families.* [Community elder]

> *All country towns are struggling people are crying out for assistance … all of these barriers that stop us from moving forward to reduce alcohol and drugs.* [Community elder]

In acknowledging the issues faced by the Aboriginal workforce, one of the key factors to consider is the need to recognise that Aboriginal people are also part of their community, and therefore are often the 'bridge' between the organisation and their community. However, it is evident from the community-level consultations that this alone is not adequate. Community-level consultations were held in two regions (Pilbara and Goldfields). These consultations were with people who had an understanding of some of the services available in their regions, but not all. It should be noted that one of participants stated the regional hospital as a place they could go for AOD support. This is often primarily for acute care such as intoxication and alcohol-related injuries.

The community consultations had three themes. Firstly, the drugs of concern in their communities. These participants all spoke of the harms to their communities resulting from alcohol consumption. Secondly, they spoke of what is needed in their communities. With one participant saying that alternatives to alcohol and drugs are necessary. Thirdly, they all spoke of complex situations that place Aboriginal staff as the bridge (duality of roles) between the services and their community. This was highlighted by one story:

> *I saw this man, he only had one leg and he couldn't walk, and it was raining. I was worried about him, but I'm an elderly woman, I couldn't do much. So I rang the police, and I rang some other places, but no one would do anything. I ended up ringing the local Aboriginal AOD worker from (redacted) … I know him so I was able to ring him outside of work hours and he went out straight away and helped him when no one else would. He's always helping people outside his normal work hours, always giving back to the community.* [Community consultation].

Another pair of community members described a situation where the community were supporting a family, and the local AOD service was attempting to support the children to reduce the harms. The pathways for the organisation to respond were limited:

> *There are four kids in town that are frequently intoxicated from alcohol and sniffing (VSU) … The community knows but the children won't speak up and nothing gets done about it. Child Protection (DCP) came and spoke to the community organisation about the VSU use but they were told that it's not illegal and there's nothing they can do. The education department said the kids are fine, the community organisation tried to give them jobs but got backlash from the school, because they weren't at school. They liked working at the community centre, it gave them a little money and they were safe* [Community member consultation].

There are a few things that can be taken from these examples for consideration of a culturally secure service model. For Aboriginal staff, they are obligated to their community, and will respond to requests even if they were outside their funded role. It is likely that retention of staff is linked to this, especially if they feel powerless or are prevented from responding to community requests. As can be seen from the second quote, some organisations are culturally responsive to needs. The greatest concern about the children discussed, was their safety – the community organisation responded with providing a safe space. Strong connection to the local community, and cultural leadership is necessary for an organisation to be able to respond. This is greater than having Aboriginal staff; multiple connections and accountability to the local community are necessary.

The importance of this, is highlighted in another community consultation where the target community is primarily Aboriginal, however the services do not operate in culturally secure ways.

> *The people in these positions aren't able to do their jobs, they don't listen to their own ways of working … They should be 'working together' with community … They don't learn 'em both ways … They only work Western ways … They should be working with Aboriginal community and be guided by their cultural knowledge; they should be putting their healing-ways of being into responding to trauma and dealing with complex issues.* [Community member consultation].

One community elder highlighted the importance if community knowing and understanding what services are available for them and their families. This links strongly to the next section, and the need for organisational connection with communities.

> *Services need to equip community in how to respond to their family members' alcohol and drug use. There's no point getting your son or daughter off drugs when there are no service to support them.* [Community elder]

### *What has been done*

The consultations have highlighted that some organisations have made efforts to develop relationships with local Aboriginal elders and their community. One even appointed an Executive Manager with the remit of Cultural Leadership across the organisation.

A number of the urban-based organisations have worked with the Looking Forward, Moving Forward[31] project to co-design cultural change throughout an organisation. The Looking Forward, Moving *Forward* uses the Debakarn Koorliny Wangkiny ('Steady Walking and Talking')[32] conditions to develop:

> *...meaningful, purposeful relationships between Elders and service staff. The conditions 'hold' relationships so that services can develop: (a) inclusivity, (b) trustworthiness, (c) reciprocity and (d) adaptability.*[33]

A culturally secure and safe approach is represented in the ability of organisations and service providers to understand and respond to the needs of their local community. This can be evidenced in many different ways, including:

- local Aboriginal community understandings of the services and how they operate.
- local Aboriginal community members accessing and engaging with the services.
- recruitment and retention of local Aboriginal staff.
- organisations and service providers responding to the needs and priorities of the local Aboriginal staff and community.

### *What needs to be done*

There are several actions highlighted in the consultations that would assist organisations and service providers in responding to the needs of their local Aboriginal community.

At present there is no National or Western Australian Aboriginal-specific AOD Strategy informed by the needs of Aboriginal people and communities throughout Western Australia. The development and implementation of such a strategy would direct the planning of service provision for Aboriginal people, families, and communities in a systemic and accountable way. [Recommendation 1]

The development and implementation of cultural competencies across the AOD sector, including training on local protocols, procedures, and practice; Aboriginal world-view and understanding of health and wellbeing; spirit of reconciliation and self-determination; and cultural awareness including local history and experiences. A systemic response to the AOD service needs of Aboriginal communities requires the development of a culturally responsive service model informed by independent research. Such a model should be flexible and adaptive for local contexts. [Recommendation 4]

The relationship between organisations providing AOD services, and their local Aboriginal communities requires efforts to ensure the ongoing maintenance of relationships. Such relationships require the embedding of processes that maintain relationships and accountability with the local Aboriginal community and elders through the organisation. [Recommendation 7]

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[31] Looking Forward, Moving Forward. (2022). https://debakarn.com/our-work/looking-forward-moving-forward/#

[32] Above

[33] Looking Forward, Moving Forward. (2022). https://debakarn.com/our-work/looking-forward-moving-forward/#

## Organisational perspectives

AOD service providers are at the nexus and key to the ensuring that their services are culturally secure for Aboriginal staff, clients, and the wider local Aboriginal community. There are a number of key factors at play that can facilitate or inhibit the ability of the AOD organisations and service providers to provide culturally secure services:

- Service model to meet the needs of clients.
- Community expectations.
- Aboriginal community connection, guidance, and leadership.

### *Service model to meet the needs of clients*

Organisations spoke of not being able to fully meet the needs of their communities. One factor in this are the predefined performance indicators, rather than the needs of the local communities and clients. The diversity of Western Australia means that service models need to be adaptive locally, however if their priorities and performance indicators are generic there is a risk of not being able to report on actual activities or respond to generic performance indicators. For instance, one service provider discussed the service approach as being focused on healing rather than treatment. This is reflective of both the client and community needs, as clients need support to address more than just their AOD use.

> *They're coming to us. We don't have the resources to deal with the level of harm, and we turn people away because we don't have the resources to deal with them. Government needs to listen to us. We're an AOD service, but we are moving into becoming a safe place to heal – keeping people out of prison, keeping children within families, supporting employment and cultural needs, and then the AOD stuff.* [Sector CEO]

The reference group discussions also highlighted the importance of recognising that the community and clients are facing more than AOD issues. That is other agencies, including education, housing, and most importantly health, need to be involved in supporting the community and clients. The service model needs to meet the needs of the clients and community.

> *It hasn't got better, it's got worse. I can't understand how all organisations are not working together – health, education, housing … there is nothing there.* [Community elder]

### *Community expectations of service providers*

Often Aboriginal staff are connected closely to their local communities; there is a strong duality in their roles in the organisation and their community. This connection is valuable for organisations and service providers and can be very important for the community. For Aboriginal staff, however, this can be problematic, as they are often the conduit between the organisations and their community. As also members of the local Aboriginal community, they have obligations, which can be in conflict with those of their organisation. It is important to recognise these tensions, and the risks it poses. The first risk relates to retention of staff as for many Aboriginal people, the cultural (and community) obligations are greater than those of their employers.

The second risk is that the service is simply not meeting the needs of the communities and placing staff at risk within their communities. The survey and consultation participants provided perspectives regarding the community expectations of services.

> *It's disempowering, you ask yourself 'why show up'. If your community doesn't see results, it's disempowering.* [Reference group planning day]

Further to this, there is also the issue of the community not understanding the role of the organisation. Such as expressed by this participant. This emphasises a need for organisations to utilise the community connection of their staff and explain what the organisation can do within their remit.

> *We hear concerns every day at work. People come in – mothers, fathers, elders – sometimes attacking us 'what are we doing?' we hear their concerns but also about educating community … our current capacity can't meet demand.* [Reference group planning day]

> *Some services have family support, and yet there are many families that don't know what to do. And don't know these services are there, or know how to get help from them. It's not just parents, but also grandparents who are worried for their family.* [Community elder]

> *We have urged organisations to come to the table to discuss solutions with the community. If organisations don't agree with us, they have to tell us why.* [Community elder]

## *Aboriginal community connection, guidance, and leadership*

> *There are AOD services out there working on the ground in the community and working together with people. We need agencies that really want to work with our people – to help everyone.* [Community elder]

Some organisations have developed and maintained connections to the local Aboriginal community beyond having Aboriginal staff members. This is vital to the improvement and development of culturally secure services. Through organisations working with their local communities and elders, they are able to avoid the additional demands often placed solely on Aboriginal staff. Therefore, addressing a power imbalance that can result from reliance on Aboriginal staff to bring the change within their organisations.

One organisation CEO spoke of the importance of strong cultural leadership across all services in the sector. Recognition of this is important, as it acknowledges organisational cultural security relies on more than Aboriginal staff; rather change is needed throughout.

> *Organisations need to have strong cultural leadership, and in mainstream services this needs to be supported by non-Aboriginal leaders and senior staff.* [Sector CEO]

Similarly, a survey respondent spoke of the ways they have worked with their Aboriginal staff to ensure that they have input into cultural security at an organisational level. This has been by engaging with Aboriginal staff in all facets of planning within the organisation, rather than just service provision.

> *It is essential for all Aboriginal staff to be engaged in [our] organisational policy and planning processes. This includes all strategic planning: policy and curriculum changes; work activity re-design processes; performance and benchmarking for programs; and funding agency reviews* [Sector Survey Response].

> *We need to bring prevention and community development and engagement back to the alcohol and drug sector – we can't just focus on treatment.* [Community elder]

The consultations also emphasised the need to community development model, where the services are connected closely with the community rather than relying on the community to access the service. These prevention/ early intervention approaches can be effect in supporting the community, especially when considered in the context of the Aboriginal worldview and understandings of wellbeing. The consultations highlighted the importance of community connected services, that communicated closely with the local Aboriginal community.

## *Aboriginal self-determination*

Throughout this discussion, there has been the recognition of Aboriginal people's right to self-determination, however how this can be exercised at a service level is difficult to identify. One approach to progress this critical issue, is for organisations and service providers to work with their local communities to develop relationships and identify the most appropriate way for Aboriginal self-determination to be exercised. Consideration of this is also important at many levels, with: local elders and Aboriginal community; staff; and clients. There is need for support of organisations and service providers to develop and build their culturally secure capability, as these processes take time to develop and be authentically secure.

## *What needs to be done*

The consultations have highlighted a number of areas where efforts can be focused to ensure culturally secure AOD services in WA.

The development and implementation of cultural competencies across the sector, including: training on local protocols, procedures, and practice; Aboriginal world-view and understanding of health and wellbeing; spirit of reconciliation and self-determination; and cultural awareness including local history and experiences. A systemic response to the AOD service needs of Aboriginal communities requires the development of a culturally responsive service model informed by independent research. Such a model should be flexible and adaptive for local contexts. [Recommendation 4]

The resource, planning and support for service provision and the AOD workforce needs to be supported and informed through routine and ongoing reporting and monitoring of sector data. [Recommendation 5]

There is a need to ensure that all organisations are operating and maintaining culturally aware, safe, and secure services and workplaces, including ensuring all staff have completed a minimum level of cultural security training. [Recommendation 6]

The relationship between organisations providing AOD services, and their local Aboriginal communities requires efforts to ensure the ongoing maintenance of relationships. Such relationships require the embedding of processes that maintain relationships and accountability with the local Aboriginal community and elders through the organisation. [Recommendation 7]

## Government policy, planning, and commissioning of services

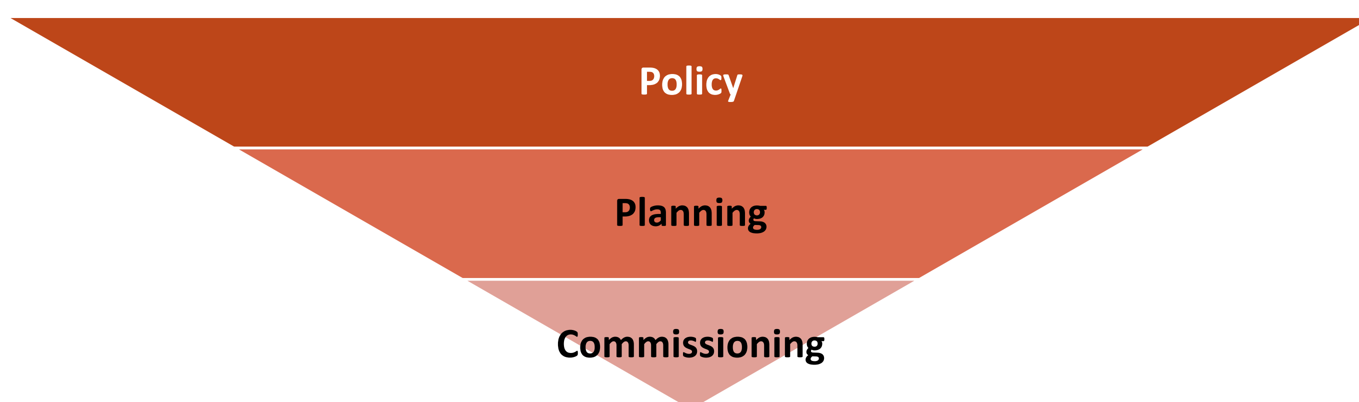
> *The policy, planning, and commissioning process is foundational to ensuring all else works effectively, because it has so much influence over the sector.* [Community member]

The policy, planning, and commissioning processes were recognised as a significant factor by the advisory committee. The influence of national and state policies on planning, and then commissioning of services should not be ignored in addressing the issues identified in this report.

> *Many people are tired of the shallow talkfest. We've already said what is needed. Where is the connection to community? We need to build a whole sector and build equity across the state.* [Sector CEO]

Overall, the consultations highlighted the need for policy, planning, and commissioning of services to be done differently to meet Aboriginal peoples' needs. A community-driven Aboriginal voice is essential, as is co-design and transparency of commissioning for Aboriginal communities to ensure accountability to the principles of self-determination. Commissioning indicators need to be tailored to reflect this broader purpose.

**Figure 2**: Inter-related government processes – policy through to commissioning




### *Policy*

In this context there are multiple policies that inform and influence AOD issues and First Nations Australians. These are inter-related with additional or supplementary policies that specifically target Aboriginal peoples and issues, as well as alcohol and other drugs (in the context of mental health and workforce). These strategies are at both the national and state levels. Ideally these would be inter-related and reference other strategies. However as evidenced in Table 7 there are many strategies and plans aimed at the various areas (AOD, Health, Aboriginal community control, and workforce).

The consultations and discussions acknowledged and recognise the influence of these policies in developing current AOD services, and future services for Aboriginal communities. The consultations with the advisory group acknowledged the high-level factors such as a voice to parliament, and the absence of First Nations Australian perspectives in AOD policy and strategy.

*Voice to parliament*

At the highest level of policy, is the absence of the requirement of Aboriginal people to be included or engaged at a federal level. One participant noted the need for a First Nations voice to parliament. While this is well out of the scope of this work, it is vital to recognise that nationally there is a recognised absence of First Nations Australian influence in policy decisions.

> *What can we do to get voice in parliament and what is the vision for us and what are we here for and how do we drive it and push it and get implemented.* [Reference group planning day]

*National context in the AOD sector*

The consultations with the sector highlighted previous examples of Aboriginal people's input into strategies and programs at both state and federal levels. From 2004 until 2014, at a national level the prime minister had two specific AOD advisory and advocacy groups. Firstly, there was the Australian National Council on Drugs (ANCD): a body of community members, academics, health experts, provided advice and guidance on alcohol and other drug issues. In 2004, the National Indigenous Drug and Alcohol Committee (NIDAC) was formed to advise the ANCD on the issues affecting First Nations Australians. While not all members were Aboriginal, they all brought a specific expertise, and were linked to communities nationally. Both were essentially disbanded in 2014 and replaced with the Australian National Advisory Council on Alcohol and Drugs, effectively reducing the Aboriginal voice in the national AOD arena from many to one (an additional position was added later). One participant highlighted the obvious effect the 'merging' of the two committees and reducing Aboriginal perspectives to two individuals at best.

> *Aboriginal voice in AOD sector has gone backwards. ANCD, and within that we had NIDAC. Both got chopped. Now we have a whitefella ANACAD … We're going backwards re. an Aboriginal voice to inform AOD. Part of the governance structure, we're hoping it can drive the need for a strong and united voice re. how we represent an Aboriginal voice.* [Reference group planning day]

One implication of this is the absence (or lack of commitment toward the development) of a National Aboriginal and Torres Strait Islander AOD Strategy. The most recent strategy, developed by the now defunct Intergovernmental Committee on Drugs, ended in 2019. To date there has been no effort towards the development of a new National Aboriginal and Torres Strait Islander AOD strategy – nor is there any representative or advocacy body responsible for developing it. Such strategies identify the priorities and areas of focus for planning and commissioning. Essentially highlighting the marginalisation of AOD issues for First Nations Australians, with no-one responsible for ensuring that there is First Nations Australian perspectives at a national level. The absence of any recognition of Aboriginal voice, or even a pathway to contribute was noted by a couple of participants. There are two key risks linked to this issue. Firstly, that planning, priorities, and commissioning of Aboriginal specific services will not necessarily reflect the needs of Aboriginal communities.

> *The National Drug Strategy harm minimisation approach does not address the current harms experienced in Aboriginal communities.* [Sector CEO]

Secondly, that the focus will revert to supply reduction and law enforcement focused approaches – as can be evidenced in some jurisdictions.

> *The balance in AOD strategy is out of kilter, with most resources going to law enforcement and supply reduction – further marginalising and criminalising Aboriginal people.* [Sector CEO]

*Western Australian context in the AOD sector*

At the state-level in Western Australia the responsibility for AOD policy planning and commissioning of services sits with the Mental Health Commission. There have been some efforts to ensure Aboriginal perspectives – such as elders-in-residence, an Aboriginal person on the WA AOD Advisory Board, and Aboriginal staff across the MHC, including a specific workforce development team. However, there was a dominant point throughout the consultations, that Aboriginal people needed to be involved in decision-making across all levels.

> *I think that at a state level, there isn't much of an Aboriginal voice. It's great the MHC has a program area, but it's a level 7 manager, focusses on a single program management, no executive.* [Reference group planning day]

This is reflective of the experiences of AOD organisations and service providers, where there are often Aboriginal representatives at the governance level, and a strong Aboriginal AOD workforce. However, there is space and calls for improvements in order to provide culturally secure services and a move towards Aboriginal people exercising their right to self-determination in the AOD sector. Broadly speaking, the prioritisation and importance of Aboriginal AOD issues within the WA context is minimal. There remains no WA Aboriginal AOD strategy, with only few mentions of alcohol and tobacco as contributing to health issues in the WA Aboriginal Health Strategy. The participants recognised that the constant changing political environment has resulted in both the absence of Aboriginal perspectives and peoples in the decision-making processes:

> *… because of covid, government people couldn't leave their office. They were calling me and I was a bit peeved, and I had to get a lot of [Regional town] voices, load them in our buses and take them to [nearby regional town] for a day trip to attend the consultation. …. It was too shallow and very mainstream.* [Reference group planning day]

> *When I see when I look at that, there are voices in some places, but I wonder how far that voice is from the reality of what our community needs. I question myself as I'm not in the frontline, so I need to volunteer, so I can bring it up. We have some voices, but too many levels between the grass roots and the voice.* [Reference group planning day]

*Any effective strategy needs to endorse participatory approaches, we need a strong entity that applies engagement and representation principles. This entity would benefit from being auspiced by WANADA.* [Community elder]

*We're building a case now. But the procurement (commissioning of services), it's so important. We need as part of the strategy, we need … everyone, to be on the procurement (service commissioning) council and take leadership and make decisions. What are the products they need to be buying to enhance Aboriginal service procurement (commissioning) across departments? We need voices from across the AOD sector to influence it, not just Aboriginal health.* [Reference group planning day]

### *Planning (AOD service provision)*

In the Western Australian context, planning for AOD service provision is the responsibility of the Mental Health Commission. It is well recognised that there is a need for increased AOD services across the spectrum including prevention, harm reduction, support, community treatment, bed-based residentials, and forensic services.[34] The Mental Health, Alcohol and other Drug Services Plan 2015–2025 (the 10 Year Plan)[35] reflects the need for service expansion in WA. The initial 10 Year Plan was extensively informed by sector consultation and practice wisdom and informed by the Drug and Alcohol Service Planning Model (DASPM). However, this was developed without a specialised tool for planning Aboriginal and Torres Strait Islander service provision. Therefore, the appropriate loading to reflect both Aboriginal and the Western Australian regional and remote community service needs was not considered.

One of the aims of the 10 Year Plan was for: 'greater engagement and accessing of services by Aboriginal people through the provision of culturally secure services addressing mental health, alcohol and other drug problems; and ensuring the sector workforce is culturally competent.'[36] This focus on cultural security is presented as an element of mainstream service delivery (e.g. culturally secure programs, or dedicated Aboriginal beds as part of services). The 10 Year Plan recognises the limited number of Aboriginal specific services, with one action (#42) for an Aboriginal AOD specific residential service offering 30 beds in the south of the state, with development to commence by 2017.[37] The expectation for Aboriginal services otherwise is through incorporation in culturally secure mainstream service delivery.

The absence of any additional considerations in the planning tool, highlights the need for an evidenced Aboriginal loading/adaptation of the DASPM. While there was a tool developed for estimating service needs

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[34] Ritter, A., Chalmers, J., Gomez, M. (2019). Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model. *Journal of Studies on Alcohol and Drugs*, Supplement, (s18), 42–50.

[35] Mental Health Commission. (2019). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (Plan)* Update 2018, Mental Health Commission, Government of Western Australia.

[36] Above

[37] Gomez, M., Ritter, A., Gray, D., Gilchrist, D., Harrison, K., Freeburn, B., and 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. Drug Policy Modelling Program National Drug and Alcohol Research Centre UNSW.

for Aboriginal and Torres Strait Islander communities, such an approach needs to be informed by Aboriginal co-design, service delivery experience, access rates, and appropriate identification of Aboriginal dedicated service needs.[38] Differences in service needs and models needs to be acknowledged in the planning and facilitated in the commissioning of services.

### *Existing strategies that inform*

There are a number of existing policies and strategies that recognise and identify the importance of Aboriginal community leadership in the planning of services.

At a national level, in addition to the National Alcohol Strategy (2019–2028)[39] and National Drug Strategy (2017–2026),[40] the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019*[41] remains the most recent complementary strategy for Aboriginal and Torres Strait Islanders services. While the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy* has now lapsed, as with its predecessor,[42] there remains examples of actions that support organisational planning:

- Acknowledge community ownership as the guiding principle for planning, delivery and evaluation (Priority area 1; Outcome 1.1; Example action 1).
- Enable community-controlled services to plan, implement and evaluate services based on locally identified need. (Priority area 1; Outcome 1.1; Example action 4).

At a state level there are also a number of key strategies, plans, and frameworks that relate to Aboriginal health and AOD that provide guidance in the development of Aboriginal Leadership in the policy, planning, and commissioning of AOD services.

In addition to Western Australian Mental Health, Alcohol and Other Drug Services Plan 2020–2024,[43] there are two recent strategies that provide valuable guidance for this project.

***The Western Australian Alcohol and Drug Interagency Strategy 2018–2022***[44] identifies Aboriginal people as a priority group. Further to this, there are eight key principles, including *promoting access and equity*. Under this principle there is recognition that:

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[38] 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.

[39] Commonwealth of Australia (Department of Health). (2019). *National Alcohol Strategy 2019–2028*. Commonwealth of Australia, Department of Health, Canberra.

[40] Commonwealth of Australia (Department of Health). (2017). *National Drug Strategy 2017–2026*. Commonwealth of Australia, Department of Health, Canberra.

[41] Intergovernmental Committee on Drugs (IGCD). (2017). *National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019*. Intergovernmental Committee on Drugs.

[42] Ministerial Council on Drug Strategy. (2006). *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*. Canberra: Ministerial Council on Drug Strategy

[43] Mental Health Commission. (2019). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (Plan)* Update 2018, Mental Health Commission, Government of Western Australia.

[44] Mental Health Commission. (2018). *Western Australian Alcohol and Drug Interagency Strategy 2018–2022*. Mental Health Commission, Government of Western Australia.

*'For Aboriginal people and communities this means adopting a holistic approach that respects the legitimate rights, values, beliefs and expectations of Aboriginal people and centres on connection to country, spirituality, family and community.'*

***The Aboriginal Empowerment Strategy Western Australia 2021–2029***[45] has six principles, including *Empowerment and self-determination*. Under this principle there are a number of factors that are recognised in their approach:

- Empowerment and self-determination are essential for Aboriginal people's wellbeing.
- Policy decisions about Aboriginal people cannot be made without Aboriginal people.
- For decisions with high potential impact or opportunity for Aboriginal people, this means partnership and/or shared decision-making.
- For other decisions, it means genuine engagement with affected Aboriginal people at a level proportional to the potential impact or opportunity.
- Aboriginal people must have the opportunity to engage from an informed perspective, with clarity about process, expectations, and responsibilities.[46]

The Western Australian Department of Communities released the ***Aboriginal Community Controlled Organisation (ACCO) Strategy (WA) 2022–2032***[47] in August 2022. The purpose of the strategy is to provide: 'a framework for how Communities will work together with and support Western Australian ACCOs to achieve self determination to create safe and healthy families and communities.'[48] There are three pillars, that relate closely to the points discussed in this report:

- *Cultural Safety and Governance*: That all services for Aboriginal children, families and communities are grounded in Aboriginal knowledge and culture.
- *Partnerships*: Building genuine partnerships and engagement with ACCOs to deliver strong accountability and culturally responsive ways of working.
- *Economic Opportunities*: ACCOs are given economic and socio-economic opportunities to deliver services to their community.

## Commissioning of AOD services

The provision of AOD services in WA is primarily managed by the MHC through a commissioning process. Informed by the national and state strategies, and based on the Mental Health, Alcohol and other Drug Services Plan 2015–2025[49] AOD services are procured through an open tendering process. Though there is a commitment to culturally secure services in the strategies and the 10 Year Plan; it is evident that the commissioning processes are lacking Aboriginal community influence. However, the commissioning process

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[45] Department of the Premier and Cabinet. (2021). *The Aboriginal Empowerment Strategy Western Australia 2021–2029*. Department of the Premier and Cabinet, Government of Western Australia.

[46] Above: Page 12

[47] Department of Communities. (2022). *Aboriginal Community Controlled Organisation Strategy (WA) 2022–2032*. Department of the Premier and Cabinet, Government of Western Australia.

[48] Above: page 16

[49] Mental Health Commission (2019). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (Plan)*. (Update 2018). Mental Health Commission, Government of Western Australia.

could be a valuable tool in the development of culturally secure service delivery across the state. The process of commissioning services defines the criteria and requirements for not just service provision, but also eligibility and requirements for services.

### *Priorities*

Through the consultations there were a number of priorities that were directly and indirectly related to these policy, planning, and commissioning processes. There are three main priorities, related to policy, planning, and commissioning processes, identified through the consultations regarding the strategies for enhanced access and improved outcomes for Aboriginal peoples and the provision of culturally secure capacity across the alcohol and other drug (AOD) sector:

- Embedding and commitment to Aboriginal self-determination and leadership across the AOD sector (policy).
- Sustainability, provision and development of culturally secure services (policy, planning, and commissioning).
- Capacity of services to meet the community need (planning and commissioning).

*Embedding and commitment to Aboriginal self-determination and leadership across the AOD sector*

> *In terms of supporting control of sector development, which we need advisory groups, and we need to be pushing forward, as WANADA as a sector development support service, you need to have control over how we do sector development to support Aboriginal self-determination.* [Reference group planning day]

However, when considering solutions or ways to support and address the improvement of culturally secure service provision across the WA AOD sector – the influence of the government policy, planning, and commissioning of services is paramount. The reference group recognised the wider system factors influencing the provision of culturally secure AOD services in WA. Primarily was the absence of an Aboriginal AOD advocacy body in Western Australia. Support for establishing such an group would facilitate Aboriginal self-determination in the WA AOD sector.

While increasing and supporting the Aboriginal AOD workforce is paramount to the provision of culturally secure services, there are other macro-level factors that influence self-determination and the ability to provide culturally secure services. Underlying all of the discussions was the desire for Aboriginal people to be able to exercise their right to self-determination, throughout all levels of decision-making. A commitment to Aboriginal self-determination and leadership across the AOD sector reaches across all levels of policy, planning, and commissioning of services.

In the context of self-determination in alcohol policy, Stearne[50] has discussed and highlighted that First Nations Australian perspectives need to be evident throughout all levels and stages of policy development.

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[50] Stearne, A., Lee, K.S.K., Allsop, S. et al. (2022) First Nations Australians' self-determination in health and alcohol policy development: a Delphi study. *Health Res Policy Sys* 20, 12.

Further to this they highlight that self-determination needs to be actioned rather than just recognised in processes. In this context, it is recommended self-determination could be actioned in the development of a WA Aboriginal AOD strategy and implementation plan.

The diversity of Aboriginal cultures, communities, and experiences in Western Australia needs to be recognised and evident in AOD-related policy. Policy, planning, commissioning and service delivery needs to be done in a different way to effectively meet Aboriginal peoples' needs. A community driven Aboriginal voice is essential, as is co-design and transparency of policy to set the agenda for commissioning for culturally safe and secure services.

> *Many people are tired of the shallow talkfest. We've already said what is needed. Where is the connection to community? We need to build a whole sector and build equity across the State.* [Sector CEO]

*Sustainability, provision and development of culturally secure services*

While many policies (and strategies) have guiding principles of Aboriginal self-determination and leadership in decision making, there appears to be little evidence of these in the planning and commissioning processes. As discussed above, the right of self-determination needs to be exercised at every level, not just in policy development. In the context of planning and commissioning, exercising self-determination could be evidenced through Aboriginal leadership and decision-making beyond Aboriginal staffing.

For example, a culturally secure service model may include factors like:

- community AOD workers.
- community-based support workers.
- flexible delivery locations – including remote communities, recognising this is (human and fiscal) resource intensive.
- recruiting and retaining staff with attractive employment conditions and demands.
- locally informed and appropriate planning and commissioning of services.

Regionally based services, face significant issues and barriers through all of these factors. Though the planning reflects population needs, it does not address geography, environment, or cultural needs. Staff may spend a day, or more, travelling out to a remote community, and then the same for the return. Leaving perhaps 60% of their work week for the clients, however if they are also required to visit a nearby community their time is reduced even further. The weather – particularly wet season rains – can also impact accessibility to some regional towns and more remote communities. Cultural business or bereavement can close a remote community down completely, often without any notice. All these factors affect regional and remote service provision significantly and require consideration in the planning and commissioning of services.

Fundamentally, in order to improve the health and wellbeing of Aboriginal peoples in Western Australia, the planning and commissioning of services should not be independent of the policies and the peoples – rather they should be led by them.

*Capacity of services to meet the community need*

There were a number of tensions identified in the consultations that relate to the capacity of the services to meet the demand for AOD treatment; needs of the clients; and expectations of the community. These factors, though under the control of organisations and service providers, are impacted by externally imposed restrictions on their capacity. The service planning and subsequent commissioning processes are key influences in this. Existing planning and commissioning processes do not necessarily enable services to respond rapidly to community need.

Firstly, as discussed, the service planning model is not developed based on the Aboriginal population distribution in Western Australian. Therefore, the specific and unique needs faced by Aboriginal people are not accommodated beyond additional allowances. However, there is potential through these processes to lead the development of culturally secure services and practice throughout the process of providing AOD services in WA. Aboriginal peoples' right to self-determination needs to be exercised in planning and commissioning, as well as provision of services. While self-determination requires Aboriginal people defining the process themselves, there remains capacity for Aboriginal peoples' leadership and guidance in the provision of planning and commissioning services. This could be considered in localised planning, and commissioning. Thus, ensuring that Aboriginal community have input into their needs being met, and that the model being proposed is aligned with how the community identified. Secondly, commissioning of services has the ability to determine the requirements for organisations and service providers, to develop culturally secure service provision across the sector.

### *What needs to be done*

There are several actions highlighted in the consultations that would improve policy, planning and commissioning processes to develop and support Aboriginal leadership in the AOD sector.

At present there is no current National or Western Australian Aboriginal-specific AOD Strategy informed by the needs of Aboriginal people and communities throughout Western Australia. The development and implementation of such a strategy would direct the planning of service provision in a systemic and accountable way. [Recommendation 1]

Invest in a comprehensive Western Australian Aboriginal population-based planning process, to identify service expansion needs to meet demand and culturally secure service models that are informed by the needs of the local Aboriginal communities. [Recommendation 2]

There is a need to resource and support Aboriginal leadership and engagement in decision-making throughout all policy, planning, and commissioning processes. [Recommendation 3]

The development and implementation of cultural competencies across the AOD sector, including: training on local protocols, procedures, and practice; Aboriginal world-view and understanding of health and wellbeing; spirit of reconciliation and self-determination; and cultural awareness including local history and experiences. A systemic response to the AOD service needs of Aboriginal communities requires the development of a culturally responsive service model informed by independent research. Such a model should be flexible and adaptive for local contexts. [Recommendation 4]

There is a need for the development and implementation of a periodic and ongoing snapshot of the current AOD workforce in Western Australia, to assist in informing ongoing planning and support of the workforce and service provision. Presently, there is no available data to provide an indicator of the actual retention and development needs of the workforce across the state. All understandings are based on feedback from the sector. [Recommendation 5]

In order to develop Aboriginal leadership in the AOD sector, organisations and service providers require guidance, resourcing, and support to develop and retain the Aboriginal AOD workforce. Efforts should focus on developing and supporting the workforce beyond entry level positions, into positions of leadership. [Recommendation 6]

**Table 7:** Selected national and Western Australian strategies (and plans) relevant to Aboriginal alcohol and other drug sector

| Strategy or policy framework | Dates | Aboriginal specific? | Areas covered | Responsibility | Current or lapsed |
|---|---|---|---|---|---|
| National Strategic Framework for Aboriginal & Torres Strait Islander Peoples' Mental Health & Social and Emotional Wellbeing | 2017–2023 | Y | Aboriginal wellbeing | National | |
| National Aboriginal & Torres Strait Islander Peoples' Drug Strategy | 2014–2019 | Y | Alcohol and other drugs | National | Lapsed |
| National Aboriginal & Torres Strait Islander Health Plan | 2013–2023 | Y | Health | National | |
| National Aboriginal & Torres Strait Islander Health Workforce Strategic Framework & Implementation Plan | 2021–2031 | Y | Workforce (Health) | National | |
| National Alcohol Strategy | 2019–2028 | N | Alcohol | National | |
| National Drug Strategy | 2017–2026 | N | Other drugs | National | |
| National Fetal Alcohol Spectrum Disorder Strategic Action Plan | 2018–2028 | N | Alcohol | National | |
| National Alcohol and other Drug Workforce Development Strategy | 2015–2018 | N | Workforce (AOD) | National | Lapsed |
| General Procurement Direction - Aboriginal Procurement Policy (WA) | 2021/08 | Y | | WA State Govt | |
| Closing the Gap – WA's Implementation Plan | | Y | Aboriginal wellbeing | WA State Govt | |
| WA Aboriginal Health and Wellbeing Framework | 2015–2030 | Y | Aboriginal wellbeing | WA State Govt | |
| Aboriginal Community Controlled Organisation Strategy (WA) | 2022–2032 | Y | Self-determination | WA State Govt | |
| Aboriginal Empowerment Strategy - Western Australia | 2021–2029 | Y | Self-determination | WA State Govt | |
| Aboriginal Employment Strategy (WA) | 2011–2015 | Y | Workforce (Employment) | WA State Govt | Lapsed |
| WA Health Aboriginal Workforce Strategy | | Y | Workforce (Health) | WA State Govt | |
| WA Aboriginal Sexual Health & Blood-borne Virus Strategy | 2019–2023 | Y | Health (STIs & BBV) | WA State Govt | |
| WA State Priorities Mental Health, Alcohol & Other Drugs | 2020–2024 | N | Alcohol and other drugs | WA State Govt | |
| Western Australian Alcohol and Drug Interagency Strategy | 2018–2022 | N | Alcohol and other drugs | WA State Govt | |
| Western Australian Mental Health Promotion, Mental Illness, Alcohol & Other Drug Prevention Plan | 2018–2025 | N | Alcohol and other drugs | WA State Govt | |
| Western Australian Mental Health, Alcohol & Other Drug Services Plan | 2015–2025 | N | Alcohol and other drugs | WA State Govt | |
| Young People's Mental Health & Alcohol & Other Drug Use: Priorities for Action | 2020–2025 | N | Alcohol and other drugs | WA State Govt | |
| WA Mental Health, Alcohol & Other Drug Workforce Strategic Framework | 2020-2025 | N | Workforce (AOD) | WA State Govt | |
| WA Health Workforce Retention Framework | 2012–2015 | N | Workforce (Health) | WA State Govt | Lapsed |

**Figure 3:** Timeline of selected national and Western Australian strategies (and plans) relevant to Aboriginal alcohol and other drug sector

<table>
<tr><th>2005</th><th>2006</th><th>2007</th><th>2008</th><th>2009</th><th>2010</th><th>2011</th><th>2012</th><th>2013</th><th>2014</th><th>2015</th><th>2016</th><th>2017</th><th>2018</th><th>2019</th><th>2020</th><th>2021</th><th>2022</th><th>2023</th><th>2024</th><th>2025</th><th>2026</th><th>2027</th><th>2028</th><th>2029</th><th>2030</th><th>2031</th><th>2032</th></tr>
<tr><td colspan="10"></td><td colspan="4">National AOD Workforce Development Strategy</td><td colspan="14"></td></tr>
<tr><td colspan="6"></td><td colspan="6">National Drug Strategy</td><td colspan="11">National Drug Strategy</td><td colspan="5"></td></tr>
<tr><td colspan="6"></td><td colspan="8">National Alcohol Strategy</td><td colspan="10">National Alcohol Strategy</td><td colspan="4"></td></tr>
<tr><td colspan="13"></td><td colspan="11">National Fetal Alcohol Spectrum Disorder Strategic Action Plan</td><td colspan="4"></td></tr>
<tr><td colspan="8"></td><td colspan="11">National Aboriginal & Torres Strait Islander Health Plan</td><td colspan="8">National Aboriginal & Torres Strait Islander Health Plan</td><td></td></tr>
<tr><td colspan="5">National Drug Strategy Aboriginal & Torres Strait Islander Peoples Complementary Action Plan</td><td colspan="4"></td><td colspan="6">National Aboriginal & Torres Strait Islander Peoples' Drug Strategy</td><td colspan="13"></td></tr>
<tr><td colspan="12"></td><td colspan="7">National Strategic Framework for Aboriginal & Torres Strait Islander Peoples' Mental Health & Social & Emotional Wellbeing</td><td colspan="9"></td></tr>
<tr><td colspan="16"></td><td colspan="11">National Aboriginal & Torres Strait Islander Health Workforce Strategic Framework & Implementation Plan</td><td></td></tr>
<tr><td colspan="15"></td><td colspan="4">WA Aboriginal Sexual Health & Blood-borne Virus Strategy</td><td colspan="9"></td></tr>
<tr><td colspan="7"></td><td colspan="4">WA Health Workforce Retention Framework</td><td colspan="17"></td></tr>
<tr><td colspan="10"></td><td colspan="11">Western Australian Mental Health, Alcohol & Other Drug Services Plan</td><td colspan="7"></td></tr>
<tr><td colspan="13"></td><td colspan="5">Western Australian Alcohol & Drug Interagency Strategy</td><td colspan="10"></td></tr>
<tr><td colspan="13"></td><td colspan="8">Western Australian Mental Health Promotion, Mental Illness, Alcohol & Other Drug Prevention Plan</td><td colspan="7"></td></tr>
<tr><td colspan="15"></td><td colspan="5">WA State Priorities Mental Health, Alcohol & Other Drugs</td><td colspan="8"></td></tr>
<tr><td colspan="15"></td><td colspan="6">WA Mental Health, Alcohol & Other Drug Workforce Strategic Framework</td><td colspan="7"></td></tr>
<tr><td colspan="11">Aboriginal Employment Strategy (WA)</td><td colspan="17"></td></tr>
<tr><td colspan="10"></td><td colspan="16">WA Aboriginal Health & Wellbeing Framework</td><td colspan="2"></td></tr>
<tr><td colspan="16"></td><td colspan="9">Aboriginal Empowerment Strategy - Western Australia</td><td colspan="3"></td></tr>
<tr><td colspan="17"></td><td colspan="11">Aboriginal Community Controlled Organisation Strategy (WA)</td></tr>
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