



Victorian Dual Diagnosis Initiative Education and Training Unit

Auspiced by St. Vincent's Hospital



OUR HEALING WAYS

Successful strategies for working with dual diagnosis issues

Aboriginal way



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Developed by the Victorian Dual Diagnosis Initiative

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The Artwork:

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The Story

This story represents the Aboriginal Dual Diagnosis Project. The green circles represent the training and workers coming together and linking up with the opportunity. The figures floating around are those experiencing both mental health and drug and alcohol issues. The darkness in the circle represents the struggle they experience. The workers are gathered around the darkness trying to connect them back into their communities. The community is the yellow houses and although they struggle to support their people with both these issues they don't want to lose connection. People are waiting for those they care for to come back and be supported by their communities with the help of the trained workers.



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To the participants

We thank you for your time and the sharing of your stories. We simply cannot do justice to the richness of the experiences you shared with us in one report. The information we have gathered through your interviews will continue to be used to develop culturally appropriate resources and training. Your stories of success have contributed to the validation of the holistic, practical and client focused approach used by Aboriginal workers to enable clients to heal.

To our Cultural Consultants

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EXECUTIVE SUMMARY

Aim

The aim of this research was to gather evidence from experienced Aboriginal workers on successful strategies for working with clients with co-existing mental health and alcohol and drug issues. The purpose was to develop resources to enable Aboriginal workers to further build their capacity to provide effective healing strategies to their community from an Indigenous perspective.

Rational

Evidence of good practice for Aboriginal workers working with community members experiencing a dual diagnosis is limited and even further so from a culturally based perspective. This has meant that a Western model of evidence based practice is often imposed upon Aboriginal workers without an acknowledgement of the very different context in which these workers function. The risk of this is that Aboriginal workers are then judged based on Western understandings therefore denying their reality, context and world view.

Method

This was an exploratory, qualitative research study with a strengths based approach. Through semi-structured interviews “Our Healing Ways” identifies strategies, skills and qualities used by experienced Aboriginal Alcohol and Drug, Mental Health and Social and Emotional Wellbeing workers throughout the therapeutic process.

Ten senior Aboriginal workers were interviewed from around the state of Victoria and were asked four key questions in relation to; how they engaged clients, what they did to continue to build the relationship, strategies they used to enable people to heal and finally how they ended that episode. The interviews were recorded and later transcribed. Saturation was reached by the tenth interview and an Interpretative Phenomenological Analysis was chosen as the process to draw the most information from the data.

Results and discussion

The analysis of the data revealed a complex context that Aboriginal workers are required to manage in order to work effectively with complex presentations. Working with community members meant that workers often had dual relationships with their clients and had to care for both the professional and the personal relationship. Relationships often developed organically as being part of the community and knowing most clients meant that the working relationship was often an extension of an existing one. Meetings were likely to occur in a non-clinical environment out in the community or through a home visit. Participants identified strategies such as creating a safe and comfortable environment, listening to people’s story, having a



holistic approach and allowing clients to determine the focus of treatment as core strategies for engaging clients.

The professional relationship continued to develop through a cultural attitude of giving the time that was needed for the client to tell their story, listening deeply, being reliable, trustworthy and client focused. It was important to be honest and open “straight up” with clients and set boundaries. Throughout the interviews participants reinforced the importance of being dependable and practical.

Participants spoke of both an approach to enabling healing and successful strategies. The approach was client focused, holistic and strengths based. Strategies for enabling healing included; supporting clients to stabilize, making access to care easier and assessing needs within a holistic framework. Central to a strengths based approach was building the clients self-reliance, dignity and pride and working towards their identified goals. Information was provided according to the needs of each client and their family. It needed to be focused and matched to the client’s need in a medium they were able to comprehend.

Ending the episode of care was again an organic process and client directed. The relationship rarely ended due to an “open door” policy and the importance of being available for any relapse prevention. Participants also stated that even if the clients file was closed they would still see that person in the community and were able to monitor their progress in an ongoing, informal way.

Challenges

Although this was a Strength based study participants spoke of a number of challenges they experienced in working with complex presentations. These included; managing risks and boundaries, working with community including family, friends and colleagues and dealing with challenging client behaviors. A number of participants highlighted the importance of understanding the impact of Stolen Generations and the experience of loss and grief on mental health and substance use.

Conclusion

The depth and breadth of information gathered from this research is rich in content and cannot be captured in a single report. It paves the way to developing resources, training and models of service from an evidence based and culturally appropriate perspective. It will contribute to the process of validating the complex context that Aboriginal workers manage on a daily basis in order to provide effective healing strategies to their clients with co-existing mental health and substance abuse “Aboriginal way”.



CHAPTER 1: INTRODUCTION

The issue of co-existing mental health (MH) and alcohol and other drugs (AOD) has been identified as an important one by Aboriginal¹ workers across the state of Victoria. A statewide consultation around this issue identified that dual diagnosis was a common presentation for workers² yet they had not received training in this area. As Aboriginal workers approached their work from a holistic perspective they wanted to respond to their clients' needs in a more informed and effective manner (Bakos, 2008).

Evidence of good practice for Aboriginal workers working with community members experiencing a dual diagnosis is limited and even further so from a culturally based perspective. This has meant that a Western model of evidence based practice is often imposed upon Aboriginal workers without an acknowledgement of the very different context in which these workers function. The risk of this is that Aboriginal workers are then judged based on Western understandings of good practice therefore denying their reality, context and world view.

Dockery (2010) explores the differences in subjective wellbeing between Indigenous and non-Indigenous Australians using data from the National Health Survey. He notes the tension between the governments Closing the Gap approach that focuses on statistical equality on mainstream indicators of socio-economic wellbeing and the approach of self determination and cultural preservation that may indicate other measures and values as being more respectful of Indigenous rights. In addition he acknowledges the diversity amongst Aboriginal people yet offers evidence for the existence of some distinguishing characteristics that would imply that different factors frame subjective wellbeing for Indigenous and non-Indigenous people.

An Aboriginal perspective on successful strategies for supporting community members with a dual diagnosis to heal is vital to;

- a) Increase the capacity of the Aboriginal workforce in a culturally appropriate manner
- b) Validate the work of Aboriginal workers and provide cultural safety and security through evidence based practice
- c) Ensure that Aboriginal people with a dual diagnosis receive the most appropriate and culturally validated care to enable long term recovery and minimal relapse

(Wand, Eades & Corr, 2010; Wilkes, Gray, Saggars, Casey & Stearne, 2010)

¹ The words Aboriginal and Indigenous refer to Australian Aboriginal and Torres Strait Islander peoples. The two words are used interchangeably throughout the research to reflect the language of participants.

² The term worker includes all alcohol and other drugs, mental health, social and emotional wellbeing and other Aboriginal allied health professionals.



Evidence of Good Practice

Evidence of what works from a cultural perspective is indeed minimal not only in the dual diagnosis field but equally in the areas of MH or AOD alone. Milward (2009) looked at the “Prevention of alcohol-related harms in Victoria’s Koori communities” and identified three main studies relevant to the Victorian context. The National Drug Strategy (1996) collected data with the aim of providing educational resources to the Indigenous AOD workforce in Victoria. There was some indication that clients wanted to be followed up and that cognitive behavioral strategies for dealing with relapse would be valuable. In 2003 the Victorian Department of Human Services surveyed drug treatment services for patterns of drug use however did not identify good practice strategies. In 2007 a stock-take of drug prevention research in the Aboriginal community was commissioned by the then Victorian Premier’s Drug Prevention Council. The project identified gaps in evaluated strategies to prevent substance misuse and stressed the need for a research agenda into prevention strategies and the need for partnerships in the research process. Ultimately Milward’s review of the literature did not reveal any evidence based interventions. Through case studies presented by Aboriginal AOD workers good practice ideas were identified.

Toomey and Kluin (2007) completed a qualitative study to explore factors impacting on service delivery for Aboriginal clients with co-existing MH and AOD issues in a mainstream area health service. The Aboriginal focus groups identified issues such as;

... Service providers needing to address their attitude towards Aboriginal service users; to be more culturally aware; to have closer engagement with the Aboriginal communities; to increase their understanding of Aboriginal co-morbidity and to be aware of negative stereotyping and judgmental attitudes.

There are a number of papers that provide guidelines for non-Aboriginal workers when working with Aboriginal clients such as Westerman (2002 & 1997) who states that Indigenous understandings and experiences of mental health can be very different and highlights the importance of the process of working with Aboriginal clients. There are also a number of comprehensive resource books such as Working with Indigenous Australians (Dudgeon, Garvey & Pickett, 2000) and more recently Working Together (Purdie, Dudgeon & Walker, 2010). These two resource books are written by both Aboriginal and non-Aboriginal authors. The focus is to provide non-Aboriginal workers a context and framework for working with Aboriginal clients with MH, AOD use and social and emotional wellbeing (SEWB) issues in both Aboriginal and mainstream services.

There is still a dearth of research on good practice for Aboriginal workers around dual diagnosis. A recent study by Nagel, Robinson, Condon and Trauer (2009) designed and evaluated the effectiveness of a Motivational Care Plan for Aboriginal clients with a mental illness and



substance dependence. The study found the intervention of a Motivation Care Plan compared to the treatment as usual group improved outcomes that were sustained over an eighteen month period. In a further analysis of this study Nagel and Thompson (2010) explored the issues of family worry and family involvement on treatment outcomes. The result was a strong positive finding that “using family as motivator was a key ingredient for change” (p13). Overall the intervention of a Motivational Care Plan was designed from a strengths based perspective, was holistic, goal oriented and reinforced the role of family.

Dual Diagnosis in context

The Victorian Dual Diagnosis Initiative has been in operation over twelve years. This initiative was developed as a response to the mounting evidence that dual diagnosis was in fact the rule and not the exception in both MH and AOD services. It is also clear that clients with a dual diagnosis are far more likely to experience higher rates of relapse as one disorder impacts on the other, longer hospitalisations, an increase in severity of symptoms, and are more at risk of incarceration, poverty, general ill health and suicidal behaviours (Teeson & Proudfoot, 2003; Dual Diagnosis Key Directions, 2007; NSW Health, 2007).

The Australian national response to co-morbidity has taken the direction of a “no wrong door” policy (4th National Mental Health Plan, 2010; National Dual Diagnosis Practice Guidelines, 2010) and the states have reinforced this policy direction. This means that regardless of the service system a client with dual diagnosis attends they will have both issues assessed and addressed. This acknowledges the impact the two issues have on each other and the importance of attending to both simultaneously regardless of whether it is by one practitioner or two separate practitioners responding to each of the issues at the same time.

Dual Diagnosis in the Aboriginal Community

The documented evidence of the incidence of dual diagnosis in the Aboriginal Community is minimal (Toomey, 2007). A Data Mining Project at the Victorian Aboriginal Health Service: Family Counselling Program revealed fifty-two percent of adult clients using the service had both a diagnosed mental illness and a substance abuse disorder, and that males were more likely than females to have co-existing disorders. The study also revealed that young people between 18 to 25yrs had the highest percentage of clients with a dual diagnosis (Bakos, 2007). The anecdotal evidence suggests that the incidence of dual diagnosis is indeed high. In a Victorian state-wide consultation, Aboriginal workers reported this as a regular presentation in their work regardless of the position they were employed in (Bakos, 2008).

Statistics indicate a higher level of psychological distress amongst the Indigenous population. In the 2004-5 National Aboriginal and Torres Strait Islander Health Survey (NATSIS), 27% of Indigenous adults reported experiencing feelings associated with high or very high levels of psychological distress. The Social and Emotional Wellbeing of Aboriginal and Torres Strait



Islander Peoples report found that the rate of separation for MH conditions was 1.8 times higher than the non-Indigenous rate. “Mental and behavioral disorders due to psychoactive substance use were the most common type of mental health-related conditions for which Indigenous Australians were hospitalized (38%)” (The Australian Institute of Health and Welfare, 2009). Indigenous Australians are hospitalized for intentional self-harm at more than twice the rate of non-Indigenous Australians. The Aboriginal population is overrepresented in the use of both MH and AOD services.

Factors contributing to high levels of distress in the community

Aboriginal Australian history is encapsulated by loss, trauma and grief that continue to plague the community in 2010. Whilst some individuals and families have healed, the community as a whole continues to suffer the highest levels of poverty, unemployment, ill health, incarceration and the lowest levels of education and life expectancy than any other cultural group in Australia (Wilkes et al 2010; Thomson et al, 2009; Garvey, 2008)

Health

Trauma and grief are identified as significant issues in the context of health and wellbeing for the Aboriginal community (Wilson, 1997). Health is defined in a holistic manner

Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life.

(National Aboriginal Health Strategy 1990)

The literature has identified that psychological distress; in particular that associated with unresolved grief is “a major public health issue for aboriginal communities” (McKendrick & Thorpe, 1998).

Dispossession, oppression and degradation were common experiences that have resulted in immense loss and trauma experienced by Aboriginal people since colonization (Wilson, 1997; Hunter, 1998). Dispossession included land, family, culture and identity; Oppression in relation to culture and identity and degradation in relation to all aspects of Aboriginal life and culture.

The loss of land under the doctrine of Terra Nullius (Reynolds, 1996) was from the onset a denial of Aboriginal peoples existence and the importance of the land to their survival and overall wellbeing (Ford, 2003; Jackson & Ward, 1999). Much of the literature reinforces how “land and family are inextricably linked for Aboriginal people and is the key to health and well-being” (McKendrick & Thorpe, 1998, p4).

Past Loss

Loss of rights was another major cause of trauma and grief for Aboriginal communities who were denied basic human rights to freedom, family, culture and identity (Raphael, Swan & Martinek, 1998). Further to this loss was the systematic and forcible removal of children from



their parents, families and communities. The impact of this removal for some continues to be experienced as “regret for life that was not lived, for the cultural identity compromised or entirely lost in the institutions where a white identity was to be aspired to, but never achieved” (Koolmatrie & Williams, 2000, p163). The forcible removal of children has impact on people’s social identity (Clark, 2000), their mental health (McKendrick, Thorpe, Cutter, Roberts, Duke and Chiu, 1990; Mc Kendrick, Cutter, Mackenzie and Chiu, 1992; McKendrick & Thorpe, 1994 & 1998; Swan, 1998), their ability to parent and form attachments and to deal with their grief. Considering the large numbers of Aboriginal children removed from their families the implications for the whole community has been enormous (Wilson, 1997).

Contemporary Loss

Loss in Aboriginal communities continues in contemporary society through very high rates of premature mortality and separation from families for a range of reasons. These include:

- Higher rates of incarceration.
- Deaths in custody
- Accidents and violent deaths
- Higher infant mortality rates
- Higher rates of suicide
- Higher rates of hospitalization

(Garvey, 2008; Australian Institute of Health and Welfare, 2009; Working Together, 2010)

The literature often refers to a community immersed in death and grief. “A range of factors including earlier death, child removals, incarceration rates, suicide rates and infant mortality contribute to higher rates of grief, loss and trauma” (Indigenous Toolbox, 2005).

Trauma

The trauma that people continue to experience as a consequence of the loss has an ongoing impact on the community as minimal opportunity for healing has occurred. The trauma of removal from their lands and culture, separation from parents and family and the emotional, sexual and physical abuse experienced after the removal – this is the complexity of the continuing trauma. An apology provided by the Prime Minister of Australia in 2008 to the Stolen Generations was a beginning to the healing for some of these many generations of Aboriginal people.

Unresolved Grief

This loss and trauma has resulted in a community often overwhelmed by unresolved grief. For some this has provoked frustration, anger and violence (Hunter, 1998; National Drug Strategy, 2003). The cost of loss and grief to Aboriginal communities continues to rise as intergenerational aspects of the trauma experienced by individuals and families is passed on to their children through parenting practices, loss of role models and culture (Raphael et al, 1998). The resolution of grief is an important contributor to wellbeing and psychological and emotional health. The



Evaluation of the Emotional and Social Well Being Action Plan (Young, 2001) identified trauma and grief counselling as priority areas.

Risk Factors

Co-morbidity risk factors include; poverty, absence of good life experiences, trauma, abuse and neglect, low levels of life skills, low self-esteem and self efficacy and negative mood states (NSW Health, 2007). Given the high levels of risk factors Aboriginal peoples have experienced historically and currently and the common risk factors for co-morbidity the issue of dual diagnosis is a significant one for Aboriginal communities. Research into successful strategies to enable wellbeing from a cultural perspective creates opportunity to; further build the capacity of workers to effectively support clients and minimise the impact of having a dual diagnosis on the individual, family and community.

This research project takes into consideration the guiding principles as identified in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being (2004-2009). Specifically there is a focus on the holistic view of health, self determination, culturally valid understandings, recognising the impact of trauma loss and grief, acknowledging Aboriginal and Torres Strait Islander peoples' strength and creativity and understandings of the relationship between people and their environment.



CHAPTER 2: METHOD

Throughout the methodology for this project the recommendations on what is good practice for completing research in Aboriginal communities were kept in consideration (APS Guidelines Code of Ethics, 2006; National Health and Medical Research Council, 2003; Wand & Eades, 2008; Victorian Aboriginal Community Controlled Health Organization, 2009).

These guidelines outline six core principles and the following is a brief outline of how they were implemented through this research.

1. **Reciprocity:** In return for the knowledge and wisdom shared by the participants the Victorian Dual Diagnosis Education and Training Unit will develop a culturally relevant resource manual of good practice and distribute this to all the contributors in this project and the wider Aboriginal workforce.
2. **Respect:** All participants with their permission will be acknowledged for their contributions to the research project. The differences of those participants involved were respected and the goals and process for the research were explicit.
3. **Equality:**
 - a. The project in and of itself is about valuing the knowledge and wisdom of Aboriginal workers and services.
 - b. Our process has been transparent with participants, the Cultural Consultants group and the community.
 - c. Benefit to the wider Aboriginal AOD, MH and SEWB workforce will be provided in the form of a resource manual.
4. **Responsibility:** “Do no harm” remained a guiding principle throughout the research.
5. **Survival and protection:** The project is based on respecting the experience, skill and values of the Aboriginal workforce and their cultural distinctiveness. It is about the survival and protection of Aboriginal workers’ knowledge.
6. **Spirit and integrity:** The intent of the project has been to respect, celebrate and honor the wisdom of senior workers and the passing on of this knowledge and wisdom.

Ethics approval for this research was gained from both St Vincent’s Hospital Melbourne and Swinburne University of Technology.

Cultural Consultants Group

A Cultural Consultants group was established to advise on; the development of the project, ensure appropriate interpretation of the results, verify the researcher’s analysis of the data and make recommendations on the development of a culturally relevant resource manual.



The Cultural Consultants group consisted of two members from the three statewide Aboriginal organizations that were most relevant to the research and a community member. The services were;

1. Ngwala Willumbong; the leading Aboriginal AOD service in Victoria
2. The Victorian Aboriginal Community Controlled Health Organization (VACCHO); the statewide Aboriginal training and workforce development service
3. The Victorian Aboriginal Health Service (VAHS) Family Counselling Program; the statewide Aboriginal MH service in Victoria.

Invitations to be on the Cultural Consultants group were also emailed to all workers on the researchers existing email list. This consisted of a pamphlet outlining the project and the role of the Cultural Consultants group. A total of seven workers participated in the group that met on a monthly basis for two hours. The consultants were not reimbursed for their participation as permission was provided by their organizations for the meeting time to be part of their workload. There was an agreement the researcher would produce a resource that would go back to workers in the community as part of being mindful of the value of reciprocity.

Participants

The criteria for participation

The nature of the Aboriginal workforce in Victoria is that often workers have a history of work experience in a number of fields or work their way into varying positions in an organization. In order to maximize the opportunity to interview the most skilled workers it was decided to target the AOD, MH and SEWB workforce. These workers were the ones most likely to have the in-depth skill and experience in working with clients with a dual diagnosis.

The following criteria was decided upon as the one most likely to identify the most skilled and experienced workers and also the criteria that was likely to best match that of the relevant workforce.

1. Must be an Aboriginal worker
- 2a. Workers will have a minimum of five years experience in working with clients with a dual diagnosis and a minimum Certificate IV in their profession

Or 2b. A minimum of eight years experience in working with clients with a dual diagnosis

Recruitment of Participants

A pamphlet was designed that outlined the project and the criteria for participation. This pamphlet included an invitation to those workers who met the criteria to contact the researcher for further details. The following is a list of strategies used to recruit participants;

- A letter and a copy of the pamphlet were sent to the Chief Executive Officers (CEOs) of the Aboriginal health services in Victoria inviting CEOs to promote the project to their staff



- The pamphlet was emailed to the workers on the existing email list of the researcher
- Individual workers who met criteria and were known to the researcher were followed up with an invitation to participate
- The Cultural Consultants also followed up colleagues who met criteria and encouraged them to contact the researcher for further information

Participants

A total of ten senior workers were interviewed. There were an equal number of male and female participants. Of the ten participants five had a minimum of a diploma in their field, two had a certificate IV and three did not have any formal qualifications and had a minimum of twelve years experience each in their field. Nine of the ten participants were over the age of forty. Participants were not remunerated.

Five of the participants were working in the AOD field both in mainstream and Aboriginal organizations; three were in the MH field and two in the SEWB area. However a number of the participants had experience in more than one of these fields and often provided examples of their work other than in their current position.

Six of the participants were from the regional areas of Victoria and four from Melbourne. Again a number of the participants had worked in both regional Victoria and in Melbourne based organizations. Six of the ten participants had experience working in both Aboriginal and mainstream organizations.

Method

Interview Process

Participants were asked to put aside two hours for the interview process. This time included going through the Client Consent and Information form and providing any further details on the project. The process of the interview was explained and participants were given a copy of the interview questions. Before beginning the formal part of the interview, participants were asked about their traditional land and how they came to be in their field of work and their current position. The interview was recorded from the first question of the semi-structured interview. Before attending the interview participants were provided with a copy of the interview questions. They were asked to reflect on their work with three clients with a dual diagnosis they had supported to successfully achieve their wellbeing goals.

A semi-structured interview was designed to explore the topic with four core questions that were open ended and non-directive (Willing, 2001). A semi-structured interview was consistent with the decision to use an Interpretative Phenomenological Analysis (IPA) to understand the



data. The participants were a reasonably homogenous group i.e. Aboriginal workers experienced in working with clients with a dual diagnosis.

Data collection for IPA is usually based on purposive sampling, whereby participants are selected according to criteria of relevance to the research question. This means that the group of participants is homogenous to the extent that they share the experience of a particular condition, event or situation. (Willing, 2001 p.58)

The advantages of a semi-structured interview allowed flexibility for participants to respond to issues they felt important. It also enabled some structure and consistency for participants to be able to prepare for the interview and for the researcher to draw themes, similarities and differences across participants.

The following four questions were asked; Think about your work with these three clients

1. Would you tell me what you did with these three clients to engage them, to connect with them and to help them connect with you?
2. What did you do that helped to build up the relationship so that they would continue to come back to see you and work with you?
3. What are the sorts of things that you did with these clients that helped them get well and achieve their goals?
4. When the person had got better or achieved their goals how did you go about finishing up with them?

The formal part of the interview was approximately one to one and a half hours in length. All ten interviews were completed between April and September 2010.

Analysis of Data

Recorded interviews were transcribed and the audio recording was then deleted. Any identifying information about the participant was deleted with the aim of maintaining confidentiality. The purpose of this was to “do no harm” in regards to their standing and reputation in the community.

As this was an exploratory, qualitative piece of research an Interpretative Phenomenological Analysis (IPA) approach was assessed to yield the most valuable information from the data. Key aspects of an IPA is that it explores “in detail how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events, states hold for participants” (Smith & Osborn, 2008, p.51). This research is interested in the experience of Aboriginal workers working with clients with a dual diagnosis. This is a phenomenon that has not been previously explored and hence workers are often trained using mainstream best practice when in fact Aboriginal workers perform their work in a very different context.



The IPA process requires an in-depth, methodical analysis of the data. Steps in the data analysis followed that recommended by Smith and Osborn (2008) and consisted of;

Individual participant analysis

Document 1: The transcript

The interview was transcribed and read over numerous times to gain an overall perspective of that participant's approach. This copy remained intact.

Document 2: Notes and themes

A second document was created with the page divided into three columns. The first column became the notes section, the middle column was the transcript and the third column became where themes were identified. Notes were written as observations, sometimes summaries of points made, possible underlying feelings/thoughts being expressed, points of interest and similarities and differences. The themes section involved drawing out any themes, using short quotes to identify the theme or single words that described the themes. Often themes remained in the words of the participant.

Document 3: Themes and line numbers

Once themes were identified a third document was created with three columns, one on the left of the page with the themes, the middle column consisted of a quote from the transcript from which that theme was identified and the column on the right consisted of the line number where that quote can be found in the original transcript.

Group analysis consisted of

Document 1: Individual participant themes into cluster themes

Participant's themes for each question were placed in a column i.e. all the themes for Question 1 for each participant. The themes for each participant were then further clustered.

Document 2: Cluster and subthemes

Identified core themes for the group and sub-themes for each of the four questions

Document 3: Cluster themes list for all participants

This document was the basis for the core themes for the group

Document 4: Core themes table for group for each question

These are the tables presented in the Results and Discussion chapters

Document 5: Tables for core themes and subthemes

This document was a snapshot of each core theme for each question for each participant.

The final research report was presented to the Cultural Consultants group for verification.



CHAPTER 3: RESULTS and DISCUSSION

The results of this research were gathered from ten in-depth interviews. Saturation was reached by the tenth interview. As this was an exploratory qualitative piece of research we were interested in the breadth of successful strategies used by participants and not simply those most common.

The interviews were semi-structured into four core questions however participants chose to respond in a range of ways. Some participants chose to describe their work by reflecting on one client and explaining the strategies they used throughout the therapeutic process. Others reflected on all three of their chosen clients and the strategies they used at each stage of the therapeutic process. For this reason it is important to consider the results for each of the four questions individually and equally important to consider the results in an overall context.

The results are presented in summary tables for each of the four questions. This provides an overview of core themes with a brief description of those themes deemed to build the framework of how Aboriginal workers support clients with co-existing MH and AOD issues to heal. As themes often overlap they are discussed in only one of the four sections.

3.1 Engaging and connecting

The Context

Table 1 shows themes raised by participants provided a context for the relationship and identified strategies for engaging clients.

Terminology: “First of all they weren’t clients”

Terminology was identified as an important issue for connecting with people and created the framework of how participants related to their clients. Most workers identified knowing or having a pre-existing relationship with many of their clients hence the starting point of the working relationship was not as client and worker rather as community member, family, friend or colleague. Participant 4 referred to working with her community as “engaging someone from that community or not necessarily from your community but engaging with another Aboriginal person, one of my people.....” Participant 6 spoke of the title of client being a category and may alienate Aboriginal people

if you refer to a person as a client in front of them they can feel like a number, even though they’re part of a community, or even if they’re accessing a service they still are a person regardless of whether they’re being a client or not....Indigenous people don’t like to be categorized as such so it’s just putting people into another box again...



Throughout the interviews participants often referred to clients as community member, person or family.

TABLE 1: Strategies for engaging clients; Core themes for group and each participant

The Context	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Being part of the community										
Equals/on their level/ journey together										
An organic process “Just comes naturally”										
Qualities: Trustworthy, respectful, caring, non-judgmental, empathic, supportive										
The Strategies	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Meet in an informal “normal” environment										
Create a safe & comfortable environment										
Explain confidentiality										
Listen to people’s story/talk										
Provide the time the client needs										
Assess risk : MH, AOD & other										
Take the pressure off them										
A holistic approach/practical										
Client directed										
Build pride in Aboriginality										
Doing above & beyond what is required										
Help people manage the change process										
Identify initial goals										

Part of the community: “Being blackfella connection”

Table 1: identifies the most common response to the question of engaging and connecting with clients was related to being part of the community. Participants stated that their connection to the community eased their connection with clients. Connection to community was in the form of; being related, growing up with them, knowing them through association with parents or aunts and uncles or simply having lived in that community for a lengthy period of time. If it was not through directly knowing them it was through “just being blackfella... it’s just...I suppose it’s all the struggles that we’ve been through and we just connect” (Participant 1).

The icebreaker most commonly used by participants was “who your mob”. This involves finding out what country³ the person⁴ was from, whether they’ve visited each other’s country or whether they know someone mutually or are related to each other in some way, “ask them about their country so that then they feel a little bit of pride” (Participant 7). For some

³ Traditional land where the persons family and community are from

⁴ Participants used both terms client and person to refer to their clients as such the researcher has used both words interchangeably.



participants this also involved asking clients about their totem and the meaning it had for them. For others who were not working directly with their own community it was about identifying as Aboriginal people.

An organic process: “It just comes naturally”

A common theme was that connecting with clients was an organic process “just comes naturally”. Workers approached clients from an intuitive perspective “I’m just out there and I’m working and I don’t know, don’t realize ... what I’m doing” (Participant 3). Participant 4 spoke about it being natural as it comes from “your knowledge when you grow up in the community and how you know engage with your own people and family”. Participant 9 also said it comes naturally “I don’t know it comes natural. Treat people as you would like to be treated. Just because people are unwell, it’s not their fault, it’s an illness and they deserve respect. It all flows together”. This implies that treating people respectfully regardless of their mental illness will allow the connection to happen organically.

Equals: “Be on the same level”

The worker and client were seen to be walking side by side in the client’s healing journey. Participant 7 stressed the importance of language in treating people as equals “when you’re talking I sit really relaxed with them so that, you know you’re at their level... I never use any sort of big language or things like that I just use normal everyday talk so they don’t think you’re a real educated person, they don’t know what to say...”. Sharing stories of past experiences was considered useful and participants had a clear rationale for this as it provided;

- hope for clients
- a role model
- a coaching opportunity to motivate the client
- an opportunity to explain the concept that change was a process, not an event

Effective worker qualities

Participants identified trust, respect, being non-judgmental, supportive, caring and being empathic as qualities they most needed to connect with clients with a dual diagnosis. “Some of them can be a bit standoffish because they still have the trust issue because of what happened in their past ...” (Participant 2). Participant 4 further clarified the issue of trust “there’s a lot of mistrust in the world that they deal with all the time, whether it be with housing, whether it be with their finances whether it be with their family”. Another participant discussed trust in the context of confidentiality and knowing the client’s family.

Respect was a powerful theme throughout the interviews. It was important to show respect and acceptance for who that person was. Participants also spoke of a reciprocal respect. If workers treat people respectfully clients will return that respect “they gunna pay that back, they gunna respect you too.....treat them like they’re somebody and you will get, you will connect”



(Participant 4). Participant 7 spoke of the importance of respect for elders and their standing in the community. “I had to show that respect to him as being an elder but I also had to let him know that there were still rules that also need to be followed... and I had to work out a way of doing that without being disrespectful to him”.

Being non-judgmental was considered a requirement if engagement and connection were to occur. One participant highlighted the importance to not judge people by what they had heard about the person or know about their family. Other participants spoke of clients carrying shame for their involvement in past activities thus further highlighting the importance for workers to be non-judgmental “that one she tried to shock me, everything she done for the first three weeks was trying to shock me. We built such a strong relationship is because everything she said, I just wasn’t, wasn’t looking at her disgustingly... she had very low self esteem” (Participant 5).

The Strategies

Meet in a normal environment

Most participants thought that meeting in a non-clinical, informal environment was an important strategy for engaging clients. Workers stated that meeting in a “normal” environment meant they were likely to obtain a more genuine story from the person,

usually I get out into the community anyway, I sorta ask em if they wanna come here but most don’t ...they rather just have discussions, go for a walk and have a talk.... For a good conversation I get out of a client is sit down have a nice cup of coffee or tea...yeh that’s when it starts (Participant 3).

Participant 2 considered it important to move clients out of closed clinical spaces,

That’s the difference with Aboriginal people you’ve sorta got to talk to them on their terms, I know because I was like that myself. I wouldn’t go to the doctors and hospitals and all that because I felt you know sort of closed in but....if you do it that way you get more chance of finding out exactly what you need to find out about their problems....and you get their trust and that’s the main thing you need their trust.....

Meeting in a normal environment was considered to promote a genuine story from clients, provide workers with more information and hence a better assessment of what was occurring in the life of that person. It provides an environment for the client to feel more open and willing to build trust. This may be attributed to the client feeling an increased comfort and partly it appears that the worker making the effort to go to the client adds to the quality of the relationship.



A holistic approach

A common approach amongst most of the participants was to be holistic, practical and attend to crisis. Participants spoke of not only attending to the MH and AOD issues but to all issues needing attending to. This was a theme throughout all four of the core questions. People with a dual diagnosis were identified as often having many issues to deal with. These included; Protective Services, legal, financial, family, housing and physical health issues. It was also important to attend to any crisis as this led to an increase in rapport especially if there were good outcomes (Participant 8). A number of participants stated that Department of Human Services (DHS) issues i.e. obtaining access to their children was common amongst people with a dual diagnosis and that this was often a motivating factor for dealing with the MH and AOD issues.

Confidentiality: “Your information is gonna be safe”

Clarifying the boundaries of confidentiality was an important strategy throughout the interviews. This was especially in the context of knowing clients’ families and that people would be meeting each other in the community and at community functions “I live in the community and so I’m gonna have a bigger expectation of me with confidentiality and I explain, just because you see me at the health service or the football or basketball your information is gonna be safe” (Participant 1). Participant 5 stated that knowing the client’s family can be challenging when family members are genuinely concerned and asking how their loved one is and ensuring the client feels safe enough to tell their story “....you oughta make sure you feel safe by telling me things so I can help you, but whatever you tell me I won’t you know, I’ll keep your confidence, make sure it’s kept quiet...”

Other strategies included; build resilience and life skills, build the relationship also with family and significant others and build a relationship with other professionals to obtain better access to care for their clients.

3.2 Building the relationship

The focus of Question 2 was on strategies to build the relationship and as stated previously participants often spoke of engaging clients and building the relationship as a whole. Participant 4 identified two parts to engaging with clients; firstly making them feel comfortable and engaging them on their level so they return to the service “...they feel good, they think oh it wasn’t bad, I liked that, you know I will go back and see her because she seems to listen, she seems to understand or she seems to know, she’s just seems like one of us”; secondly is to continue to build the relationship through gaining their trust. This is done by treating people respectfully and by being dependable “if you are there to engage with that person and to help them, you got to gain their trust and part of that means to respect them, not for what they did but for who they are at that moment” (Participant 4).



Trust

Table 2 shows that building trust was identified as a core theme by two of the participants in response to this question however it was referred to by all participants as an important quality throughout the interviews. Participant 2 spoke of the importance of trust in the context of providing the most appropriate service for people. If the client trusted him as a worker they would trust his referral to a another service especially if it was a non-Indigenous service provider “...keep building their trust, which eventually leads to them seeing a proper psychiatrist, counsellors... you know if they need to go into hospital (psychiatric unit)”. Another participant spoke of trust in relation to going at the person’s pace not pushing people to talking about issues. “So I tease into it a little, then a little bit more and a bit more. It takes a while to build up that trust level that’s when the important work is done” (Participant 9). Regular contact and being reliable were identified as strategies for building trust.

Table 2: Strategies for building the relationship; Core themes for the group and participants

Core Themes	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
It’s having the cultural attitude/Aboriginal Way										
Build trust										
Everyone wants to change										
Qualities ; kind, non-judgmental, empathic, respectful, honest, patient										
Have continuous contact										
Meet in a “normal” environment/talk normal										
Be responsive to client needs										
Simply talking										
Being “straight up” and setting boundaries										
Acknowledge person when in the community										
Be reliable, dependable and practical										
Build self-reliance										

Simply talking

Talking was identified as another powerful strategy for healing and was a common theme throughout interviews. This was presented as “simply talking” however as the concept was unfolded by participants it revealed layers such as;

- It is a release of emotional energy
- People need a witness to their story
- It helps to move on from past mistakes or harms they may have caused
- To experience a shared history so they do not feel alone

Participant 2 identified talking as a way for clients to repair things “... but mainly 90% of them want to tell you what they’ve done wrong, they want to engage on that...what they’ve done



because it...it's their way of trying to fix things...90% of them with the problems they've got, the hassle they have is that they don't talk about it".

Open and honest: "Be straight up"

Participants often gave examples of being open and honest "straight up" with clients and setting boundaries. "I'm pretty well straight forward person, I don't beat around the bush, I don't tell lies to em, and I tell em straight up how it is" (Participant 3). One participant spoke of the importance of being honest with what they told clients

"...and that's something the community expects... that we're going to tell it like it is, that's something that definitely clients do feedback is you know, that they appreciate and that they wish that other people tell them rather trying to say, I guess trying to pretend otherwise, or trying to be nice about something when you know they'd prefer to say yes we can do it or no we can't" (Participant 8).

Be dependable: "Do what you say you will and don't promise what you can't deliver"

Be reliable, dependable and practical were strong themes throughout the interviews. Participants continually reinforced the importance of being dependable. Participant 6 provided a context from which to understand the importance of this issue. He highlighted the importance of workers taking the action they committed to and being punctual. He stated this kind of dependability sets up a basis for the relationship to grow as well as role modelling the behaviour. If the worker is consistently dependable the client will come to understand this, appreciate and respect this so they give it back. Being dependable was also important in terms of the worker's credibility in the community and as one participant stated it is not enough to be reliable sometimes as a worker they need to continually "step up" to that expectation otherwise they lose the client. If the worker does not consistently meet expectations, the client is unlikely to commit to the relationship and the work required for healing.

Flexibility: "Thinking outside the square"

Being practical was identified as the Aboriginal way. Participant 8 spoke of the importance of flexibility to meet the needs of the client and to build the relationship in order to resolve issues. "...flexibility and thinking outside the square...really we can catch up anywhere that suits them that can be if they have other things to do then we'll talk in the car while we're driving around you know paying their bills or doing what else they need to do". This participant spoke about the importance of making the solution fit the client rather than trying to fit the client into the solution. Being flexible and practical meant she was able to meet with clients where it was most convenient to them, complete daily living tasks that needed attending to, thus taking the pressure off the client and allowing them the space to consider their mental health and substance use. Participant 8 demonstrated by her examples that flexibility gave rise to creative solutions to difficult problems clients were experiencing.



Other strategies included;

- advocating for the client to better manage pressures from other organizations
- regularly assessing the persons mental state
- having a shared history
- helping the client to manage the changes they were experiencing
- providing useful information
- doing above and beyond what is required
- identifying goals

3.3 Strategies for enabling wellbeing and achieving goals

Themes that evolved from this question often overlapped with previous questions. Table 3 shows strategies such as regular contact, working on goals and building self reliance remain consistent as do the qualities workers need to provide effective care for their clients.

The Approach

Participants approach to their work was client-focused, strengths based and holistic.

Client focused: “Be the person they need, walk with them on their journey”

This theme involved providing the necessary support for healing; being equals, being a witness to their journey and it included sharing special moments that created significant change for the person. One participant spoke of a client who often challenged her in a range of ways and that the changing point in the relationship was a disclosure that they were both deeply affected by

I said look I’m not a sexual abuse counsellor, I could listen but I gotta tell you I would rather refer you to a sexual assault counsellor somewhere else. She said no you’ve been through with me all this way. True, I sat there and I was crying with her. Um and then from that moment on... it was really from the heart, me crying along with her most unprofessional thing you’ve ever seen clinging to one another, it was from that moment on we had this closeness...(Participant 5)

Other participants spoke of providing support and caring as a way of walking with clients on their journey. Participant 7 highlighted the importance of staying “true to your word” and Participant 8 spoke of standing alongside clients to be there for them. Participant 10 described this as being the person who is looking out for their need, someone they can tell their story to and be the person they can lean on.



Table 3: Strategies for healing; Core themes for the group and participants

The Approach	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Client focused: Be the person they need: walk with them on that journey										
A holistic approach										
Strengths based: "Talk on their achievements", focus on the positives, encourage them,										
Qualities: empathy, optimism, respect, caring, trust, non-judgmental										
The Strategies	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Assess needs: Early intervention										
Stabilize them: MH/AOD/Physical, compliance with medication, make access to care easier										
Constant contact: Be really involved with them, do normal things together										
Be practical: "Fix the nuts n bolts", oil the process, help sort the chaos, offer respite										
Let them tell their story: share stories, spend quality time, share lessons, listen, talk										
Work on goals together										
Build independence, self reliance, resilience										
Client directed: their goals, their pace, voluntarily										
Provide the right information for that person										
Build dignity: pride, connectedness										
Break the cycle: break the pattern, help them manage the change										
Involve family/significant others, support them, provide information										
Think outside the box										
Consider issues: Stolen Generations, loss and grief, finances, DHS, legal issues & practical support										
Above and beyond										



The Strategies

Be practical: “Fix the nuts and bolts”

This included helping clients sort through the confusion and stress they often experienced as a result of various issues (legal, family, and finances) left unattended. Clients with a dual diagnosis often did not appear to have the frame of mind where they were able to focus enough to take the action necessary to resolve the problem on their own; “And a lot of them you know because there’s a lot of things happening in their lives, when their lives so unbalanced and that’s just another one added into that jumble in their head... there’s so much happening it’s confusing, they can’t get it in an order so the way they talkin and behavin is unpredictable” (Participant 1)

Participants identified the importance of sorting through the practical issues so that clients can think about attending to their MH and AOD issues. “Then they’ll start to go “Okay, I do have a health issue. What can I do about this?” And a lot of the times it’s addressing the other issues before they’ll actually ask about help for their own health” (Participant 6).

it’s fixing up all those little things you know, nuts and bolts that are loose, before you can.... let that run, run freely and you know nuts and bolts is housing, Centrelink, is your court, your fines.... your children and the department..... all those things that whether you’ve been abused you know, thoughts of that, so there’s a whole lot of nuts and bolts attached to... that one person.... and it’s helping each to, get through all those (Participant 4).

Participants were holistic in their approach hence the importance of “fixing the nuts and bolts”. It was also necessary to ask questions to check how *everything* was going and not only around the clients MH or AOD use. The purpose was to implement early intervention and harm minimization strategies where possible.

Client directed action and self reliance

Building self reliance was the focus of participants’ work. Throughout all interviews participants provided examples of how they explored options with clients, supported them to make decisions and build the skills needed to live independently.

Learn em how to budget properly, all those sort things that they failing all those years when they were getting into drugs and all that, and a lot of them ... don’t have skills just on basic livin, and I found with a lot of my clients that once they start to learn that and they have their own places ... they just improved in leaps and bounds... well the three clients that I’ve been talking about two of them actually got their own flats now, um they’ve got everything in their flats, they’re goin really well, they’ve got no you know immediate hassles anymore, they ah budget well, they pretty well look after themselves now” (Participant 2).



Participant 7 spoke of going through the process of attending to issues with the client present so it becomes a learning experience for them, “I bring the client in so they can see what is going on and so they can see there is a process ... they’ve been through it with you, they know what to do, they can do it themselves”.

Participant 9 spoke of teaching practical life skills in an experiential way “so we’d do shopping trips and teaching her life skills you know budgeting and you only got this much, can you really afford a \$550 pair of runners, probably not”. Participant 9 also encouraged clients to do as much as possible for themselves “I give them phone numbers so they can make appointments. I’ll do it if they can’t but I get them to do as much as possible themselves”.

It was important for workers to judge how much responsibility a client could manage so as not to overwhelm them as this may lead to feeling defeated, non-attendance and again a sense of failure. “Weigh it up, yes because if you push someone too far you know they’re either gunna fall over or put the brakes on and they back out. So encouragement is good but use it to the level that you think they are able to handle” (Participant 4).

Psycho-education: “take out the jargon”

Participants identified it was essential to provide clear information so that clients may gain an understanding of the issues confronting them and their options. Participant 8 spoke of the importance of taking out the “jargon” and explaining things simply so that both the client and their family were able to understand the issues. Important issues requiring clear information to enable clients to make informed decisions included; their rights when using different service systems e.g. being on an inpatient unit, treatment orders, the use of medication, how to speak with medical professionals and the impact of substances on the body.

Participant 6 spoke of the importance of having a range of resources to provide the right information for that person using the medium most suitable for that client. “A lot of the times you know it’s getting that research and the right research for the person and trying out different types of resources. Because one shoe is not always going to fit all, and there are quite a number of different resources...”

It was also considered important to attend some appointments with clients. In particular when they were receiving information from medical professionals to make sense of it and to later remember what was actually said. Reinforcing the information in a gentle way without haranguing the person was important. Again finding the balance between providing the information and reinforcing it without distancing the client.



Participant 7 spoke of a number of strategies he used to provide information that were reinforced by other participants. This included

- normalizing MH issues
- allaying peoples fear about medications by providing the correct information
- increasing compliance by clarifying information
- raising issues of MH in a group situation to not single out one person
- Explore the history of mental illness in the family
- Refer clients to specialists when they need further information/support/treatment
- Provide education about a range of MH issues
- Help clients to build a relationship with their doctor so their health needs are better met
- Using visual resources to explain MH and AOD issues

At the core of these strategies is empowering clients to care for their MH through appropriate information provision.

3.4 Ending the episode of care

There was agreement amongst participants that the relationship between them and their clients remained an ongoing one and ‘once their worker, always their worker’ was a clear motto for participants. The nature of the relationship changed however it did not end. The core themes for ending an episode of care as indicated in Table 4 are that finishing up does not really happen and when it does it is generally an organic process that is guided by the client.

Table 4: Finishing the episode of care; Core themes for group and participants

Core Theme	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Don't ever really finish up										
"It just comes to them"										
Clients are doing normal things										
Goals have been achieved										
Be available to respond to relapse										
Have an "open door" policy										
When other supports are in place to maintain wellbeing										



Don't ever really finish up

All participants whether implicitly or explicitly (Table 4) stated they did not really finish up with clients unless they moved to a distant region around Victoria or interstate. The fact that participants were working with community, though not necessarily their own community members meant there would be ongoing contact with clients in the community or at community functions. Participants stated that people's files may be closed however they still continue contact in the community where they are able to monitor how the person is managing their life. This has the advantage of early follow up when they hear news of the person relapsing.

Participant 10 spoke of never really finishing up with clients because they bring their family or friends along to see him when they are unwell or want to better manage their substance use. Hence contact with his initial client is maintained through an ongoing referral process.

An organic process: "It just comes to them they're doing normal things"

All participants stated that the finishing up process was determined by clients. Participant 1 considered it a clear sign that her work was done when clients were getting on with their life and "It just comes to them because they're stepping up and doing things themselves". Other participants stated that when clients were ready they moved on, they did not need the service any more. Others said appointments became less frequent or they began to miss them. Participants highlighted the value of "having the discussion" (Participant 8) if clients were missing appointments so that there was an agreed end point. The process was identified by most participants as organic; the client was busy engaging in normal activities.

Participant 5 stressed the importance of finishing up being a client determined process

I don't say I think you are getting better I'll see you once a month is because we have had this enormous journey with some of these clients. Is that I have been a big part of their lives, we gradually have to ease off but it has to be under their terms, whether they got supports, whether with their partner that is supportive or their family is supportive or they got support in place.

Open door policy

Participants clearly recognized that healing from complex issues was not an event rather a long term process for most. An open door policy was important and clients were made welcome to return if they needed support in the future not only for MH or AOD issues rather for any issue. It was stated that any issue may trigger a relapse and it was important to intervene early.

Other issues identified by participants included;

- that relapse is often triggered by loss and grief
- the belief that trauma has broken people's spirit and the importance of never giving up on clients



- it is an obligation to watch over people/clients as they are the worker's family and community
- the worker and their client have travelled together and that it has been a shared process
- the importance of encouraging independence yet still be there to provide support if it is needed and
- that depending on the context and organization the work has been carried out in, there can be a formal ritual to celebrate the client's achievements

3.5 Challenges

Although this was a Strength based interview and we were exploring successful strategies, participants through the telling of their stories raised issues they were challenged by when working with clients with a dual diagnosis. Table 5 provides a summary of those issues. Setting boundaries, managing risks and keeping safe were themes through all four of the questions as were working with community members and families and managing challenging behaviours of clients.

Managing Risk

Participants spoke of the importance of home visits and other outreach work however it was equally important for the worker to know their client and the environment they might be stepping in to in order to manage any risks. This included possible aggression or violence from a client or others in the household.

One worker spoke about not going into an environment where the possibility of domestic violence might occur. "When there's a partner in the home I won't go into the homes ... I'll take the woman out of the home, go somewhere ... I don't put myself involved in domestics there and I don't wanna judge. I don't want to pull someone up for being disrespectful in front of me, you know and it does go on" (Participant 1).

Another participant spoke of a home visit where the client and others in the household were smoking cannabis. As this was a normal part of the client's living the worker decide to continue the visit and speak with the client in another area of the room.

"sometimes early in the morning, they'd be all, five or six of them will be smoking a bong and they'd ask hey you want one; I said no, no I'm not allowed to have that stuff... I just come to see what's-a-name and then we'd go out in the lounge and sit down and talk and then it just steamed on from there" (Participant 10).



Table 5: Challenges and issues of concern identified by participants in each question

Question 1: Engaging & Connecting Issues of concern included; • managing risks • working with their own family members • understanding the level of impact loss and grief has on peoples' mental health and substance use • Understanding the experiences of those from the Stolen Generations and the impact this has had on their wellbeing • managing challenging behaviors that clients at times display	Question 2: Caring for the relationship Issues of concern included; • being mindful of boundaries to ensure their own safety • attending work with the right attitude and not carrying their own issues that may be transferred to the client • managing work demands outside of regular work hours • managing their own concerns; worry, fear and anxiety about clients • setting boundaries "bottom lines" with clients
Question 3: Strategies for healing Issues of concern included; • being aware of boundaries • dealing with some clients' behavior • keeping self safe • juggling the roles of community member and worker • remembering that it is long term work	Question 4: Finishing up Issues of concern included; • managing the challenging behaviors of clients who were also family members • going at the client's pace so that the worker does not push the client beyond what they are able to manage at any given time • the importance of getting recognition from the community if workers are working in a mainstream organization. It was felt by some participants that mainstream services may not appreciate the complexity of the work that Aboriginal workers are often required to manage

Managing Challenging behaviours

Participant 1 spoke of knowing most of her clients and knowing the risks involved so "when um things do come bad I'll step back, because I don't wanna get myself at risk or anything like that but because of my communication I can come back in ... and I've had to pull away, enough's enough I've done my work with ya". Once the worker had supported the client to reach a certain level of functioning and other supports were in place they were able to move on from this client as their behaviour had become unacceptable. "Because it just gets too familiar, you know it's not alright to swear up at me and tell me to go get fd". This worker distinguished between early work with a client where she may deal with challenging behaviours differently and at a later stage in the relationship setting clear boundaries "the start you overlook it and say we got a job to do sis co' on and that's what I do".

Participant 3 spoke of the challenge of dealing with the behaviour of a client who is also a family member "and she just keeps arkin up and arkin up... and I try to talk calm to her, it's so hard to



talk to her when she's really over the top of me...." She was balancing both her family role and her professional role in order to manage the challenging behaviour.

Dual Relationships: Working with our own

The challenges involved in working with family, community members, friends and colleagues were part of the everyday experiences of workers. One participant spoke of having been part of a drinking group in the past and eventually moved on from this and into a worker role and the challenge this had posed for the group and her. The workers journey has been a long one and clients see what she has achieved and may be looking for that but don't necessarily see the effort she has put in to achieving the life she now has. "You know, and it's been very hard, cause some of my clients I've known all of my life I use to drink with them and for me to be on this side here and they there and they'd like a taste of what I got, but you gotta step up I tell them it's a journey..."(Participant 1).

Participant 3 spoke of the difficulty of containing her own emotions and trying to be objective when she was working with family. She often chose to be a support person for the family member/client and link them into a mainstream worker to provide the best possible service for that person.

"I notice if they break down and cry, I know I'm gonna cry that's why I rather refer em on but I always say I'll be there, if you want me to take you, I'll take you and I'll be there, ... they say you wanna come in, it's up to them if they want me to go in and listen but sometimes I umm and arhh about it myself too so sometimes I just say no. I let em know I'll be out the waiting room sittin in there waitin till they come out so yeh...it's very hard when you're working with family, very, very hard".

The other difficulty identified by participants was that working with community means that clients often disclose things about other community members/family/ colleagues that may be very difficult for the worker to hold in confidence and contain the emotion attached to that knowledge. "...a mainstream worker would not be confronting perpetrators. You know in their lives they go home to a different world we go home to out there and involves looking at them. I have to keep a straight face and not acknowledge I know".

Setting boundaries

Participants spoke of how the behaviour of clients can be challenging and the importance of setting boundaries and still remain caring.

"...because I really had to set the boundaries with her, and I said I don't really like you coming in like you are(substance affected), best we let it go, how did you get here, couple of times had to even drive her home. She only done it twice, but she's the only one that, who got through a lot, who use to test every boundary, she gave me a run for my money" (Participant 5).



CHAPTER 4: DISCUSSION

This exploratory, qualitative research revealed a complex context that Aboriginal workers negotiate in order to work effectively with clients with a dual diagnosis. Belonging to and working with members of the community and if not their own community an Aboriginal community, meant that workers often had a pre-existing relationship with many of their clients. They may be working with friends, family members, colleagues, a colleague's family member or someone they live closely with in the community. Thus workers are not simply caring for the professional relationship but also for the personal one. As Participant 1 said "when working with our mob we go in knowin em and we have to pull out knowing em". The pressure this may create for workers is in addition to the challenge of working with a complex client presentation.

Working with mainstream

This challenge was further reinforced by participants who had or were working in a mainstream service. Participant 4 stated "you don't need a boss to watch over you because your community is your boss". Participant 10 also felt the community response was most important "the recognition from the community not from your bosses because the bosses don't see this part and you try to tell them and all they worry about is the dollars". Participant 9 spoke of the challenge of working with community members outside of the work environment and trying to explain this to management, "It's different for mainstream, they don't live in the community, they're not part of it, and they knock off at 5pm and go home. For me it's 24hrs a day, 7 days a week. I understand why Aboriginal workers burn out. Management say you can't see people in your home, what am I supposed to do send them away, they know where I live, they know everything about me, they have my phone number, I can't just send people away, some of them are my relatives".

Aboriginal way is best

It is in this context that participants spoke about "Aboriginal way is best". Participants referred to issues such as;

- entering the professional relationship as equals
- preferring not to refer to community members as clients
- meeting in a non-clinical "normal" environment
- giving the time that is needed to listen deeply whilst people tell their story
- working holistically with a client directed approach
- being practical in the support provided
- setting realistic goals and working towards them
- involving family
- providing hope and working with people's strengths



- working from the basis of honesty, transparency and reliability
- doing above and beyond what their job description requires and
- rarely ever completely ending the support role in a working relationship

The process of healing was directed by clients and workers focused on building self reliance. In some ways this may appear contradictory to strategies such as having constant contact, going to the person, on their terms when in fact these strategies were the process used to achieve self reliance. The process acknowledged that people with long standing MH and AOD issues were least likely to have the life skills needed to do practical everyday activities to maintain their well-being. This self-determination reinforces the wider national Aboriginal political agenda at the primary care level.

Findings by Nagel and Thompson (2010) on the importance of a strength based and holistic approach, goal setting and involving family in care planning for those with co-existing disorders are supported by this research. As there was very limited existing research on the subject matter it is not possible to compare other findings.

Limitations

A limitation of this research was that the researcher was not Aboriginal. This may have influenced the design of the research and the interview process. Participants may have been more wary on being interviewed by a non-Aboriginal person and interpretation of the results may have been impacted by this factor. The Cultural Consultants group was established to minimize any influence this factor may have had on the outcomes of the project. The Cultural Consultants verified the interpretations of themes and these were discussed at length in group meetings.

Culturally valid understandings

The value of this research is it adds to the body of knowledge and provides evidence for the healing ways of Aboriginal workers in relation to complex issues. This creates an evidence base from which to further develop a framework of care for the MH, AOD and SEWB Aboriginal workforce in Victoria to continue to work effectively with clients with a dual diagnosis. It is an opportunity to further develop resources, training and models of clinical supervision to continue to enhance the skills of the workforce in a culturally appropriate manner.

As stated in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009 "culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally and mental health problems in particular" (p6). The findings of this research may also be an opportunity to explore existing models of care and how they may compliment the practice of Aboriginal workers.



Ultimately it adds to the validity of the practice of Aboriginal workers and the understanding of what is best for their community.

The nature and the context of the strategies shared by participants is captured by a quote from Participant 2 “that’s something my mother always taught me, always talk to people, always be kind to people, always you know, help people because... the rewarding thing in the end she used to say is what those people give back to ya”. The relationship and the sense of community spirit was indeed the basis from which healing evolved however it was clearly the skills and knowledge of the participants that enabled the therapeutic process to unfold and the strategies to be implemented according to the needs of each client.



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