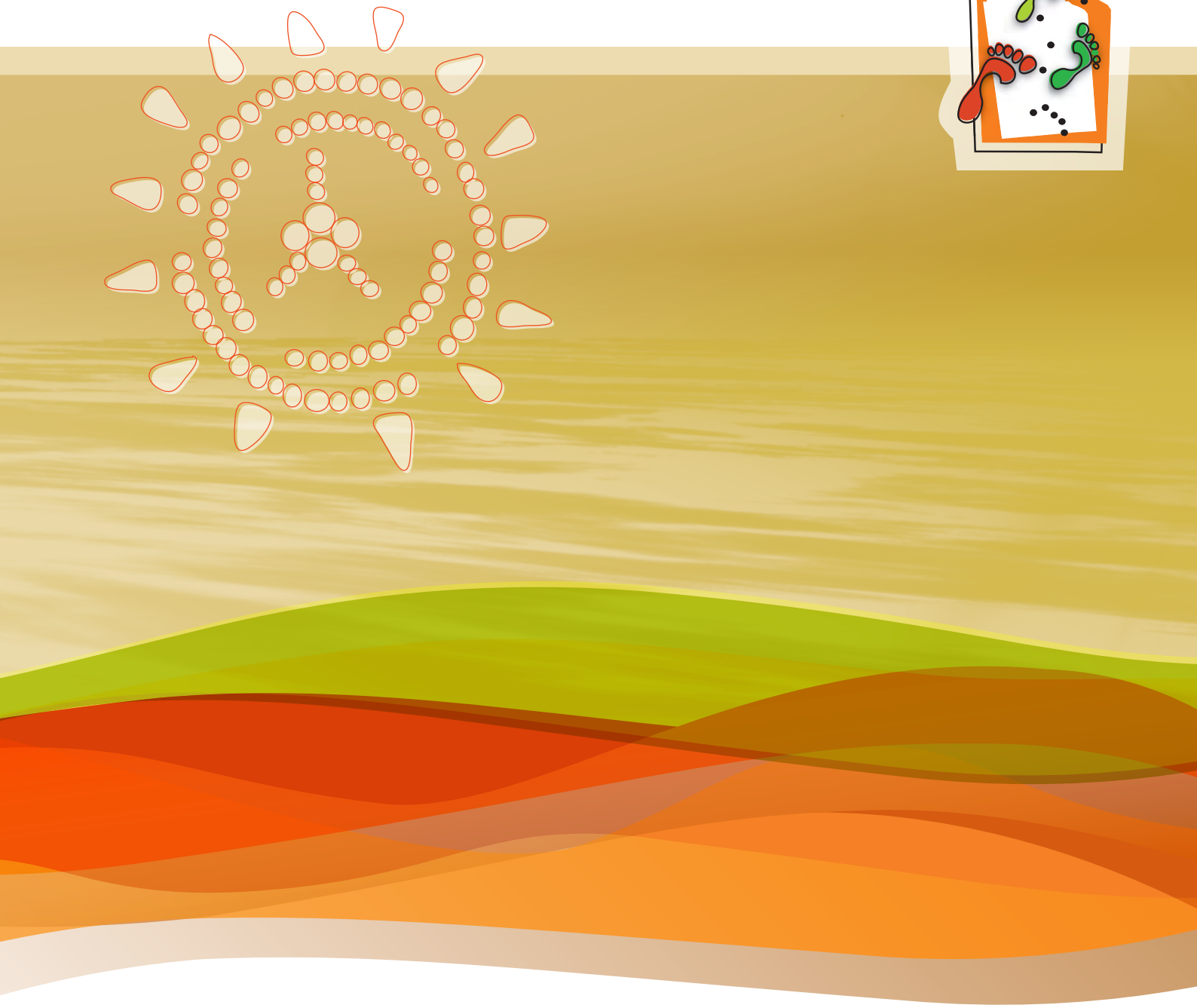
Northern Territory Government

THE REMOTE ALCOHOL AND OTHER DRUGS WORKFORCE PROGRAM

Community Development Framework



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Remote AOD Workforce and Community Development:
Working in meaningful partnership to strengthen and build strong, resilient and connected communities that value and support people to overcome their alcohol and other drug health issues and improve community outcomes.
June 2012

We value:
"strength of character to overcome difficult times and strength to lead by example".

This framework was developed by Jonathan Hermawan Tjapaltjarri on behalf of Fire & Water Consultancies for the NT Remote Alcohol and Other Drugs (AOD) Workforce Program of the Northern Territory Government Department of Health, Remote Health.

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Warning: Aboriginal and Torres Strait Islander peoples are advised that this resource may contain images and names of people who are deceased

Fire and Water Consultancies, 2012

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GLOSSARY

Aboriginal and/or Torres Strait Islander

Aboriginal and/or Torres Strait Islander (or Indigenous) peoples is a term that describes Aboriginal and Torres Strait Islander peoples of Australia as 'native or belonging naturally to a place'; this acknowledges Aboriginal and Torres Strait Islander peoples as the first peoples and original custodians of Australia.

Access

Access (and equity) is about making sure that all community members are given opportunities to participate in the AOD program (primary health care, activities and initiatives) regardless of their background, culture, religion, language, age, gender or ability.

AOD Worker

AOD Worker is a worker employed by the Workforce to provide drug treatment services to clients impacted by alcohol and other drugs (AOD) – including alcohol, tobacco, cannabis, amphetamines, ecstasy, cocaine, heroin (and other opioids), volatile substances, benzodiazepines and other drugs.

Best Practice

Best Practice are methods, techniques, principles or approaches to AOD education, health promotion, primary health care and community development that have consistently shown results superior over other means.

Capacity Building

Capacity Building provides opportunities to increase the skills, knowledge, trust, and leadership of individuals and communities whilst working in partnership with others towards a set of shared health goals.

Community

A group of people who are connected through a common residential location/area, shared common interests or common cultural identity.

Community Development

Community Development is working with communities to assist communities in finding plausible solutions to the problems they have identified. 'Mob' or people focused community development principles are included in this framework.

Community Engagement

Community Engagement is a broad range of interactions with people within the community to actively involve them in decisions, programs and initiatives that affect them related to AOD.

Critical reflexivity/reflection

Critical reflexivity/reflection is the ability to honestly reflect on one's personal and professional practice. It involves questioning, analysing, identifying issues, seeking other's perspectives, recording and observing one's work in order to enhance/improve one's work.

Culture

Culture is defined by the practices and beliefs owned by a community or people group and provides its distinctive identity such as language, gestures, customs and traditions that define values and organise social interactions, religious beliefs and rituals – this includes dress, art and music as forms of cultural and symbolic expression.

Cultural Awareness

Cultural Awareness is a process of developing one's knowledge about a particular people or cultural group – its history, customs and traditions, distinguishing features, belief system/s, language/s and geographical features. Cultural awareness is limited in that it can be obtained with little or no cultural immersion that is, through means other than direct interaction with the culture/people group e.g. books, documentaries and university.

Cultural Competence

Cultural Competence is a commitment to engage respectfully with people from other cultures. It requires more than cultural awareness and fundamentally hinges on the ability to identify and challenge one's own cultural assumptions, one's values and beliefs, in order to work effectively in cross-cultural contexts. Cultural competence development requires cultural immersion that is, direct interaction with a culture/people group in order to successfully develop the skills required to be culturally respectful.

Cultural Safety/Security

Cultural Safety/Security develops as a result of activities, behaviours and policies that promote the highest level of cultural competence on individual, community and organisational levels. This means that regardless of context, people feel culturally acknowledged, safe, secure and respected to access, participate and express themselves freely in the workplace, program or initiative without fear of judgement, shame or condemnation.

Health Promotion

Health Promotion is a process of activities that provide people with opportunities to increase their understanding of what influences their health (known as determinants) in order to improve their health.

Quantitative

Quantitative is a term used to describe certain types and methods of gathering information (or data) that is numerical by nature e.g. gathering attendance numbers or figures through a survey or questionnaire. This is sometimes also referred to as objective data.

Qualitative

Qualitative is a term used to describe certain types and methods of gathering information (or data) that is not numerical by nature e.g. gathering information on program meaning and experiences through interviews or stories. This is sometimes also referred to as subjective data.

The 'Workforce'

The 'Workforce' refers to the Remote Alcohol and Other Drugs (AOD) Workforce NT.

ACKNOWLEDGEMENTS

The Remote Alcohol and Other Drugs (AOD) Workforce NT acknowledges the traditional custodians of the land comprising the NT communities we currently live and work on. We pay our respect, honour and gratitude to the Traditional owners, Elders and their families, celebrate their continuing culture and acknowledge the memory of their ancestors from the following NT communities and surrounding country:

Mparntwe (Alice Springs)
Larrakia (Darwin)
Katherine
Katherine West
Tennant Creek
Titjikala
Gunbalanya
Jabiru
Borroloola
Angurugu
Umbakumba
Elliott
Alekarenge (Ali Curung)
Aputula (Finke)
Ltyentye Apurte (Santa Teresa)
Ntaria (Hermannsburg)
Nauiyu (Daly River)
Nhulunbuy/Gove
Yirrkala
Kalkarindji
Julanimawu (Bathurst Island)

The following members of the Remote Alcohol and Other Drugs (AOD) Workforce NT are acknowledged for their contribution to this community development framework and in recognition of their tireless community development efforts – Jennifer Frendin (Coordinator), Lauren Buckley (Clinical Supervisor), Fiona Bell (Training, Education & Clinical Program Officer), Joel Stewart, Barak Sambono, Norman Dulvarie, Asman Rory, Gregory Sheldon, Bruce Wurrawilya, Claude Poulsen, Chris Hawke, Chris Wallace, Damien Yunupingu, Debra Young, James Manhire, Jill Rogers, Joseph Knuth, Keith Mamarika, Kellie Doyle, Lalambarri Yunupingu, Patricia Raymond, Patricia Taylor, Peter Clottu, Robert Wilson, Samson Henry, Scott Nelson and Willa Brough.

The Remote Alcohol and Other Drugs (AOD) Workforce Program NT would also like to acknowledge the workers, contributors and stakeholders past and present for their contributions to this framework, including Jasmine Bald, Tricia Nagel, Menzies School of Health Research, and the Office for Aboriginal and Torres Strait Islander Health (OATSIH) for their support.

Jonathan Hermawan Tjapaltjarri on behalf of Fire & Water Consultancies would also like to acknowledge the following individuals for their contribution to the framework and Aboriginal, Top End and Torres Strait Islander peoples' perspectives on community development – Alan Palmer Pelterre, Merindah Donnelly Nakamarra, Simon Dixon Jungarrayi, Rex Japanangka, Gwen Paterson-Walley, Charles Hodgson Ampetyane, Chuna Lowah Pengarte, Larissa Minniecon, Monica Robinson Nangala, Rev Raymond Minniecon, Raymond Campbell Ampetyane, and Alison Multa Napurrula.

EXECUTIVE SUMMARY

- Northern Territorians consume alcohol at 1.5 times and Indigenous Territorians at 1.7 times the national average. This is the highest per capita consumption of any state or territory.[2]

- 60% of assaults and 67% of domestic violence incidents are alcohol related[3]

- Alcohol-related crime costs the NT $642 million a year – or around $4,197 for every adult in the NT, compared to $944 nationally.[4]

- Aboriginal and Torres Strait Islander Australians have high rates of substance misuse and co-morbid disorders such as chronic disease and mental illness, yet there is limited access to integrated community based substance misuse treatment services in the Northern Territory.

- The 2009 Australian Institute of Health and Welfare (AIHW) analysis of the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) results revealed that only 12% of those with a substance misuse disorder sought help, that help was usually sought through primary health care settings, that young people were less likely to receive treatment, and that young men and older men were less likely to receive treatment. Additionally:
  - Over one-quarter (27%) of Indigenous Australians reported high or very high levels of psychological distress (higher in outer regional/remote areas)
  - Indigenous Australians were twice as likely to report high or very high levels of psychological distress than non-Indigenous Australians

- Social and emotional wellbeing (SEWB) is a well-recognised concept that acknowledges an Australian Indigenous view of health. This view recognises that achieving optimal conditions for health and wellbeing requires a holistic and whole-of-life view of health that encompasses the social, emotional and cultural wellbeing of the whole community (SHRG, 2004).

- The Remote AOD Workforce is well positioned to provide a framework for community development utilising the holistic concept of social and emotional wellbeing to further improve treatment services, improve partnerships linked to local, NT and national AOD legislation and initiatives - which meet community needs and is directly aligned with Objective 3.1 of the National Drug Strategy *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan*.

- A community development framework builds upon the significant momentum of the Remote AOD Workforce over the past 3 to 5 years in providing an effective framework for clinical community-based AOD treatment services, embedded in local organisations and empowering local identities (70% of the Workforce now being local Aboriginal and Torres Strait Islander people).
  - The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2004-2009* highlights under Key Action Area 1, the importance of enhancing 'the

capacity of individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs, and promote their own health and wellbeing.'

- Remote AOD Workforce further provides opportunities to enhance Indigenous SEWB by working within parameters of strong and established relationships and comprehensive and adaptive programs that strive to encompass physical, spiritual, cultural, emotional and social wellbeing; whilst being controlled by the community, rather than people outside.

- An effective community development framework will provide practical actions to improve service delivery in addressing the following identified issues impacting on health outcomes for Aboriginal and Torres Strait Islander peoples:
  a. Overcome worldview difference[1] - through strategies that improve worker cultural competence, value for Indigenous languages and cultures, and critical reflexivity
  b. Promote health literacy and compliance through relationship[2] - through innovative, flexible and responsive planning & delivery of community-based programs
  c. Use cultural identity as a health promotion tool[3] - through cultural competence and development and empowerment of local workers and identities
  d. Develop empowerment and ownership within community[4] - through participatory approaches aligned to community development principles
  e. Promote access to those in need[5]

- Key challenges for the Workforce continue to be divided into those of governance, sustainability, and implementation of best practice. In addition to ongoing concerns around career structure, worker wellbeing, professional isolation, uncertainty of funding and high staff turnover – the implementation of a community development framework raises the new challenge to embed existing processes within:
  - the ongoing development and review of community development tools;
  - effective training and education of workers;
  - clinical supervision;
  - continual quality improvement through evaluation and review of activities; and
  - access to best practice models and research information relevant to community development and social and emotional wellbeing indicators in Aboriginal and Torres Strait Islander communities.

We value:

"respect for everyone and everything we have to offer. We accept all skills, strengths and abilities."

1 Social Health Reference Group for National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group, (2004).
2 Harrington, Z., et al., (2006).
3 Kirmayer, L, S.C., and Cargo, M., (2003).
4 Baum, F. et al., (2006).
5 Australian Bureau of Statistics, (2006).

MISSION STATEMENT

The Remote Alcohol and Other Drugs (AOD) Workforce Program NT:

Working in meaningful partnership to strengthen and build strong, resilient and connected communities that value and support people to overcome their alcohol and other drug health issues and improve community outcomes.

What we do

As a specialist AOD service provider, working within primary health care and embedded in local services, the Remote AOD Workforce NT supports remote clients and communities through clinical treatment services (assessment, counselling and referrals), community education, health promotion and awareness raising activities in response to identified health, and alcohol and other drug use/ misuse issues to improve individual and community health and wellbeing.

Our values

The work undertaken by the Remote Alcohol and Other Drugs (AOD) Workforce is not met without constant challenges, difficulties and a range of both predictable and unpredictable factors inherent in remote and cross-cultural NT community contexts. We recognise that it is our unique and diverse values that unify, strengthen and sustain us individually and collectively to support us to overcome these factors – articulated by workers at the May 2012 Workforce Forum, and detailed throughout this framework.

Our values are:

Strength	*Trust*	*Loyalty*	*Determination*
Passion	*Learning*	*Spirituality*	*Resilience*
Wisdom	*Love*	*Respect*	*Commitment*

"We like being members of the Remote AOD Workforce because we feel like we are a part of a team and are able to get extra support for our role…outside the work organisation. We have the opportunity to share ideas, hear what's happening in other communities and visit other communities." *Remote AOD Workforce Forum November 2012*

REMOTE ALCOHOL & OTHER DRUGS WORKFORCE PROGRAM

In 2006 funding through the Council of Australian Government was provided to enable the establishment of an Alcohol and Other Drugs (AOD) Workforce tasked with delivering services to remote communities. Funding was allocated to specific Department of Health (DoH) Remote Primary Health Care Centres and Aboriginal Medical Services to develop and implement a Remote AOD Workforce framework.

The Remote AOD Workforce Program aims to be:

- Manageable and sustainable
- Working within a primary health care model through continuity of care
- Culturally appropriate
- Delivering evidence-based services

There are at present 27 funded positions for 2013-14 with AOD Workers in:

Department of Health

Ali Curung
Angurugu (Groote Eylandt)
Aputula (Finke)
Borroloola
Elliott
Gunbalanya (Oenpelli)
Jabiru
Julanimawu (Bathurst Island)
Nauiyu (Daly River)
Titjikala
Umbakumba (Groote Eylandt)

Aboriginal Medical Services

Anyinginyi, Tennant Creek
Central Australian Aboriginal Congress, Santa Teresa (Ltyentye Apurte)
Danila Dilba, Darwin
Katherine West Health Board, Katherine
Miwatj Health, Nhulunbuy
Wurli Wurlinjang, Katherine

Western Aranda Health Aboriginal Corporation, Ntaria (Hermannsburg)

In addition to these positions, the Workforce Program Support Unit provides support to the primary health care services and social emotional wellbeing teams that are attached to them. The Workforce is supported by this central Program Support Unit which includes the Workforce Coordinator, the Clinical Supervisor, the Training & Education Program Officer and the Program Support Officer. These four positions are employed within the Department of Health, Remote Health branch in Alice Springs.

The purpose of the Remote AOD Workforce Program is to strengthen the AOD Workforce in remote, regional and urban communities within the Northern Territory in order to increase capacity for service provision at the local level, and enable appropriate support for individuals, families and communities affected by substance misuse issues.

The specific goal of the Program is to develop and implement a Remote AOD Workforce Program which is:

- Based within a primary health care service
- Providing a service to people that currently have limited access to AOD services
- Culturally appropriate
- Evidence based
- Sustainable

The role of the Remote AOD Worker is to undertake activities that increase the capacity for service provision at the local level, and enable appropriate support for clients, carers, families and communities affected by AOD and related issues. This role involves the Remote AOD Workforce engaging in two fundamental areas of service delivery and capacity building. Therefore the workers engage in two types of activities:

1. Individual and Family Service Delivery (see Figure 1.1)
2. Community Development (see Figure 1.2)

Individual and Family Service Delivery

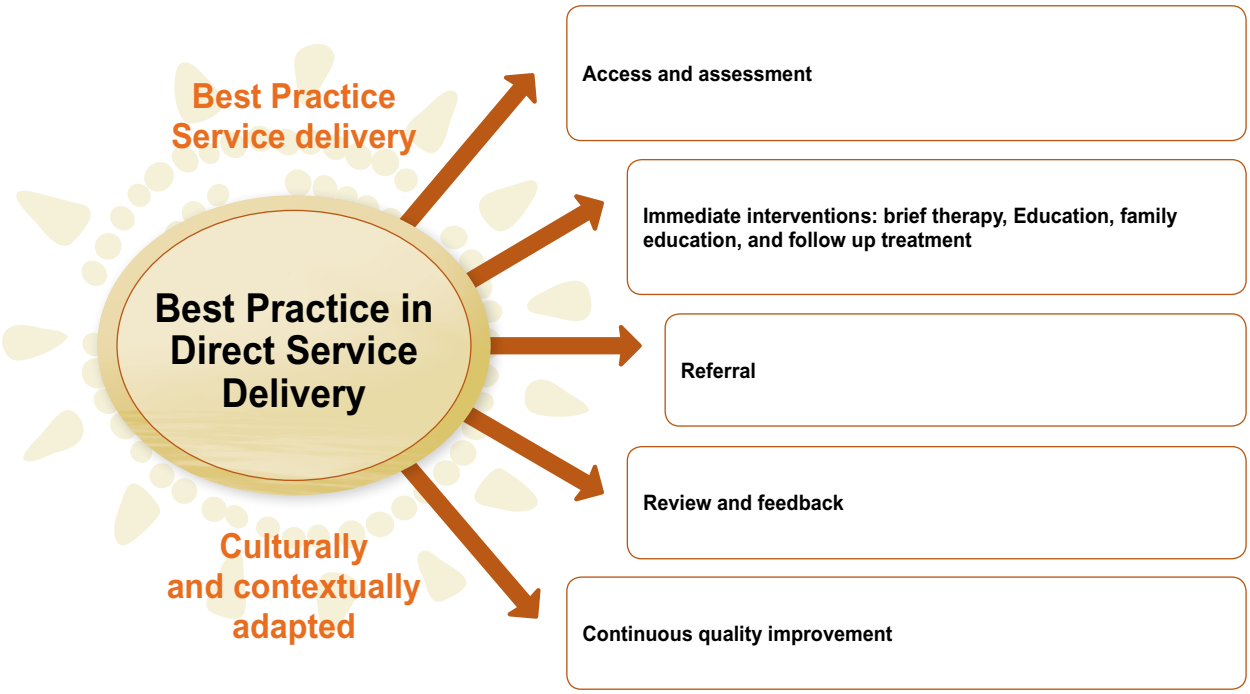


Figure 1.1

Community Development

Figure 1.2

This community development framework, in conjunction with the direct client service delivery model, enables workers to utilise principles and practices inherent to Aboriginal communities. The opportunity exists for community development approaches & strategies and ways of thinking to be implemented and practiced in a culturally-appropriate manner in remote, regional and urban communities across the Northern Territory, and in the wider Australian context.

The Workforce's current model represents a 'hub and spoke' model of service delivery. Central administrative and programmatic support is provided to workers in distant sites. Fly in fly out specialist back up support (coordinator / clinical supervisor/ trainer) is provided to community workers on the ground, who are embedded in local services which provide on-the-ground service support. Although this model is familiar and similar to the delivery of health services across the Northern Territory there are a number of aspects of the model which are unique. It extends across both government and non-government services, it introduces dedicated AOD Workers to primary health care settings, and it represents an opportunity to join together best practice with recent NT research. In addition to this, the Workforce is drawn from the community, rather than from health professionals with specialist AOD qualifications wherever possible. The emphasis is on supporting workers with local cultural knowledge to develop expertise in AOD to complement their cultural knowledge and expertise.

This is an Indigenous Workforce and the majority of these positions are filled by Indigenous workers (over 70%). The skill levels range from Certificate II to Certificate IV through to Degree Level, the majority encompassing AOD training. One of the main focuses/purposes of the Program Support Unit is to facilitate the appropriate training and professional development of the Workforce. This enables the frontline workers to be equipped with the necessary skills & knowledge to effectively work within the Remote AOD Workforce Program's service delivery and capacity building framework.

The key challenges to the Workforce can be divided into those of:

- Governance
- Sustainability
- Implementation of best practice.

In terms of governance there is a need to ensure that the Workforce is provided with regular clinical supervision and clinical review, clarity of management accountability, professional responsibility, and clarity of role.

In terms of sustainability, the Workforce needs to be supported to deliver services in both personal and practical ways such as: professional development, peer support, advocacy as a group, career structure, and travel & accommodation support.

Finally, in terms of best practice there is a need to provide tools and resources which support best practice in both individual and family service delivery and community development. These tools include assessment and care planning tools, educational resources, and guidance with respect to community development principles, data collection tools and information systems to support planning and decision making.

The Workforce has continued to strengthen over the last 5 years. Indicators of the success of the program are reflected in the high staff retention rate and stability of the Workforce. Many of the workers have remained in their positions since the program's inception (over 40%) which is largely attributed to the internal support structures provided to the workers through both the Primary Health Care Centres and the central Remote AOD Workforce Program Support Unit. This support includes fortnightly teleconferences, twice yearly forums, and regular consistent face to face and telephone contact, as well as clinical supervision. Systems and processes are being put into place to ensure all workers have regular clinical supervision and client review.

The recognition from the Commonwealth of the success of the program is reflected in the ongoing funding. The Remote AOD Workforce Program continues to have the opportunity to embed substance misuse service delivery into primary health care settings, enabling holistic client care and community capacity building in remote, regional and urban communities across the Northern Territory.

NATIONAL DRUG STRATEGY 2010-2015

Community development is a key strategy for improved community wellbeing which is defined in the National Drug Strategy *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009* as follows:

"A growing body of research demonstrates that social capital – resilience, the capacity to work collaboratively, the ability to recognise commonalities, connections that bridge difference within a community, and the ability to resolve conflicts – is profoundly important to peoples' overall sense of emotional and social wellbeing. In preventing alcohol, tobacco and other drug related harm, community and social capital are factors of crucial significance."

Harm minimisation

In the development and implementation of this framework, activities are aligned with the philosophical approach of *harm minimisation*, which has underpinned Australia's National Drug Strategy since its inception in 1985. According to the National Drug Strategy (2004, p.2):

Harm minimisation does not condone drug use rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches including abstinence-oriented strategies.

Australia's harm-minimisation strategy focuses on both licit and illicit drugs and includes preventing anticipated harm and reducing actual harm. The Remote AOD Workforce NT works under the strategic pillars of the *National Drug Strategy 2010-2015* in the area of *demand reduction* and *harm reduction* in achieving outcomes. These pillars (including *supply reduction*) are:

- *Supply reduction*: strategies to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs;
- *Demand reduction:* strategies to prevent the uptake and/or delay the onset of use of alcohol; reduce the misuse of alcohol in the community; support people to recover from dependence and reconnect with the community; and support efforts to promote social inclusion and resilient individuals, families and communities.
- *Harm reduction*: strategies to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The Workforce also supports these pillars in alignment with the *National Drug Strategy* with community development commitments to:

- building Workforce capacity;
- evidence-based and evidence informed practice, innovation and evaluation;
- performance measurement; and
- building partnerships across sectors.

COMMUNITY DEVELOPMENT FRAMEWORK ACTION PLAN

NT REMOTE AOD WORKFORCE
COMMUNITY DEVELOPMENT FRAMEWORK ACTION PLAN

Guiding Principles/Frameworks:

- Community Development Principles
- Building AOD Workforce 'Tips' – Theory into Practice
- Remote AOD Workforce NT Interim Report (2009)
- Evidence Based and Best Practice Alcohol and Other Drugs Principles & Frameworks
- Aboriginal and Torres Strait Islander Peoples Health Principles
- Cultural Competence Frameworks

National Drug Strategy 2010-2015

National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2004-2009

Supply Reduction

Demand Reduction

Harm Reduction

OUTCOMES:

1. Prevent uptake and delay onset of alcohol and other drug use
2. Reduce use of alcohol and other drug use on the community
3. Support people recover from dependence and reconnect with the community
4. Support efforts to promote social inclusion and resilient individuals, families and communities

OUTCOMES:

1. Reduce harms to community safety and amenity
2. Reduce harms to families
3. Reduce harms to individuals

Community Development Framework

Activities:

1. Gathering Information
2. Community Planning and Action
3. Linking and Networking
4. Community Reflection and Assessment

Values:

Strong PEOPLE

Strong PLACES

Strong PARTNERSHIPS

Strong PARTICIPATION

Cultural Competence

Valuing Indigenous Languages and Cultures

Wellbeing

Key Program components:

1. AOD Treatment Services (screening, assessment, counselling/intervention and referrals)
2. Community Awareness, Education and Health Promotion
3. Demographic Specific Targeted AOD activities – youth, male, female, men, family, elderly
4. Community Development female/youth/etc

Program Materials:

- Clinical Package – Brief Interventions, Counselling and Assessment Tools, Referral Processes and Clinical Supervision
- Community Awareness, Education and Health Promotion activity plans, lessons and aids, activities and teaching tools
- Community Development Framework Package

Figure 1.3

BACKGROUND CONTEXT

"a positive Indigenous community development model must incorporate 'yarning up not down" *(Burchill, 2004)*

Across the Northern Territory, many of the Aboriginal communities are the result of previous government policies, developed without regard to fundamental Aboriginal human rights, historical and tribal boundaries, protocols and laws. This resulted in the displacement of many Aboriginal people groups — from different cultures and languages — from their custodial and traditional lands. After varied periods of time, they then experienced forced segregation on missions and reserves. Government policies later on enabled some of these communities to return 'back to country' and experience some degree of self-management - however, Aboriginal people have rarely been provided with 'authentic' autonomy – that is, 100% control over their affairs and the future direction of their own people and individual language groups. This relatively involuntary establishment of what are now known as 'communities' and the subsequent upheaval, has brought about a range of complex health, cultural and social issues for people right across the NT.

The workers employed by the Remote AOD Workforce NT who both work and/or live on NT communities (including Aboriginal, Islander, Torres Strait Islander and non-Indigenous workers) experience the effects of this past history and also a range of new and contemporary issues as the cultures of multiple worlds collide. Understanding this as the basis for many Aboriginal and Islander communities will help workers understand how and why certain situations have come about and why certain issues seem extremely difficult to resolve. Effective community development is the vehicle that will hopefully provide opportunities for workers to develop strategies to support communities to overcome these issues.

Some starting-point key reminders

This framework is a positive community development model that incorporates 'yarning up not down' and begins with the following key reminders for workers to consider:

- Take the time to reflect on the historical context of your community;
- Identify and build on existing individual and community strengths and knowledges – this means valuing the people who are there and who will be there long after you may have gone;
- Plan and deliver programs as a 'two-way street' – ensuring that you value the input of others and harness and integrate the strengths of both western *and* Indigenous cultural values and practices;
- Regularly reflect upon and challenge your values, assumptions and worldview in order to move beyond cultural awareness (as a starting point) to developing your *cultural competence*; and
- Always and regularly check back with the community.

HARNESSING THE STRENGTHS OF TWO WORLDS

"Our worldviews have constantly been described as primitive or sub-human, by the dominant cultures past and present, however make no mistake, traditional Aboriginal knowledge is powerful, sophisticated and of considerable practical value. For example skin grouping that prevents wrong marriages/relationships/birth defects to keep bloodlines strong, systems for identifying and naming country including water locations, sets boundaries with respect and relevance, and the use of plants for medicinal use is quite powerful." (Paterson-Walley, 2012)

"Western clinical practices and ways of thinking can work really well within Aboriginal contexts if implemented thoughtfully and respectfully. Western methods often draw on a wide range of information sources, research and models which are constantly improving. Effective data gathering through written, recorded and multimedia means can be really useful also for getting an accurate and holistic understanding of a community's key health issues, for comparing with similar data, programs or initiatives being implemented anywhere in the world, and for coming up with a wide range of solutions to empower people to access opportunities they may never have had before. Good practitioners know that it is through years of service in remote regions and cross-cultural contexts, listening, learning, experiencing and constantly reflecting on what works and what doesn't – that teaches one to know what the strengths of our western culture is, and its connections with Aboriginal cultures."(Remote RN, Kiwirrkura Community, 2010)

"The best thing for me about being an AOD Worker is that I am helping my own people overcome AOD issues. I can offer them my support and knowledge from my experience growing up where we would feel sick going home from school on a Friday because we knew that there'd be drinking and fighting going on – and helping to change this so that kids today don't have to experience the same things I did. My cultural identity from my father's side makes me proud of who I am which has nothing to do with the colour of my skin but the Aboriginal blood that pumps through my heart – so I can draw on both worlds to work hard in my job and come up with solutions one step, one person at a time. I put my culture first which sometimes means my job doesn't go from 8am to 5pm but whenever someone needs me."
(Joel, Remote AOD Worker, 2012)

"I enjoy being part of a great team of people who work together to achieve great results which sees the community happy and healthy. I want to be able to listen to the elders and the youth more – to hear their stories about their culture and to find out what they want. I feel highly satisfied in my job most of the time and want to give the young fellas especially, a strong positive sense of the future. I'm out in the community every day, they see me out there. It's hard at first but it gets easier. It makes my job easier when I show respect, when I listen, and they act

on what they want. We must listen and hear their stories and then they open up. Show they are important, show compassion. Acknowledge when they (clients) are doing well, apologise when we (workers) have done the wrong thing and always be fair. Respect goes two ways. It can not be one way. " (Gregory, Remote AOD Worker, 2012)

We value WISDOM:

"to celebrate and honour everyone's life journey, because we all have a shared story – if we have the wisdom to listen honestly".

WHAT IS COMMUNITY DEVELOPMENT?

"Working with communities to assist communities in finding plausible solutions to the problems they have identified" (Sherwood, 1999).

"The aim of community development activities is to achieve better community outcomes for Indigenous communities" (Burchill, 2004).

"(It is the) community identifying priorities, issues and solutions" (Aboriginal Health Promotion Officers NT, 1992).

"It's a two-way street, so far it's only been one way" (Dodson, 2002).

Community development asks 5 key questions:

- Where are we now?
- What are the issues?
- Where do we want to be?
- What needs to be done in order to get there?
- Who do we need to help us?

Indigenous academic Jaunita Sherwood (1999) defines community development as "working with communities to assist communities in finding plausible solutions to the problems they have identified" (p. 7). Often not recognised nor acknowledged is that Aboriginal and Torres Strait Islander peoples in Australia have participated in community development for thousands of years, yet they have been forced to adapt to a non-Indigenous community development model for several decades. Sherwood emphasises the importance of community development processes being "initiated by the community and not put upon the community" (p. 8).

Marlene Burchill (2004) provides her perspective:
"Community development practitioners arriving in Indigenous communities today must come armed with the education, knowledge, patience, skills, cultural understanding, courage and respect. Community development workers arrive in Indigenous communities with their aspirations, their tools, knowledge and expert advice; to build hope, to raise community consciousness and to the problems that have led to their exploitation, isolation, oppression and racial prejudice. For all of their good intentions and visionary exploits – little has changed. Well-meaning efforts that ultimately fail contribute to the suspicion and mistrust that does exist within Indigenous communities and individuals".

Mainstream models of community development—as well as other more intensive therapeutic practices such as counselling and medical interventions to support Indigenous people—in many respects draw heavily on a western model of thinking rather than a combined effort to integrate western and Indigenous cultural practices. Patrick Dodson (2002) emphasises that for change to occur "it's a two-way street, so far it's only been one way" (p. 22).

In relation to the Remote AOD Workforce, for effective community development and change to take place within NT Aboriginal communities, it is vital that workers do not contribute to another generation of poverty, isolation and inequality. Well-meaning workers without the necessary skills and understanding required to address this will still come from across Australia in an attempt to support Indigenous communities thinking that they may create change or empower Aboriginal people to take charge and control over their own lives and their communities – but in actual fact, end up doing more harm than good.

Typically, there have been many obstacles to overcome in this regard and many initiatives have become bogged down and left in the 'too hard' basket. In the past and even today, many Aboriginal communities continue to settle for second best. This means they get the leftovers (similar to mission rations of brown sugar and white flour). They do not get the best, most educated, knowledgeable professional assistance. Aboriginal communities and organisations in the NT have been a 'honey pot' for organisations and individuals who can access the funding provided by government but rarely achieve positive and lasting outcomes.

In reiterating the aim of community development activities undertaken by the Remote AOD Workforce - *To work in meaningful partnership to strengthen and build strong, resilient and connected communities that value and support people to overcome their alcohol and other drug health issues and improve community outcomes.*

We value LOYALTY:

"to be loyal to the communities I work in; to carry out promised tasks (and to) accept loyalty as a value, as it is, without qualification".

REFLECTING ON PAST LEARNING – NT PROGRAMS

We value DETERMINATION:

"I want to absorb as much from others more experienced; and learn from the past, not make the same mistakes twice".

The past 10 to 15 years has seen the implementation of a number of NT programs focussed on Aboriginal health and Alcohol and Other Drugs (AOD). The evaluation of the *Living with Alcohol* program, the *Aboriginal Mental Health Worker* (AMHW) program, the *Audits of Best Practice in Chronic Disease* (ABCD) program and the *Aboriginal and Islander Mental Health Initiative* (AIMhi) program have provided useful insight to inform the strategic forward direction and align the activities of the Workforce with approaches that best suit the unique NT context. This information has been utilised in response to the opportunity the Workforce has to translate relevant research into action as recommended in the National Drug Strategy *Aboriginal and Torres Strait Islander Peoples Complementary Action* Plan and to bring action research to effective service delivery.

Details of these programs are highlighted below. In many regards, the aspects drawn out in the evaluation of these programs has already informed much of the Workforce progress to date – the community development (CD) considerations of these programs now being formalised in the development and implementation of this framework.

Living with Alcohol (LWA) Program

The LWA program was introduced in 1992, being initially funded through monies raised with the introduction of a tax levy on alcohol sold in the NT. The program ceased in 2002 and two evaluations were undertaken, the first in 2002 and the second in 2004. These results revealed that the LWA program resulted in significantly reduced alcohol-attributable deaths and financial cost savings to the NT. Key take home messages from this program included that interventions can make a difference, and that the components of success include a focus on treatment services and broader awareness raising campaigns linked with supply reduction though alcohol taxes[6].

Considerations for the Remote AOD Workforce CD framework:

» **Continuous quality improvement of interventions** including clinical and educational tools and resources , but particularly in relation to activities that engage the Workforce in community development (e.g. health promotion, awareness raising and education) – to ensure they are adaptable, developmentally and culturally appropriate, and aligned to best practice in order to

6 Chikritzhs, T, et al., (2004).

maximise effectiveness of impact upon both individual client/s and communities;

- **Key to achieving health outcome success is the development of effective partnerships, linked to broader community AOD projects and initiatives** (including local, regional and national) and tailored to be sensitive and responsive to individual client and local community needs/issues - the Workforce being extremely well positioned to play a critical role in this; and
- **A new focus on developing workers' key values and skill-sets around effective community development** – respectful communication, conflict resolution, community partnerships, self-awareness and critical reflexivity, planning and action, cultural competence, wellbeing, and targeted Indigenous staff support is needed, whilst maintaining a continued focus building upon the existing strengths of the Workforce e.g. Indigenous and local knowledge, relationship connections, trust and accountabilities, clinical treatment services and workplace supervision.

Aboriginal Mental Health Worker (AMHW) Program

In 2001, the Top End Division of General Practice (TEDGP) secured funding under the Australian Government's *More Allied Health Services* (MAHS) program to employ Aboriginal Mental Health Workers (AMHWs) alongside General Practitioners in five remote health centres. Through partnership with *beyondblue* and the Foundation for Alcohol Research and Education (FARE) the number of workers and health centres was increased to a further three centres. The general objective of the AMHW program was to develop the role of the Aboriginal Mental Health Worker as a member of a community-based mental health team in participating communities, linking cultural knowledge and expertise of AM HWs with GPs.

Evaluations of this program found limitations to[7]:

- communication of client social and cultural issues
- 'two way' collaboration with workers
- integration into health service models of practice
- career development
- meeting the need to have both male and female workers available
- system support for training and supervision, management and administration

Considerations for the Remote AOD Workforce CD framework:

- **Cultural safety skills development** – opportunities for workers to develop and improve their skills required to foster culturally safe and supportive environments, including things like locally developed cultural protocols, safe 'yarning' spaces and processes to enable clients to freely communicate their broader social and cultural issues that impact upon their AOD use/misuse;
- **Training and education** – tailored opportunities for workers to improve their professional confidence and competence within shared/individual professional learning/development pathways

7 Robinson, G. and Harris, A., (2005).

– leading to informal and formal development and acknowledgement of qualification/s and achievements, whether AOD, community development work, health science or otherwise; and

» **Development of 'two-way' partnership processes** – to address the range of barriers that limit partnership success being things like breakdown of communication, conflict of interest, power imbalance, worldview/cultural difference, social inequality, lack of shared goals, lack of trust in relationships and other social, cultural and historical factors.

The Mental Health Initiative (AIMhi) NT

The Aboriginal and Islander Mental Health Initiative (AIMhi) in the Northern Territory worked with Aboriginal Mental Health Workers (AMHWs) from 2003 to 2009 to develop culturally appropriate assessment and treatment tools for remote community settings[8]. It sought to overcome challenges of distance, language, literacy and worldview.

The AIMhi program of research developed tools for mental health promotion, tools for care planning, and an Indigenous mental health training course. The mental health training course resulted in significant improvements in confidence and understanding of Indigenous mental health in service providers from a broad range of backgrounds, particularly in relation to recognising the correlation between high prevalence of comorbid mental health, chronic disease and substance misuse.

The care planning tools were incorporated into a brief psychological intervention (or *low intensity cognitive behavioural intervention*) which was tested in a randomised controlled trial. A mixed methods design was used to test the effectiveness of the intervention called, Motivational Care Planning (MCP)[9].

Results found significant improvements in wellbeing, mental health and substance dependence which suggested that MCP is an effective treatment for Indigenous people with comorbid mental illness. These findings confirmed the results of other studies that showed improved outcomes in response to problem solving, motivational interviewing, cognitive behavioural therapy and self-management intervention. The consistent theme is that brief therapies do make a difference and that integrating substance use and mental health treatment is a successful approach – in the context of primary health care *and* community-based treatment.

The results of these findings have already had a significant influence in the development of the current range of assessment, screening, treatment and education tools being used by the Workforce. It is now anticipated that these mechanisms will also guide the design and use of relevant community development tools.

8 www.menzies.edu.au/AIMHI/
9 Nagel, T et al. (2009). Remote AOD Workforce Program Interim Report

Audits of Best practice in Chronic Disease (ABCD) program

The ABCD program is a Continuous Quality Improvement (CQI) project tailored to meet the needs of services providing primary health care to Aboriginal and Torres Strait Islander peoples and has been operating since 2002. It has since expanded to over 60 sites around Australia. The aim of the project is to improve chronic illness outcomes for Indigenous primary health care settings and to support services to assess and improve their systems for the delivery of best practice care. The project demonstrated that continuous quality improvement processes and tools are appropriate to and well accepted in Indigenous primary health care services.

The principles of CQI already provide a framework of evaluation for the Remote AOD Workforce program as detailed below (Figure 1.4).

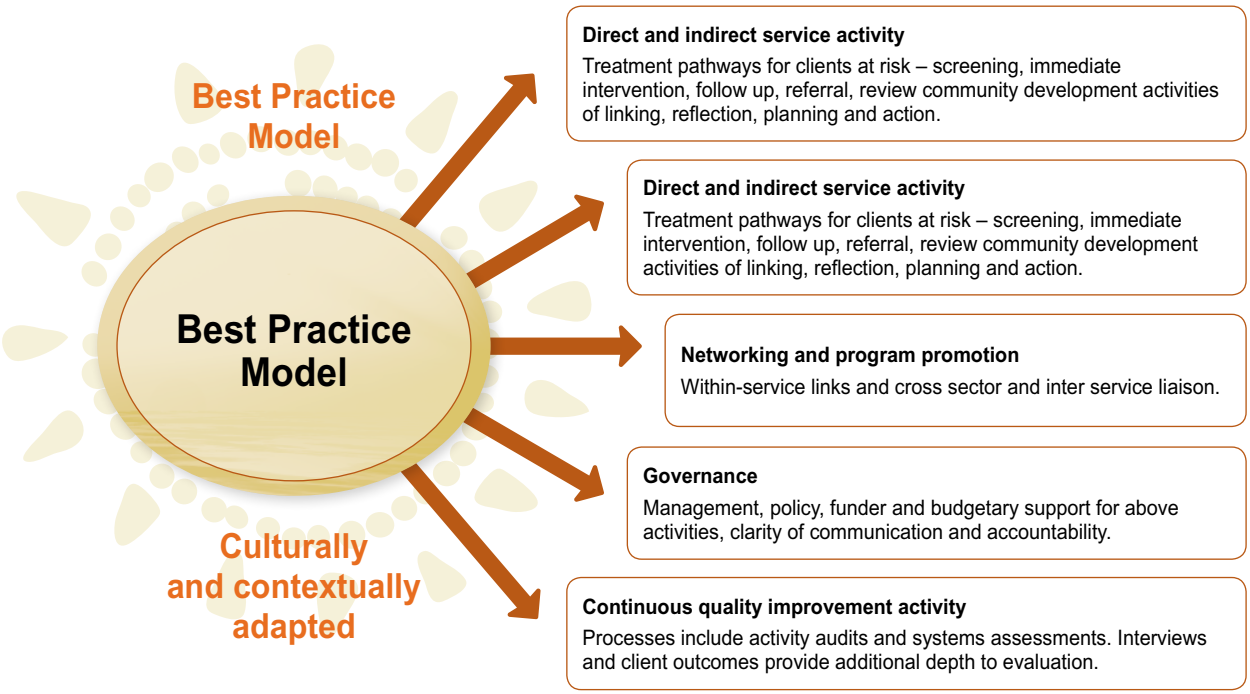


Figure 1.4

Best practice in service delivery

A key feature of the Remote Workforce AOD Worker role is that it comprises two distinct related sets of activity – direct service delivery and community development. The model defines best practice in each of these areas. Best practice in service delivery is defined by the best practice pathway in Figure 1.5 and comprises eight activities from assessment to feedback.

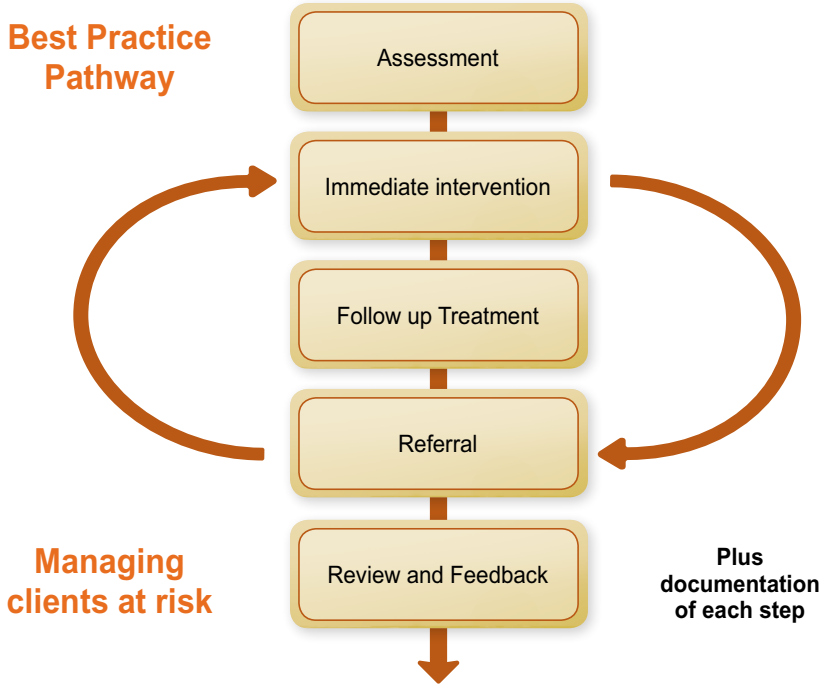


Figure 1.5

Best practice support 'tool kit'

The Workforce has developed a best practice 'tool kit' to support the best practice models in service delivery and community development (Figure 1.6).

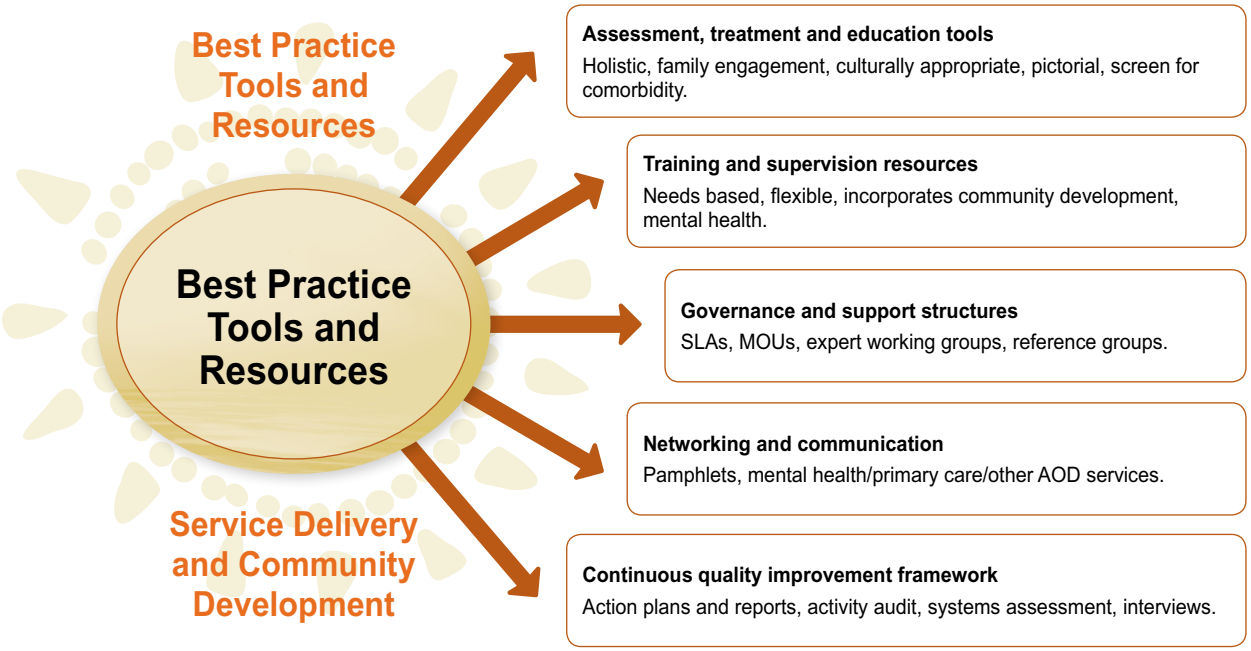


Figure 1.6

HOW TO USE THIS FRAMEWORK

There are 4 key action areas in this framework:

Key

SERVICE ACTIVITY	COMMUNITY DEVELOPMENT	CD
ACTION	Networks and Linking	NL
ACTION	Gathering Information	GI
ACTION	Community Planning and Action	CPA
ACTION	Assessment and Reflection	AR

Each section of this framework manual identifies at the top which action area it addresses.

For example, you will see:

SERVICE ACTIVITY	CD
ACTION/S	AR

Refer to page 35 for key action areas.

That this chapter is about Assessment and Reflection in community development. If you are looking for ideas for evaluation, assessment and reflecting on your project, or how you work, this chapter might help you.

When you see this:

SERVICE ACTIVITY	CD
ACTION/S	GI

It means this chapter or section will help you gather information to undertake your community development project.

Use these action areas to help guide you in your community development work and understand this framework better.

Objectives

In supporting timely and effective delivery of alcohol and other drugs (AOD) services to individual clients, families and the broader community, this framework has been designed to assist Remote AOD Workers to strengthen the work they do through the integration of practical community development approaches. To improve Aboriginal and Torres Strait Islander community engagement with this framework, these approaches have been strategically aligned with values traditionally inherent in Indigenous communities.

The objectives of this framework are:

1. To **improve AOD services delivery** by supporting Remote AOD Workers to effectively implement the four best practice community development activities of:
   - » Networking and Linking
   - » Gathering Information
   - » Community Planning and Action
   - » Assessment and Reflection
2. To **reinforce and integrate Aboriginal and Torres Strait Islander cultural values** into contemporary community development processes

Traditional Aboriginal and Torres Strait Islander value systems and cultural (including social) structures have long modelled (often without due recognition) what is now known in a contemporary sense, as effective community development. These approaches are based in evidence and focus on building strong, vibrant communities by valuing the following:

1. strong **PEOPLE** – supporting resilience, help-seeking and tools for positive change
2. strong **PARTNERSHIPS** – establishing & maintaining healthy, working relationships and partnerships
3. strong **PLACES** – of opportunity, cultural security and cultural exchange
4. strong **PARTICIPATION** – and community engagement in AOD programs and community-based activities & initiatives

These two objectives are achieved through the provision of opportunities that develop the skills of the Workforce in the following ways. Opportunities to improve:

- » cultural competence;
- » ability to plan, deliver and evaluate meaningful community-based AOD programs and health promotion activities;
- » skills required to effectively communicate, develop and build healthy working relationships and partnerships, and avoid/resolve conflict;
- » support for Aboriginal and Torres Strait Islander workers and their capacity to manage work expectations with their cultural obligations, responsibilities and pressures; and
- » processes that support the overall health & wellbeing of the Workforce.

Main components

1. Framework overview
2. Community development 'mob focussed' principles
3. Explanation of best practice action areas
4. Cultural competency development
5. 'Yarning about' exercises
6. Worker case study scenarios
7. Tools and resources lists

Training – Supervision – Evaluation and Support

Findings prove that training in itself is not enough to change a health professional's behaviour or to introduce new approaches to practice[10]. Multifaceted interventions are needed which include engagement of workers in development of training and feedback of outcomes. Participatory approaches to research, training and evaluation is also consistent with effective community development involving service providers, workers and community members each step of the process to drive change, find empowering models of care and community-based solutions to local issues.

The Remote AOD Workforce NT is committed to providing relevant and responsive ongoing training, supervision and support for workers in the area of community development (Figure 1.7) This aims to ensure that each worker is adequately equipped to effectively reflect upon practice, consult, plan and deliver community-based activities, in response to community identified AOD needs whilst utilising culturally safe practices, best practice approaches and access to current and innovative research findings.

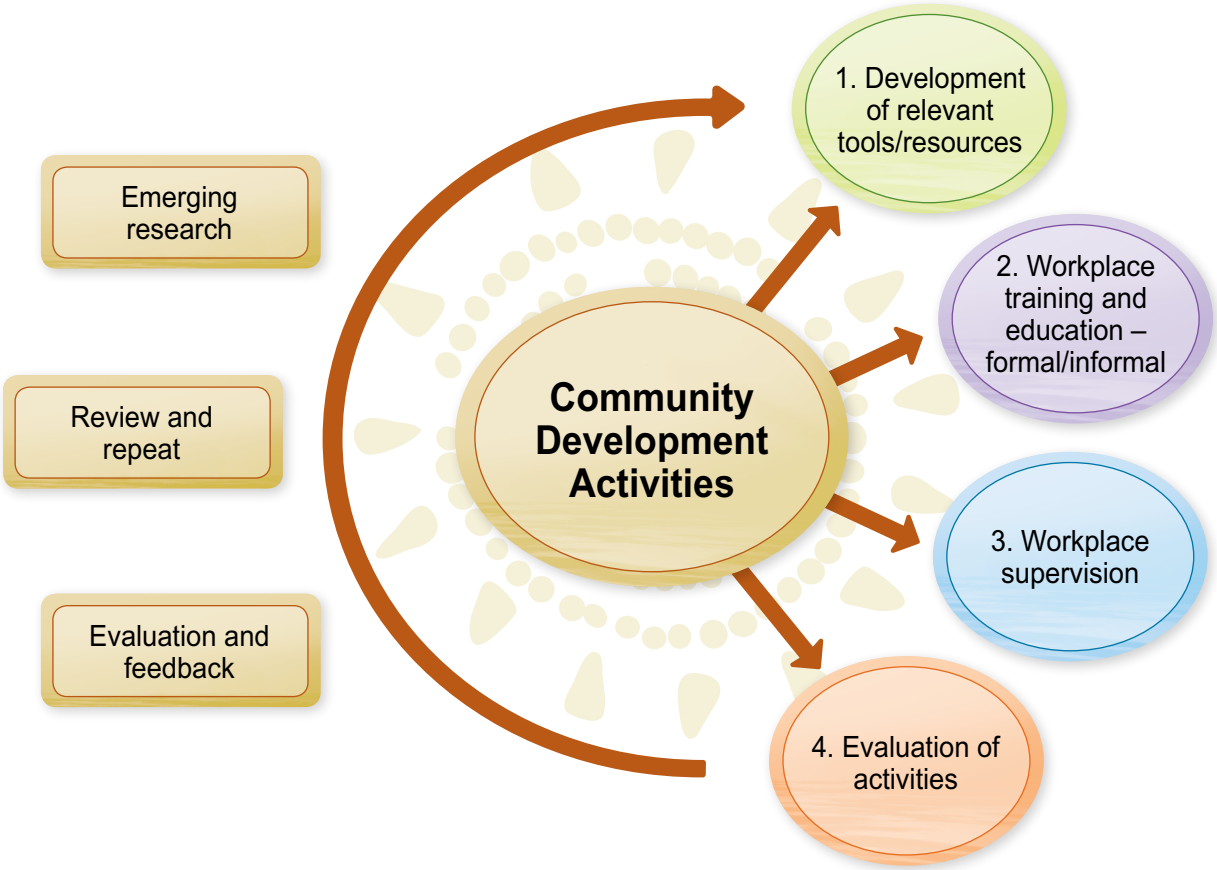
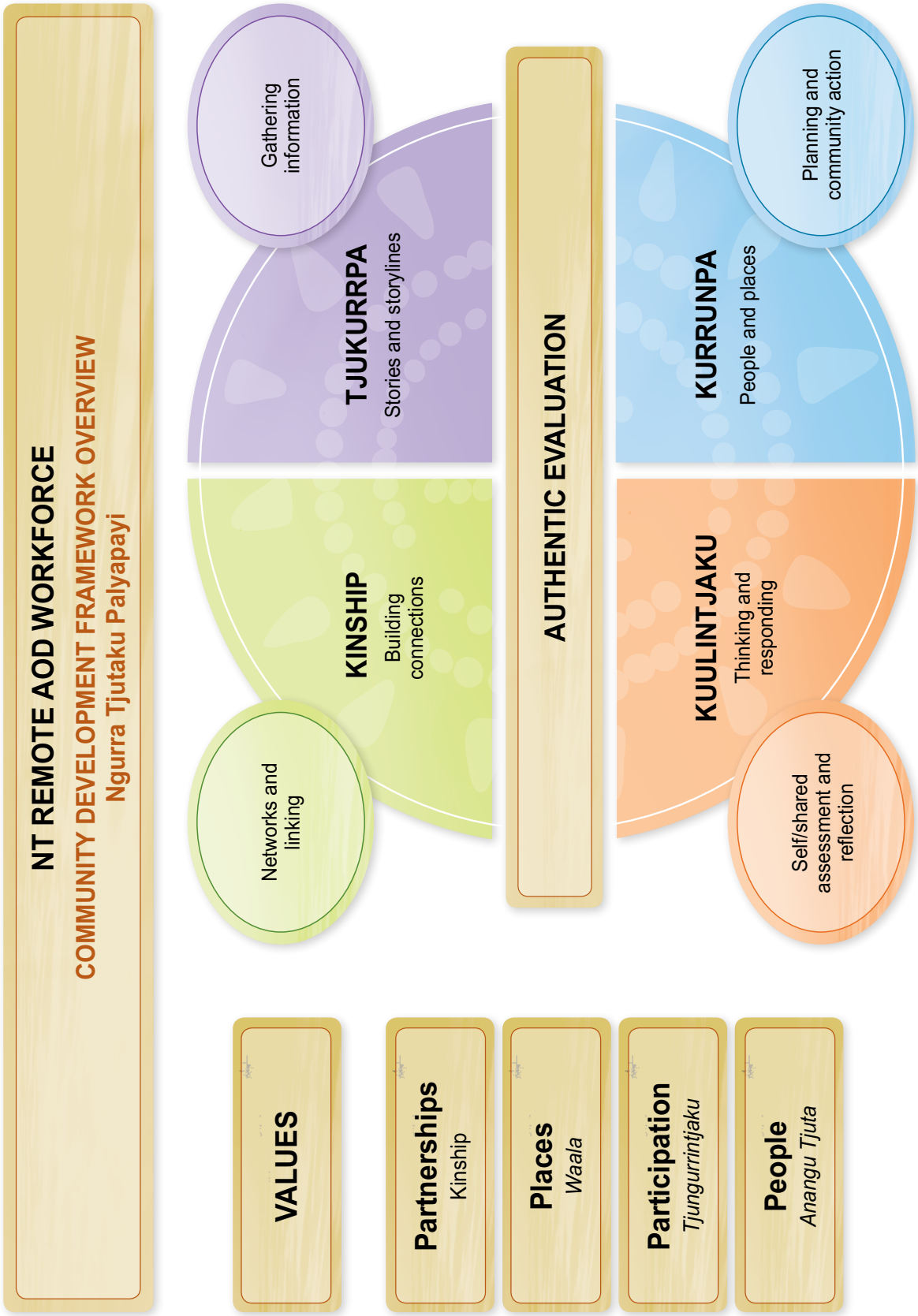


Figure 1.7

10 Bero, L., et al. (1998).

COMMUNITY DEVELOPMENT FRAMEWORK OVERVIEW



Luritja language used in this document: use your own language on the following page to tell your own community development story.

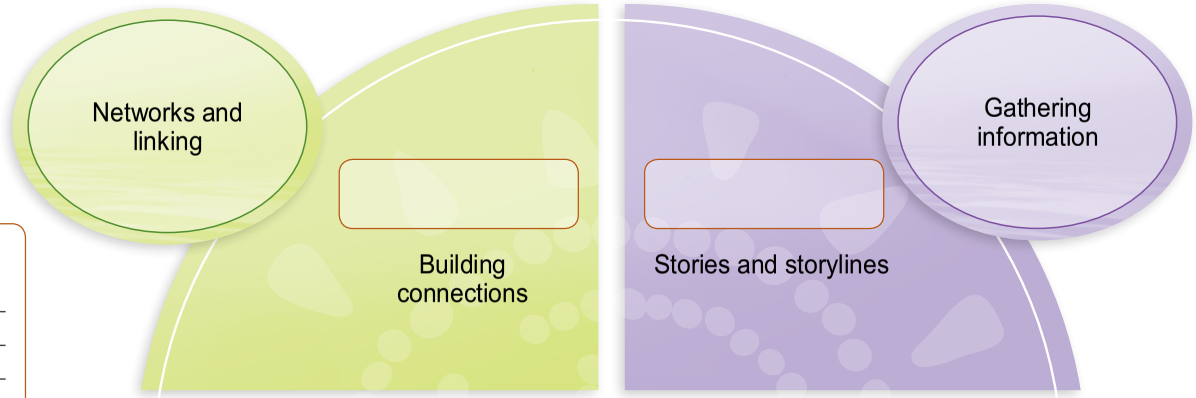
Figure 1.8A

Figure 1.8B

NT REMOTE AOD WORKFORCE

COMMUNITY DEVELOPMENT FRAMEWORK – ACTION AREAS

Ngurra Tjutaku Palyapayi



Kinship

Do you have a name in language for **kinship**?

_____

_____

_____

Stories and storylines

What words would you use to name the **stories and storylines** of where you live and work?

_____

_____

_____

AUTHENTIC EVALUATION

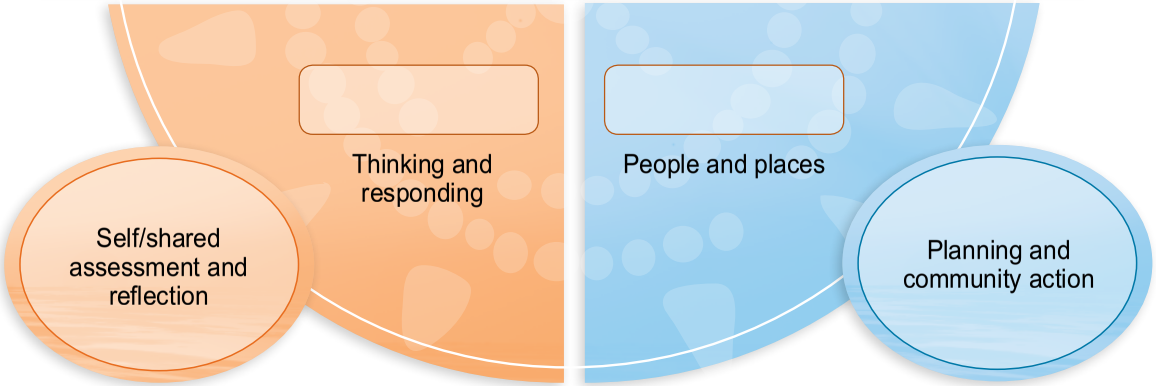
Thinking and responding

Are there words for **thinking and responding** in your language?

_____

_____

_____



People and places

What are the words you would use to describe the **people and places** of your community?

_____

_____

_____

My language is: _____

The community I work in is: _____

NT REMOTE AOD WORKFORCE

COMMUNITY DEVELOPMENT (CD) ARTWORK

Ngurra Tjutaku Palyapayi *(Working for our Community)*

Sharing and working together highlighting the importance of being connected and belonging, family being most important.

Spiritual depiction of unity- the white dot signifies one spirit, one people, all human.

People and different cultures, colours, creeds working, sharing and growing together.

People yarning and reflecting individually & together in different contexts- remote, homes, workshops, schools, work, in the dirt and sand.

Gathering information and collecting stories.

Intergenerational storytelling of long and short stories. Dreaming, knowledges, story lines, wisdom from old men and women.

Groups of people: family, language, tribes and kinship.

Tools, instruments, weapons, resources to help us work together.

Figure 1.9

COMMUNITY DEVELOPMENT KEY ACTION AREAS (see Tools and Resources section)

SERVICE ACTIVITY	CD			
ACTION/S	NL	GI	CPA	AR

ACTION AREA 1	Networks and Linking	NL	ACTION AREA 2	Gathering Information	GI
BEST PRACTICE INCLUDES: » Meeting with key people & stakeholders related to AOD services » Meeting with community elders and leaders » Development of a resource guide, contact and email list » Developing community networks » Organising and supporting network meetings, ideas and participation » Attending and publicising network meetings » Recording meeting outcomes » Supporting the network to observe and reflect » Supporting the network to plan and act » Recording the linking activities for qualitative data collection			**BEST PRACTICE INCLUDES:** » Supporting collection of information & data about AOD and its impact in the community » Assistance with: conducting surveys, reviews or audits related to the issue , as well as analysing and interpreting the above activities asking: » Where are we now? » What are the issues? » Where do we want to be? » How do we get there? » Who do we need to help us? » Linking planning and action with the analysis » Recording the activity for data collection (qualitative and quantitative)		
ACTION AREA 2	**Community Planning and Action**	**CPA**	**ACTION AREA 4**	**Assessment and Reflection**	**AR**
BEST PRACTICE INCLUDES: » Health promotion and community education activities » Awareness raising activities » Training and capacity building in the community » Research » Funding applications for new programs, research or initiatives » Evaluation & reflecting on the above activities » Recording & reporting the activities for data collection			**BEST PRACTICE INCLUDES:** » Individual, shared and community reflection » Exploring barriers, concerns and issues » Linking with family and kinship » Reflecting on professional practice » Reflecting on personal values and assumptions » Observing cultural respect and protocols » Checking for cultural concerns and issues » Authentic evaluation – formal and informal » Qualitative and quantitative data collection		

Table 1.0

ABORIGINAL & TORRES STRAIT ISLANDER VALUES AND PROTOCOLS GUIDE

ATSI VALUE: PLACES	ATSI VALUE: PEOPLE
» Does your organisation and workplace foster a culturally friendly environment? How? » Do all relevant community members feel safe to access the services you provide? Consider work environment, location, hours of business and accessibility. » Do the staff display attitudes and behaviours that demonstrate respect for ATSI peoples and other cultural groups? » Do you have access to places other than your workplace or organisation that allows you to deliver or facilitate culturally safe AOD activities or programs for specific client groups? Where and what are they? If you answered 'no' to any of the above, what can you do to change the outcome/s for your clients or the community?	» Do you have positive relationships with community members and clients? How do you know? » Do you collaborate with Aboriginal and Torres Strait Islander persons or groups when planning events, programs, service delivery or community activities? » Do you value the cultural knowledge and experience of your Aboriginal and Torres Strait Islander staff, workers, clients and community members? How do you show this? » Do you use appropriate communication methods, language and mediums when working with clients? What are they? » Does your organisation or program unit appropriately acknowledge local Aboriginal and Torres Strait Islander people/s within programs and at events and functions? If you answered 'no' to any of the above, what can you do to change the outcome/s for your clients or the community?
ATSI VALUE: PARTNERSHIPS	**ATSI VALUE: PARTICIPATION**
» Do you have knowledge of local Aboriginal and Torres Strait Islander groups and organisations? » Do you have knowledge of local Aboriginal and Torres Strait Islander cultural protocols? List 5 specific to your community. » What formal and informal partnerships have you established with your clients, community organisations or other groups? » Do you have knowledge of protocols for communicating to culturally and linguistically diverse groups in the community? E.g. post-initiated young men or female elders? » Do you have appropriate partnerships to support individual clients that link to their family (including extended and kinship) and other people or organisations working with them? If you answered 'no' to any of the above, what can you do to change the outcome/s for your clients or the community?	» Do you provide programs and activities that encourage active participation from community members? » Do you adapt programs to effectively cater for different community members including children, youth, adults, men, women and the elderly? How? » Do you try to address the barriers that limit the participation of particular groups in your AOD program? What are the barriers? How do you try to address them? » Does your organisation or program unit celebrate Aboriginal and Torres Strait Islander events, achievements and identities? How? » Does your organisation or program unit acknowledge or commemorate local and national events of cultural and social significance? If you answered 'no' to any of the above, what can you do to change the outcome/s for your clients or the community?

Table 1.1

COMMUNITY DEVELOPMENT PRINCIPLES – MOB STYLE!

SERVICE ACTIVITY	CD			
ACTION/S	NL	GI	CPA	AR

These principles have been specifically adapted from a range of universal community development ideas. They are mob (people) focused and should be used as a guide when planning community development activities.

Principle 1: Get mob involved!

Encourage mob to get involved! This means valuing the contributions and participation of community members regardless of what level of input or at what stage of the program or activity they join. Community members (young, old, unpaid or paid) are integral to the decision-making, delivery, evaluation, participation and direction of the program. Participation in Aboriginal and Torres Strait Islander contexts can also strongly gauge the sense of cultural safety and confidence that the community has in a program as community members often actively 'vote with their feet' not necessarily their words.

Principle 2: Make mob rules!

Actively involve other workers, community members and those who form part of the multidisciplinary PHC team in decision-making so they have ownership of the Workforce's activities. The governance model should be developmental, working co-operatively and collaboratively with key elders and senior community members, clinic staff, volunteers, clients and the wider community. These rules also define the cultural protocols required by workers to effectively plan and implement their individual community activities as they support the development of key knowledge and skills like cultural awareness (e.g. storylines, land & country, languages, family and kinship relationships), appropriate interactions between male/female workers and clients, respectful communication, use of adaptive language and self-reflection of workers' worldviews and the impact of this on their personal and professional practice.

Principle 3: Give mob skills and pride!

This is a process that draws out peoples' strengths (not weaknesses) and respects, values and enhances their ability to have control over their lives and their communities. This process encourages clients and community members to address their AOD issues/needs and aspirations in a self-aware and informed way which takes advantage of their 'two-way' skills, cultural knowledge, experience and potential. Change and growth occurs when individuals and communities are empowered to develop and implement local solutions; this should have a strong process/developmental focus, whilst not overpowered by an outcomes focus, keeping in mind that it is a mechanism to develop individual and community pride and skill that often results from experiences of both success and failure.

Principle 4: Support mob to learn for life!

Model what it means to value learning. Don't be afraid to make mistakes or admit your inexperience or lack of understanding. Remind yourself and others that learning is a lifetime and two-way process and integrate it within all aspects of your activities, thus building and supporting the personal skills, knowledge, abilities and resilience of people. Develop the health, wellbeing and connection of people and their families, through formal and informal pathways in education, employment and self-development.

Principle 5: Don't leave mob behind!

This principle values the diverse contributions that community members make no matter what their age, gender, background or varying abilities. Acknowledge individual and local needs and address them through informal interactions like yarning, family sharing or general community understanding. Identifying these needs and issues through a range of methods (e.g. active listening, informal questions, verbal or written surveys, evaluating previous and current initiatives) is instrumental to informing the planning and development of activities and programs. Don't get too carried away with timeframes or your own program needs that you forget who you're working with and for!

Principle 6: No place for shame, only safety!

Shame and lack of cultural safety destroys opportunities for people to access health services. Put things in place that ensure mob feel your program is accessible, culturally safe and welcoming. Shame-free and culturally safe programs promote a fair opportunity for community members regardless of their gender, social, financial or cultural context to access health services and benefits, AOD support, counselling and interventions, economic resources and power between people. Consider all aspects of your program – cultural protocols, time of day, duration, location, lighting and layout, use of language/s, educational tools and use of multimedia, content and demographic.

Principle 7: Help mob to make the change!

Make sure you allow yourself and community members to examine and analyse the factors (internal and external) that impact upon the local community either historically or present day to makes decisions around how to address, alleviate or avoid their effects. These could be social, cultural or political. Developing and restoring broken relationships and communication between individuals, families, language/tribal/community groups and organisations is central to community transformation and gains momentum and social power when people work together.

Principle 8: Help mob to stick up for themselves and others!

In meeting individual and group needs, workers should act with, or on behalf of, community members and clients. Having said that, if you see an injustice or inequality taking place, don't become reactive but assume unless you act, no-one else will! Ownership and understanding is critical here – if you act on someone else's behalf, make sure they know why! This is especially important when advocating on behalf of those in lesser positions of power e.g. children and youth, elderly, sick or marginalised groups.

Principle 9: Mob know Kinship!

Linking, forming partnerships, collaborating and working with individuals, groups, other agencies, government and businesses both formally and informally are crucial to achieve connections within local communities. But when developing relationships and partnerships, learn from Indigenous kinship values! Work within existing strong relationships, find connections within families and key individuals and elders, follow healthy ways of interaction between different groups and avoid possible confrontations/conflict using this understanding.

Principle 10: Help mob seek help!

Individual clients, families and groups should be supported in such a culturally and spiritually safe way that they share information, knowledge, skills and life experience in order to meet their own AOD and health needs, including personal goals to quit, slow down or manage their alcohol and other drug use/misuse issues. Role model attentive and respectful listening, help-seeking behaviour, and avoid sending clients away when they genuinely seek help – even if it is inconvenient at the time. This is a difficult challenge, but not if you have good understanding of client risk assessment e.g. threats of suicide, alcohol withdrawal, and prioritise your time effectively.

TOOLS & RESOURCES FOR COMMUNITY DEVELOPMENT: CULTURAL COMPETENCE FOR COMMUNITY DEVELOPMENT

SERVICE ACTIVITY	CD			
ACTION/S	NL	GI	CPA	AR

Refer to page 35 for key action areas.

We value: *"the ability to recognise the beauty, frailty and strengths of our own humanity and character of others".*

CULTURAL COMPETENCE

SERVICE ACTIVITY	CD
ACTION/S	AR

Refer to page 35 for key action areas.

What is culture?

Culture is widely defined by the practices and beliefs owned by a community or people group and provides its distinctive identity such as language, gestures, customs and traditions that define values and organise social interactions, religious beliefs and rituals – this includes dress, art and music as forms of cultural and symbolic expression.

What is cultural competence?

Cultural competence is widely defined as a set of skills, knowledge and awareness needed by individuals and communities in order to promote constructive interactions between people of different cultures. It is a commitment to engage respectfully with people from other cultures and requires more than being culturally aware. Cultural competence development requires *cultural immersion* that is, direct interaction with a culture/people group in order to successfully develop the skills required to be culturally respectful.

It is now generally recognised that cultural competence for one population may not necessarily translate to another (Kim et al., 2006; Sue, 1999, 2003). For this reason, it is important to recognise that it is an ongoing responsibility and development process for all workers to critically reflect on their worldview and adapt their behaviour relative to their understanding, for each and every particular cross-cultural context. For some workers, the practical ability to do this (sometimes referred to as 'code switching') in some instances may occur even as frequently as a visit to a neighbouring community or another region in the NT.

Why develop cultural competence?

The need to improve cultural competence arises from the recognition of the importance that culture, ethnicity, racism, histories of oppression and other contextual factors have in the experiences of

individuals and communities (Purdie, 2010). These experiences significantly affect health outcomes for Aboriginal and Torres Strait Islander peoples. This is a critical area of practice, and Parker (2008, citing Morgan, 2006, p.203) points out that 'serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor (and worker)/Aboriginal patient interactions', particularly in remote communities. Failure to recognise the need to instil culturally safe practices diminishes and erodes the fundamental cultural and human rights of Indigenous peoples (Purdie et al, 2010).

How?

The development of cultural competence relies upon:

- the ability to identify and challenge one's own cultural assumptions, values and beliefs;
- contextually specific cultural awareness and understanding; and
- culturally respectful and responsive protocols and processes (behaviours, actions, policies) that reflect and act on this understanding.

Whilst it may often be assumed that due to upbringing or innate cultural capacity, Aboriginal and Torres Strait Islander workers develop these skills more quickly or have a predisposed advantage towards cultural competence development, Indigenous cultural diversity in Australia dictates that all workers should be given opportunities to develop in these three areas, not just non-Indigenous workers.

The development in these areas should ultimately enhance cultural safety – that is, workers who act and behave in ways that enhance rather than diminish individual and communal cultural identities, and that both empower and promote individual and community health & wellbeing.

How is Cultural Awareness different to Cultural Competence?

Cultural awareness is a process of increasing knowledge about a particular people or cultural group – its history, customs and traditions, distinguishing features, belief system/s, language/s and geographical features. Cultural awareness differs to cultural competence in that it is limited by being fundamentally knowledge-based (rather than skills-based) and can be obtained with little or no cultural immersion that is, through means other than direct interaction with the culture/people group e.g. books, documentaries and university. Having cultural or contextual information about an Aboriginal community serves as a good foundation – but it is not adequate to ensure that workers will act or behave in a manner that is culturally safe or respectful.

Cultural Safety leading to Cultural Security

Cultural safety/security develops as a result of activities, behaviours and policies that promote the highest level of cultural competence on individual, community and organisational levels. This means that regardless of context, people feel culturally acknowledged, safe, secure and respected enough in order to access, participate and express themselves freely in the workplace, program or initiative without fear of judgement, shame or condemnation.

Figure 2.0 illustrates how cultural security is built on cultural safety, and in turn is built on cultural awareness. Cultural awareness being only the **starting point** of the entire process.

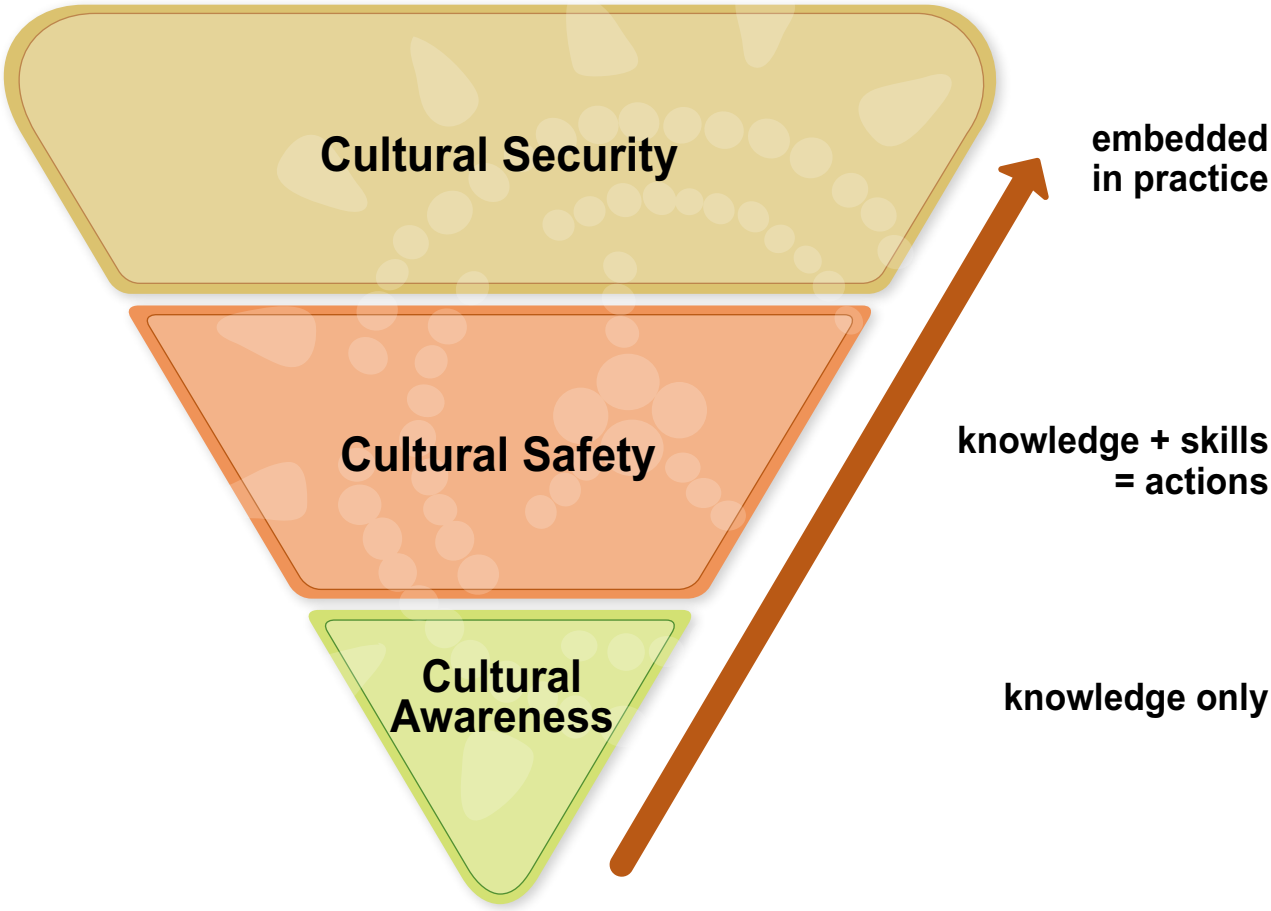


Figure 2.0 (Adapted from Coffin, 2007)

The previous reflection questions (Table 1.1) and the following questions, exercises and checklists (Table 1.2) have been designed to support personal and professional critical reflection of values and assumptions in order to support the process of cultural competence development.

ELEMENTS OF CULTURAL COMPETENCE[11]

KNOWLEDGE	VALUES
» understanding the nature of how worldviews and culture shape identity and human behaviour » understanding how general and contextually specific patterns of history have impacted upon Indigenous lives and how they continue to do so today » understanding contextually specific information about your community – history, language/s, geographic features, significant elders and families, law and cultural practices	» being aware of your personal values and beliefs » having the capacity and willingness to move away from your own cultural values in order to engage with the cultural values of others » having an awareness of how your values, biases and beliefs influence your professional practice and how this impacts upon people from other cultures
SKILLS	**ATTRIBUTES**
» all aspects relevant to AOD clinical practices, community development and primary health care » written and verbal communication » risk assessment, crisis assessment and management » decision-making skills » problem-solving skills » best practice principles » time management » ability to work as a team member » conflict resolution » debriefing skills » self-reflection » working collaboratively with a wide range of health services and providers	» having the ability to reflect accurately and honestly on your individual values and attitudes towards particular people or people groups, organisations and/or systems » being able to understand the nature and dynamics of 'power' as it relates to your practice and the broader community and society » recognising the nature and impacts of unearned or inherited privilege (on both Indigenous and non-Indigenous people) » understanding the nature and effects of racism and prejudice » understanding the history of relationships between Aboriginal and Torres Strait Islander peoples and other Australians, at both local and national levels » understanding how Aboriginal and Torres Strait Islander perspectives have been shaped about western institutions, professions and ways of thinking that have constrained and hindered their ability to meet the needs of Indigenous peoples and their communities

Table 1.2

11 (Adapted from Purdie, et al., 2010, p. 164)

VALUING ABORIGINAL & TORRES STRAIT ISLANDER LANGUAGES AND CULTURES

SERVICE ACTIVITY	CD			
ACTION/S	NL	GI	CPA	AR

Refer to page 35 for key action areas.

We value LEARNING: *"knowledge about Indigenous community values and beliefs; learning skills to address these values and beliefs in an appropriate way".*

ABORIGINAL CULTURAL DIVERSITY AND CULTURAL PROTOCOLS

SERVICE ACTIVITY	CD
ACTION/S	AR

The Remote Alcohol and Other Drugs (AOD) Workforce acknowledges that the NT is home to a diverse range of Aboriginal peoples who all possess a unique and valuable cultural identity and understanding of what it means to be an Aboriginal person, and part of an Aboriginal community in Australia.

There are over 200 Aboriginal and Torres Strait Islander language and people groups across Australia, with many of the most traditional language speaking groups found within the NT and surrounding tri-state regions. It is not uncommon in many of these NT regions for community and family groups to be related across language and tribal lines. This means that in many homes 2 or 3 languages (not just dialects) or more may be preferred to be spoken over English.

Additionally, many family groups reside in regional town centres and/or town 'camps'. Those families balance their lives between urban and remote or 'bush' living, including varied levels of involvement in traditional and contemporary cultural activities and traditions. This also includes many Aboriginal and Torres Strait Islander peoples who have come from other states and territories who also call the NT home.

The Remote AOD Workforce acknowledges this diversity and considers it to be a critical factor when planning, designing and implementing community development activities. In so doing, the Workforce aims to be culturally respectful and responsive in meeting the needs of each target audience, regardless of the context. It is the responsibility of every worker to develop their own cultural understanding of their particular community, as these are often varied and unique – history, language/s spoken, sacred and sites of significance, kinship systems and cultural protocols.

Northern Territory Aboriginal Interpreter Service – 08 8999 8353

The Northern Territory Aboriginal Interpreter Service works with 51 Indigenous languages to support organisations working with traditional language speakers.

The table below lists the languages workers can seek support with.

REGION	LANGUAGES
Alice Springs (Central) and **Tennant Creek** (Barkly)	Alyawarre, Anmatyerre, Central Arrente, Eastern Arrente, Jingili, Kaititj, Mudbarra, Luritja, Ngaanyatjarra, Ngaatjatjarra, Pintupi, Pitjantjatjara, Southern Arrernte, Wambaya, Warlpiri, Warnmanpa, Warumungu, Western Arrernte, Yankunytjatjara, Wuriaki
Borroloola	Yanyuwa
Darwin	Larrakia
North Eastern Arnhem	*Yolngu languages:* Dhay'yi – Djarrwark, Dhalwangu Dhangu – Golumala, Rirratjinu, Gallup, Wanguri Duala – Gupapuyngu, Gumatj, Manggalili Dhuwala – Wubulkarra, Madarrpa Dhuwal – Djambarrpuyngu, Liyagalawumirr, Datiwuy Dhuwal – Marrangu, Djapu Djangu – Warramiri, Mandatja Djinang – Murrungun, Mildjingi, Wulagi
Groote Eylandt	Alawa, Anindilyakwa, Kriol, Nunggubuyu
Katherine	Gurrindji, Jawoyn, Kriol, Mayali, Ngaringman, Walpiri, Nunggubuyu
Kunbarllanjanja (Oenpelli)	Jabiru Burarra, Kunwinjku
Litchfield (Batchelor)	Madinarl, Mariamu
Nauiyu Nambiyu (Daly River) **Peppimenarti**	Kriol, Ngangikurrungurr, Ngangiwumirri Marithiel
Maningrida	Burarra, Djambarrpuyngu, Djinang, Guninggu, Gurrgoni, Kriol, Nakkara, Ndjebbana, Rembarrnga, Yanyangu
Ngukurr	Kriol, Marra
Tiwi Islands	Tiwi
Wadeye (Port Keats)	Mari-Jarran, Murrinh-Patha, Nungu Jamidi.
Warruwi (Goulburn Island)	Maung, Walang, Iwaidja

Table 1.3

CULTURALLY APPROPRIATE USE OF LANGUAGE

SERVICE ACTIVITY	CD
ACTION/S	CPA

In many Aboriginal and Torres Strait Islander health contexts – female and male health for example, very specific and culturally responsive language is required when communicating with clients and community members. Each and every community will have its own specific cultural protocols and it is the responsibility of all workers to respectfully engage with community members to discover what these are.

Here are some NT examples:

Aboriginal and Torres Strait Islander Peoples – This term describes Aboriginal and Torres Strait Islander peoples of Australia as 'native or belonging naturally to a place'; this acknowledges Aboriginal and Torres Strait Islander peoples as the first peoples and original custodians of Australia. The terms 'Aborigine, Aboriginal and/or Aboriginal person/peoples' is most widely accepted and used by people to describe themselves in Central Australia for example, however 'Indigenous' is often a more appropriate term to use in an urban centre like Darwin.

Males: refers to all males – from infants through to the elderly.

Men and/or Young Men: often refers to men and young males who have been initiated through traditional ceremonial law. Use of these terms should be strictly avoided with mixed audiences (age, gender or tribal) and if unsure, or if a visitor or someone is new to a remote community. Inappropriate use of these terms can seriously offend and marginalise individuals who may or may not have been initiated through traditional law or otherwise not had opportunities to participate in traditional cultural practices as determined by their upbringing or their individual community cultural norms. To avoid this, alternative language terms are provided below.

Alternative terms used when referring to males: fellas, fellows, guys, lads, blokes and/or mob.

Elders: refers to senior men (and males) and women of authority who are respected by the community as either traditional owners or custodians of particular areas of land (or country), the holders (or caretakers) of traditional law and knowledge, and who are the key community decision makers. Elders function in various ways to ensure the appropriate interaction between traditional values and law and the range of contemporary issues/contexts that affect their communities. Permission to visit, travel, participate and/or contribute to a community program by elders should always be sought prior to the implementation of any community development activity.

Kinship: this refers to the complex arrangement of family groups and relationships within Aboriginal communities. Traditional Aboriginal kinship systems ensure the interconnection of all community members and define their rights, rules and responsibilities around family, marriage, cultural obligations, storylines and relationships. Kinship or 'skin' names are used within a number of NT people groups however this isn't always the case e.g. Pitjantjatjara, and use of these terms will vary from community to community.

KINSHIP SYSTEMS

Unlike Western society which is strongly individualistic, Aboriginal social values emphasise belonging and connectedness to a group and the obligations and responsibilities of individuals to share and meet the needs and expectations of the other - traditionally for the purpose to survive, thrive and prosper. For many Aboriginal people, family and community are of central significance, and group interests and needs are a fundamental part of an individual's identity and self-fulfilment. Personal identity and self-esteem is expressed in places of belonging (country, dreaming and totems) and one's place within the extended family, rather than individualistic characteristics or achievements.

- Aboriginal people define 'family' very differently than non-Aboriginal people. There is biological (straight or full) family and there is kinship family, however each is as distinctly important as the other and it should never be assumed, judged or questioned on the legitimacy of one over the other – both make up 'one family' who have a shared, life-long care responsibilities to each other.
- Aboriginal people have many mothers, fathers, aunties, uncles, sons, daughters, nieces and nephews.
- Kinship, clans and language influence how a majority of the Northern Territory communities operate on a daily basis.
- There are double relationship names, e.g. cousin—brother or niece—daughter.
- Even when Aboriginal people come into town centres e.g. Alice Springs or Darwin, they are still bound by kinship rules.
- Members are constantly making connections with people to confirm family and relationships.
- When people die, the relationships between the living family members may change.

Central Australia kinship terms

PINTUPI-LURITJA		WARLPIRI		ARRERNTE
MALE	**FEMALE**	**MALE**	**FEMALE**	**MALE/FEMALE**
Tjapaltjarri	Napaltjarri	Japaljarri	Napaljarri	Peltharre
Tjakamarra	Nakamarra	Jakamarra	Nakamarra	Kemarre
Tjampitjinpa	Nampitjinpa	Jampijinpa	Nampijinpa	Ampetyane
Tjupurrula	Napurrula	Jupurrula	Napurrula	Purrula
Tjapangati	Napangati	Japangati	Napangati	Pengarte
Tjangala	Nangala	Jangala	Nangala	Angale
Tjungarrayi	Nungarrayi	Jungarrayi	Nungarrayi	Kngwarraye
Tjapanangka	Napanangka	Japanangka	Napanangka	Penangke

Table 1.4

Iwaidja-Minjilang and Cobourg Peninsula kinship terms

IWAIDJA-MINJILANG AND COBOURG PENINSULA	
MALE	**FEMALE**
Nawulanj	Ngalulanj
Nangarrij	Ngalngarrij
Nawmut	Ngalamut
Namarrang	Ngalamarrang
Nangila	Ngalangila
Nawagaj	Ngalawaj
Nawuyug	Ngalwuyug
Nawangari	Ngalwangari

Table 1.5

What if I'm given a 'skin' or kinship name but I'm not Aboriginal or from that community?

As already highlighted, the Aboriginal and Torres Strait Islander value around kinship is primarily focused on one thing – to belong and to be connected. Unlike many non-Indigenous or Western models of thinking, belonging and connectedness in this sense is not performance or judgement based. Rather, it means that so long as you are a person living and participating in community life (whether Indigenous or not), you naturally require to be connected somewhere in the kinship system.

This kinship value often results in people who are not Indigenous or from the community to be given a 'skin' or kinship name by a community member, partner, friend or elder. Amidst initial feelings of self-admiration and perceived acquisition of culture, the first thoughts that go through a person's mind are predominantly Western influenced ideologies based on performance – things like, "I must have done something really good" or "they must really like me or accept me" or "now I must have gained their trust". Whilst this may be true also, this type of thinking often misinterprets and undervalues the true reason why kinship names are given. Some individuals even go to the extent of becoming presumptuous, arrogant and judgmental of others who may not yet have been given a kinship name – which all negatively impact upon community development.

If you are given a 'skin' or kinship name and are either not Indigenous or from that community – be humble, respectful, receive it with thanks and remind yourself that it relates not to your performance as much as the need for you to be connected to the community and the responsibility that comes with being there – the continued need for you to work respectfully, effectively, diligently and cooperatively with your community.

Kinship based system of belonging

BELONG → **BELIEVE** → **BECOME**

» **No criteria** placed on membership or acceptance.

RESULT

All belong

» Your values, beliefs, skills and qualifications are unique and valued – difference does not disqualify you.

RESULT

The group benefits from diverse skills, beliefs/values and qualifications.

» You achieve your potential through whatever means made possible by belonging to the group.

» Your level of achievement or lack-thereof never disqualifies you from belonging or being accepted.

Figure 2.1

Performance or judgement based system of belonging

BECOME → **BELIEVE** → **BELONG**

» **Set criteria** for membership and acceptance – either through achievement, performance or qualification.

RESULT

Only those who meet the criteria will belong.

» You must share the same beliefs, skills, qualifications or performance standards in order to maintain membership.

RESULT

You must achieve and maintain these for risk of losing acceptance.

» Once you have met and maintained the criteria, you belong and are accepted but subject to ongoing judgement and appraisal.

RESULT

Acceptance and belonging is based on performance and subject to change at any time.

Figure 2.2

ABORIGINAL AND TORRES STRAIT ISLANDER PERSPECTIVES: SPIRITUALITY

SERVICE ACTIVITY	CD
ACTION/S	AR

Refer to page 35 for key action areas.

We value SPIRITUALITY: *"(to) connect with our deepest spirit and connections and learning systems with each other".*

'Spirit' © by Alan Palmer Pelterre

This image is a holistic depiction of an Aboriginal person, as it should be – valuing and nurturing all the attributes of a person including their spiritual wellbeing (which emanates from the *kngerrtye* or 'core'), language & cultural wellbeing (shield or *alkwertye* and hair bun) and their physical wellbeing. The *tjurrunga* are storylines from *altjerre* or 'in the beginning' and are painted on the body, shield and earth – which are unchanged values of the past. These are tools that an Aboriginal person will then draw on to which they apply to their present and future contexts, to help them overcome and succeed.

Figure 2.3

7 Tribes, 7 Stories

Reflecting upon Aboriginal and Torres Strait Islander peoples' perspectives on spirituality is fundamental to developing an understanding and respect for the way individuals, families, people and language groups view their lives and their communities. This subsequently relates to how many communities might deal with issues like alcohol and other drug use/misuse. Indigenous spirituality for this reason is far more complex than a 'feeling or emotion' that many often attribute to an Indigenous person's connection to the land; it is constant ebb and flow of spiritual energy - a fluid movement that has potential to influence two ways: destroy people and the community or strengthen, sustain and invigorate people and the community.

The best way to gain an understanding of Aboriginal and Torres Strait Islander peoples' perspectives on spirituality and reflect on one's own views as a health worker is to hear the following from **7 Tribes, 7 Stories:**

1. *"As a desert man my spirituality lives in my culture and country. I believe our spirit is never ending unlike our bodies. Our spirit always returns home back to its country, to give life again – as a person or as its original self. Every animal we hunt goes through a process of being killed, cut, handled, cooked and shared according to our law and this process allows the spirit of that animal to return home to where it came from. We are no different when we die. The reason we have this law is because the spirit of that animal might give life to a baby person or a baby animal.*

Whatever country our spirit came from, it belongs there and will always return there - that's where our ancestors are; we are just as much a part of them as they are us. Today people can choose whatever they want to believe or anything that makes sense and feel more connected to. Sometimes it's our choice, sometimes we have no choice - it's what we were taught. Spirituality, whether it's a foreign religion, practice or your own culture, it's what makes you feel whole both inside and out – when your spirit is happy, that's what matters".
Arrernte, Kaytetye & Alywarre/Anmatyerre man, 30 years

2. *"Long ago, when our kids were sniffing petrol, they would walk around night-time and act rama-rama (crazy). Sometime they walk around with a petrol can all day – but not open their eyes, smile or say anything. I tried to talk to the sniffers, take them for school, but they only look at me, and wouldn't speak. Other kids told me stories like being followed by mamu (evil spirit/s) and said the sniffers act same like those mamu from movies you know? We lost one community boy from petrol sniffing like this – but we know that it wasn't just the petrol that he passed away from but also evil spirits that took his spirit away from his family".*
Pitjantjatjara woman, 48 years

3. *For me, at this stage in my life, my spirituality is entwined with learning more of my culture, learning my creation stories and learning my dreaming and song-lines. The more I learn about my culture, the more I learn about my spirituality. It's quite extraordinary that I have so much faith in something I don't know, but I guess that's what faith is. I don't know all my creation stories or my dreaming, and the truth is, due to colonisation, I may never know. But I know that my culture and spirituality is what makes my heart beat and the blood pump through my veins. Its survival is my reason for living. I ask my ancestors to watch over me and guide me to make the right choices. I ask for answers, I try my hardest, and I have faith that I will be everything I am supposed to be".*
Wiradjuri woman, 29 years

4. *"Spirituality to me is about protecting myself and my family through what Aborigine law taught me by my grandfather - that spiritual forces are real and there are both dark (evil) and light (good) spirits. Aborigine people are taught to know how to tell the difference. When missionaries came, they told us what we already knew – but didn't acknowledge it. But in our songs, stories and dance we have been communicating with the Spirit of our Creator (white fellas call him God) for thousands of years, long before they came. He is our very source of life, who we turn to in our joy, grief and loss, who created us, gave us our identities and placed us in our tribes and language groups. Spirituality to me starts on the inside of my heart to protect me and help me make right choices. When that's right, I feel strong for my family".*
Pintupi-Luritja man, 32 years

5. *"I believe spirituality is a oneness with land and peoples' thoughts. It is this foundation through which we express ourselves in ceremonies, totems, storytelling, dance & dreamings. It helps me to understand my place in this world. We have a unique connection to the spirit/supernatural world to God & his creations. We have the ability to see into the spiritual & natural & at times can combine the two in expressing who & what we are as a people. Our spirits link each other across the land giving & feeling of belonging, united as one race".*
   Aboriginal & Torres Strait Islander woman, 45 years

6. *"The foundation of my spirituality and knowledge is based on the following scripture from the Bible. It goes, 'From one man he made all the people of the world. Now they live all over the earth. He decided exactly when they should live. And he decided exactly where they should live. God did this so that people would seek him. Then perhaps they would reach out for him and find him. They would find him even though he is not far from any of us. In him we live and move and exist. As some of your own poets have also said - we are his children' (Acts 17:26 – 28). Aboriginal spirituality is connection to land, each other, our environment, our understanding of who our Creator is. To me, this gives a Biblical basis for the legitimacy of Aboriginal spirituality and Aboriginal sovereignty".*
   Kabi Kabi man and Reverend, 51 years

7. *"We see Spirituality as holistic, multisensory and boundless in scope and inclusive of the universe, man, animal or plant. It is a very complex concept and not something that is single or can be clearly defined. It is something you have to live to have an insight into. In essence Spirituality is interconnected to all things, land, food, culture, spirit and identity and is expressed through our language, stories, song-lines, ceremonies, rituals, totems, artwork (rock or modern day). It is our Gulbarl (Ngoonooru Wadjarri), the essence of our being. We have our stories that relate to every aspect of life on Earth (our Dreaming) and through these stories it is strongly articulated that we have a daily spiritual duty to maintain the health and balance of nature that should not be ignored in the modern world, as difficult as it can be."*
   Ngoonooru Wadjarri elder

YARNING ABOUT SPIRITUALITY

SERVICE ACTIVITY	CD
ACTION/S	AR

1. What aspect/s of these stories stand-out to you?

2. What aspect/s of these stories can you relate you?

3. What is your understanding or experience of 'spirituality'?

4. When reflecting upon your own understanding or experience of 'spirituality', what aspects of these stories are:
   a. Similar?
   b. Different?
   c. Challenging for you?

5. How could these **similarities** affect the way you work with Aboriginal and/or Torres Strait Islander peoples on your community?

6. How could these **differences** affect the way you work with Aboriginal and/or Torres Strait Islander peoples on your community?

7. How could the **challenging aspects** affect the way you work with Aboriginal and/or Torres Strait Islander peoples on your community?

CULTURAL PRESSURES & OBLIGATIONS FOR ABORIGINAL & TORRES STRAIT ISLANDER STAFF

SERVICE ACTIVITY	CD
ACTION/S	AR

Refer to page 35 for key action areas.

SUPPORTING ABORIGINAL AND TORRES STRAIT ISLANDER WORKERS WITH CULTURAL RESPONSIBILITIES, OBLIGATIONS AND/OR PRESSURES

If you are both an Aboriginal and/or Torres Strait Islander person and a Remote AOD Worker, you may have particular family and kinship relationships involving responsibilities, obligations and/or pressures to members of your community that have an impact on your personal and professional life.

This can result in a variety of pressures and expectations for you as an AOD Worker to:

- feel obligated to work with clients out of hours or over weekend rest periods;
- feel obligated to share your resources with family members including time, care of children, vehicle, money, phone, computer, personal belongings, home and so forth;
- be unable to work with or support certain community members due to avoidance relationships and/or family fighting;
- be exposed to high levels of stress resulting from the fact that potentially all clients who experience distressing circumstances may be related, or closely connected to you;
- be under immense pressure as a result of community expectations, which in certain situations may be impossible to deliver on;
- be the target for blame if something goes wrong with the treatment of a client; and
- oscillate between being a respected individual and community role model or an all too familiar community member whose past or current weaknesses are well known by others. For example, *"Don't listen to him, he used to drink, smoke and gamble with the rest of us – he's still that same fella".*

Other cultural expectations and obligations you may face:

- attendance at funerals – even if the deceased is not directly related. Attending funerals is a cultural expectation around respect and honour for the deceased and for their family. Failure to do so can result in a range of significant cultural repercussions;
- attendance at community events, festivals and sport weekends; and

» participation in customary ceremonies and law, during times of significant cultural activity – often for months at a time.

For the above reasons, it is acknowledged that there is immense pressure on you as a remote AOD Worker to manage, and at times compromise, your professional and cultural ethics due to the family and kinship issues within your individual situations.

CULTURAL RESPONSIBILITY

SERVICE ACTIVITY	CD
ACTION/S	AR

This yarn is about identifying, sharing and improving ways the Remote AOD Workforce can support you as an Aboriginal and/or Torres Strait Islander person living and working on community in relation to the cultural obligations and pressures that you may face. These cultural obligations may also affect you if you are a non-Indigenous person married or in a relationship with a local Indigenous community member. As obligations may change over time, it is recommended that this yarn be undertaken at least *once per year* between supervisor and worker and similar discussions be undertaken during biannual Workforce Forums to further develop effective mechanisms to support workers in this area.

Cultural responsibility and obligation means there is an expectation on you to share/provide certain community members (including children, partner, extended and kinship family) with your:

» Time
» Money
» Care or guardianship
» Home and/or personal belongings
» Cultural knowledge or leadership
» Vehicle

For Aboriginal and Torres Strait Islander peoples, these obligations are a part of life, a value that has been core to traditional Indigenous community development – a means that has sustained strong community connectedness through shared provision of resources. In the modern context however, the constant pressure of these obligations can become extremely difficult to maintain due to the relentless outpour of resources in one direction – something known as 'humbug'.

The role of the supervisor and workplace is to ensure that Aboriginal and Torres Strait Islander workers are adequately supported to meet these obligations whilst balancing responsibilities at work and to provide strategies to minimise unnecessary stress and burden associated with 'humbug'.

YARNING ABOUT CULTURAL RESPONSIBILITY

SERVICE ACTIVITY	CD
ACTION/S	AR

Context

QUESTION 1: What is your relationship with the community?

- I was born here and/or grew up here
- I am related through both family and kinship
- I am related through kinship only
- I have cultural obligations here
- I have cultural obligations on other communities
- I am here for work only

Responsibilities

QUESTION 2: I would rate my current level of cultural obligation/responsibility as:
(Circle a box between 1 and 10)

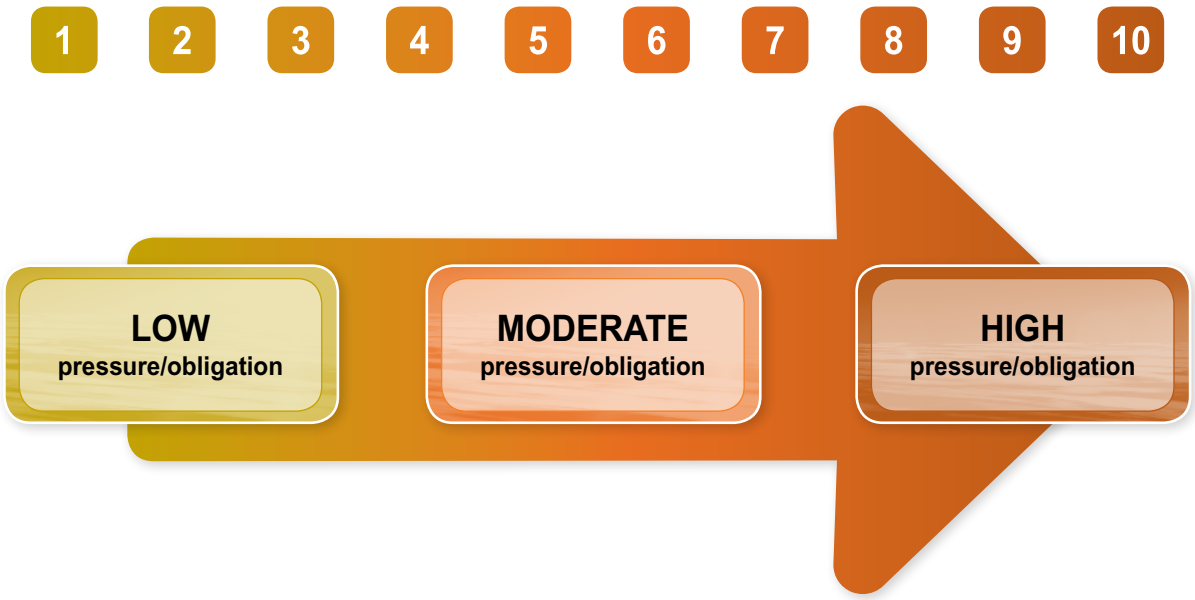


Figure 2.4 **Cultural Responsibilities**

LOW: My cultural obligations are for myself and my immediate family only. I do not take day-to-day or regular responsibility for extended or kinship family. I am obligated only to attend whole-of-community events e.g. funerals. I do not have any avoidance or 'poison' relationships. Other events I may attend on a voluntarily basis e.g. sport weekends. Saying 'no' or my lack of attendance at these events would **not** upset, offend or cause trouble for me and my family.

MODERATE: I have cultural obligations for myself and my immediate family and a moderate level of responsibility and obligation toward my extended or kinship family. There are 1 to 2 people on the community I have avoidance or 'poison' relationships with. I am obligated to attend both whole-of-community events e.g. funerals and also family specific activities e.g. sorry camp, ceremonies, meetings about my family's traditional land. Other events I may attend on a voluntarily basis e.g. sport weekends, but I still have a strong sense of obligation to these. Saying 'no' or my lack of attendance at these events would **moderately** upset, offend and cause trouble for me and my family.

HIGH: I have cultural obligations for myself and my immediate family, and a high level of responsibility and obligation toward extended and kinship family or a large portion of the community. I take a leadership role in law, culture and ceremony. There are 2 to 5+ people on the community I have avoidance or 'poison' relationships with. I am obligated to attend or lead whole-of-community events e.g. community meetings, funerals and sport weekends. It is a community expectation that I attend all community-related activities and events. Saying 'no' or my lack of attendance at these events would **highly** upset, offend and cause trouble for me and my family.

QUESTION 3: What are your main responsibilities or obligations?

- Time - (giving my personal or work time for people)
- Money - (paying for things, giving money away)
- Care or guardianship - (looking after kids or adults)
- Home and/or personal belongings - (sharing my house and things)
- Cultural knowledge or leadership - (law and culture, community leadership)
- Other _____

QUESTION 4: I have little or no control over these obligations:

- Sorry business and funerals
- Cultural meetings/events
- Sport weekends
- Use of my vehicle
- Money humbug
- Court hearings
- Other _____

QUESTION 5: I have some or a lot of control over these obligations:

- General money humbug
- Town visits
- Shopping
- Hunting or bush trips
- Appointments
- Family trips
- Other _____

Stress and worry

QUESTION 6: How much do you worry or stress about your current cultural responsibilities and obligations?

LITTLE BIT: I do not stress or worry too much about my cultural obligations. It affects my wellbeing and my ability to attend work and do my job only a **little bit**.

HALF: I sometimes stress or worry about my cultural obligations. It sometimes affects my wellbeing and my ability to attend work and to do my job about **half**.

BIG MOB: I always or often stress or worry about my cultural obligations. I cannot say 'no' very often as it upsets or offends my family. It affects my wellbeing and my ability to attend and to do my job **a lot**.

Figure 2.5

Concerns and Issues

QUESTION 7: How do your responsibilities and/or humbug affect you? (Tick the boxes)

- ☐ Trouble sleeping
- ☐ Stressed, tense or anxious
- No money for:
  - ☐ fuel
  - ☐ food
  - ☐ bills
  - ☐ clothes
- ☐ Need time off work
- ☐ Messy house from visitors
- ☐ Too many people at home
- ☐ Problems with partner
- ☐ Tired, worn out
- ☐ Sick or poor health
- ☐ Eating too much rubbish food
- ☐ Kids not getting to school
- ☐ Car needs fixing
- ☐ Always have to say no to family
- ☐ House needs fixing
- ☐ Fighting and arguing
- ☐ Can't focus at work
- ☐ Weight increase
- ☐ Smoking more

Other_____

QUESTION 8: What are the main concerns?

FOR WORKER	FOR SUPERVISOR

Actions

QUESTION 9: What actions can we put in place?

For example:

- establish trust and open communication between worker and supervisor
- approve and support appropriate leave
- take into consideration busy cultural times of the year when planning and programming
- be more flexible with work hours
- meet with family, community members to raise concerns from workplace perspective

WORKER	SUPERVISOR

SOME USEFUL TIPS TO AVOID OR MINIMISE 'HUMBUG'

SERVICE ACTIVITY	CD
ACTION/S	AR

Useful reminders

- As an AOD Worker and community member, your first and foremost priority should be on your own health & wellbeing. You can only provide high quality support to others when you feel healthy physically and emotionally.
- Learn to recognise your individual warning signs – stress, anxiety, pressure and worry.
- Be honest with your supervisor when *Yarning about Work* – he/she is there to support!
- Remember it's ok to say No! Indigenous culture is about *shared-responsibility*, so don't be afraid to say 'no' or refuse to help someone if you feel their request is emotionally manipulative (e.g. making you feel culturally guilty), unreasonable, unwarranted or not motivated by genuine need.

Work-related

- Use work or your supervisor as an excuse not to provide family with work-related resources, for example:
  - "my boss will get upset/angry with me"
  - "I can't use the work car on weekends"
  - "fuel we use will come out of my pay cheque"
  - "the car is due for a service"
  - "I don't have any more spare tyres"
  - "I don't keep the office/workplace key at home or when I'm on leave"
  - "I can't carry a firearm in the work car, I could get fined or lose my job"

Cigarettes, alcohol or drugs

- Use 'I' statements and language of concern when people ask you to buy them cigarettes, alcohol or drugs, for example:
  - "I'm worried about you getting sick again"
  - "I can't buy grog/drugs because I'm worried about losing my job"
  - "I feel crook today, so can't go drinking with you"
  - "the doctor said my medication won't mix well with alcohol"
  - "You mob have footy competition soon, so don't ruin our chances of winning this year by drinking/smoking too much again"
  - "I respect you by NOT buying you grog/smokes/gunja, because I want you to live healthy and strong – that's real respect you know"

Money

- Try not to carry spare change (or 'silvers'), notes or your key card around with you unless you are going specifically to the shops to buy something in mind
- Carry an empty wallet with you to show people that you are actually 'out of cash'
- Try to keep loose change in a safe, secure place at home or elsewhere – not in the car, at the office, or where people can access it easily (including kids)
- Try to avoid giving out cash wherever possible - offer to buy food, groceries or goods and pay for bills yourself directly e.g. car registration, electricity etc.
- Carry with you an old bank statement (mini statement) with a low balance figure – and show people who ask for money
- Avoid bragging or letting others know when you are being paid or receiving payments
- Respectfully, use accountability language, for example:
  - "Last time you promised me it wasn't for grog – now you want me to trust you again"?
  - "I didn't have enough money for the kids' food last time I gave you"

Now it's your turn

What other tips can you think of that would work for you?

_____

_____

_____

_____

_____

_____

_____

TOOLS & ACTIVITIES TO SUPPORT COMMUNITY DEVELOPMENT PRACTICES

SERVICE ACTIVITY	CD			
ACTION/S	NL	GI	CPA	AR

Refer to page 35 for key action areas.

GATHERING INFORMATION CHECKLIST

SERVICE ACTIVITY	CD
ACTION/S	GI

	YES	NOT YET
1. **Have you collected stories about the impact of AOD in the community?**		
a. Cannabis?		
b. Sniffing?		
c. Grog?		
d. Other drugs?		
2. **Have you put the right date it was recorded?**		
3. **Have you asked for permission to record the stories? Why?**		
a. For protection or safety of those involved		
b. For cultural acknowledgement		
c. For privacy/confidentiality		
4. **Have you asked permission to use names (where appropriate)?**		
a. Of individuals		
b. Of family groups		
c. Of organisations		
d. Of the community or surrounds e.g. places, community names, venues, residential camps/houses, buildings		

	YES	NOT YET
5. **How did you collect the stories?**		
a. Spoke with community members		
i. Elders		
ii. Families		
iii. Individuals		
iv. Workers		
v. NT Police		
vi. School/teacher/principal		
vii. Health practitioners		
viii. Other		
b. From other sources		
i. Local research		
ii. Letter		
iii. Reports or other papers		
iv. Client notes or records		
6. **How did you record the stories?**		
a. Told by community member and wrote the story down		
b. Written on paper, email or computer		
c. Recorded on device – e.g. camera, phone, mp3, video, voice recorder		
d. Client notes or records		
e. Other		
7. **Have you verified that the stories are true and accurate?**		

Table 1.6

YARNING ABOUT YOUR COMMUNITY

SERVICE ACTIVITY	CD
ACTION/S	GI

1. **How, why and when was your community established?**

2. **What is the name of the traditional custodians of the land where you are?**

3. **What language(s) did/do they speak?**

4. **Where did/do their lands extend?**

5. **Who are/were the neighbouring peoples?**

6. **Are any Indigenous words used to name local features – geographical features, streets, areas, organisations? What do they mean or refer to? Who can you ask about these features?**

7. **In your area, what are the main historical events associated with the arrival of non-Indigenous peoples?**

8. **What are the main local Indigenous organisations? What have they been set-up for? What are their main issues or concerns currently?**

9. **Can you think of 6 nationally historically important people? What made them significant?**

10. **Who are some prominent local Indigenous people? What are their roles?**

11. **Are there local Indigenous painters, artists, dancers or musicians? Where are they and where could you see their work?**

12. **In addition to sportspeople, can you name 10 well-known contemporary Indigenous people? What are they known for?**

13. **Who designed the Aboriginal[12] flag and when? What is the significance of its features?**

14. **What does the Torres Strait Islander flag look like? What are it's features intended to capture? Who designed it?**

12 Refer to appendices for information on ATSI flags

NETWORKING & LINKING CHECKLIST

SERVICE ACTIVITY	CD
ACTION/S	NL

Have you:	YES	NOT YET
1. **Attended a local cultural induction or awareness program?**		
2. **Met with key mob related to AOD services?**		
3. **Met with community elders/leaders?**		
4. **Developed a resource guide?**		
5. **Developed a contact and email list?**		
6. **Organised a meeting between key stakeholders?**		
7. **Developed a community network or planning group?**		
8. **Supported mob to meet, share ideas and participate?**		
9. **Attended network meetings?**		
10. **Let mob know of meetings? How?**		
a. Newsletters		
b. Flyers/posters		
c. Reports		
d. Announcements		
e. Word of mouth		
11. **Recorded meeting outcomes? How?**		
a. Minutes		
b. Actions		
12. **Supported the group to observe and reflect? How?**		
a. Individual yarns		
b. Feedback		
c. Group yarns		
13. **Supported the group to plan and act?**		
a. Is a plan in place?		
14. **Recorded the activities, including:**		
a. Who was involved?		
b. How many people were involved?		
c. What happened?		
d. The outcome/s?		

Table 1.7

Name: **Health Centre:** **Date of activity:**

Name of Project/ Activity		TICK			TICK
(WHY) are you planning this project or activity?	AOD concerns Cannabis		**(WHAT) do you want to achieve?**	Diversion activity	
	Sniffing			1.Culture	
	Alcohol			2.Sport	
	Tobacco			3.Music	
	Health concerns			4.Health	
	Community initiative			5. Bush/community trip	
	Request for service			General education	
	General education/awareness raising			Increased awareness	
	Training workshop			Other:	
	Event				
	Other reasons?				
(WHO) is the target group?	School students		**(WHERE) will the activity or project happen?**	Meeting room	
	Young males/men			Conference	
	Young females/women			Outstation	
	Adult men			School	
	Adult women			Community based	
	Elders			Bush trip	
	Mixed group			Clinic	
	Health professionals			Other:	
	Other:				
	How many people?				

Table 1.8 A

PARTNERS Who is working with you on this project or activity?	1.	**COSTS**	**BUDGET: HOW MUCH WILL IT COST?**
		Fuel	
	2.	Food and catering	
		Advertising	
	3.	Education resources	
		Staff payments	
	4.	Other costs	
	5.		
		$ TOTAL	

JOB LIST What jobs need to be done? e.g. approvals, organise car, send out flyers, buy food and camping gear.	1.	5.
	2.	6.
	3.	7.
	4.	8.

REFLECT How will you know how it went?		**TICK**	**SHARE How will you yarn about it?**		**TICK**
	Evaluation			Photos or video	
	Survey			Newsletter	
	Participant stories/feedback			Monthly Report to Remote AOD Workforce Program	
	Other?			Teleconference / Phone / Forum (circle)	

Table 1.8 B

REFLECTION TIME

SERVICE ACTIVITY	CD
ACTION/S	AR

General Questions

What are the most rewarding or great things about being an AOD Worker?

What are the most challenging things about being an AOD Worker?

How would you rate your passion, enthusiasm and energy for your job?

For example: **LOW** – Mostly low but sometimes high
AVERAGE – High most of the time
GREAT – The BEST!

Why did you give it this rating?

Aboriginal and Torres Strait Islander workers

What are the most rewarding or great things about being an Indigenous person and an AOD Worker?

Do you find it easier or harder being both Indigenous and an AOD Worker? Why?

Who do you find are the most difficult people/organisations/groups to work with? Why? How do you overcome these difficulties?

How does your cultural identity empower you to educate and promote good health in your role as a worker?

Specific questions (all workers)

REFLECTING ON…

INFLUENCE: Consider your leadership as an AOD Worker and community member for a moment. How would you describe your style of leadership in a few words? What leadership styles do you see on your community and are they effective?

VALUES: What are four of your values? List them. How do you show these values in the work that you do?

LEARNING: Have you ever made a really bad 'screw-up' in your job or on the community? What was it and did you learn from the experience?

PARTNERSHIPS: How important are partnerships (i.e. working together with people) to you in your job? When has a partnership worked really well? When has a partnership not worked well?

CULTURE: Describe in a few sentences, what your culture is. Consider things like your heritage, upbringing, traditions, way of life, values, your neighbourhood/community, family and religious beliefs. What are the strengths of your culture that you bring to the Workforce? What are the limitations of your culture that may impact upon the work that you do as an AOD Worker?

PEOPLE: Think of an instance where community people were either really happy or unsatisfied with a program or event that you delivered or organised. How did they show how they felt? How did you respond and how did it make you feel?

ACCOUNTABILITY: Have you ever had to make a decision or speak up even though you knew others (on the community or otherwise) wouldn't agree or support you? Why? How did you communicate how you felt? What was the outcome? Could you have done anything differently?

SPIRITUALITY: What does spirituality mean to you? What is the source of your spirituality? Does your spirituality impact on your life in relation to your values/beliefs, understanding of self, community and wellbeing? How does your spirituality impact on the spirituality or lives of others?

PRIVILEGE: Privilege refers to a variety of situations which disproportionately benefit certain people groups; it ranges from being in control of the economic and political system to more simple forms such as being able to buy certain products e.g. bandaids and cosmetics available for certain people and watching television programs or books/magazines representative of majorities (adapted from Macintosh, 1992; Tannoch-Bland, 1998).

EXAMPLE EXERCISE: reflect on your position of privilege – tick which apply:

POSITION OF PRIVILEGE	YES	NO
I can be reasonably confident that in most workplaces my ethnic group will be in the 'majority' and I won't feel isolated as the only, often token, member of my people group.		
When I am told about Australian history or about civilisation, I am shown that people of my colour/people group made it what it is.		
I can send my children to school with unironed or dirty uniforms without it reflecting on their people group.		
I can dress down, get drunk in public or be unemployed without reinforcing negative stereotypes about my people group.		
When I speak in public, my people group is not on trial.		
When I'm late, my lateness isn't seen as a reflection of my people group.		
When I win a job, scholarship or promotion, I am not suspected of doing so because of my people group rather than my merit.		
When I seek legal, medical or financial help, my people group doesn't work against me.		
I expect that my neighbours will be neutral or friendly to me.		
From among my own people group, I can choose from a wide range of professional role models.		

Table 1.9

CROSS-CULTURAL EXPERIENCE: Recall a time when you had an experience in a cross-cultural setting, other than what you were used to. What was the situation? How did you feel, act or behave? What were the challenges that you faced in that situation? What strategies did you use to help you to adjust to the different culture? What skills did you learn as a result?

CONFLICT RESOLUTION: Reflect on a time when you were involved in a conflict situation with another person or group. What were the reasons/factors that led to the conflict or disagreement? How did the conflict end? Was it resolved well for both parties (e.g. win/win) or not? What could you have done differently?

DISCRIMINATION/PREJUDICE: Have you ever experienced a situation involving discrimination against you or another person close to you? (consider things like ethnicity, gender, disability, age, social/economic status) What was the situation? How did it make you feel? What do you think were the reasons behind it? How did you respond?

SPIDERGRAM

SERVICE ACTIVITY	CD
ACTION/S	CPA

Where are we at?

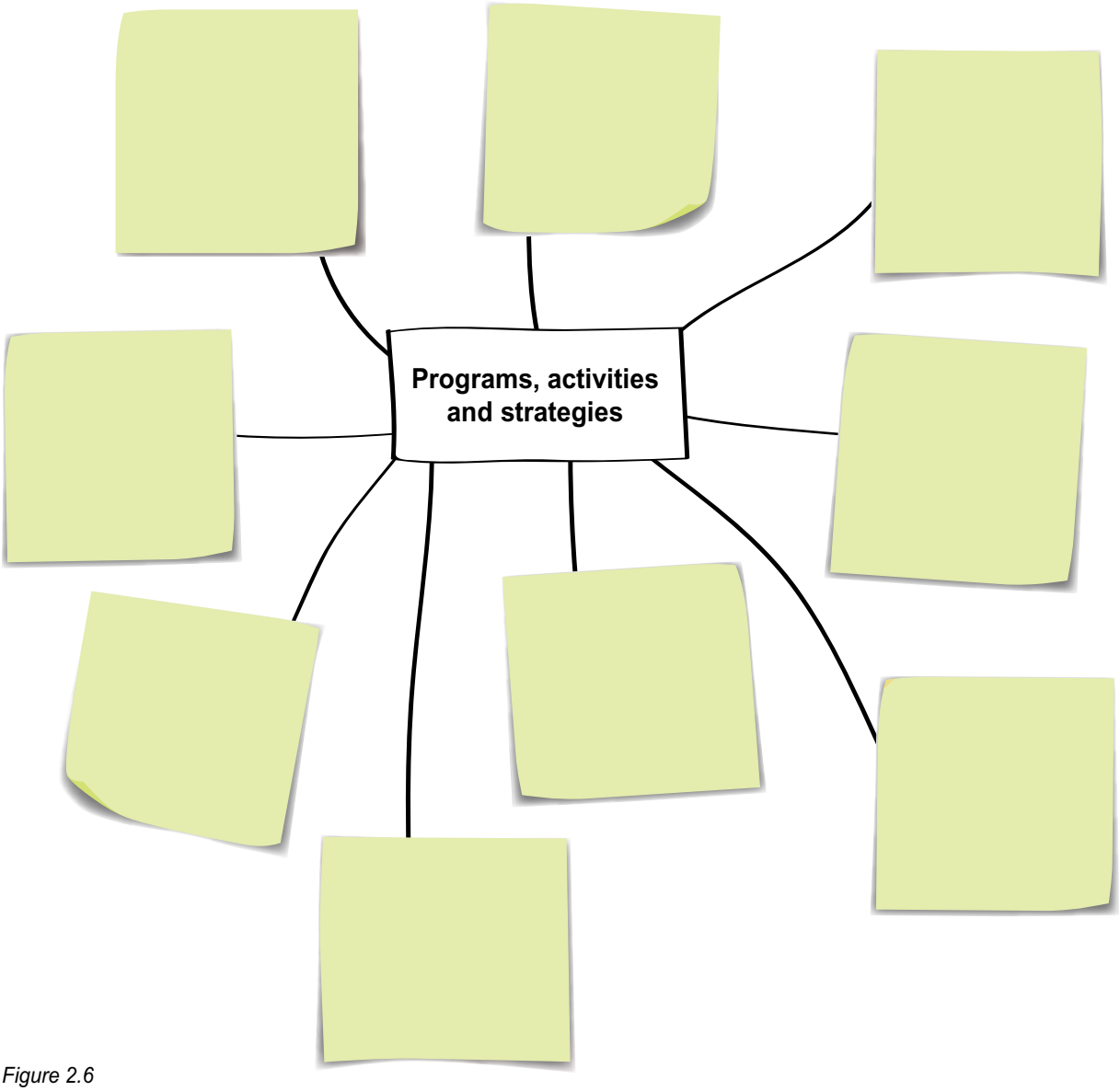


Figure 2.6

1. Create a community development spidergram for your work program or organisation.

a. What things are you doing well?

b. What are the key aspects of your program?

c. Headings could be: 'partnerships', 'resources', 'young people', 'cultural activities (including camps/bush trips)', 'community events', 'governance', 'clinical practice', 'men/women's program', 'celebrations', and 'professional learning'.

AOD AND YOUTH

SERVICE ACTIVITY	CD
ACTION/S	CPA

National Principles for School Drug Education

The following 12 principles were published in 2004 by the Australian Government and support AOD Workers, teachers and schools to plan, develop and implement strategies and curriculum programs that effectively prevent and minimise the impacts of drug use/misuse issues on school communities. Further detailed information (including posters) of the Principles for School Drug Education can be found at: http://www.det.nt.gov.au/students/support-assistance/safety-wellbeing/health

Comprehensive and evidence-based practice

Principle 1: School practice based in evidence
Principle 2: A whole school approach
Principle 3: Clear educational outcomes

Positive school climate and relationships

Principle 4: Safe and supportive environment
Principle 5: Positive and collaborative relationships

Targeted to needs and context

Principle 6: Culturally appropriate an targeted drug education
Principle 7: Recognition of risk and protective factors
Principle 8: Consistent policy and practice

Effective pedagogy

Principle 9: Timely programs within a curriculum framework
Principle 10: Programs delivered by teachers
Principle 11: Interactive strategies and skills development
Principle 12: Credible and meaningful learning activities

Evidence-based messages for remote AOD Workers and young people[13]

The following messages act as an effective guide for AOD Workers on how to communicate and/or present education lessons in a practical sense to young people around substance use/misuse issues. They should be referred to particularly if you are value-adding to an already existing Drug Education and Wellbeing program in a school setting or supporting teachers to do so. This will ensure that the appropriate message will be presented to students and is consistent with evidence based research.

Message 1: Knowledge is not enough.

Having accurate knowledge about drugs and their effects is important but it is not enough to keep young people from taking risks with drugs. Make sure you look at the pressures and influences that can affect a young person's decisions and give them opportunities to plan and develop the skills they need to help them handle different decisions and pressures.

Message 2: Provide accurate information.

Research shows that young people want accurate information in relation to drugs. Sometimes scare tactics, which aim to highlight the dangers associated with an activity, can also make the activity seem more attractive – a way to rebel or add excitement to life. Accurate information is essential and will lead young people to think through their choices.

Message 3: Watch you don't normalise or glamorise risky behaviours.

It is important not to create the impression that most young people use drugs. This can happen if we talk about drug use as if we assume everyone is doing it. This false assumption can pressure students to take up such activities in order to fit what they believe is normal. Examine the NT statistics – particularly those relating to 'regular use'. They show that 80% of 12 year olds and 60% of students overall had never smoked cigarettes. Up to 93% of 12 year old girls are most likely to be non-drinkers or have just 'a few sips' and 12% overall have never had even part of an alcoholic drink[1]. Similarly, the vast majority of Australians have never used an illicit drug.[2] If students are involved in a role-play or drama, avoid portraying the risk-taking characters as more glamorous or interesting. Using ex-users as guest speakers can also glamorise high-risk behavior by sending an inadvertent message in their testimonial – 'I took all those risks, but look – I survived, and now warrant special attention.'

13 Adapted from Leading Education about Drugs (LEAD), published by the Australian Government Department of Education, Science and Training, 2006: http://www.dest.gov.au/NR/rdonlyres/2F26D2C1-2BD4-48CC-A3CD-18526031F2C7/12249/LEADinfobook22May06forwebsite1.pdf

Message 4: Think about safety.

Young people need to be asked what the risks or harms of certain behavior may be, e.g. binge drinking or 'drinking to get drunk' and think about and plan for how to best make safe choices.

Message 5: Strategies have to match the person and the circumstances.

It is important to develop the skills and strategies needed to both prevent and reduce harm that has occurred as a result of someone's drug use behavior. When developing strategies it is best to attune them to the circumstances, people and contexts that are likely to occur.

Message 6: Interactive strategies work best.

It is best to use activities that actively engage and involve young people. They need to be mixing, talking, thinking and enjoying themselves!

Message 7: Tailor the program to suit the needs and interests of the target audience.

Choose activities that are suitable for the age group of the students, being sensitive to cultural and religious beliefs in the community.

COMMUNITY ENGAGEMENT

SERVICE ACTIVITY	CD
ACTION/S	NL

Tips to engaging with the community

1. Get involved!

Try to get involved with community activities in order to connect with community members of all ages, even if this means trying something new.

Some examples include:

- join a local sport team e.g. football or softball
- attend local events like sport weekends, cultural celebrations, music festivals
- start a music band or 'jam' session with local musicians
- attend language or cultural classes
- start a local activity group e.g. walking/jogging group, mens/womens group, dads/mums group or youth group

2. Get to know your community!

Complete the Yarning About Your Community activity by getting around the community and finding out the relevant information from people. If done respectfully, most community members enjoy sharing the history of their community and pointing out key features that make them feel proud to be a part of it.

3. Learn the names of people, places and things!

Don't underestimate the power of learning key words (in language or English) that make the community unique. This could be peoples' names or local language words for different types of food/ bush tucker or even key geographical features e.g. local mountain or a rock hole.

4. Get out of your comfort zone!

Don't be afraid to put yourself in a position that takes you out of your comfort zone. This could mean trying new food/s, working different hours, learning a new language or even sitting in the dirt yarning with people. Trust the people on the community to look after you and don't be afraid to make mistakes or look like a cultural novice – modelling trust and humility often results in the same being offered in return.

5. Communicate your intentions!

Community members often wonder what the intentions and motivations of workers are. Don't be afraid to be honest and share your hopes, dreams and visions for your program or initiative – how can you win the community over if they don't know what it is you want to achieve and their critical role in helping to guide its success?

6. Always follow through on your word!

When communicating with community members remember that words without action are meaningless and you should never make promises you can't keep. Even though it may be extremely difficult at times to say no, it is often far better to do so than to say yes and not follow through. This could be as simple as offering someone a ride to town or saying yes to borrowing/lending money or making a promise to a young person that they could use your guitar or instrument.

7. Listen twice as much as you speak!

Attentive and quiet listening often takes far more skill than speaking and it is also far more respectful. Put the effort into listening to community members before offering advice, guidance or your perspective on the situation. Show that you also comprehend what they're saying by reflecting back what they've shared when you do speak – and don't be afraid to receive correction if you misinterpreted or misunderstood anything. In time, they will respect your words twice as much if they know that you know how to listen.

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APPENDICES

Use of term 'people group' instead of *race:*

The term 'race' has deliberately been omitted for the following reasons –

All human beings in the world today are classified as *Homo sapiens sapiens*. Scientifically, increasing research is confirming that, biologically, there really is only one race of humans. For instance, a scientist at the Advancement of Science Convention in Atlanta stated, *"Race is a social construct derived mainly from perceptions conditioned by events of recorded history, and it has no basic biological reality* (and) *curiously enough, the idea comes very close to being of American manufacture."*[14]

Reporting on research conducted on the concept of race, ABC News (USA) stated, *"More and more scientists find that the differences that set us apart are cultural, not racial. Some even say that the word race should be abandoned because it's meaningless."* The article went on to say that *"we accept the idea of race because it's a convenient way of putting people into broad categories, frequently to suppress them—the most hideous example was provided by Hitler's Germany. And racial prejudice remains common throughout the world."*[15]

In an article in the Journal of Counselling and Development[16] researchers argued that the term "race" is basically so meaningless that it should be discarded. In the field of genetics, researchers have concluded that the genetic differences between the co-called races account for only *0.012*% of biological variation. More recently, those working on mapping the human genome announced "that they had put together a draft of the entire sequence of the human genome, and the researchers had unanimously declared, there is only one race—the human race."[17]

The Aboriginal Flag

The Aboriginal flag was designed in 1971 by Harold Thomas, a Luritja man from Central Australia.

The flag is divided horizontally into equal halves of black (top) and red (bottom), with a yellow circle in the centre. The black represents the Aboriginal people – past (ancestors who were the first inhabitants of Australia), present and future. The yellow represents the sun, the giver of life and of light and warmth. The red represents the Created Earth from whom all life and spirituality have come.

The flag unifies Aboriginal people all across Australia.

14 Hotz, R.L., Race has no basis in biology, researchers say, Cincinnati Enquirer, p. A3, February 20, 1997.
15 We're all the same, ABC News, September 10, 1998, www.abcnews.com/sections/science/DyeHard/dye72.html.
16 Cameron and S.M. Wycoff., (1998). The destructive nature of the term race: growing beyond a false paradigm, Journal of Counselling & Development, 76: pages 277–285.
17 Angier, N., (2000), Do races differ? Not really, DNA shows, New York Times.

The Torres Strait Islander Flag

The Torres Strait Islander flag was designed by 15 year-old Bernard Namok of Thursday Island and accepted by the Island Co-ordinating Council on behalf of all Torres Strait Islander people. The flag was flown at the Torres Strait Cultural Festival at Thursday Island in May 1992.

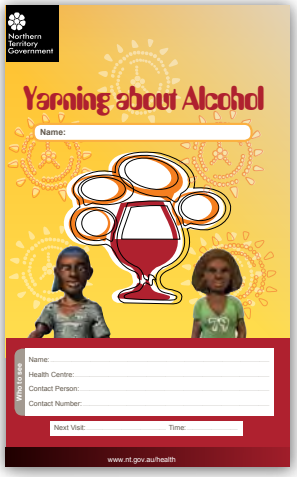
The environment, and its relationship to the masses of land to the north and south of the Torres Strait, is reflected in the design, together with the history and cultures of the Torres Strait Islander peoples.

The green upper and lower panels represent the land. The blue panel represents the waters of the Torres Strait. The black lines and the white feathered *dhari* (headdress) represent the Indigenous people of the Torres Strait. The white of the star represents peace. The five divisions of the Torres Strait region are depicted in the five-pointed star: Eastern Islands; Western Islands; Central Islands; Waibene (Thursday Island), Nurapai (Horn Island), Muralag (Prince of Wales Island), Kirrir (Hammond Island); and Northern Peninsula Area, mainland Torres Strait Islanders.

USEFUL RESOURCES

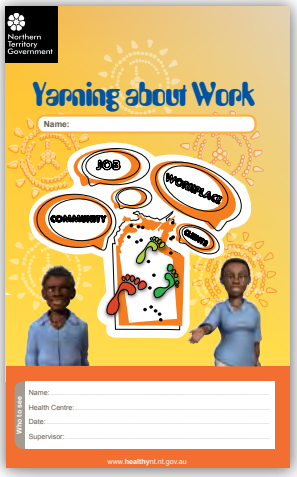
Remote Alcohol & Other Drugs Workforce Program Resources

The NT Remote AOD Workforce has a number of resources created for use by AOD Workers for direct family and client delivery and for worker support and supervision. Soon to be released are *Yarning about Wellbeing, Yarning about Alcohol & Pregnancy, Yarning about Sniffing* and *Yarning about Smoking*. Menzies School of Health Research have also produced resources *Yarning about Mental Health* and *Yarning about Sadness* (for enquiries contact info@menzies.edu.au). The Workforce has produced dvds, *Yarning about Gunja on Groote Eylandt* and *Yarning about Remote AOD Work* with Remote AOD Worker Bruce Wurrawilya. For more information or copies of the Remote Alcohol & Other Drugs Workforce Program resources contact the Remote AOD Workforce Program on (08) 8951 7808. Resources can also be accessed and viewed on the Remote AOD Workforce Program website: www.remoteaod.com.au

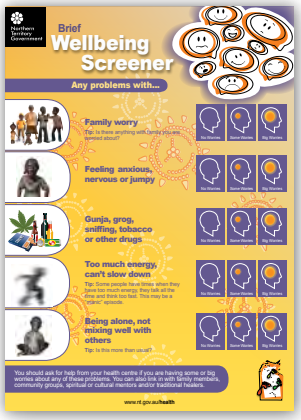


A resource using Audit C to measure alcohol withdrawal and dependence scale in a strengths-based framework

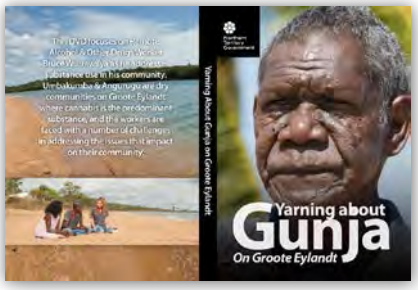
A resource using Motivational Interviewing and Severity of Dependence Scale in a strengths-based framework



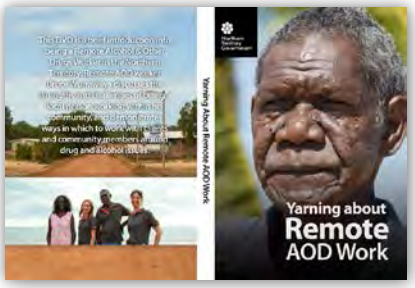
A resource exploring worker wellbeing and reflection on work in a strengths-based framework for clinical supervision



A resource designed to assess mental health issues quickly and easily, questions coming from Menzies School of Health Research's *Yarning about Mental Health.*



This dvd is a explores the impact of cannabis in the remote communities of Angurugu and Umbakumba on Groote and Bickerton Islands in the Northern Territory.



This dvd is a brief introduction into being an AOD Worker on remote communities in the Northern Territory.

Aboriginal Interpreter Service (AIS)
www.dlghs.nt.gov.au/ais

Northern Territory Department of Local Government and Housing Central booking service 08 8999 8353. AIS helps to alleviate the language barriers faced by Indigenous people throughout the Northern Territory, particularly in relation to health and legal issues. The service was established in April 2000 and maintains and uses a register of Aboriginal interpreters and languages in the Northern Territory. It provides a service for government and non-government agencies that require on-site Aboriginal language interpreters. The AIS provides a 24 hour seven day a week central booking service.

Clients must provide the following information when booking an interpreter:

- name of the organisation/section requesting service
- name, skin name, age and gender of Aboriginal person requiring service
- name, age and gender of Aboriginal person seeking service
- language required (AIS can assist with determining the correct language)
- location, date and time the service is needed
- topic of assignment.

Bookings need to allow time for travel and accommodation arrangements to be made. Fees apply, however, the Northern Territory Government has allocated additional funding to the AIS to enable non-government organisations to access the service at no cost to the organisation.

Surviving the Day to Day Hassles: A Self-Care Guide for Remote Health Workers
Council of Remote Area Nurses of Australia, 2000.

Surviving Stress with Self-Care: A Guide for Remote Health Workers & Their Families
Council of Remote Area Nurses of Australia, 2000.

These texts are guides for health practitioners going to work in remote areas. They can be ordered at www.crana.org.au

Remote Area Health Corps (RAHC) Cultural Orientation Handbook
Remote Area Health Corps, 2009.

This handbook provides further detailed information into the cultural issues that health practitioners will encounter as they live and work on Aboriginal communities in the NT. It is a very practical and useful guide including cultural information not normally easily attained by new people to the NT.

Binan Goonj: bridging cultures in aboriginal health (2nd edition)
Eckermann A, Dowd T, Martin M, Nixon L, Gray R and Chong E, 2005.

Binan Goonj means 'hearing but not listening'. This text provides a comprehensive introduction to the historical and socio-political context of Aboriginal health, and continuing Indigenous disadvantage and marginalisation. The book is primarily aimed at non-Indigenous health care providers. It can be purchased by contacting the Council of Remote Area Nurses of Australia on 08 8959 1111 or from www.crana.org.au

Bush Crisis Line
1800 805 391 (free call)

A 24-hour confidential telephone debriefing and support for multi-disciplinary rural and remote health practitioners and their families.

Central Australian Rural Practitioners Association
www.carpa.org.au

PO Box 8143
Alice Springs NT 0871
Ph: 08 8951 4700
Fax: 08 8951 4777

Publications include:
- *CARPA standard treatment manual* (4th edition)
- *The medicines book for Aboriginal health workers*
- *The CARPA manual reference book*
- CARPA newsletter.

Keeping Company—an intercultural conversation (2nd edition)
Franks C and Curr B, 2007.

This text was written in partnership with traditional Aboriginal authors from Central Australia. It explores the structure and complexity of the Aboriginal kinship network and protocols, and the concept of true reconciliation. It can be ordered from:
Spencer Gulf Rural Health School
Ph. 08 8647 6036
Fax. 08 8647 6164.

Murri Way! Aborigines and Torres Strait Islanders reconstruct social welfare practice
Lynn R, Thorpe R and Miles D, 1998.

This report details findings from a research project into Aboriginal and Torres Strait Islander helping in a social welfare context.

The Public Health Bush Book

Northern Territory Department of Health and Community Services
PO Box 40596
Casuarina NT 0811
Ph: 08 8985 8019
Fax: 08 8985 8016

The public health bush book is a valuable resource of two volumes for those who work in remote Aboriginal communities in the Northern Territory. It is written by those who have worked in and with remote community health care teams. The book can be ordered in hard copy, or downloaded from: www.health.nt.gov.au/Health_Promotion/Bush_Book/index.aspx

Power, Participation and Partnerships for Health Promotion

LaBonte, R. (1997). Melbourne, Victorian Health Promotion Foundation. Online: www.vichealth.vic.gov.au/Content.aspx?topicID=368

Principles for Better Practice in Aboriginal Health Promotion

NSW Health, (2002). The Sydney Consensus Statement Online: www.health.nsw.gov.au/pubs/2004/pdf/principles_aboriginal.pdf

For more copies of this Remote AOD Workforce Program Community Development Framework, contact the Remote AOD Workforce Program on 0439 184 398, or visit remoteaod.com.au

i 2005 Australian School Students Alcohol and Drug Survey, NT Results.
ii 2010 National Drug Strategy Household Survey.