

How do drug service workers in the field of Aboriginal substance misuse describe the experience of being trained as family therapists and using family therapy in their work?



Submitted by

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`Foot steps to Healthy Families'. Artwork designed by Joanne Dwyer

Significance of Artwork

The artwork is a story of the journey of engaging and maintaining Aboriginal people/families into family therapy healing/practices to bring about strong and healthy individuals, families and communities. The painting highlights the need for more Indigenous therapists and also demands that current Aboriginal health workers be recognised for their often innate healing qualities that are also undervalued. The larger number of Aboriginal figures than non-Aboriginal figures has demonstrated this, which is in opposition to the current trend. The symbols within the outer rim of the circles depict complex family structures, which can include immediate, extended family and/or other community members. The figures inside the circles are the therapists/healers both Indigenous and non-Indigenous. The lone therapist/health worker who is not encompassed by symbolic people highlights the difficulty in engaging family into family therapy. This is partly due to a natural shyness of Aboriginal people and/or shame factor in acknowledging family dysfunction which can be further enabled through current organisational processes which are often time consuming and culturally void. The male/female figures in the two yellow circles represent elders/respected persons; this is recognisable by the more elaborate headdress. They are integral in overseeing and ensuring culturally safety and culturally sensitive practices within the therapeutic environment. This is fundamental to the long-term health and wellbeing of Aboriginal people. The footsteps painted in random fashion shows the healing process in action and families coming together. This is the result of culturally appropriate Family Therapy in action.

The Art Work and Story were created by Joanne Dwyer (2008) for the Indigenous Program Team and is used with permission. Copyright @ The Bouverie Centre

**This thesis is dedicated to my mother Carole and father Allan Sundbery who inspired
a love of learning and the opportunities to pursue my passions.**

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Abstract

This thesis contains the perspectives of Alcohol and Other Drug Service Providers on their experience of being trained as family therapists and using family therapy in their work with Aboriginal and Torres Strait Islander people. Those participating in the research included drug service workers engaged in a post Graduate Certificate in Family Therapy, their managers and those involved in the provision of the training.

For the workers participating in the research, family therapy represented a culturally congruent means of approaching Aboriginal substance misuse, as well as other associated health concerns due to its contextual and relational view of problems. Family therapy was found to offer a means to address transgenerational trauma, which was believed to be central to understanding Indigenous substance misuse as well as providing a strengths based intervention which could include the experience, skills and cultural resources of family and community.

The workers' ability to traverse both Aboriginal and non-Aboriginal worlds, whilst maintaining respect in each makes their stories particularly significant. The workers reported improved confidence in their skills as a result of the training which had enabled them to take up more senior clinical and management roles. There were also a variety of constraints operating to their professional development and these obstacles are outlined and recommendations are made regarding how they could be ameliorated.

Another important aspect accounting for the engagement of the drug service workers with family therapy as a modality was seen to be as a result of the processes by which it was imparted. The efficacy of the collaborative methods evident in the pedagogical approach, within an Indigenous Program and within the research processes were found largely to result from acknowledgement and respect for the experience and skills of Aboriginal people. Possibilities exist for the transferability of the principles underpinning these methods for use in other domains.

Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma. No other person's work has been used without due acknowledgment in the main text of the thesis. This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

Signed:

A handwritten signature in dark ink, appearing to read 'Jacquie Sundbery', is written on a light blue rectangular background.

Jacqui Sundbery

Date:

16th February 2015

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Chapter 1 Introduction

Background to the Research

This thesis explores the impact of family therapy as a model of treatment for Aboriginal¹ substance misuse from the perspectives of drug services workers employed in this field. The research seeks to understand how the skills gained by the drug service workers within a family therapy training program were perceived, both from the perspectives of those receiving the training and from their managers. To understand the context through which the drug service workers became familiar with family therapy approaches the pedagogical practices employed and the learning styles emphasised in the postgraduate program will also be explored through those receiving the training and those involved in its delivery.

Working from the Outside. A non-Indigenous researcher engaged in this area is presented with particular difficulties, both as an outsider to the community and as part of the dominant culture within Australian society. As a non-Indigenous woman, who is part of the dominant culture I am afforded greater privileges and opportunities to choose to be involved or not involved in Indigenous issues, whereas Indigenous people may not experience the same freedom to avoid or deny the inequities in Australian society. An awareness and understanding of my privilege and difference provides an ethical basis from which to address my role as researcher.

The integrity of both the research project and those researchers involved has been cited as a determinant of the success and implementation of research processes and outcomes (Phillips, 2003; Pyett, 2000; Smith, 1999). In order to gain access to Indigenous community as an outsider it is important to be open about my background, interest and commitment to the topic as well as make plain the research aims and methods. It is also necessary within an academic context to make transparent the biases and assumptions which inform my perspective as a researcher.

This research focuses upon the relevance of family therapy interventions and family therapy training to drug service workers involved in the field of Aboriginal substance misuse and to this subject area I bring a range of personal and professional influences. I am part of a family and

¹ Throughout this thesis, the term Aboriginal or Koori refers to both Aboriginal and Torres Strait Islander people. It is recognised that Indigenous culture and people are diverse and that there are important differences between Aboriginal people and Torres Strait Islanders, just as there are important differences within these broad groupings. The term Aboriginal is used in preference to Indigenous when referring to the research participants as this reflects their wishes; and Indigenous and Indigenous Australians are also used when referencing reports, programs or quotations.

community affected profoundly by substance misuse and have worked in mainstream Alcohol and Other Drugs (AOD) services for a period of twelve years particularly within youth and family programs. Alongside this, has been a career as an actor, artist, academic and community cultural development worker. Within the AOD sector I witnessed the impact on families of substance using behaviours and came to the firm belief that the AOD system needed to engage more fully with families and include them within the holistic service delivery that was often espoused.

I saw many young people and family members who claimed to have given up on their relationship with each other or who said that their relationship was one of limited contact or influence, only to find after some curious questioning that the contact and importance of the relationship had been minimised through disappointment, fear of rejection and often the desire to protect a relationship which was perceived to be fragile (Miller & Dwyer, 1997).

I was working with families who had experienced intergenerational sexual abuse, trauma and welfare dependence. As a result they were suspicious of services and difficult to engage. The level of chaos and disorganisation in their lives meant that engagement could best be achieved through an assertive outreach approach. It was at this point that I became convinced that active engagement with families was necessary for those marginalised within our community.

My background in mainstream services influences my perception of Indigenous AOD services and raises questions for me around the similarities and differences between them. Prior to this research project my contact with Indigenous clients was limited to young people, who with some regularity were clients of a youth detoxification unit that I had worked for. I also had spent some time with Pitjantjatjara people in my early twenties, both on country and in urban settings, as a part of a community initiated cultural exchange and intervention into petrol sniffing. I came to this research with the assumption that Indigenous services would include families routinely in service provision, as it is culturally appropriate to do so, but I didn't know how it might be supported within the service structure. So it was as a novice to the field of Indigenous AOD services with a desire to 'remain vigilant, humble and open to instruction' (Reid & Frisby, 2008, p. 3) that this study began.

The relationship of education to disadvantage and to the lives of the AOD workers participating in the research and training is important to this study and my own relationship to education will inform this. Having spent most of my adult life in education both as student and educator I have a love of ideas and for the connections they afford. I also have a particular sensitivity around who has the right to speak, with what authority and who seemingly has the power to grant this

right. Within my family of origin it was a struggle for my own experience to be voiced and witnessed and partially my commitment to ongoing education can be seen as a way to gain the authority to speak and be heard. This has served to fuel my preoccupation with how to make space for everyone at the table to have a voice, even the most unruly and those provoking anxiety and discomfort. In this way I recognise the significance of qualifications to afford respect and legitimate voice.

Within this research there is an attempt to adopt a 'learner's mind' (Swantz, 2008, p. 38) so that assumptions are minimised around the possible meanings that people attribute to their experiences, however my perceptions will influence analysis and will be accounted for in the following sections relating to methodological rigour and trustworthiness. Within my work as a family therapist personal responses are seen to both limit and enhance possibilities and are useful in their ability to shed light on, parallel, magnify, provoke and challenge systems. Within the methodologies adopted in this research my reflections, biases and assumptions will provide a source of information and data for analysis.

The Context

What this Thesis Describes. This research describes from the perspectives of drug services workers in the field of Aboriginal substance misuse the usefulness of family therapy and family therapy training to their work. Indigenous AOD workers, their managers and those involved in the delivery of the post Graduate Certificate in Family Therapy, Bouverie Centre, La Trobe University are the participants in this research.

The context in which family therapy has become known and utilised by the drug service workers is central to this study and so a background to the Bouverie Centre and its training of Aboriginal health, child, youth and family workers (HCYFW) will be detailed here.

The Bouverie Centre. The post Graduate Certificate in Family Therapy for Indigenous health, child and family workers (HCFW) is provided by the Bouverie Centre, La Trobe University. The Bouverie Centre is a state-wide integrated clinical, consultation, training and academic service funded by the Victorian Department of Human Services (DHS) and located within the Faculty of Health Sciences, La Trobe University (LTU). The Centre has for many decades trained family workers and strengthened families experiencing mental illness, sexual abuse, intergenerational trauma, brain injury, HIV/AIDS, family violence and drug and alcohol problems. In recent years the Bouverie Centre's Indigenous work has included: a service partnership with Western Suburbs Indigenous Gathering Place for the provision of culturally sensitive family work with Aboriginal families; clinical mentorship in Bargoongagat (Indigenous Innovations); family

therapy supervision to Aboriginal families dealing with acquired brain injury. The Centre is currently in a partnership with the Victorian Aboriginal Child Care Agency (VACCA), The School of Social Work & Social Policy, La Trobe University, The University of Melbourne and Berry St, Take Two to deliver family therapy training in the recently developed post Graduate Certificate in Child and Family Practice and post Graduate Diploma in Child and Family Practice Leadership for DHS child protection workers, many of whom are Indigenous workers in protective roles within their organisations.

In late 2006, the DHS Children and Family Services Division – Indigenous Initiatives Unit (IIU) engaged the Bouverie Centre to develop and implement a family therapy training program for Indigenous child and family workers employed by, or working closely alongside ACCOs. The aim of the training program was to increase the capacity of Aboriginal child and family workers to better meet the needs of families in community; particularly vulnerable and at risk Indigenous families.

The Indigenous Program Team. The Indigenous Program Team was constituted to deliver the training and was composed initially by staff from within the Centre. It then undertook to recruit, for the first time staff identifying as Aboriginal who could provide the expertise necessary for credibility to be established within the Aboriginal community. Currently, the Team comprises of a non-Indigenous Program Manager, an Indigenous Cultural Consultant and Project Officer, two non-Indigenous trainers, two Indigenous trainers and cultural consultants and an Indigenous family clinician.

The Bouverie Centre delivered a Family Therapy Training Program (FTTP) to its first cohort of trainees in regional locations in 2008 with a further two graduating from the training before the IIU funding expired in 2010. Regional training, where the course was delivered in community was promoted in order to improve accessibility and so that workers from the same area and organisations could support each other around the skills and knowledge that they were acquiring.

Decisions regarding the development of the FTTP were made in the context of an umbrella commitment by the Bouverie Centre's Indigenous Program to be advised by their Indigenous partners including the Advisory Group, the Aboriginal students participating in the first round of Training and managers from the Aboriginal controlled service from which a number of workers were employed.

The genesis of the AOD focussed family therapy training program. Subsequent to the IIU funding expiring, the Mental Health, Drugs & Regions Division, Department of Health

funded a training round in order to build the capacity of Aboriginal workers in the AOD sector and to a specified number of non-Aboriginal AOD workers who worked with Aboriginal families and clients. As workers in these positions were employed across a range of services and locations, this training differed from previous ones as it was not delivered within a single regional community. This presented some problems with recruitment, as most students needed to travel outside of their community to a metropolitan location and so did not receive the same level of support from their agencies or co-workers. Initially, insufficient AOD workers expressed interest in the training to make it viable, so the criteria was broadened to include Social and Emotional Wellbeing workers, where individual places could be funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH), and Student Wellbeing workers employed within secondary schools funded by the Department of Education and Early Childhood Development (DEECD). For the first time the Program was conducted in metropolitan Melbourne² through consultation with the Telkaya³ network. Five out of the ten students resided in metropolitan Melbourne and they represented the highest proportion of people attending the training from a particular geographical area. The Metro training comprised of six AOD workers, three Social and Emotional Wellbeing workers and one Student Wellbeing Counsellor. The AOD workers who attended this particular training came from both mainstream and ACCOs and are the primary participants in this study.

The FTTP assumes Recognised Prior Learning (RPL) equivalent to an undergraduate bachelor degree according to the Australian Qualifications Framework and requires three years support, counselling or case management experience with Aboriginal families. The commitment involves six hours per week for twenty-six weeks over the course of one year and at the completion of the training the students are provided with monthly group supervision over a two year period to support the implementation of their family therapy skills. The positions are fully funded with a ratio of Indigenous to non-Indigenous students capped at 3:1 in order to provide a generative and culturally safe learning environment.

Training grounded in Indigenous consultation. The provision of training to Indigenous workers by a mainstream organisation presents a number of challenges, including attracting funding and gaining the confidence and support of the Indigenous community. The Bouverie Centre, prior to 2008, had limited experience and knowledge of working with Indigenous families and so it needed to build relationships and negotiate partnerships with

² Henceforth referred to as the Metro training

³ Telkaya is a network of Koori alcohol and other drug workers in Victoria.

Indigenous agencies to ensure the uptake and sustainability of the training. The Centre has been on a steep learning curve regarding how to provide culturally appropriate services and training to the Indigenous community.

Though the Bouverie Centre has been at the forefront of family inclusive workforce development in Victoria it has found that, along with many other mainstream organisations that Aboriginal workers and ACCOs are under-represented in their programs. The Centre's Beacon Project has been innovative in its strategies to support the AOD, mental health and gambling sectors to implement purposeful family inclusive practices though it had not been able to successfully engage ACCOs.

The training of Indigenous AOD and social and emotional wellbeing workers, within the FTTP complements the Beacon workforce development strategy and demonstrates the degree of commitment to community consultation required by a non-Indigenous organisation, to address the workforce development needs of Indigenous workers.

The successful engagement and retention of Aboriginal workers in the FTTP has also rested on the Program's ability to deliver course material in a culturally relevant way that includes the implementation of a recursive feedback process. During the delivery of the training to the first cohort of students in Shepparton in 2008 it was determined that an alternate teaching approach was needed and the development of the 'Black and White Approach' began. Along with the Training being delivered by a non-Indigenous trainer and an Indigenous trainer and cultural consultant, the group and trainers work together to change the mainstream curriculum of the Program so that it reflects and incorporates the student's knowledge and practice wisdom of the students in the group. This co-created knowledge then becomes the foundation for the practice in experiential exercises. The model incorporates adult learning principles acknowledging the considerable skills and knowledge possessed by the group whilst deconstructing, understanding and applying mainstream theories and practices in culturally inclusive and relevant ways. This approach has proven to be critical to the success of the Program and will be discussed in more detail in Chapter 8.

The Indigenous Program has been financially supported through partnerships between La Trobe University; Philanthropic Funding bodies such as The Myer Foundation, R.E Ross Trust, John T. Reid Foundation; Fouress Foundation; and short-term contributions from OATSIH, DEECD and the Lowitja Institute as it endeavours to secure long-term Commonwealth funding.

The research contained in this thesis though informed by the research and evaluation of the FFTP training at the Bouverie Centre (Latham, 2010, 2012; Perlesz & Proctor, 2009) differs from this prior work through its focus on the training's relevance to drug services workers in the field of Aboriginal substance misuse and their particular workforce development needs and issues.

Structure of the Thesis

The artwork which is included in this thesis was produced by my field supervisor Robyne Latham and by Joanne Dwyer who have both worked with me closely throughout the research and made significant contributions towards my approach and understanding of the subject area. The meaning and significance of the artworks are explained in detail on the opening and closing pages of the thesis.

This thesis represents my exploration and meta-analysis of the research findings that have been forged through my relationships with the research participants. As the focus of this research is about the practice of working with substance misuse in Aboriginal communities and involves the perceptions of those engaged in the work on the relevance of family therapy interventions and training to their professional context, the intersections between theory and practice have been privileged throughout the thesis.

Chapter 1 introduces the study and how it came into being from a personal perspective as well as its relationship to the training program with which it is associated.

Chapter 2 examines the literature which is able to provide the context for drug service worker perspectives on substance misuse interventions, family approaches and the possibilities and challenges of engaging with education as suitable workforce development. This literature includes: Aboriginal health and substance misuse and that which determines it historically, politically and socially; interventions and therapeutic approaches that are culturally appropriate and effective; Indigenous education inclusive of strategies for engagement, Indigenous pedagogies and learning; and the workforce development of those drug service workers in the field of Aboriginal substance misuse.

Chapter 3 describes the ethical and theoretical basis for the selection of the methodological approaches and the ways it was translated into practice including the data collection processes, data analysis and research constraints.

Chapter 4 to 9 present the research findings and are grouped together to answer the various components of the research questions including how the search participants perceived family therapy in terms of a culturally appropriate means to address substance misuse, the usefulness of the family therapy training in terms of skills acquired, the cultural appropriateness of the

training, the pedagogical approach utilised and reflections on my own journey through the research.

Chapter 10 provides a discussion of the research findings, outcomes and possibilities for future research.

Anonymity of Research Participants. At all times throughout the research I have endeavoured to protect the anonymity of all research participants and the employing organisations of the managers, colleagues and drug service workers interviewed. Though the identity of the Indigenous Program Team is in the public domain I have chosen to refer to them under their job titles to offer some degree of anonymity.

Terminology. Throughout this thesis, the term Aboriginal or Koori refers to both Aboriginal and Torres Strait Islander people. The term Aboriginal is used in preference to Indigenous when referring to the research participants as this reflects their wishes; and Indigenous and Indigenous Australians are also used when referencing reports, programs or quotations.

Aboriginal community refers to a particular community of Aboriginal people as located within a specified area.

Aboriginal peoples and Communities (plural) are used to acknowledge the diversity of Aboriginal peoples and Communities within Victoria, all of whom have different histories, political dynamics, social situations, cultural characteristics, economic resources and administrative capabilities.

Family in the context Aboriginal culture refers to biological kin (blood kin), affinal kin (related through marriage) and classified kin (one who has earned a particular role and stature within the family). For example, a person who is not a blood relative can earn the role as a grandparent, parent, sibling or uncle and aunt, having equal stature within the family.

Mainstream is a contested term as Aboriginal people consider themselves an integral part of mainstream society. For the purpose of this research the term is used to refer to dominant society responses to health, education and research.

The 'Black and White approach' is the term used to describe the delivery of a mainstream family therapy curriculum in culturally relevant and sensitive ways. It was coined by the Aboriginal trainer and Aboriginal family therapy students participating in the first post Graduate Certificate in Family Therapy for Aboriginal child and family workers in 2008.

Acronyms. Throughout this thesis a full definition of terms (see below) is used in the first instance followed by the acronym in brackets. With subsequent use of the terms the acronym is utilised.

List of Key Acronyms and Abbreviations

ABS	Australian Bureau of Statistics
ACCO	Aboriginal Community Controlled Organisation
AOD	Alcohol and Other Drugs
ATSIC	Aboriginal and Torres Strait Islander Commission
COAG	Council of Australian Governments
DEETYA	Department of Employment, Education, training and Youth Affairs
FTTP	Family Therapy Training Program
HCFW	Health, Child and Family Workers
HREOC	Human Rights and Equal Opportunity Commission
NAHSWP	National Aboriginal Health Strategy Working Party
PTSD	Post-Traumatic Stress Disorder
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SEWB	Social and Emotional Wellbeing

Glossary of Key Government Reports

Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009

Koori Alcohol Action Plan 2010-2020

The Little Children are Sacred Report 2007

Ministerial Council on Drug Strategy (MCDS)

National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)

National Aboriginal and Torres Strait Islander Social Survey (NATSISS)

National Aboriginal Health Strategy (NAHS) 1989

National Drug Strategy (NDS) 2010-2015

New Blueprint for Alcohol and Drug Treatment Services 2009-13

Victorian Alcohol Action Plan 2008-13

Victorian Aboriginal Health Plan (VAHP)

Royal Commission in to Aboriginal Deaths in Custody (RCIADIC)

West Australian Aboriginal Child Health Survey (WAACHS)

Chapter 2 Literature Review

Introduction

The focus of this literature review provides a context for understanding the experience of drug service workers in the field of Aboriginal substance misuse being trained as family therapists and using family therapy in their work. In order to accomplish this, a number of fields have been traversed. To understand Aboriginal substance misuse in Australia the historical factors that contribute to the existence and maintenance of this problem will be considered. The causes of and treatments for Aboriginal substance misuse are contested in the literature and broadly focus on the degree to which trauma impacts on problematic substance use and in what realms can the implementation of policy and practice empower and encourage personal and community responsibility and sustainability. The literature reveals a variety of possibilities around the types of interventions available and how they can be employed when considering the various barriers to health and healing for Aboriginal Australians.

The inclusion of family in treatment, especially in the context of the social and emotional wellbeing of Aboriginal people is often mentioned within available literature though without the specifics on how this work is conducted or with clarity as to the rationale and orientation of the work. Research has yet to be conducted on family as the central unit of treatment for Indigenous substance misuse nor has workers' perception of the usefulness of the inclusion of families in treatment been gauged as a means to ascertain the potential of this modality.

The literature that will be reviewed in this chapter will firstly include the areas of Aboriginal health, trauma and substance misuse, thence social and emotional wellbeing and therapeutic approaches to addressing substance misuse in Aboriginal communities and finally Indigenous education and Indigenous pedagogies. The choice of literature reflects the intention to approach the research questions from Aboriginal concepts of health and wellbeing and then investigate the ways that family therapy as an approach may accord with Aboriginal beliefs, culture and practices and whether family therapy training could provide useful workforce development. This has meant that family therapy literature that reflects on working with Indigenous populations has been omitted. Critical theory has largely not been engaged as discussion around essentialism or whiteness theory was not evidenced in the research conducted. What was present in the data was a great need to acknowledge and engage around difference. The context that has been chosen to frame the research does however account for the ways that history and discourses have influenced policy and practice in the area of Aboriginal education, health and wellbeing.

The primary focus of this review is upon Australian literature surrounding Aboriginal health and substance misuse, Indigenous education and workforce development. International literature is

also drawn upon especially with regards to working with traumatised populations and where substance misuse treatment has incorporated both western and First Nation approaches. This literature is particularly relevant as treatments for Indigenous substance misuse in Australia have been influenced by practices by North American and Canadian First Nations peoples.

The databases utilised to compile this review included Informit, ProQuest and EBSCOhost under the terms Aboriginal/Indigenous; substance misuse/use/abuse, family counselling, family therapy, higher education, pedagogy, workforce development. Google Scholar alerts were received which tracked literature that included the search terms Indigenous, therapy, counselling, substance use, drugs, alcohol. Another important resource was the Australian Indigenous Health *InfoNet*, Kurungkurl Katitjin, Centre for Indigenous Australian Education and Research Edith Cowan University. This internet resource contains research compiled to inform policy and practice in Indigenous health. Subject areas accessed included: alcohol use, illicit drug use, volatile substance use, social and emotional wellbeing, counselling, Aboriginal and Torres Strait Islander Healthworkers, family violence, protective and risk factors. Other resources included the Australian Drug Foundation library, commonwealth and state government departments and drug and alcohol service provider websites.

Aboriginal and Torres Strait Islander Health in Context

Social Determinants of Health and Substance Misuse. This literature review begins with a discussion of Aboriginal health contextualised in relationship to the social determinants of health which includes those factors that have been seen to impinge and strengthen health and wellbeing. This literature provides the foreground for perceiving Aboriginal substance misuse and the applicability of interventions for this area.

The adverse health outcomes of Aboriginal and Torres Strait Islander people.

Over the past three decades it has been widely accepted that social inequity relates to health and developmental outcomes (Loxley, 2004; Marmot et al., 1991; Wilkinson, 1999). It has been argued that the health status of individuals and communities, including health-damaging behaviours such as substance misuse have a relationship to levels of education, financial status, adequate housing, sanitation, diet and access to a range of goods and services (Carson, Dunbar, Chenhall, & Bailie, 2007; Zubrick et al., 2004). Aboriginal people in Australia continue to experience significant levels of poverty, unemployment, ill health, incarceration and the lowest levels of education and life expectancy in relationship to any other cultural group in Australia (Garvey, 2008; Siggers & Gray, 2007; SCRGSP, 2011; Walter & Siggers, 2007). Aboriginal and Torres Strait Islander children are also grossly over-represented in child protection and out of home care statistics in Australia (AIHW, 2013; Australian Government Productivity Commission,

2014) which is significant in determining health outcomes over the life course (ABS & AIHW, 2008).

Understanding health in terms of social determinants arose in an International context in the 1970's. The Ottawa Charter in 1986 articulated that the conditions and resources for health include peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, equity in housing, adequate income and social power (Carson et al., 2007). In Australia since the late 1970s the Royal Commission into Aboriginal Deaths in Custody, The House of Representatives Standing Committee as well as the National Aboriginal Health Strategy Working Party reported a link between the social determinants of health and the poor health status of Aboriginal Australia (Cunneen & ATSIC, 1997; House of Representatives Standing Committee on Aboriginal Affairs, 1979; NAHSWP, 1989). The Royal Commission saw disadvantage and inequality as directly connected to the processes of disempowerment employed since colonisation (Cunneen & ATSIC, 1997).

Stressful life events can have a significant effect on social and emotional wellbeing and they may be experienced directly by an individual or people can be affected through the experiences of those close to them (ABS, 2010a). In 2008, 77% of Indigenous adults (aged 15 years or over) reported that they or their close friends or family had experienced at least one life stressor in the previous 12 months. The most common types of stressors reported were the death of a family member or close friend (39%), serious illness or disability (31%), inability to get a job (22%) and drug and alcohol problems (20%) (ABS, 2010a). An AIHW report (2009) into the health and welfare of Aboriginal and Torres Strait islander people found that the rate at which Aboriginal people experience life stressors is 1.4 times higher than for other segments of the population and this includes experiencing racism which has been found to impact health negatively (Paradies, 2007).

Reportedly more than one-quarter of Indigenous adults in 2010 experienced discrimination recently (ABS, 2010a) which can have ill-effects on both physical and mental health (AIHW, 2011; Paradies, 2007).

Though the causes of substance misuse are complex there is a growing body of evidence that links alcohol and drug misuse to the social determinants of health (Hunter, 1990; Loxley, 2004). Substance misuse has been attributed as both a cause and an effect of poor health where it is simultaneously a health problem and a cause of other health problems that generate and maintain conditions of disadvantage (Loxley, 2004; NAHSWP, 1989).

Resiliency. Though the risk factors for poor health outcomes have been more thoroughly documented protective factors have been identified which assist in mitigating them (Catto & Thomson, 2008; Garvey, 2008; Zubrick et al., 2010). Aboriginal people's resiliency is evidenced through the National Aboriginal and Torres Strait Islander Health Social Survey in 2008 where many Aboriginal people reporting a sense of wellbeing and of being happy most of the time despite the structural disadvantage they faced (ABS, 2010b). This resiliency has been found to be promoted through continuing and improving work opportunities (Hunter, 1993), social cohesion (Wilkinson & Marmot, 2003), strong family functioning (AIHW, 2006), and connection to land and culture (Rowley et al., 2008). Anderson has also suggested that an increased sense of mastery and control works to offset social stressors (2007).

Educational attainment is associated with better employment prospects and higher income which can increase access to health-related services, enhance self-esteem and decrease social alienation (SCRGSP, 2011). It appears that education is of most benefit to the social and emotional wellbeing of students when formal schooling is connected to knowledge they have acquired within their home and community (Dunbar & Scrimgeour, 2007). Malin (2003) suggests that the positive health effects of schooling found in Third World populations can be cancelled out for Aboriginal people when social exclusion extends into the classroom and that it is necessary for Aboriginal students to be adequately supported for the positive benefits of education to be felt.

Summary. Though many sections of the population suffer as a result of structural disadvantage with resultant impacts on health and substance misuse, the degree to which Aboriginal people experience these layers of disadvantage requires particular attention when considering the appropriateness of interventions for health and substance misuse. The protective factors that contribute to the resiliency of Aboriginal people also need to be drawn on, in order to capitalise on what is known to be of benefit in mitigating risk factors and life stressors. The literature on the social determinants in relationship to Aboriginal people indicate that systemic interventions across a range of domains are required to redress the social inequity that Aboriginal people experience. The research contained within this thesis can be viewed as addressing some of the known risk and protective factors contributing to substance misuse such as improved family functioning and social cohesion with a focus upon the agency of families and communities. As educational attainment is positively correlated with improved health and wellbeing outcomes this study's attention to understanding what constitutes accessible and relevant higher education can positively contribute to closing the gap for Aboriginal people

The Social and Historical Context of Substance Misuse in Aboriginal and Torres Strait Islander Communities

Underlying Indigenous disadvantage and the social determinants of health, is the history of Aboriginal people in Australia since colonisation in 1788 (Atkinson, 2002; Carson et al., 2007; Garvey, 2008). This history has included dispossession, loss of autonomy, racism, social exclusion and assimilationist policies that provided a legal framework for the removal of children from families. This history does not account for all the factors contributing to drug and alcohol misuse by Aboriginal people but the way substances have been used by this population can be seen in response to this history.

Smith (1999) has commented that framing substance misuse as a result of social inequity can function to remove social stigma and blame so that drug and alcohol issues are perceived to be not just individual or community problems but rather ones that need to be understood in a broader context. This assists in empowering individuals so that feelings of personal condemnation and inferiority do not power a cycle of abuse and disadvantage and it can be a part of communities taking control of how their problems are perceived and treated. Many Indigenous activists from different parts of the world have argued that mental illness, alcohol and drug problems and suicide are primarily a result of colonisation or lack of collective self-determination (Smith, 1999). Other commentators (Langton, 2012; Pearson, 2007) believe this approach has operated to place Aboriginal people in a position where their agency is reduced through focussing upon overwhelming structural disadvantage and an inequitable and traumatic past.

The acknowledgement of history is repeatedly cited as an essential starting point to address Indigenous health concerns (Atkinson, 2002; NAHSWP, 1989; Zubrick et al., 2010). Trauma therapists as well as those seeking reconciliation between Indigenous and non-Indigenous peoples recognise the importance of acknowledgement of past and present harms as a critical first step in a healing process (Herman, 1992) .

A History of Substance Use in Aboriginal and Torres Strait Islander

Communities. A number of factors have influenced Aboriginal people's relationship to drugs and alcohol some of which have already been discussed including the affects of colonisation and continuing inequity and disadvantage in terms of health and welfare indicators. The social anthropologist Maggie Brady has also contributed insightful accounts of the history of drug and alcohol use prior to white settlement and has tracked how particular patterns of usage have developed and been informed since colonisation by official and unofficial policy and practices. This work builds upon the work of Hunter (Hunter, 1990, 1993; Kahn, Hunter, Heather, &

Tebbutt, 1991) who has contributed greatly to a context for understanding Aboriginal substance use, misuse and treatment.

Prior to colonisation some Aboriginal communities drank fermented drinks with a low alcohol content though there are no accounts of this use being problematic and these beverages appear to have been associated with ritual rather than frequent use (Brady, MacKenzie, & Alcohol Education Rehabilitation Foundation, 2008). The Makassans had a good relationship with the Aboriginal people of Arnhem land and from 1720 they traded Arrack in order to access their sea and lands. This beverage had a high alcohol content and the Makassans drank to excess when socialising with Aboriginal people and passed on this way of drinking to them.

The British brought with them a drinking culture where alcohol was an intrinsic part of economic and social life. Colonial governments at that time believed that alcohol was harmful to 'full-blood' Aboriginal people as it was thought that they were not able to control their consumption and that self-control was an important element of modern 'civilised behaviour'. It may also have been the case that the British wished to decrease the likelihood of an alcohol fuelled insurrection by the traditional owners and so it was for a combination of reasons that from the early days of the colony governors Phillip and Macquarie ordered white settlers not to supply Aboriginal people with alcohol (Brady et al., 2008).

Contrary to the wishes of the ruling classes, Aboriginal people were often given alcohol in payment for services and tobacco was included as part of rations (Langton, 1993). Though Aboriginal people were witness to examples of moderate drinking in some quarters of white society many also experienced white rural workers binge drinking to a level where it was common for them to pass out. These workers frequently came to town on leave and drank all their wages and then returned to work in the bush again (Johnston & RCIADIC, 1991). Some of the Aboriginal men of the Kulin nation in Victoria were also employed as bush labourers and they too adopted a pattern of hard working and hard drinking where they would binge on alcohol until they passed out (Brady et al., 2008).

By 1838 laws began to be enacted throughout Australia prohibiting the sale of alcohol to Aboriginal people, with Victoria commencing its legislation in 1864. There were exemptions made for those who could demonstrate that they were sufficiently assimilated into white society which required distancing themselves from their family and culture (Reay & Beckett, 1964). These laws rather than acting as a deterrent and dissuading Aboriginal people from drinking, increased alcohol's desirability because of its illicit status and association with individuals' rights and freedoms. People were still able to purchase alcohol from those willing to sell it to them, though they were excluded from social venues where its use was supervised and were relegated

to the fringes of towns in parks and by rivers (Brady et al., 2008; Wilson, Stearne, Gray, & Saggars, 2010). Aboriginal people took to buying large quantities of high potency alcohol and consuming it hastily to avoid detection and in order to obtain the maximum effect in a short period of time (Brady, 2007; Reay & Beckett, 1964). This pattern of drinking continues to have an effect in the way that some Aboriginal people drink today.

Many Aboriginal people confined to missions were taught that alcohol was evil and so for some Aboriginal people drinking could be a source of guilt and shame as well as a mark of resistance against the missionaries and those promoting temperance (Brady et al., 2008; Phillips, 2003).

As the laws surrounding access to alcohol were racially and culturally based alcohol became a symbol for civil rights, freedom and independence. Citizenship was granted to Aboriginal people in 1963 and prohibition laws governing the right for Aboriginal people to drink were repealed the following year, so for some Aboriginal people citizenship and the right to drink were conflated with human rights (HREOC, 1995). The change in laws did not result in people moderating their drinking but rather it created a spike in alcohol consumption and a continuation of the drinking patterns previously established (Brady et al., 2008).

What is missing in this socio-historical account is the significant relationship between Aboriginal people, substance misuse and trauma. What follows is an account of the theories that generally relate to substance misuse and trauma and then specifically to the legacy and manifestations of trauma in Indigenous communities.

Trauma and Substance Misuse

There are a number of perspectives regarding how trauma impacts on problematic substance use. Though trauma is considered a risk factor for substance misuse it has been observed that many people who have been through traumatic experiences do not go on to develop problems in this area (Stewart, Pihl, Conrod, & Dongier, 1998). Similarly not all people who have been through highly stressful circumstances go on to develop Post Traumatic Stress Disorder (PTSD) (Carlson, 1997; van der Kolk & McFarlane, 1996; Wiechelt, 2007).

Link between PTSD and substance misuse. The prevalence of co-occurring PTSD and substance use disorder has been documented in recent years (Chilcoat & Menard, 2003; Jacobsen, Southwick, & Kosten, 2001). This finding has been reported across a range of populations including military veterans (Kulka, 1990), female survivors of sexual assault (Ullman, Filipas, Townsend, & Starzynski, 2005), and survivors of disasters (Adams, Boscarino, & Galea, 2006). Though the link between substance misuse and PTSD has been established the ways in which they relate is less understood. There are a number of hypotheses that seek to explain this

interaction, most commonly it is believed that self-medication occurs when people seek to relieve their trauma symptoms through using substances (Khantzian, 2003; Levine, 1997). Another view is that substance misuse places people in high-risk situations that increase their chances of being traumatised (Chilcoat & Breslau, 1998; Chilcoat & Menard, 2003; Stewart et al., 1998). Some also believe that substances change neuro-chemical functioning so that people become more susceptible to developing stress related disorders in response to traumatic events (Chilcoat & Breslau, 1998; Chilcoat & Menard, 2003).

It is unlikely that any one of these possibilities will be proven to be the singular factor determining the relationship between PTSD and substance misuse. It is perhaps more useful to understand how these possibilities operate for individuals and communities and in what particular ways substance misuse and trauma maintain one another.

Link between grief and loss and substance misuse. Within other literature dealing with the causes of substance misuse the effects of grief and loss are highlighted (Coleman, Kaplan, Gallagher, Downing, & Cains, 1982; Coleman, Kaplan, & Downing, 1986). Stanton and Todd's research with heroin users and their families found that there existed a high frequency of parents who had experienced a significant loss in their lives before the age of sixteen. It has been suggested that the substance using behaviour is part of an unresolved mourning process whereby family members re-enact the premature or unresolved deaths of other family members (Stanton & Todd, 1982).

Other studies have reinforced the theory of incomplete mourning where substance misuse functions to help families cope with death, separation, and loss (Coleman et al., 1982; Coleman et al., 1986). The premise of these studies has been that substance using behaviours act to unify the family around constant crises that make it difficult for the substance user to separate from the family. Patterns of interaction are maintained that keep the family in a state of mourning where feelings of hopeless and despair predominate (Coleman, 1991). Stanton and Todd (1982) describe a pseudo-individuality created through problematic substance use where a degree of separation is afforded though the family maintains involvement through frequent crises and avoidance of personal responsibility on the part of the user.

This model has some resonance in the context of Aboriginal substance misuse due to the high number of losses families have experienced. In 2008 almost half of Indigenous adults had lost a family member or friend in the past twelve months which was 2.4 times the rate for other Australians (ABS, 2010b).

Historical trauma in Aboriginal and Torres Strait Islander Communities. Within Indigenous communities the impact of PTSD and grief and loss are exemplified by the following.

Collective Trauma. Collective or cultural trauma are terms used to describe the intergenerational stress that has been transmitted to and experienced by Aboriginal people in Australia today as a result of the multiple traumas suffered through colonisation (Atkinson, 2002). Traumatic events experienced by past generations can be passed down to the survivor's children and grandchildren. These traumas become cumulative when they have not been acknowledged and when opportunities for healing have not occurred. As Atkinson notes 'today the trauma remains in the hearts, minds and souls of Aboriginal families whose ancestors survived those times' (Atkinson, 2002, p. 64).

Though collective trauma does not have the same acute impact normally associated with other types of trauma, it has longer-lasting repercussions (van der Kolk, 1987). It can affect the ways that individuals and communities perceive themselves, so that they come to feel victimised and full of rage which they can't express towards those who perpetuated their traumas (Atkinson, 2002). Inter-generational trauma manifests in identity crises, fractured families and communities, internalised shame, self-hate and self-destructive behaviours such as violence and self-harm (Phillips, 2003).

In order to comprehend the prevalence of violence in some Aboriginal communities it has been suggested that an understanding of trauma needs to be appreciated (Taskforce on Violence, 1999; Atkinson, 2002; Hunter, 1990) When people are suffering from stress related disorders caused by trauma the disinhibiting effects of alcohol provide a release for anger. When multiple violations have been experienced in situations where it is not possible to express natural feelings of anger the anger is stored in the body until, when under duress and often fuelled by alcohol, it is explosively expressed towards the self and others (Erikson, 1976; J. Herman, 1992).

Bessel van der Kolk says that the essence of psychological trauma is *'the loss of faith that there is an order and continuity in life. Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions and experiences...Trauma then is spiritual at its deepest level'* (van der Kolk, 1987, p. 226). The extent of trauma experienced by Aboriginal people can only be found in other populations subjected to systematic torture, genocide, concentration camps or urban or family violence (Raphael, Swan, & Martinek, 1998). Studies from these populations provide a basis for considering how these experiences may have impacted on Aboriginal people as there have not been sufficient studies completed to fully understand the effects of intergenerational trauma on Aboriginal Australians (Raphael et al., 1998).

Gagne's work, which takes a sociological approach to trauma in relation to First Nations people in Canada, also has relevance for Aboriginal Australians. She describes four tiers of trauma that can be located within a cycle of traumatic events. The first tier is colonialism, the second tier political and socioeconomic dependency, the third tier residential schools and alcohol and substance abuse, and the final tier including cultural bereavement, family violence/accidental deaths/child abuse/sexual abuse (Gagne, 1998). Parallels can be drawn between the experiences of those who experienced systematic processes of separation from their family and homelands in Australia, the Stolen Generations and those who were forced into residential schools in Canada.

The Stolen Generations. The term Stolen Generations describes the Aboriginal and some Torres Strait Islander people who were forcibly removed from their families as children by past Australian Federal, State and Territory government agencies and church missions from the late 1800s to the 1970s. These removals were carried out as acts of parliament and the children removed were sent either to institutions or adopted by non-Indigenous families.

It is estimated that over 100,000 Aboriginal and Torres Strait Islander people have been affected as a result of this systematic removal of children from families and communities with direct effects for at least 1 in 10 families (Raphael et al, 1998). Some would argue (Hunter, 1993; Raphael et al., 1998) that there are current vestiges of these practices, with Aboriginal children in Victoria are 11 times more likely to come into contact with the child protection system than other Victorian children (ABS & AIHW, 2008).

Stressors experienced by children from the Stolen Generation include separation distress, searching behaviours, multiple grief, emotional and behavioural disturbances, denial and stigmatisation of their Aboriginality and cultural heritage and loss of identity (Raphael et al, 1998). Post-traumatic stress syndromes are the most prevalent effect likely to follow such experiences of separation (Raphael et al, 1998). PTSD impacts personality and identity and through an increased vulnerability to self-harm, suicide, substance abuse and re-victimisation (Raphael et al., 1998).

Parents who suffer from PTSD as a result of being one of the Stolen Generations can pass on the effects of trauma to their children. Some of these parents have not experienced adequate care and nurture themselves so they do not know how to provide this for their children (Wilson, 1997). Impairment in parenting can result from PTSD symptoms so that children take on increased responsibilities in the home including care for the parent and for their siblings (Irwin in Raphael et al, 1998). These children may continue the role of nurturer more generally

throughout their lives which Bowlby (1979) defines as care of the vicarious object, where the individual cares for the wounds of others as he or she would like to be cared for.

The effects of the multiple traumas are intensified when the systems designed to protect instead cause re-victimisation (Levine, 1997; Raphael et al., 1998). Aboriginal Protection Legislation was designed to care for the needs of Aboriginal people in each state and create safety for people who had been traumatised. The protector was the legal guardian of every Aboriginal child in the state under the age of 21. Instead of ensuring the wellbeing of Aboriginal people the protectors often kept families apart; denied them the right to practice their culture and ceremonies or speak traditional languages; enforced dependency; perpetrated sexual abuse; and provided limited access to essential services (Atkinson, 2002; HREOC, 1991).

Government and non-government bodies, at times though well-intentioned have interceded intrusively into Aboriginal communities creating dependencies and dysfunctions that have re-traumatised and compounded feelings of hopelessness (Atkinson, 2002, p. 58). The social systems within Aboriginal communities that can ameliorate the effects of trauma have been so damaged in some circumstances that the opportunities for healing have been diminished (Atkinson, 2002; Siggers & Gray, 2007). With kinship and family ties broken social norms disrupted traditional forms of social control were broken down (Hunter, 1993). It has been noted that males particularly have suffered a loss of identity and this coupled with a lack of connection to traditional expressive outlets has contributed to alcohol misuse in Aboriginal communities (Albrecht in Hunter, 1993).

The emphasis on the effects of trauma needs to be balanced with an understanding of resiliency, strengths and successes in Aboriginal communities as too much focus on trauma may reinforce images of disorganised, hopeless communities which require paternalistic interventions (Gagne, 1998). Some have argued that the Northern Territory Intervention⁴, which has required the repealing of certain sections of the Racial Discrimination Act has served to perpetuate this discourse through its top down disempowering approach to issues in Aboriginal communities (Central Land Council, 2008).

⁴ On 21 June 2007, the Australian Government announced a 'national emergency response to protect Aboriginal children in the Northern Territory' from sexual abuse and family violence. This has become known as the 'NT intervention' or the 'Emergency Response'.

Recent Policy and Practice in the Prevention of Substance Misuse

Self-determination. During the 1970s and 1980s there was a growing understanding of the importance of personal agency and self-determination in regards to the health of individuals and communities. The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) centred its recommendations around the empowerment of Aboriginal people and their 'right to exercise maximum control over their own lives and that of their communities' (Johnston & RCIADIC, 1991, p. 27). The Commission stressed that the elimination of Indigenous disadvantage which led to the high rates of Aboriginal incarceration could only be achieved through empowerment, self-determination and reconciliation (Johnston & RCIADIC, 1991). The RCIADIC's findings supported the establishment of alternative interventions to alcohol misuse other than incarceration which included the decriminalisation of public drunkenness and the establishment of community-based sobering up facilities (Cunneen & ATSIC, 1997).

Significant to the goals of self-determination was the creation of Aboriginal controlled organisations (Bartlett & Boffa, 2005). These organisations aimed to have community members involved in decision making regarding all aspects of their health including how services were provided. It was hoped that these more culturally relevant services would improve Aboriginal people's access to them as mainstream organisations struggled to engage and attend to the special needs of Aboriginal people (Brady, 2007).

Central to achieving self-determination was acknowledging the land needs of Aboriginal people. Land rights could enable Aboriginal people to exercise control over their lives which in turn would improve their health and wellbeing (Johnston & RCIADIC, 1991; NAHSWP, 1989). The National Aboriginal Health Strategy Working Party (NAHSWP) explained that Aboriginal peoples' relationship to land was part of a three dimensional model of health including 'the inter-relationships between people and land, people and creator beings and between people' (NAHSWP, 1989, p. x). The inter-dependency of these systems meant that for Aboriginal people health was a sovereign issue.

National Aboriginal Health Strategy. This National Aboriginal Health Strategy outlined in 1989 a change in the way substance misuse and health more broadly was approached in terms of policy and service provision (Hunter, 1993). The NAHSWP emphasised the need to view health in terms of social, emotional and cultural wellbeing and that,

'Health' to Aboriginal peoples is a matter of determining all aspects of their life, control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.

Though this definition of health was subsequently taken up by government departments and included in policies and frameworks pertaining to health and substance misuse, insufficient resourcing meant that the strategies and recommendations outlined by RCIADIC and the NAHSWP were not implemented adequately (Cunneen & ATSIC, 1997; Gray et al., 2008).

Prior to 1990 two separate government departments handled Aboriginal health with neither employing Aboriginal staff (Brady, 2004). In 1990 the Aboriginal and Torres Strait Islander Commission (ATSIC) took over the responsibility for Aboriginal health at a national level in order to involve Indigenous people in the processes of government that affected their lives. ATSIC developed its response to Aboriginal substance misuse separate from the strategies implemented by the National Drug Strategy (NDS) so that some new developments in treatment were not incorporated into Aboriginal services (Brady, 2004).

Harm minimisation. In 1985 the NDS adopted harm minimisation⁵ as its guiding approach to substance misuse which was in contrast to the majority of the Aboriginal AOD sector which saw abstinence as the primary goal of substance misuse interventions (Alati, Peterson, & Rice, 2000; Brady, 2004). Residential rehabilitation with an abstinence philosophy was the predominant form of treatment for Aboriginal substance users (Alati et al., 2000) and by the mid-1990s, Indigenous people were more likely than non-Indigenous Australians to be receiving this type of treatment (Brady, 2007). A broader range of interventions, including AOD interventions in primary care settings were slow to be taken up (Brady, 2007) though there were some innovative acute interventions recognised by international research also instituted at this time by Aboriginal community based organisations (Brady, 2007).

Philosophical differences existed between the residential services who based their programs on the 'disease model'⁶ and the Aboriginal Health Services who favoured a social model of health.

⁵ Harm minimisation involves the principles of supply reduction, demand reduction and harm reduction. Supply reduction refers to strategies to limit the supply and production of illicit drugs and the control of legal drugs. Demand reduction involves prevention strategies that aim to reduce risk factors that encourage the use of drugs and alcohol. Harm reduction focusses upon reducing the negative effects of drug and alcohol use on those already involved in substance use.

⁶ E. M. Jellinek is regarded by many as the father of the modern disease model. His research produced two major constructs, the stages of the disease and the species of diseases. The stages of the disease had a major impact on how alcoholism (and addictions in general) were viewed. According to his theory there are four stages in alcoholism, pre-symptomatic stage – no problems with alcohol; prodromal stage – characterised by blackouts (amnesic episodes), guilt and increasing drunken episodes; crucial stage – characterised by failed attempts at controlling use, loss of willpower; and the chronic stage – mental and physical complications and increasingly lengthy binges. Many of these symptoms can be seen in heavy drinkers but Jellinek distinguished heavy drinkers from 'real alcoholics' by their ability to control their drinking (ie stop at will or decide whether or not to drink). Jellinek suggested that although there were exit points at each of these stages (ie the alcoholic could stop drinking) the majority of alcoholics would continue to the chronic stage. It was at this stage, when physical and mental damage had occurred that change would be most likely to occur. The American Medical Association (AMA) had declared that alcoholism was an illness in 1956. In 1991,

The federal government who directly funded residential treatment helped to maintain this segmentation by not providing sufficient management support nor capacity building around the knowledge and delivery of a broad range of treatment modalities (Brady, 2004). Part of the reason for this was that government departments were unsure of how to both disseminate evidence based approaches and maintain the principles of self-determination and community control (Brady, 2007).

The Little Children are Sacred Report. The conservative national government on taking power in 1995 closed down representative bodies such as ATSIC and relocated responsibilities to mainstream government departments. There was a shift away from self-determination to an emphasis on national unity and the integration of policies and services with 'practical' rather than 'symbolic' forms of reconciliation (Wilson et al., 2010). The Little Children are Sacred Report in 2007 (Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, Wild, & Anderson, 2007) saw the onset of the Northern Territory (NT) Intervention (Commonwealth of Australia, 2008) and the introduction of compulsory health checks for Aboriginal people. To be applied the NT intervention needed to repeal certain parts of the Racial Discrimination Act and it attracted strong opposition for its perceived lack of consultation and 'top down' approach (Brown & Brown, 2007; Central Land Council, 2008; Combined Aboriginal Organisations of the Northern Territory, 2007). Noel Pearson's support for the NT Intervention has been defended by others such as Marcia Langton (Langton, 2012) where he believed that an over emphasis upon the traumatic history and rights of Aboriginal people has translated to toleration of unacceptable levels of abuse in Aboriginal communities which need to be acted on directly without consideration for context in order to promote responsibility in those communities (Pearson, 2007).

Significant steps in the right direction. A new national Labor government in 2008 made an apology to Aboriginal people on behalf of all Australians (Rudd, 2008) and committed itself to 'Closing the Gap' between Indigenous and non-Indigenous Australians. The Council of Australian Governments (COAG) committed \$4.6 billion towards closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation, halving the gap in mortality rates for children under five; and addressing Indigenous disadvantage in areas of education and employment (COAG, 2009). Increased funding was also directed towards services dealing with drug and alcohol rehabilitation and treatment (Gleadle et al., 2010). The 'Closing the Gap' initiative has generated a national Indigenous representative body (National Congress of Australia's First Peoples), reformed many health policies and created a minister for Indigenous

The AMA further endorsed the dual classification of alcoholism by the International Classification of Diseases under both psychiatric and medical sections.

health. Many objectives of Closing the Gap are still yet to be realised such as a long-term plan to incorporate evidence based strategies into Aboriginal health services and adequate resourcing and support for services to fully participate in the decision making and responsibility for their health needs (Holland & Close the Gap Campaign Steering Committee for Indigenous Health Equality, 2012). The continuance, under the previous Labor government of the Northern Territory Intervention until 2024 disappointed and angered many as it represented a lack of community control in determining how Aboriginal health and wellbeing is approached (Combined Aboriginal Organisations of the Northern Territory, 2007).

Closing the Gap. In the state of Victoria the 'Closing the Gap' health targets and actions have been incorporated into the Victorian Aboriginal Health Plan (VACKH, 2009) which identifies key strategies to close the health gap between Aboriginal and non-Aboriginal people in Victoria. The plan seeks to progress a holistic approach to health care that can more effectively meet the needs of Aboriginal people. This includes strengthening ACCHOs, supporting community development and leadership, promoting culture and encouraging positive social structures. Coordinating the delivery of health care across services and facilitating collaborative action between the health and non-health sectors are central to achieving these outcomes (VACKH, 2009)

Within the Koori Alcohol Action Plan 2010-2020 (DoH, 2010) and the Victorian Alcohol Action Plan 2008-13 (DHS, 2008c) there is an emphasis on including family in treatment as well as instituting a range of early intervention, prevention activities and improved treatment options (DHS, 2008a). As part of the New Blueprint for Alcohol and Drug Treatment Services 2009-13 the Victorian government committed to clients being supported to engage and reconnect with their families and their communities (DHS, 2008b).

At a national level other important current policies include National Drug Strategy 2010-2015 (MCDS, 2011) and the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009 (MCDS, 2006). Reviews on the implementation of current policies and programs highlight a decrease in the resourcing of community controlled organisations and a waning commitment to Aboriginal organisations leading the provision of culturally appropriate services (Brady, 2007; Gleadle et al., 2010; Gray & ANCD, 2010). Also noted is a lack of specific services for young people, women and families and those with co-occurring disorders (Gray & ANCD, 2010).

Some of the key aspects of best practice in service delivery for Indigenous substance misuse have been identified as: sustainable programs where funding, leadership and coordination are evaluated; the strengthening and empowerment of family and community to take responsibility

for the health of community members (SADoH, 1999); improved access to a wide range of Indigenous specific interventions; better access to training and professional development and increasing incentives for workers entering into the sector (Gray & ANCD, 2010).

Having discussed the contextual factors impacting on Aboriginal substance misuse such as the social and historical influences including trauma, the effects of colonisation and recent policy, a specific review of the extent of the problem will be undertaken.

Substance Misuse among Aboriginal and Torres Strait Islander People

Substance misuse by Aboriginal and Torres Strait Islander people varies across communities and the associated harms experienced by these communities also differ in relationship to other contextual factors (DoH, 2010). The following statistics represent national figures however, where regional differences are collapsed they serve to provide the greatest amount of information in which to gain an understanding of the problem. The data presented here have largely been accessed from the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW). Studies such as the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) have also been drawn upon, though it is recognised that these studies have not been designed specifically to address issues of alcohol and other drug use and can reflect a tendency towards under-reporting (Wilson et al., 2010). Gaps also exist in the data surrounding the ways in which alcohol and other substances are consumed and the differences that may occur between subgroups.

Impact of Substance Use and Misuse on Aboriginal and Torres Strait Islander Communities. Substance use and misuse plays a significant role in the disparities between Indigenous and non-Indigenous Australians in life expectancy and health outcomes. The differences in the substance use patterns between Indigenous and non-Indigenous are particularly apparent in higher rates of smoking and short-term risky drinking (AIHW, 2011).

Table 1. Current Substance Use (previous 12 months), percentage of persons aged 14 and above, by Aboriginal status, 2004

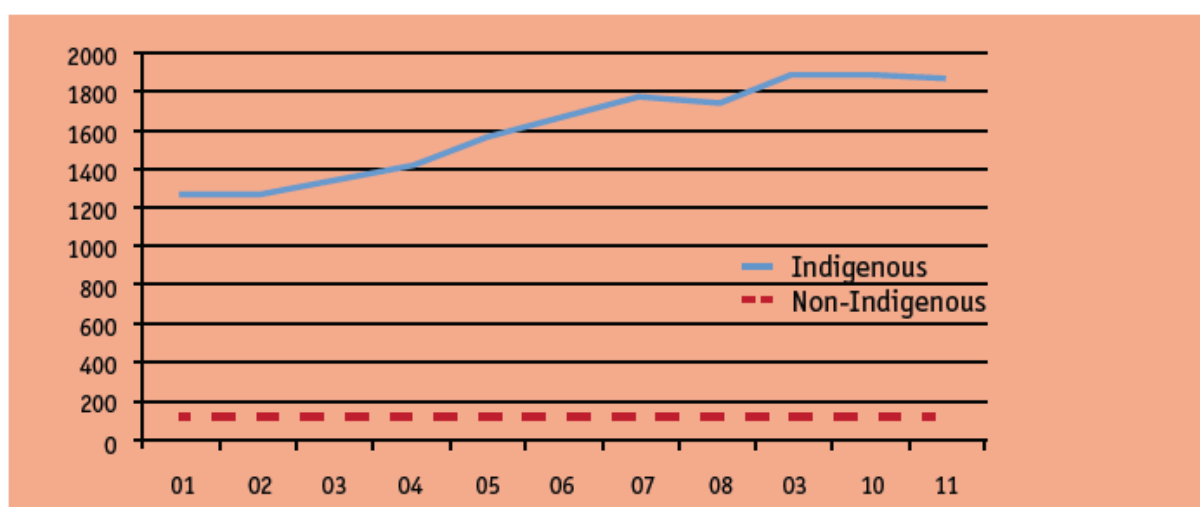
Substance	Aboriginal	Non-Aboriginal
Tobacco	52.0	22.5
Alcohol		
Abstainer	21.3	16.1
Short-term high risk	52.0	35.5
Long-term high risk	22.7	9.7
Cannabis	23.0	11.3
Meth/amphetamines	7.0	3.2
Pain killers/analgesics (non-medical use)	6.0	3.1
Inhalants (including petrol)	≈1.0	0.4
Heroin	≈0.5	0.2
Injected drugs	≈ 3.0	0.4

Note. Reproduced from Australian Indigenous HealthInfoNet (2010). Source AIHW 2005, 2006.

High incarceration rates. Alcohol misuse has significant social costs and contributes to the high rates of violence and incarceration of Aboriginal people. Aboriginal females and males were 35 and 22 times more likely to be hospitalised due to family violence-related assaults as other Australian females and males, respectively and approximately 19% of Indigenous Australians reported having abused someone while under the influence of alcohol in the past 12 months. In the periods 1999-2000 and 2008-09, 71 per cent of Indigenous homicides involved both the victim and offender having consumed alcohol at the time of the offence, compared with 25 per cent of non-Indigenous homicides (SCRGSP, 2011). Indigenous females and males are nearly ten and nine times more likely to die due to assault as non-Indigenous females and males, respectively (Al-Yaman, Van Doeland, & Wallis, 2006).

Alcohol and illicit drug use have been found to be the two most significant factors relating to the imprisonment of Aboriginal people (Weaderburn, Snowball, & Hunter, 2006). The rates of incarceration of Indigenous people is over 15 times higher than for non-Indigenous people (ABS, 2013) and whilst the non-Indigenous prisoner rate has remained constant between 2001-2011 the rate of Indigenous incarceration has almost doubled during that same period (ABS, 2011).

Table 2. Indigenous and non-Indigenous prisoners 2001-2011 (rate per 100,000 relevant persons)



Note. Reproduced from NIDAC (2013). Source ABS (2011).

The proportion of prisoners who are Indigenous varies markedly across states and territories and in 2013, the Northern Territory had the highest proportion (86%) and Victoria had the lowest proportion of Indigenous prisoners (7%) (ABS, 2013).

Burden of disease. Substance misuse contributes significantly to the burden of disease in the Indigenous population and in 2003 tobacco smoking was the number one risk factor contributing to cardiovascular disease (33%) and cancer (35%) and alcohol contributed greatly towards injury (22%) and mental disorders (16%) (Vos, Barker, Stanley, & Lopez, 2007). In addition, the burden of ill-health due to the harmful use of alcohol was 4.5 times greater than that experienced by non-Indigenous Australians (Vos et al., 2007).

The emotional harms inflicted by substance misuse are evidenced by the fact that Indigenous people are hospitalised for mental and behavioural disorders caused by substance misuse at four and a half and three times the rate of non-Indigenous men and women (ABS & AIHW, 2008). Indigenous people reported experiencing a high/very high level of psychological distress at two and a half times the rate for non-Indigenous people (32 per cent compared to 12 per cent). The proportion of people experiencing a high/very high level of psychological distress increased from 27 per cent to 32 per cent in 2009, while the proportion of non-Indigenous people remained relatively stable (SCRGSP, 2011).

Substance misuse has also been associated with other harms such as suicide and self-harm, road trauma, child abuse and neglect, social disruption and diversion of income (Wilson et al., 2010, p. 6).

Indigenous healthcare services. Some of the barriers for more effective responses to Aboriginal substance misuse can be located within the provision of services for Aboriginal people. The majority of Indigenous services are provided by non-Indigenous health care providers which is an issue as most Aboriginal people prefer services managed and staffed by Aboriginal people so it is not surprising that mainstream services are not being accessed at the commensurate level of need (Gray, Haines, & Watts, 2004; Howard, 2009; MHDRD, 2010).

However some Aboriginal people prefer to access mainstream health services for a number of reasons. Confidentiality can become an issue when Aboriginal controlled organisations are staffed with people from within their own communities and people may wish to protect their privacy and speak to someone who is unaware of their history and family (NRHPF, 1999). Accessibility to mainstream services can be improved for those needing to access these services through employing Aboriginal staff, undertaking cultural awareness training and forming partnerships with Aboriginal controlled organisations (DoHA, 2010; Teasdale et al., 2008). Financial, cultural and other barriers to Aboriginal and Torres Strait Islander access to mainstream services exist in all areas (NACCHO 2001).

In Victoria Indigenous specific AOD services face a number of challenges in providing services to their community. A recent report found that many Aboriginal Community Controlled Organisations (ACCOS) were hampered by insufficient resources, short-term funding cycles, difficulty attracting qualified and trained staff, and trouble accessing training and workforce development (Gray & ANCD, 2010). The majority of AOD services for Indigenous people are not provided through these services but are supplied by primary health care workers who have not had access to sufficient information or training to be able to respond adequately to the issues they face (AHMAC, 2002). Many staff members at specialist Indigenous AOD services are ex-clients, which is also common practice in non-Indigenous AOD services as well and though these workers possess significant experience they often lack formal qualifications which can limit the range of interventions they are able to provide (Gleadle et al., 2010; Gray et al., 2004).

AOD work in any context is demanding though Aboriginal workers also need to manage, stigmatisation of clients and workers, heavy workloads, under-resourced programs, lack of workplace support and inequitable remuneration (Gleadle et al., 2010). Workers also find it difficult to deal with the expectations of their communities alongside that of their non-Indigenous employees and colleagues which contributes to stress, burnout and a high attrition rate (DoHA, 2010).

Current Approaches and Interventions in the Prevention and Treatment of Substance Misuse in Indigenous Communities

Current treatments for Aboriginal substance misuse occur in a variety of settings including primary healthcare, community and residential settings. It has been found that Aboriginal substance users present for treatment at a later stage than that of the general population and often with a number of co-occurring conditions (DoHA, 2010; Gleadle et al., 2010; Loxley, 2004). Intervention into substance misuse can be classified as prevention, early intervention, secondary prevention or tertiary intervention. Some of the approaches offered are brief interventions, home-based withdrawal, inpatient detoxification, residential treatment, and drug and alcohol counselling (Gray et al., 2008).

Primary prevention. Primary prevention includes understandings around what constitute risk and protective factors of substance misuse and aim to attend to these factors to decrease the amount of people going on to have issues with substances later in life. Such activities include education with parents around the effects of substance misuse on unborn children and support that enables smooth transitions through schooling. Positive family functioning is encouraged through involving parents in programs with young people and parenting programs (Bamberg, Blyth, Toumbourou, & Forer, 2001; Templeton, Velleman, & Copello, 2005; Velleman, Templeton, & Copello, 2005). For young people mentor programs, access to sports and other types of recreation such as wilderness and culture camps can help to increase young people's connectedness to family and community which has been shown to decrease the likelihood of substance misuse occurring later in life (Brook, Brook, & Pahl, 2006; Gray & ANCD, 2010; Templeton et al., 2005; Velleman et al., 2005).

Dennis Gray et.al. (2000) have reported that the most successful interventions designed for Aboriginal people to address alcohol misuse have arisen from within communities rather than from implementation of institutionally derived programs. What can be seen to be significant in this finding is the necessity for communities to have ownership of interventions which is consistent with the belief in Indigenous self-determination as a prerequisite for the health and wellbeing of Indigenous people (Johnston & RCIADIC, 1991; NAHSWP, 1989). The control of supply has been employed successfully by remote communities and has significantly reduced harm however this approach cannot be employed in all communities and is not always appropriate (Brady, 2004; Gray et al., 2000). Other types of supply reduction activities have included; the creation of 'dry communities' where alcohol is banned, restrictions on opening hours and days when alcohol can be sold, limiting the types of alcohol available and creating 'dry houses' where people are able to find protection and respite from drinking environments (Brady,

2004; Gray et al., 2000). The focus on supply reduction within some Aboriginal communities is in marked contrast to the general trend in Australia where alcohol is increasingly accessible (Gray et al., 2000).

Some of the other more effective community led interventions have been those supported by non-government Indigenous organisations such as women's land councils and legal and health services and have included the use of Indigenous media for prevention messages, sobering up shelters and community patrols (Brady, 1995c, p. 20; Hazlehurst, 1994).

Communities in the Northern Territory in response to solvent abuse led the introduction of Avgas in the early 1990s and then in 2005 due to Avgas's high lead content it was superseded by Opal fuel. Both of these substances due to their low volatility prevent intoxication and have decreased petrol sniffing in remote communities in South Australia, Northern Territory, Western Australia and Queensland (d'Abbs & Shaw, 2008).

The World Health Organisation has been instrumental in creating the perception that the supply of alcohol and other substances of dependence represent a public health issue (WHO, 2010a, 2010b). Though supply reduction has been successful it does not address the social aspects of substance misuse and within Australia The Royal College of Physicians has urged government to seek to fund other prevention and treatment activities to commensurate amounts as to that awarded to law enforcement of supply reduction (RACP, 2004). The Northern Territory's Select Committee on Substance Misuse in the Community also has claimed that there has been an over-reliance on supply reduction and recommended other forms of treatment and demand reduction also be utilised (SCSAC, 2007).

In Australia primary or tertiary prevention are the most prevalent forms of intervention with less focus placed upon secondary prevention (Brady, 2004). Residential and community treatment programs predominate as tertiary forms of preventions with the many services combining Alcoholics Anonymous or abstinence based approaches with other types of treatments (Clapham, O'Dea, & Chenhall, 2007).

Secondary Prevention. It is within the sphere of secondary prevention that family therapy can be located as an approach to the treatment of substance misuse. Secondary prevention activities have not garnered as much funding or support though there has been research that suggests their effectiveness within Aboriginal populations in Australia (Hayman, White, & Spurling, 2009; Mayers & Couzos, 2004). Secondary prevention involves intervening once some of the negative effects of substance misuse begin to show through physical symptoms, family and relationship issues and problems surrounding work and education. In

recent years in Australia brief interventions have begun to occur through assessments in primary care settings so that early detection of the harmful use of substances can halt the progression towards chronic and acute conditions through the provision of advice, counselling and support (Hayman et al., 2009; Mayers & Couzos, 2004).

Brady (2004) has also given weight to the case for secondary prevention activities where Aboriginal people who had managed to stop using alcohol harmfully recalled how a 'health scare' and a medical practitioner giving them a 'hard talk' had helped them realise the harmful role of alcohol in their lives. Other reasons people cited for cutting down or quitting drinking were family responsibilities including the care of children or elderly parents, conflict with partners, losing a driver's license or a job and other work issues all were cited as causes for change. Considering the importance of family as a motivating factor for the cessation of problematic substance use lends weight to the potential benefit and efficacy of family-based interventions.

Though the number of prevention and treatment strategies have increased over the past few decades there is a lack of evidence to adequately demonstrate the most useful approaches (DoHA, 2010; Wilson et al., 2010). Siggers and Gray (1998) found that, of 205 Indigenous alcohol and drug projects, 39 per cent had no evaluation component, 31 per cent collected data on administration processes and only 30 per cent conducted some form of formal evaluation. Whilst informal accounts bear witness to the effectiveness of particular approaches and knowledge is growing on what constitute the elements of effective practice, policy and treatment guidelines rely mostly on qualitative studies which reveal equivocal results (Clapham et al., 2007; DoHA, 2010).

The Primacy of Residential Treatment.

The influence of Canada and North America. Residential models have been a central component of treatment for Indigenous problematic substance misuse and reflect the beliefs and practices that have informed this field for nearly forty years. Though available research into the efficacy of residential treatment programs is sparse they have predominated, largely because of the influence of residential programs for First Nations people in Canada and North America (Brady, 1995a; Gray & ANCD, 2010; Kahn et al., 1991).

Gregory Phillips (2003) has researched this connection and explains that this model of treatment was readily taken up in Australia partly as a result of the parallels in experience existing between the communities and because,

Culturally Indigenous Australians and First Nations peoples – while featuring marked traditional diversity and identities – all believe in earth-based spiritual creation stories, and all believe in and practice reciprocal obligations to their creator beings, their lands, and their animal and floral environments...thus, not only do Native peoples share similar cultural and spiritual values and beliefs with Indigenous Australians, but also histories of colonisation, traumatisation and continuing oppression, histories of stolen generations...and other experiences in government policy and strikingly similar histories of alcohol and other drug usage and related violence.

(2003, p. 138)

Important to the North American and Canadian programs is the incorporation of First Nation cultural and healing practices into mainstream treatment (Brady 1995a; Phillips 2003; Narayan et al., 1998; Rose, 1992). Examples of this are the sweat lodge (a type of traditional steambath or sauna) and the medicine circle which have both become associated with a new positive cultural identity (Phillips, 2003). The premise on which their inclusion is based, is that through embracing traditional practices, a positive cultural identity can be developed which makes the achievement of abstinence more likely. One Sioux elder after receiving treatment described how a changed identity was key to recovery from his alcohol dependency as, 'the problem lay in me trying to be someone I was not' (Hazlehurst, 1994, p. 103).

The Nechi Institute and Poundmaker's Lodge, a residential rehabilitation facility in Alberta Canada are important centres of research and training for those working in First Nation communities. The Nechi Institute offers training for AOD workers in culture and traditional values, family and group work, suicide prevention and grief and loss. The family work component comprises forty five hours of training which would enable workers to be family inclusive rather than be able to apply family therapy interventions. What is not clear is the ways families are included in treatment. The literature speaks of the family disease that would focus on how many people close to a substance misuser are affected. What can occur in mainstream treatment, when people have minimal training in family interventions, is to focus on how family members can support the substance misuser in their recovery rather than applying systemic interventions that involve whole families.

Intrinsic to the program at Poundmaker's Lodge and to many other rehabilitation services for First Nations people, is an abstinence philosophy based on the twelve steps of Alcoholics Anonymous (AA). Other components of the Poundmaker's program include psychoeducation around the effects of drugs and alcohol on the individual and their relationships, group work, behavioural therapy, counselling, anger management, tobacco cessation, recreation and leisure

programming, nutrition, career planning or training, budget planning, relapse prevention (Poundmaker's Lodge, 2012). A psychosocial approach is central here with counselling and family work less the focus than the development of life skills. As a result of the resonance of the program for Aboriginal people, aspects of this approach have been taken up within Australian treatment facilities such as Benelong's Haven Namatjira House and Oolong House. Another reason for the success of the Poundmaker's Lodge program may be that there has not been sound alternatives to an abstinence based approach so this model has come to be seen by some as best practice. An abstinence model is generally a part of viewing substance misuse as a disease which is best addressed when a person has 'hit bottom' which means a focus on tertiary interventions.

Research undertaken by the Nechi Institute has focussed on the activities graduates of their program have become involved in as part of their aftercare. AA top scored at 47%, spiritual and cultural activities 27%, therapy and counselling 16%, work and career 12% (Phillips, 2003, p. 140). This sample, though representing only people experiencing a particular type of program, does indicate what they found most useful and the types of treatment they were willing to engage in. The low rating of therapy and counselling could reflect the emphasis in the program on social and cultural supports which concurs with the success in mainstream of multi-dimensional family therapy (MDFT) in the treatment of substance misuse with adolescents or interventions that encourage a range of supports across a number of domains (Liddle & Rowe, 2006).

Other studies of First Nation programs in Nth America have shown that success, in terms of continued abstinence is dependent largely on the quality of support received by clients when they exit rehabilitation (Hazlehurst, 1994). Similarly, it has been found that those not attending residential treatment who are seeking to recover from substance misuse have a much higher chance of success if they have the support of people in their community (Hazlehurst, 1994). What can be surmised from these findings is that mobilising the family and community around substance misuse is critical and that one of the ways to do this is to provide supports for the family and community to manage the effects of substance misuse on themselves so that they are able to create a strong community providing alternatives to substance using behaviour. Within mainstream treatment in Australia there has been an increasing emphasis on including families in treatment where families can be a part of either supporting change or maintaining the status quo (Guttman, 1981; Quadrio, 1987) and provide the sustained support which service providers cannot (DHS, 2008b).

Within the treatment in Canada of native adolescents who misuse substances, it was found that the most promising interventions currently available are those focussing on psychosocial factors such as resistance, personal and social skills training (Brady, 1995b). Skills training, particularly around managing conflict and effective communication are behavioural interventions which are prominent in mainstream treatment (Liddle, 2004; Templeton et al., 2005).

Residential Treatment Models in Australia. The first Indigenous residential rehabilitation treatment facility was Benelong's Haven established in 1976 in Sydney. Its framework was based on the First Nations programs in Canada and North America which had a twelve step focus and which blended in this context with Aboriginal spirituality (Brady, 2004). People from all over Australia attended and the program inspired similar services throughout the country, such as Namatjira House and Oolong House. In its first seven years Benelong's Haven treated 1,200 people and claimed a 25% sobriety success rate (Hazlehurst, 1994).

In 1992 Eric Shirt from the Nechi Institute was employed by Central Australian Aboriginal Alcohol Planning Unit (CAAAPU) to set up a community based residential AOD service. The program commenced in 1993 and like Poundmaker's Lodge had a training unit which trained community members to be employed as staff (Hazlehurst, 1994).

In the Northern Territory the Council for Aboriginal Alcohol Program Services Inc (CAAPS) is a lead organisation in the field of alcohol misuse. This program believes that *'the misuse of alcohol and other drugs can be treated more holistically and effectively by involving the whole family in the recovery process'* (Strempe, Saggars, Gray, & Stearne, 2003). The program is based on the Minnesota model, which originated in the United States in the 1940's though recently the program has been distancing itself from the disease model and from the cultural practices of Indigenous communities internationally (*Council for Aboriginal Alcohol Program Services Inc.*, 2012). The program draws on family systems theory and provides family and community based substance misuse services that offer prevention, treatment, outreach, education and after-care programs for Indigenous people and families in urban and remote communities. CAAPS also offers a Certificate III or IV in Community Services and AOD work for staff members as well as other free workplace training. Unfortunately the program and training has not been thoroughly evaluated at this time.

We Al-Li (the Woppaburra term for fire and water) is another important centre for training and treatment around abuse and trauma, substance misuse and other addictions. It is a community-based program begun in 1993 in Northern NSW and devised by Professor Judy Atkinson. It incorporates trauma theory with traditional cultural and healing practices to aid people in their recovery. Healing in this context is achieved through the creation of a safe place where people

strengthen their cultural and spiritual identities, make sense of their stories, identify their feelings, move through layers of grief and loss, take ownership of their choices and develop a sense of family and community (Atkinson, 2002). The We Al-Li program formed a foundation for people to continue their personal and professional growth through Gnibi, the College of Indigenous Australian Peoples, Southern Cross University, NSW, where the courses currently offered include Bachelor of Indigenous Studies and a Bachelor of Trauma and Healing. What is particular about this approach is the integration of trauma theory throughout the curriculum with attention to Indigenous approaches to health and healing, however skills for working with families and communities are less of a focus. The importance of workers doing their own healing work concurrently with their professional roles is embedded throughout these training programs because as Phillips has also emphasised, the 'Native counsellor must be well, and confront their own issues in training if they are to be effective' (2003, p 140).

Aboriginal approaches to healing, illness and substance misuse. Traditional conceptions of illness and health differ across Aboriginal cultural groups which can affect the ways in which they are treated. Here the focus will be upon what has been documented in terms of approaches dealing with substance misuse currently that have been developed from traditional methods of healing. It needs to be considered that problematic substance use is a relatively new issue in the 60,000 year history of Aboriginal people, hence these methods are still developing. As Aboriginal cultures stem from an oral tradition many examples will not have been recorded which partially accounts for the scarcity of documentation and research from the perspective of Aboriginal people in this area. What does predominate are notions about how connection to Country and to culture provides healing. Important scholars in this area include Ernest Hunter a leading figure in psychiatric research with Indigenous people in Australia, Maggie Brady, social anthropologist and Geraldine Slattery a psychologist who is one of the few authors to discuss ways of working with the belief systems of Aboriginal people and families.

A common conception of illness in Aboriginal communities is that it is the result of social or spiritual disturbance. Illness can manifest because of a moral breach by an individual or community and can be connected to responsibilities to the land (Hunter, 1993; Slattery, 1987; Vicary & Andrews, 2000; Westerman, 2004). Traditional healers, ritual specialists or Elders help to mediate these ruptures both within the social and sacred spheres (Slattery, 1987).

Whilst there does not appear to be traditional ways of dealing with substance misuse, as prior to settlement this problem appears not to have existed, there is some evidence of healers currently utilising ritual singing to heal damage to the brain that is believed to have occurred as a result of using inhalants (Brady, 1995b). More common, is for Aboriginal concepts of health and healing

to be applied generally to the problem of substance misuse and illness. Hazlehurst (1994) describes how the Anangu concept of health and well-being promotes caring for country, eating bush food, the performance of ceremonial activity, showing kindness to countrymen, practicing specific parenting practices, the recognition of individual autonomy and ownership of story-line. Current research does not include the ways in which Aboriginal people seek out traditional practitioners nor how the services they provide interact with other forms of treatment.

Connection to country. Land is central to Aboriginal identity and when Country is well, people are likely to be well and experience a sense of wholeness and belonging (Atkinson, 2002; Rose, 1996). Belonging to land is often encapsulated by the word 'country' which Rose has defined as,

Country in Aboriginal English is not only a common noun but also a proper noun. People talk about Country in the same way that they would talk about a person: they speak to Country, sing to Country, visit Country, worry about Country, feel sorry for Country, and long for Country...Country is a living entity with a yesterday, today and tomorrow, with a consciousness, and a will toward life. Because of this richness, Country is home, and peace; nourishment for body, mind and spirit; heart's ease

(1996, p. 7)

Separation from the land is believed by many aboriginal groups around the world to contribute to ill-health so spending time on the land provides a way to find healing (Brady, 1995b). According to Dreaming Law when people are on their country they have the right to be autonomous and expect not to be dominated by others. Their country is where they are needed and wanted (Rose, 1992). This may provide understanding around why people wish to return to their country after rehabilitation, as there they may find the space and sense of belonging that will assist their recovery.

Outstations and bush camps have been increasingly used in Australia for those needing time-out from substance use and as places to nurture and heal young people. There are often few structured activities at bush camps as the land itself is seen to be restorative (Brady, 1995b).

Though the land can provide healing, it is also thought to hold the energy of whatever activities have been performed there, whether ceremonial or traumatic so for some returning to country also means connecting to traumatic memories (Atkinson, 2002).

The Healing Roles of Men and Women. The understanding of what traditional roles and obligations Aboriginal men and women have and do hold in regards to healing provides a

context for locating how various interventions may be applicable to Aboriginal people and how they may be taken up by communities.

Healers in different regions are known by different names such as 'clever men' mobarn/marban, or medicine men (Dudgeon, Garvey, & Pickett, 2000). The role of healer was traditionally taken on by men and Elders including women (Slattery, 1987; Tonkinson, 1982) and could involve the removal of outside forces from a person through physical contact and massage (Bell, 1983). The roles of Aboriginal men and women in regards to healing were greatly disrupted through colonisation as until recently many were prevented from performing ritual activities to ameliorate trauma or to attend to breaches of the law (Atkinson, 2002; Hazlehurst, 1994; Phillips, 2003).

As a result of traditional laws being supplanted through colonisation Aboriginal men's obligations to family and community have been undermined. Many Aboriginal men struggle to find their identity and in some areas a culture of drinking and violence has emerged (Cripps, 2004; Hazlehurst, 1994). Roe (2000) believes that many young men have turned to alcohol and drugs as a means to create a new form of male identity, one that is thrill seeking, violent and different to the authority of senior Aboriginal men and white society.

Women's land based and site-specific ceremonial activity, though not specifically to do with the healing of illness, has been perceived as providing nurturing to the land and to all living beings (Brady, 1995b). Women have held central roles in ceremonial practices that relate to the life cycle such as birthing and mourning (Bell, 1983) and within some communities have in recent years been involved in conducting ceremonial practices to resolve conflict (Slattery, 1987).

Aboriginal women are more likely to be abstainers from alcohol and less likely to misuse substances though they are frequently recipients of alcohol fuelled violence (Catto & Thomson, 2008; Wilson et al., 2010). Some Aboriginal women, particularly in remote communities have felt powerless to effect changes around alcohol use as the prevailing culture is one where people exercise their 'right' to drink and where drinking is seen as men's business (Hazlehurst, 1994; Phillips, 2003). Urban Aboriginal families are strongly matriarchal with males often absent from these households, which is a common pattern in poor urban minorities across the world where men have limited opportunities to contribute to the broader society (Anderson, 2007; Marmot et al., 1991; Slattery, 1987).

Internationally, Aboriginal women, as a result of experiencing the deleterious effects of substance misuse have taken up key roles in movements against alcohol. Aboriginal women in Australia have led community-based actions to control drug and alcohol misuse including

objections to the granting of liquor licenses and they are the mainstay of many substance misuse programs where they are counsellors, sobering-up shelter workers, and carers for neglected children (Brady, 1995a).

Supporting Aboriginal women's strength and ability to take the lead regarding intervening in substance misuse in communities alongside changing circumstances and activities which enfranchise and empower Aboriginal male identity would appear to be necessary to address substance misuse.

Cultural Constraints and Challenges to Treatment and Prevention. There are a number of cultural factors that can offer both constraints and possibilities for change in the prevention and treatment of substance misuse in Aboriginal communities.

The meaning of autonomy. Personal autonomy is valued highly across many Aboriginal cultures with people asserting their right to comport themselves as they wish and family members at times protecting substance users from intercessions to curb their behaviour (Brady, 1995b). The valuing of autonomy would appear to be at odds with Aboriginal collectivist culture but as Phillips (2003) has noted respect for individual choice may have increased through the need to avoid confrontation on Missions⁷ when people from different cultural groups were forced to live together in close confines.

Autonomy has also become associated with an oppositional lifestyle where for some being arrested for 'drunk and disorderly' represents an anti-authoritarian ethic (Brady, 1995; Hazlehurst, 1994). An attitude of defiance is common to those with substance use issues from a variety of cultures though in the context of Aboriginal use it is exacerbated by a history of dispossession and control by white authorities.

A sense of autonomy for Aboriginal people sits alongside a powerful sense of relatedness, where people are required to demonstrate their connections to each other through acts of generosity and sharing, reciprocal demonstrations of concern and through making demands and claims on

⁷ Missions were set up in the 19th century usually by clergy, to house, protect, and 'Christianise' Aboriginal people. Those inhabiting the Missions were forced to live in close confines with Aboriginal people from different cultural groups who had different laws and customs, this necessitated the need to adapt in order to maintain peace and harmony.

Many Aboriginal people disliked the mission system and demanded their own land. The colonial government responded by setting up Aboriginal reserves or stations. These reserves had their own machinery, and farmed their own crops and livestock though people's freedom and autonomy was still gravely restricted. Whilst living on Aboriginal stations, many people experienced forced confinement, the imposition of strict religious observance, separation from and removal of their children, the breakdown of traditional values and the banning of their languages and cultural practices. Despite such hardship, Aboriginal people formed and maintained strong communities and used their confinement as the impetus for political campaigns, human rights movements and the fight for the return of their land.

others. Traditional Aboriginal people are not free to choose their friends, as relationships are determined by the subsection one is born into and so by refusing gifts or offers of alcohol from one's social group can be seen as a rejection of those relationships (Hunter, 1993; Kahn, Hunter, Heather, & Tebbutt, 1990).

In some communities, people's effort to save money and get ahead or to remove themselves from drinking environments is met with suspicion. People may be called a 'whiteman' or a 'coconut' as a result and are accused of 'trying to be different' or getting 'too flash' (Brady, 1995; Hazlehurst, 1994; Perlesz & Proctor, 2009). This levelling behaviour serves to reinforce a restrictive view of what it means to be Aboriginal (see pp. 137-140).

To counter social pressure Aboriginal ex-drinkers describe how their sense of personal autonomy can also make them determined not to 'back down' on their commitment to themselves or their families to change their drinking behaviour and how they would be 'shamed' if they went back to drinking (Brady, 2004).

Some Aboriginal people choose abstinence from alcohol because of the difficulty of moderating consumption within an environment where people are drinking without restraint, others leave their communities to avoid the intense social pressures to continue substance using behaviours (Brady, 2004; Gray & ANCD, 2010; Gray et al., 2008; Langton, 2013). Unfortunately, this can mean disconnection from the positive aspects of culture and family. Though they can reinforce problematic behaviour, families can also provide motivation for changing substance use as they exert pressure for individuals to fulfil responsibilities and obligations such as looking after children and grandchildren or sick or aging parents (Brady, 2004; Van Der Sterren, Anderson, & Thorpe, 2006). Aboriginal people have commented that being needed can be source of strength for them and that experiencing the love and concern of their family has had the power to turn them away from substance misuse (Brady, 1995).

The integration of these cultural considerations into an understanding around what types of counselling interventions may have the most efficacy indicate non-directive approaches that emphasise personal agency, strengths and skills and that involve the family system in reflection on the constraints and motivations for change.

Interventions that acknowledge Aboriginal concepts of health and illness are more likely to be taken up as they offer possibilities for building upon the strengths of families and communities. As many Aboriginal people have been familiar with seeing a person who holds special knowledge in regards to illness it is not incongruous for people to work with a counsellor or family worker

around health issues and if the approach to substance misuse is social, where the spiritual aspects of illness are included it may be more likely to succeed.

Bridging Indigenous and non-Indigenous approaches to healing. Internationally, there is a lack of recorded information regarding the incorporation of Indigenous approaches to treatment into contemporary settings informed by Western approaches to health. The work of Mehl-Madrona (2007), a First Nations practitioner and researcher does however include an extensive study of Indigenous approaches to healing and offers a compelling rationale for the inclusion of traditional narratives surrounding health and healing when treating Indigenous people. His work draws on practices from native North American, traditional Chinese, Ayurvedic medicine from India and African medicine and though he does not incorporate Aboriginal conceptions of health and healing there are useful correlations to be made. He argues that family and community need to be part of reinforcing interventions and the narratives that inform them in order for change to occur. Mehl-Madrona explains,

I have tried to bridge cultures and to develop an approach that will allow the patient and his or her family to be active collaborators in the healing process, recognising the wisdom of indigenous cultures – that relationships matters, that people have to believe in the treatment and the doctor, that the support of family and community are necessary to make treatments work, and that far more than biology and pharmacology determine the success or failure of each medical encounter

(2007, p. 4)

For Mehl-Madrona (2007) clinicians need to construct narratives around illness and healing that do not differ too much from those of the individual and family with which they are working otherwise it is likely that people will revert to more familiar explanations and discard the clinicians recommendations. This means that pragmatically professionals need to take the time to hear the stories of their clients (Mehl-Madrona, 2007). His work has resonance with narrative therapy that utilises scaffolding conversations to build upon the knowledge and experience of clients in order to extend towards the client's preferred identity (White, 2007).

Family and community for Mehl-Madrona are part of a systemic solution where they are in the best position to provide ongoing sustained support. Family and community can also enact powerful rituals which can serve to focus the attention of the individual and community on healing and change through repetition (Mehl-Madrona, 2007). He explains it thus,

Systems (meaning wholes which are greater than their parts) are self-healing (self-correcting), demonstrate emergent properties (meanings that new things emerge that cannot be anticipated or predicted), and are capable of developing unique, novel outcomes that are not relevant or applicable to other systems

(Mehl-Madrona, 2007, p. 105)

This systemic view of problems, central to family therapy Mehl-Madrona argues can be utilised to re-author stories about a person through involving the whole community rather than working with individuals privately in a therapy session and expecting changed narratives surrounding self-concept and related behaviours to emanate outwards (Mehl-Madrona, 2007).

Mehl-Madrona (2007) envisages the next step for medicine when treating the broader population no matter whether they are from Indigenous or non-Indigenous backgrounds, is to understand that health and disease cannot be separated from the plot and action from the story in which they appear.

Levels of intervention. Central to considerations of interventions into Aboriginal substance misuse is the need for a holistic view of health in order to deal with the complexities of substance use as well as the pragmatics of engaging Aboriginal people in prevention and treatment. 'Social and emotional wellbeing' (SEWB) is a term which encompasses the meaning of health for many Aboriginal people and which has been incorporated into government documents when discussing mental health and treatment (ABS, 2010a; AIHW, 2011). It includes the social, emotional, spiritual and cultural wellbeing of the individual and their community (Garvey, 2008). It provides a means of acknowledging the history and context of current health issues, encapsulating mental health and substance misuse as well as identity issues, family violence and suicide (Garvey, 2008).

Taking into account all the factors that impact on Aboriginal health, interventions across multiple domains are necessary to effect meaningful and sustained change to substance misuse (Hunter & Tsey, 2003; Loxley, 2004). Hunter's (2004) taxonomy indicates the different levels of intervention that are required.

Figure 1 Four levels of Intervention to improve SEWB

Level	Activity
Society	Social justice, reconciliation
Community	Community development empowerment
Family/clan	Family wellbeing and parenting programs
Individual	Indigenous therapies
	Adapted/appropriated therapies (e.g. narrative therapy)
	Culturally appropriate conventional therapies

Note: Reproduced from Hunter (2004, p. 3).

Possible Therapeutic Approaches with Aboriginal People

When discussing the possibilities for therapeutic approaches with Aboriginal people, it is recognised that a coordinated approach addressing all aspects of SEWB is necessary and that consultation and respect is critical to engagement and to implementation (Wilkes, Gray, Saggars, Casey, & Stearne, 2010). However the primary focus of this research is upon the suitability of family therapy as an approach rather than other possible levels of intervention. Any therapeutic approach needs to take into account that some Aboriginal people are hesitant about being involved in therapy as they are unfamiliar with the ways in which it may be helpful. They can be unsure whether a worker may be able to appreciate their history, social and cultural context and may also fear being blamed or shamed for having a substance use problem (Dudgeon & Ugle, 2010; Pattel, 2007; Walker & Sonn, 2010).

The focus on strength-based approaches. Many writers and practitioners emphasise the importance of approaches that focus upon the strengths, skills, knowledge and abilities of Aboriginal people to deal with their issues (Pattel, 2007; Roe, 2000; Vicary & Andrews, 2000; Whiteside, Tsey, McCalmana, Cadet-James, & Wilson, 2006). This shift towards a focus upon strengths and healing began in the 1990s and marked a movement towards cultural rejuvenation and increased responsibility (Hazlehurst, 1994; Pearson, 2007). Healing is believed to 'involve liberation from dependency of all kinds - colonialism, alcoholism and self-oppression' (Hazlehurst, 1994, p. 51). The motivating philosophy is that despite the impact of past

government policies and current structural inequities Aboriginal people can develop the knowledge, skills and attitudes to enable them to take greater control over the issues that affect their lives (Pearson, 2007; Tsey, Whiteside, Deemal, & Gibson, 2003).

There is a recognition amongst some Aboriginal people for the necessity to both build upon traditional practices and 'to deal with...new pressures and change, we need to gain skills and to select new tools which will carry us forward as a united people' (Hazlehurst, 1994, p. 47). The opportunities for collaborative therapeutic and educational relationships exist which can facilitate and support healing and autonomy.

In terms of how therapists approach working with Aboriginal people, a non-expert position and a non-directive approach is indicated where people's efforts to deal with their issues are supported. Generally Aboriginal people do not respond well by being told what to do (Brady, 2004; Denborough, White, & Wingard, 2009) as within a traditional belief system there is the view that there should be no bosses (Sackett, 1978). It is more culturally acceptable to move people to a point of change and then allow them to find a solution that fits within their own schema (Slattery, 1987).

Effectiveness of AOD counselling interventions. The literature on the effectiveness of AOD counselling interventions with Aboriginal clients is scarce though there have been small scale research studies on particular methods and programs as well as principles developed to guide the choice and implementation of interventions. Atkinson (2002) suggests that multiple pathways need to be offered to people recovering from substance misuse, who often also have a history of trauma. These include creative modalities and group processes as these appear to be more powerful for Aboriginal people than individual work. Hazlehurst too posits that 'If the problem is group orientated – such as alcoholism then the best solution will also be group orientated' (1994, p. 154). Working with groups, whether they are composed of family or community members helps to facilitate their capacity to support one another towards health and wellbeing.

Given the history of trauma and oppression of Aboriginal communities and their cultural practices it is apparent that a critical component of substance misuse treatment and prevention is cultural restoration and support (Boyd-Ball & Dishion, 2006; Phillips, 2003; Wilkes et al., 2010). Though there is a lack of research to support the use of culture within treatment programs (Brady, 1995b) there is evidence to say that cultural connection can act as a prevention for substance misuse (Dockery, 2010). Both Phillips (2003) and Brady (1995b) concur that connection to country is not on its own sufficient to treat or address all the complexities associated with substance misuse.

Mainstream AOD Interventions and Aboriginal Communities. In order for equity to be maintained it has been argued that Aboriginal people need to be able to choose from a full range of interventions (Brady, 2004; Gray, Pulver, Saggars, & Waldon, 2006; MCDS, 2006). However interventions arising from outside of Aboriginal communities can be deemed an imposition (Clifford & Shakeshaft, 2011) so careful attention needs to be given to the ways in which interventions are implemented. An understanding of some the key elements of particular mainstream approaches may provide opportunities for them to be adapted in ways that make them accessible and culturally relevant and will be reflected upon (Novins et al., 2011).

Brief interventions. Brief interventions have been used successfully to address non-dependent alcohol use in mainstream populations (Kaner et al., 2009). They can be administered opportunistically by a range of health professionals underscored by the recognition that many people can benefit from being given appropriate information at the right time. The evidence base for their use in Indigenous Australian populations has yet to be validated through research though a clinical trial has provided preliminary evidence for their use in Native American populations (Villanueva, Tonigan, & Miller, 2007). Brief interventions often include motivational interviewing, low-risk drinking advice and information and education and can involve a single session or include follow-up sessions. Motivational interviewing is non-directive and impartial in nature as it seeks to build on the clients own reasons for changing behaviour around substance use and so may be useful for populations who prefer a non-directive approach that respects individual autonomy.

Brief interventions have the advantage of being able to be delivered by GP's, nurses, Aboriginal health workers, social workers and counsellors in a range of settings where early intervention into problematic alcohol and drug use is possible (DoHA, 2010). However, some sectors of the Aboriginal population in Australia are sceptical of the benefits of brief interventions partly because trials indicating their effectiveness arise from outside their communities (Clifford & Shakeshaft, 2011). Other concerns that have been noted are that brief interventions do not acknowledge the effect of socio-political factors affecting alcohol consumption (Prilleltensky & Nelson, 2002), do not include a spiritual dimension and that the drinking patterns prevalent in their communities are not encouraging of moderate consumption (Kahn et al., 1991).

Brief Interventions have been adapted for use with Aboriginal clients through the development of the Indigenous Risk Impact Screen (IRIS) the use of a pictorial tool, adopting a holistic approach to strengths and stressors that include family and the spiritual, cultural, emotional, mental and physical domains of life (Nagel & Thompson, 2008). At this time adequate training has yet to become available to address the barriers to the widespread implementation of brief

interventions within Aboriginal controlled organisations (Catto & Thomson, 2008; Clifford & Shakeshaft, 2011).

Intensive treatment approaches. For those who are experiencing substance dependence or who have less problematic substance use but have more complex health presentations it is thought that other approaches, beyond brief interventions are required (DoHA, 2010). This is also the case for those with an intellectual disability, Acquired Brain Injury (ABI) and serious mental health issues. It is widely accepted that alcohol or drug dependence requires more intensive treatment in either residential or non-residential settings (DoHA, 2010). Mainstream residential programs offer a variety of interventions, including counselling, 12 step groups, relaxation techniques, skills training and relapse prevention therapy that is more intensive than that generally offered in non-residential settings (Shand & NDARC, 2003). In Indigenous specific services 12 step programs have incorporated Aboriginal cultural beliefs and practices into a method of treatment which for some is effective though for others 12 step models represent an imposition of a non-Indigenous approach (Brady, 1995; Novins et al., 2011).

Other more intensive treatment which may be included either within or outside of residential treatment and that are recommended within the Alcohol Treatment Guidelines for Indigenous Australians (DoHA, 2010) include couples and family therapy, cognitive behavioural therapy, grief and loss counselling and narrative therapy. There are few accounts of how they have been culturally adapted though this is critical to their implementation and there is a lack of evidence surrounding the efficacy of these approaches with Aboriginal people (DoH, 2010; MCDS, 2006; Novins et al., 2011; Wilson et al., 2010). The Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009 (MCDS, 2006) is the most recent government document that makes recommendations regarding the treatment of substance misuse with Indigenous communities. The recommendations include broadening the range of interventions whilst ensuring that programs incorporate and promote culture, spirituality, language, tradition, the role of Elders, traditional healers and that children are a priority (MCDS, 2006). Though the benefits of counselling are acknowledged along with the necessity to involve family and significant others in treatment, there aren't recommendations surrounding the approaches that are particularly suited to this population. At this time, except in the case of alcohol there are no existing guidelines pertaining to the treatment of those with issues surrounding the use of a particular substance.

Narrative approaches. Narrative therapy has widespread acceptance amongst Aboriginal people as a culturally appropriate means to address a variety of issues (Brady, 2004; DoHA, 2010; Hunter, 2004) and is increasingly being used as a counselling approach in

mainstream AOD treatment (Bacon, 2007; Hegarty, Smith, & Hammersley, 2010; Ikin, 2008; Man-kwong, 2004). Narrative therapy with its emphasis upon story is particularly resonant for Aboriginal people who come from an oral tradition. The literature indicates that this approach can respectfully build upon the strengths and skills of Aboriginal people to manage substance use issues on individual and community levels (White, 1997; White, 2007; White & Epston, 1990). Aboriginal health workers from the mid-1980s were involved in the development of narrative practices including Barbara Wingard and Tim Agius⁸ who inspired and guided the development of the first community gathering that used a narrative approach and focussed upon Aboriginal deaths in custody⁹ (White, 2003). Since that time David Denborough, Cheryl White and Barbara Wingard have developed collective narrative practices which have been utilised with Aboriginal communities from all over Australia and have been applied extensively internationally (Denborough, 2008; Denborough et al., 2009).

Trauma focussed approaches. Previously in this review the connection between substance misuse and traumatic experiences has been made (Atkinson, 2002; Hunter, 1990; Phillips, 2003). The focus though here will be to consider how therapeutic approaches to the treatment of problematic substances may be informed by trauma work more generally and hence how family therapy as a modality may be useful in this context.

Within mainstream treatment approaches the sequence most frequently begins with behavioural interventions to support the person towards reducing the impacts of their substance use before addressing mental health or experiences of trauma. In recent years this approach has been challenged and within the Victorian AOD sector there is an increased expectation that workers will be able to respond to both mental health and substance use issues (DHS, 2007, 2008b).

Considering the intergenerational trauma that Aboriginal people have experienced and the need for acknowledgement around past and present injustices that accompany those experiences, it is of great importance for those working with Aboriginal people with substance use issues to have the capacity to work with trauma (Atkinson, 2002; Hunter, 1990; Phillips, 2003).

⁸ Barbara Wingard and Tim Agius were also part of the formation of Aboriginal Health Council of SA Inc.(AHCSA) in 2001 which is the peak body representing Aboriginal community controlled health and substance misuse services and Aboriginal health advisory committees across South Australia.

⁹ In 1987 a Royal Commission was formed to investigate the causes of deaths of Aboriginal people while held in State and Territory gaols. The Royal Commission was established in response to a growing public concern that deaths in custody of Aboriginal people were too common and poorly explained. The Commission examined all deaths in custody in each State and Territory which occurred between 1 January 1980 and 31 May 1989, and the actions taken in respect of each death.

The healing of trauma requires the establishment of an environment of safety without judgement or prejudice (Atkinson, 2002). Part of this process includes recognising the cultural practices and connections to family and community which serve as valuable resources. As Phillips explains,

Philosophies of healing vary from community to community, and indeed from individual to individual – yet, at the same time, largely encompass beliefs that: the journey of healing towards wellness is a spiritual journey; that revival of culture and ceremony is critical to that journey; that by being responsible for your own healing and sharing your journey with others, a ‘healing community’ may be re-created.

(2003, p. 142)

Van der Kolk (2007a) has also found that the impact of trauma can be moderated through adherence to religion and dedication to a political cause. For Aboriginal people this could translate to advocacy for the rights of Aboriginal people and the involvement in cultural regeneration, healing practices and efforts to strengthen cultural and spiritual identity.

Judith Herman (1992) describes a staged process through which healing from trauma can occur:

1. Establish safety for the trauma stories to be told
2. Reconstruct the trauma story
3. Restore the connections between survivors and their communities

Cloitre et.al (2010) and her colleagues found in a randomised control trial that there was strong evidence for a staged treatment for those with complex PTSD where firstly problems with affect regulation and interpersonal relationships are addressed before embarking on trauma focussed exposure.

Atkinson emphasises the need for trauma recovery to include methods of expression such as storytelling, drawing, writing, dancing and drama based on Aboriginal cultural tools (Atkinson, 2002). The use of culture as a source of strength can help address the depersonalisation and loss of identity that can result from trauma and by contacting the skills and resources that have been recruited throughout a person’s life, self-esteem can be improved. As one participant in the We Al-li program expressed it,

Saddest thing is they don't even realise they've got all the coping mechanisms, and they've been healing themselves all these years. If this was pointed out to them then things would really start to happen. They would build on it, because they know that some things are wrong, but they just don't know what to do about it. What I've learnt is, healing is facing up to the fact that you've got choices, and there is no need to live all of your life in pain. You can always get out of it. Yeah, just knowing that fact is healing thing itself

(Atkinson, 2002, p. 141)

Arieh Shalev's (2007) work on the prevention of PTSD has emphasised that the way in which events are construed can affect the way in which they are processed by individuals and that trauma is essentially embedded in language. For Shalev, the greatest predisposing risk factor for the development of PTSD after a traumatic event is firstly a lack of social support and secondly ongoing stress (Shalev, 2007). This knowledge has implications for treatment and highlights the importance of a systemic approach that includes family and community support and tackles racism, discrimination and the minimisation of harms incurred by Aboriginal people in order decrease stress and promote trauma recovery.

Other trauma researchers (Dwyer & Santikarma, 2007; Levine, 1997; van der Kolk, 2007a) have agreed that whilst trauma is experienced in the body and mind it finds expression and meaning in dialogue with cultural, ethical and political discourses around what it means to suffer and who's pain is more worthy of attention and amelioration.

Aboriginal and Torres Strait Islander Access, Participation and Retention in Higher Education

Graduates are what we need. The more graduates we have, the more they can contribute to Aboriginal communities and organisations and to Australian society generally. Graduates are our most powerful potential force for combating our social, political and economic inequality. For Indigenous people in particular higher education results in both a private return for the individual and a social return for the whole community.

(Andersen, Bunda, & Walter, 2008, p. 3)

Having so far discussed the history, context and treatments for Aboriginal substance misuse the discussion will now turn to Indigenous education. This research is involved with the usefulness of a family therapy training program to Aboriginal workers and from this standpoint it is important

to understand how the processes involved with the engagement, learning and retention of students is situated more broadly. As this research is located within the literature on Indigenous education, pedagogy and learning styles this discussion will also seek to understand the significance of the research within this context.

The rationale and need for improved accessibility of educational programs for Aboriginal people is clear as in 2008 only one-quarter (25%) of Indigenous people reported having a post-school qualification, compared with almost one-half (47%) of non-Indigenous people; and only 1.7% of Indigenous people reported attending a university, compared with 4.1% of non-Indigenous people (ABS, 2009, p. 17). Behrendt et al. found in their 2012 review of higher education access and outcomes of Aboriginal and Torres Strait Islander people that Aboriginal and Torres Strait Islander students had lower completion rates over a five-year period compared to non-Indigenous students. In 2010, 40.8% of Aboriginal and Torres Strait Islander students who commenced a bachelor course in 2005 had completed their course, compared to 68.6% of non-Indigenous students in (unpublished DEEWR report in Behrendt, Larkin, Griew, & Kelly, 2012, p. 10).

Access to education is a social justice issue as well as a social determinant of health as educational attainment is positively associated with health status and improved economic outcomes (AHMAC, 2012; Hunter & Tsey, 2003). Andersen et al. (2008) view education as a priority, as increasing the number of Indigenous graduates can enable Aboriginal people to hold positions of power within institutions and exercise voice and greater control of their destinies.

A number of barriers have been identified which impede Indigenous students' transition into tertiary education these include: lack of support from family (ABS, 2010b; Andersen et al., 2008; Hossain, Gorman, Williams-Mozely, & Garvey, 2008); access to career guidance which maps out pathways from education into career based employment (ABS, 2010b; Andersen et al., 2008; Hossain et al., 2008; Rigby et al., 2010); financial considerations (ABS, 2010b; Andersen et al., 2008; Hossain et al., 2008; Toombs & Gorman, 2010); acknowledgement and understanding of Indigenous knowledge and culture within training programs (ABS, 2010b; Rigby et al., 2010) and racist attitudes (Hossain et al., 2008; Rigby et al., 2010).

For many Aboriginal people they are part of the first generation who have considered professional careers and a university education. This can make it difficult for family and friends to provide support as they are unaware of what the commitment entails or what challenges accompany academic success (Andersen et al., 2008). Hossain et al. (2008) also found that a negative self-concept can affect education choices as some Aboriginal students did not want to

be seen to 'big note' themselves by stepping outside what others in their community had achieved.

Factors in the university environment which impeded uptake of university place by Aboriginal people included lack of Indigenous staff within the mainstream university system, limited support and culturally inappropriate teaching that lead to negative learning experiences which decreased motivation to continue. Aboriginal students also reported difficulties with leaving close-knit rural communities and finding the university environment unfamiliar and isolating. The importance of community support and liaison with the university and marketing of health courses to the Indigenous communities in the region were key issues that participants identified as needing further attention (Kippen, Ward, & Warren, 2006).

Other commentators assert that in order for higher education to be accessed equitably by Aboriginal Australians the university sector needs to be engaged both practically and philosophically with specific strategies to improve student pathways, participation and completion of courses of study (Andersen et al., 2008). Anderson (2008) has noted that some of the gains in recent years made at universities where Aboriginal student participation is higher, is a result of effective support mechanisms being implemented and through universities Indigenous education being viewed as core business. The recruitment of highly dedicated staff able to support and strengthen students throughout their education is important particularly in the first semester and first year of study as students are more vulnerable to withdrawing at this time so resources need to be allocated to ensure adequate bridging and support programs. Another important factor supporting student engagement and retention is having Aboriginal staff employed across the university, not only within Indigenous Centres in order to provide role models within the mainstream of the university (Andersen et al., 2008).

Cultural safety. Bin Sallik (2003) has emphasised that success in the engagement and retention of Indigenous students is predicated by the degree of cultural safety which they experience. Cultural safety can be defined as an awareness and respect of cultural difference where cultural identity is legitimised and where individuals are empowered (Rigby et al., 2010). Williams (1999) emphasises 'learning together with dignity, and truly listening' in an environment which 'empowers individuals and enables them to contribute' (Williams, 1999, p. 213).

Some of the elements that contribute to creating cultural safety in higher education have been located by Rossingh & Dunbar (2012) at the Australian Centre for Indigenous Knowledges and Education (ACIKE). The Centre's critical focus is on improving completion rates of Aboriginal students at Charles Darwin University in the Northern Territory by building upon and

incorporating previous work in the field of Indigenous higher education both nationally and internationally. As well as focussing upon the supports available for students transitioning into tertiary study and education programs which include Indigenous knowledge and spirituality, language and culture. An evaluation model is also implemented aiming for continuous improvement through constant review and responsiveness to suggested changes (Rossingh & Dunbar, 2012, p. 63).

Teaching methods. As well as the necessity to provide adequate supports for Aboriginal students transitioning into tertiary education there has been over the last thirty years, scholarship dedicated to what and how to teach Aboriginal students once they have begun higher education. Work in this field has taken different forms including the development of an Indigenous pedagogy; a focus in Indigenous education on how Aboriginal students can best be included within mainstream education and how all students can be taught about Indigenous cultures. The Batchelor Institute now a part of ACIKE (Ober, 2009), the Curriculum Development Centre of the Department of Education, Employment and Training (Hughes, Williams, & More, 2004), and Indigenous academic Paul Hughes (Clapham, Digregorio, Dawson, & Hughes, 1997; Hughes et al., 2004) have attended to what learning styles may best suit Indigenous students in order to encourage and promote Aboriginal success in education. Much of the literature is focussed upon primary and secondary school students rather than at the tertiary level however there appears to be some transferability across different stages of education.

Changes in the discourse surrounding Indigenous education can be tracked in relationship to assimilationist policies, movements towards self-determination, mutual responsibility and an increased focus upon Aboriginal identity and cultural revitalisation. Since Aboriginal people have been included in mainstream education there has been a progression from expecting Aboriginal people to adapt to the structure and content of schooling, to the inclusion of discrete units of Indigenous education within the pre-existing structure, to considering how teaching methods could be altered to better respond to the ways of learning favoured by Aboriginal people and then seeking to decolonise schooling and transform its foundations in order to encompass Indigenous philosophies and methodologies and provide a critical understanding of Western systems of thought.

What is apparent is that work surrounding the formation of an Indigenous pedagogy in this country has been under theorised (Biermann & Townsend-Cross, 2008). It is likely that a number of successful programs exist within a variety of post school studies but they have not been evaluated or researched and so remain outside the scope of this review. The scholarship that is

available contains principles and philosophies underpinning various teaching methods though there exists a lack of clarity about how they are translated in practice.

The development of Indigenous pedagogies based on Indigenous values, philosophies and methodologies though still relatively new in Australia have been underway in other parts of the world for some time (Hickling-Hudson & Ahlquist, 2003; Lambe, 2003; McNally, 2004; M. Smith & McLaren, 2010). In Australia, centres that have a focus upon developing Indigenous pedagogies include ACIKE, the now defunct Curriculum Development Centre of the Department of Education, Employment, and Yunggoorendi First Nations Centre for Higher Education and Research at Flinders University. There are also a number of schools within universities that have sought to target and support Aboriginal students such as Gnibi College of Indigenous Australian Peoples, Southern Cross University, and the School of Indigenous Australian Studies at James Cook University. There are also courses designed predominately for Aboriginal students that have reported innovative and successful educational programs such as the Indigenous Australian Cultural Studies program, Curtin University, the Centre for Indigenous Studies, Charles Sturt University and the Rural Clinical School at the University of New South Wales. Though these courses have achieved notable success across a number of domains and a range of principles have been articulated which guide the educational practices, there is an inherent difficulty in knowing in what forms principles are evident in practice.

Indigenous pedagogies as they exist in Australia and internationally have been influenced by the decolonising and critical approaches to education espoused by Friere (1970), Mignolo (2009) and Macedo (1999). Critical pedagogy has been defined as 'an approach to understanding and engaging the political and economic realities of everyday life' (Smith & McLaren, 2010, p. 332) where teacher and student engage in a dialogic process where knowledge is shared and the institutional structures and social relations which maintain them are reflected upon. This approach is counter to what Freire call the 'banking model' of education where students are seen to be in deficit of particular information which the teacher deposits and then requires the student to regurgitate back under examination (Freire, 1970). Through the development of a critical approach to dominant discourses the aim is for students to engage in an education which will act as a lever for social and political transformation (Freire & Schor, 1987). This mode of education is in contrast to Noel Pearson's educational approach that is concerned with raising expectations surrounding Aboriginal students' ability to perform as well as non-Aboriginal students by providing the supports and incentives for this to occur but with no change to the content or structure of courses. For Pearson the emphasis needs to be on responsibility, strengths and skill development without adaptation to the local context as previously attention

to a structural analyses of Indigenous disadvantage has resulted in the 'soft bigotry of low expectations' (Pearson, 2007, p. 19).

Australian authors (Gillepsie, 1998; Nakata, Nakata, Keech, & Bolt, 2012; Smith & McLaren, 2010) have argued that without an understanding of both Indigenous and Western knowledge systems Aboriginal people are not adequately equipped to address inequity. In the New Zealand context Smith (2003) has argued that without 'conscientization' or consciousness raising it isn't possible to move away from hegemony as oppressed groups will take on the dominant group thinking as 'common-sense'. Nakata et al. (2012) claim that Indigenous students in Australia need to understand the ways in which western thought is constructed in order to be empowered and similarly Yunupingu (1994) has expressed that Aboriginal students can address the issue of power through the utilisation of non-Aboriginal knowledge for Aboriginal purposes.

A dilemma facing Aboriginal people seeking higher education has been articulated by Stephen Harris (1990) as a hope among Aboriginal community members about 'coming up level' but also having the previous experience of young people 'losing themselves' after having gone away to receive training and education, where they either did not return or felt that they no longer fitted in when they did return to community. Many Aboriginal people by the 1990s had come to value a western education more highly as they wished to have Aboriginal people deliver services across all of the professions (Clapham et al., 1997). There was the recognition that 'to live in both worlds we need to achieve a high standard in education' but people did not wish to lose their identity in the process (Ober, 2009, p. 9). A demand was created for education which included western systems of knowledge, the teaching of Elders and Indigenous forms of knowledge (Clapham et al., 1997).

In summary, in order for Aboriginal people to be successfully engaged with education, courses need to include and respect Indigenous values, philosophies and methods. Accordingly, it has been found that a key factor leading to Aboriginal student success in vocational education and training is an institution's ability to acknowledge Indigenous students' cultures (McIntyre, 1996).

Both-way Learning. The 'both-ways' philosophy developed in Australia and internationally as a result of the need to provide education for Indigenous people that included both Indigenous and western knowledge systems. However, different interpretations and meanings are associated with this and other similar terms, depending on the context in which they were formulated and implemented.

The first recorded articulation of this philosophy as practiced at Batchelor College¹⁰ was given by Pincher Nyurrmiyarri in 1976 (McConvell, 1982). He described the college as a 'one-way school' - that is, 'only kartiya (European way)' and gave the alternative as a 'two-way' school ' - both kartiya way and ngumpit (Aboriginal) way' (McConvell, 1982, p. 62). Pincher Nyurrmiyarri articulated how a 'two way' school curriculum is created by an exchange of knowledge where both sides learn from each other. He believed that western and Aboriginal knowledge can only come together if there is genuine respect for Indigenous wisdom and where Aboriginal people are a part of the development and implementation of educational programs (Wunungmurra, 1989).

The 'both-ways' philosophy currently implemented at the Batchelor Institute, seeks to acknowledge Indigenous Australian traditions of knowledge through the skills, language and culture of students and then find a bridge into Western academic knowledge. The aim is for a synthesis of these knowledge systems in order to empower Aboriginal people across all sectors of society (Ober, 2009).

Like the Batchelor Institute, the Indigenous Cultural Studies program at Curtin University seeks to have Indigenist (Rigney, 1999) cultural ways and knowledges drive the learning and to have curriculum development and learning processes informed by community experiences and perspectives (Dudgeon & Fielder, 2006; Ober, 2009). Dudgeon and Fielder (2006) have articulated how the program at Curtin University, seeks to move beyond entrenched power relations through the creation of a 'third space' where Indigenous and non-Indigenous knowledge is drawn upon and a genuine exchange is facilitated between Indigenous and non-Indigenous students. Though they also recognise that there is an inherent difficulty within universities of maintaining an educational space between 'black' and 'white', as their structures and practices are predominately 'white' and western.

These approaches philosophically accord with a culturally relevant education as well as practically aligning with adult-learning principles. Respect is given to what students bring in terms of experience and knowledge and this foundation is built upon during the learning process (Gray et al., 2004; Waples-Crowe & Pyett, 2005; White, 2005). The technique of scaffolding developed from Vygotsky's (1994) theory is also relevant, as within this technique current skills and knowledge are extended towards a higher level of competence and then the educator

¹⁰ The Batchelor Institute began as Batchelor College in Darwin and provided an Associate Diploma of Teaching (Aboriginal schools) for Indigenous students. Currently the Batchelor Institute is part of a joint initiative with the Australian Centre for Indigenous Knowledges and Education (ACIKE) and Charles Darwin University (CDU). The aim is to provide a shared facility for the delivery of a specific range of Higher Education and Postgraduate study options including Indigenous Knowledges and Governance, Health and Education. Most Batchelor ACIKE courses are open only to Aboriginal and Torres Strait Islander peoples in keeping with their longstanding commitment to Indigenous self-determination and empowerment.

slowly withdraws support until the student can sustain the new skills on their own (Trouw, 1997).

Teaching partnerships between Indigenous and non-Indigenous teaching staff can help ensure the cultural and academic integrity of educational programmes (Dudgeon & Fielder, 2006; Latham, 2012; Morgan & Golding, 2010). Dudgeon and Fielder (2006) describe how within the program at Curtin University, teaching staff are from culturally diverse Indigenous backgrounds and that process is privileged over content in order to facilitate genuine cultural exchange, critical self-reflection and 'informed respect'. Morgan and Golding (2010) discussed how at the University of Ballarat they found that the combination of both an Indigenous and non-Indigenous lecturer was beneficial as it modelled respectful interactions between the presenters who could discuss various perspectives and knowledges associated with the material.

At Gnibi College of Indigenous Australian Peoples at Southern Cross University they offer a Bachelor of Indigenous Studies and a Bachelor of Trauma and Healing. Their teaching method is founded on 'the broad principals of identity and relatedness, couched in the contextual values of reciprocity, inclusiveness, nurturance and respect' (Biermann & Townsend-Cross, 2008, p. 150). Within this school, attention is given to the students' ability to be reflective about their practice, exercise a degree of responsibility for their learning and articulate their own journey, identity and worldview (Biermann & Townsend-Cross, 2008).

Shahjahan et al. (2009) have discussed the need to include spirituality in Indigenous education. They perceive this as a decolonising strategy, as multiple ways of knowing can be acknowledged and the inward and outward learning journeys are attended to. The inward journey is described as including the heart and spirit of the individual where personal development is encouraged and students are affectively engaged in the learning process.

Aboriginal Ways of Learning. Work with Aboriginal learning styles in Australia is evolving and the work that has been done cannot be considered definitive because as Hughes (2004) has noted, there is great diversity across Aboriginal cultures and communities and these differences also interact with individual life experiences and formal instruction. Hughes (2004) prefers not to refer to Aboriginal and Torres Strait Islander learning styles but rather to Aboriginal ways of learning in order to encompass how children are educated before entering formal schooling and that they will preference particular types of learning which may or may not be the style in which the person is the strongest. Hughes (2004) was an inaugural member of the National Aboriginal Educational Committee (NAEC) and then acted as co-ordinator of Aboriginal Education South Australia where he pursued an interest in Aboriginal learning styles, including the study of Native American and Canadian First Nations ways of learning. Hughes's

work, though focussed largely on primary and secondary school students also has resonance with scholarship focussed upon tertiary education (Clapham et al., 1997; Main, Nichol, & Fennell, 2000).

Traditionally, Australian Aboriginal people learnt through the observation and imitation of those closest to them, there was no designated teacher role up until the time of initiation where additional knowledge was transmitted from others less familiar. For this reason western education is a foreign construct however what can be translated from this premise is a preference for person-centred learning where a strong relationship is built between the student and the teacher and respect is gained through the quality of the relationship with the teacher rather than from authority conferred by the position (Clapham et al., 1997; Hughes et al., 2004; Main et al., 2000; Swisher & Deyhle, 1987).

Aboriginal culture emphasises holism and synthesis which has been found to have implications for teaching (Christie, 1985; Clapham et al., 1997; Hughes et al., 2004; Sayers, 1988). For Aboriginal students it is more effective to include an overview of the subject being taught with demonstrations of how each component is linked rather than confining attention to learning blocks which build toward a total picture (Christie, 1985; Clapham et al., 1997; Hughes et al., 2004; Sayers, 1988). Western learning is often sequential and reference based with gratification deferred whereas in Aboriginal culture there is a privileging of spontaneity and immediate gratification and an acceptance of whatever consequences arise as a result (Hughes et al., 2004).

Imaginal ways of learning have also been found to be valuable for many Aboriginal students (Hughes et al., 2004; Main et al., 2000). Prior to conceptual frameworks being introduced concrete visual representations are utilised with opportunities for observation and imitation and student thoughts and experiences of the learning process are included (Hughes et al., 2004; Main et al., 2000). A tradition of applied knowledge rendered through trial and error translates into a preference for kinaesthetic learning with students participating in tactile 'hands on' learning. (Clapham et al., 1997; Main et al., 2000; Waples-Crowe & Pyett, 2005; White, 2005). Contextual learning has also been found to be effective as the relevance of the subject to the students' lives is emphasised and there are clear links made between theory and practice (Clapham et al., 1997; Main et al., 2000; White, 2005).

As Aboriginal people come from a collectivist culture, education models and the means of assessing knowledge and skills can have a greater cultural relevance when they involve cooperative learning and group processes (Hughes et al., 2004; Ober, 2009; White, 2005). Group solidarity is valued and kinship ties are strong, so when an Aboriginal person learns it is for the good of the whole group, their families and community (Hughes et al., 2004; Ober, 2009). As

assessment can be particularly confronting for Aboriginal people a range of assessment modes are recommended including self and group where skills and knowledge are demonstrated through visual, physical and written modes (Deyhle & Swisher, 1997; Hughes et al., 2004; Main et al., 2000).

General teaching methodologies based on traditional approaches to education that have been found to be effective both in Australia and internationally include; little direct questioning, not singling students out either for praise or for comment, developing strong teacher-pupil relationships, using out-of-doors as a classroom where possible, emphasising participation and practical experience, cooperation and group processes and reducing the amount of verbal communication, competition or focus upon individual achievement in the teaching process (Deyhle & Swisher, 1997; Hughes et al., 2004; Swisher & Deyhle, 1987).

As evidenced by the literature surrounding Indigenous education there is still much to be learned about Indigenous pedagogies in an Australian context. Though this field is developing in Australia much of the work has been centred on primary and secondary school education with much less attention paid to tertiary settings. Partially this can be explained by attention and resources being drawn to the gap between the literacy and numeracy of Aboriginal children to that of non-Aboriginal children in the hope that by addressing this failing greater opportunities will be afforded to Aboriginal people for post school learning. However, without adequate resources attributed at a tertiary level to the development of an Indigenous pedagogy and to its practical articulation, universities will struggle to attract and retain Aboriginal students.

Aboriginal AOD Workforce Training and Education

Extending from the literature surrounding Indigenous tertiary education a more specific focus will be applied to the workforce development of those employed in the Indigenous Drug Services sector.

The leading centre for research into Aboriginal drug and alcohol workforce development is the National Centre for Education and Training in Addiction (NCETA) at Flinders University. Their extensive research both with Aboriginal and non-Aboriginal AOD workers and managers uncovers many of the stresses and workplace issues for drug and alcohol workers that affect workplace retention.

Working in the drug and alcohol field often involves heavy workloads and complex presentations (Duraisingam, Pidd, Roche, & O'Connor, 2006; Duraisingam, Roche, Pidd, Zoontjens, & Pollard, 2007; Gray et al., 2004; Phillips, 2003). For Aboriginal workers who work live and belong to the community in which they work there are added complexities surrounding dual relationships

including confidentiality and professional boundary issues with many workers reporting that their job is 24/7 (Logan & Bakos, 2011; Phillips, 2003; Roche & Pidd, 2010). Additional issues which Indigenous workers contend with include racism, lack of culturally appropriate support and supervision and difficulties working in rural and remote areas where they may be the sole workers and have less resources available to support their clients (Roche & Pidd, 2010).

A commonly reported workplace issue, negatively impacting on staff turnover and job satisfaction are inadequate salaries (Duraisingam et al., 2006; Duraisingam et al., 2007; Gray et al., 2004). Aboriginal AOD worker salaries are significantly lower than their non-Aboriginal counterparts and they are half as likely to earn more than \$60,000 (Roche, Duraisingam, Trifonoff, & Tovell, 2013). Partly the disparity in salaries can be attributed to the role in which workers are employed and the level of educational qualifications. These conditions make the attraction and retention of suitable workers difficult (Gray et al., 2004; Roche et al., 2013; Roche & Pidd, 2010)

Aboriginal workers across a number of studies have identified the need for appropriate training and education to support them in their roles as well as clear career pathways (Gray et al., 2004; Phillips, 2003; Roche et al., 2013; Roche & Pidd, 2010). Though almost all AOD workers have a counselling component to their roles many have no specific training in counselling skills (Gray et al., 2004). Phillips found that workers often felt ill-equipped to deal with 'the intensity and seriousness of the helping issues they are regularly confronted with' (Phillips, 2003, p. 114) and that more advanced counselling skills were required than that provided at Certificate III and IV level (Phillips, 2003; Roche & Pidd, 2010).

The NCETA review of alcohol and other drug and mental health training found that in comparison to mental health workers there are substantially less training opportunities available for AOD workers (Roche, Duraisingam, Wang, & Tovell, 2008). The training that is available through mainstream organisations is often not found to be culturally relevant. As a result many workers resort to training provided 'in-house' or 'on the job' though this type of training is often not accredited which can limit future professional opportunities and remuneration (Gray et al., 2004). The NCETA National Indigenous workforce survey found that the Aboriginal AOD workforce is relatively young with proportionally fewer mature age workers. This can mean that younger workers lack the support, mentoring and role modelling which older more experienced workers can provide (Roche et al., 2013).

Prior to 2001, no Koori Drug and Alcohol Worker in Victoria had relevant formal tertiary qualifications. As a result a training program was initiated through the Department of Human Services, to deliver Certificate or Diploma qualifications in Community Services (Alcohol and

Other Drugs) to Aboriginal workers. This program saw twenty nine Koori Drug and Alcohol and Resource Service workers graduate from the two programs with impressive overall retention rates (DHS, 2003).

Though the need for appropriate training and education of AOD workers is clear (Gray et al., 2004; Roche et al., 2013; Roche & Pidd, 2010; Rose, 2008) it has been argued that without adequate follow-up training and workplace support newly acquired skills and knowledge can be lost (DHS, 2003; Goold, Turale, Miller, & Usher, 2002; Gray et al., 2004) which then impact on staff retention as workers value opportunities to implement their learning (Roche et al., 2013).

The literature on Aboriginal AOD workforce highlights the need for appropriate and accessible training particularly at more advanced levels (Phillips, 2003; Roche & Pidd, 2010). There is a lack of information on what constitutes successful training and education for Aboriginal AOD workers and further research is needed to underscore the philosophical underpinnings, methodologies and translation to practice of such programs. What is consistent across both the Indigenous AOD workforce and Indigenous higher education literature is that there is a pressing need for educational programs that can accommodate Aboriginal ways of learning in an environment which respects and acknowledges Indigenous culture and knowledge through building upon the students' skills, experience and knowledge (Biermann & Townsend-Cross, 2008; Clapham et al., 1997; Gray et al., 2004; Roche et al., 2010; Roche & Pidd, 2010; White, 2005; Yunupingu et al., 1994).

Conclusions

Summary. This literature review has provided a social and historical context for Aboriginal substance misuse and the interventions, training and workforce development that can usefully support those drug service workers in this field.

What is apparent from the literature is that Aboriginal substance misuse requires a multi-systemic approach that responds to the different contexts in which the problem occurs and which can address the layers of disadvantage and marginalisation that both create and reinforce conditions for problematic substance use. The literature has demonstrated the extent of the problem of substance misuse in Indigenous communities and how the social determinants impact upon this issue (Loxley, 2004). Particularly pertinent are the risk and protective factors that are likely to exacerbate or mitigate problematic use. Important protective factors that have been discussed include Aboriginal people's sense of power and control in their lives (Anderson, 2007; Johnston & RCIADIC, 1991; NAHSWP, 1989) which can be enhanced through the use of strength base interventions (Pattel, 2007; Roe, 2000; Vicary & Andrews, 2000; Whiteside et al.,

2006) and the importance of social support, social cohesion and strong family functioning (AIHW, 2006; Wilkinson & Marmot, 2003).

The significance of trauma recovery to the treatment of substance misuse has been discussed by a variety of authors who have indicated that family and community can provide the necessary social supports to aid recovery (Atkinson, 2002; Shalev, 2007; van der Kolk, 2007a). The potential of family therapy within this context to promote and facilitate these supports appears significant.

Family therapy training for drug service workers working in the field of Aboriginal substance misuse exists within an environment where there are calls within the literature for more suitably trained Aboriginal health professionals (ABS, 2009, Behrendt, 2012, Andersen an 2008).

Appropriate training opportunities can address the inequity that Aboriginal people experience (Phillips, 2003; Roche & Pidd, 2010) through the positive correlation between education and health (AHMAC, 2012; Hunter & Tsey, 2003). In order for educational programs to be successful in engaging and retaining Aboriginal students many authors stress that Aboriginal ways of learning need to be adopted and the knowledge and expertise of Aboriginal cultures drawn upon (Biermann & Townsend-Cross, 2008; Clapham et al., 1997; Gray et al., 2004; Roche & Pidd, 2010; White, 2005; Yunupingu et al., 1994).

What is apparent through the literature that has been reviewed is that in order for service provision, educational programs and interventions within the field of Aboriginal substance misuse to be engaged with a strong base of acknowledgement and respect for Aboriginal history, culture and expertise needs to be evident.

Broad areas of concern. The broad areas of concern and the development of the research questions have emerged through my personal and professional life experience, the participation in the research project and the review of the literature. The particular areas of concern include:

- An exploration of the ways that Aboriginal and non-Aboriginal people can collaborate in order to achieve equity in access to health interventions and educational opportunities for Aboriginal people.
- The ways in which career pathways for Aboriginal health workers can be facilitated to enable a greater representation of Aboriginal people in leadership positions within health services.

Research Questions. The following research questions evolved in response to the research project where perceived needs and gaps were apparent through direct engagement with the field and through the literature:

- How do drug service workers in the field of Aboriginal substance misuse describe the experience of being trained as family therapists and using family therapy in their work?
- What are the processes that enable collaboration and the sharing of knowledge between Aboriginal and non-Aboriginal people in the delivery of family based interventions and family therapy training?

Conclusion. What this literature review has highlighted is the relevance of the research questions in relation to interventions for Aboriginal substance misuse from the perspectives of those workers in positions to apply these interventions, as well as the potential value of a family therapy training program for the workforce development of drug service workers providing services to Aboriginal clients.

In the next chapter I discuss the theoretical and methodological approaches that informed how the research was conducted and the processes through which the research questions were investigated.

Chapter 3 Methodology

This chapter outlines the nature of the research prior to the analysis and discussion of the research findings in chapters 4 to 10. The theoretical underpinnings of the research will be located within a decolonising framework where naturalistic and grounded theory methods have been employed. Ethical considerations will include discussion of the roles undertaken throughout the course of this study and what these various roles provided in terms of strengths and limitations. The data collection and analysis sections will include explanation of recruitment processes, interview procedures and participant profiles in order provide the framework for interpreting the research findings.

Aim of the Study

The aim of this study is to understand how drug service workers in the field of Aboriginal substance misuse describe the experience of being trained as family therapists and using family therapy in their work. A secondary aim is to explore the processes that enable collaboration and the sharing of knowledge between Aboriginal and non-Aboriginal people in the delivery of family based interventions and family therapy training. In order to accomplish this the drug service workers engaged in the training were interviewed on two occasions both at the commencement of the training and after the training was completed. Further to this the managers and colleagues of the students were also interviewed to better understand the workforce issues the workers faced and how the family therapy skills they had gained were perceived as relevant in their work contexts. Interviews were also conducted with those engaged in providing the Family Therapy Training Program (FTTP) at the Bouverie Centre, La Trobe University in order to understand how drug service workers from the field of Aboriginal substance misuse had been engaged through the use of a particular pedagogical approach.

Research with Indigenous Communities

Ethical research needs to benefits the lives of the participants and do no harm in the process (Onemda, 2008: VicHealth, 2000). It is important for researchers to think through carefully the intended and unintended consequences of the work so as not to replicate exploitative or colonialist practices (Pyett, 2000).

Research has been used historically to legitimate power and as a means to dominate Indigenous people. Colonisers marked themselves as superior and different through evaluation and categorisation which served to rationalise their treatment of Aboriginal people (Smith, 1999). In Australia, Aboriginal people have been systematically discriminated against and marginalised

through assimilationist practices which separated people from their culture and from their ways of knowing and being. It involved removing children from their parents, culture and community, moving communities to missions, forbidding cultural practices and the speaking of native language and terrorising people through brutality, murder and other dehumanising treatment (Smith, 1999).

The adoption of positivist research methods when working with Indigenous people are an anathema. Central to these methods is the possibility for truths to be found by separating out parts from a whole, which is antithetical to the holistic, interconnected and interdependent nature of family, community and the environment to Aboriginal people (Lincoln & Guba, 1985). Positivist methods assume that there can be temporal and contextual independence so that under certain conditions findings are applicable across various contexts. This notion supports a reductionist view that may deny the differences across Indigenous nations, clans and kinship groups. A positivist assumption is that the values of the researcher can with adequate rigour be removed from research findings, this allows for definitive statements to be made about the lives of Aboriginal people without their consultation, involvement or right to determine their own destiny (Lincoln & Guba, 1985).

From the perspective of Indigenous people whom research has historically not greatly benefitted, research can be seen as self-perpetuating, with problems being created through its methods which only further research can remedy (Smith, 1999). People from outside of the community define the problem, design a way to tackle it and try to implement it. It is arguable to what extent these practices continue today and in the recent past it may be that for Indigenous people, research has 'told us things already known, suggested things that would not work, and made careers for people who already had jobs' (Smith, 1999, p. 3). Within much of the research, there has been a focus upon deficit models which construct Indigenous people as the cause of their problems without looking at the broader social, economic and policy context of how various issues were constituted (Smith, 1999; Stanfield & Dennis, 1993). If Aboriginal people are cast as disorganised or not having the skills or education necessary to be full participants in research activities, then the processes and outcomes of research are removed from their control.

In this context, research with Aboriginal people requires attention to the processes by which the research is conducted in order to ensure that respectful and collaborative relationships are maintained and prioritised over the outcomes of the research. This is necessary as it has been

the processes of colonisation that have created inequity in Australian society and so if research processes are not empowering any outcomes gained can be assessed to be of limited value.

This study, with a collaborative approach to research design and method, focuses upon the ways in which Indigenous people utilise their strengths in finding solutions to their own issues. The following section will account for the need for decolonising practices and the means by which this study enacted them.

Decolonising Methodologies

Historically, western thought has taken itself to be the benchmark in relationship to research processes, critical thinking and reflective practice however internationally there has been a growing movement towards an Indigenous research agenda which situates centrally the perspectives of Indigenous peoples and respects Indigenous ways of learning and knowing (Duran & Duran, 2000; Louis, 2007; Smith, 1999; Tomlins-Jahnke & Taiapa, 1999).

It may be that the focus for research in Indigenous communities is about the control of knowledge, its interpretation and distribution with community ownership of community problems. As Hazlehurst attests 'any way forward must address the fundamental issue of Aboriginal community empowerment' (Hazlehurst, 1994, p. xii) which means that Indigenous people need to move from the position of object or victim of research to those controlling it (Smith, 1999).

Research with Indigenous Australians, in the words of Aunty Liz Hoffman an Aboriginal Elder 'was never done right in the first place' but it is possible to adopt decolonising practices that can utilise research to benefit the lives of Aboriginal people (VicHealth, 2000, p. 7).

Decolonisation can be seen 'as a long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power' (Smith, 1999, p. 98). Within Australia a number of principles have been included within an Indigenist research agenda:

1. Resistance as the emancipatory imperative
2. Political integrity
3. Indigenous voices privileged and central within the research

(Henry et al., 2002)

Since 1999, universities have endeavoured to build and extend these principles within an Australian context, including the University of Newcastle (1999) and the Aboriginal Research Institute at the University of South Australia in 2000. Onemda, the Koori Health Research Unit at Melbourne University conducted workshops with Indigenous community members to formulate Koori research principles. It was identified that research needed to: build the capacity of Aboriginal people and strengthen communities; provide a catalyst for change at the level of policy, practice and programs; be led and advised by Kooris; and for outcomes to be acted upon and fed back to the community in a meaningful way (Onemda, 2008).

Decolonising praxis needs to be relational in that the researcher must be willing to give back something rather than just take people's story away for their own academic ends (Phillips, 2003). As an experienced researcher commented to me, because of the nature of the inequities between academic researchers and Indigenous participants there are times when 'you need to be giving twice as much as you perceive you are getting' (Journal entry, 10.8.10). The empowering aims of this project are evidenced in capacity building in research processes and through supporting ACCOs and mainstream organisations to develop career pathways for their workers. Other ways in which research participants benefitted are outlined in chapter 10.

A decolonising research agenda that includes the participants in the research design and which seeks to hear and respond to the voices of Indigenous people is credible when 'the truth and the knowledge of the community is privileged and communicated' (Grant, Nelson, & Mitchell, 2008: NHMRC, 2006, p. 201). Methodological processes can be evaluated on their capacity to achieve this aim (Henry et al., 2002). The following discussion specifically locates the research within particular research methods which are congruent with a decolonising research agenda.

Naturalistic Inquiry and Constructivist Grounded Theory

Naturalistic inquiry seeks to understand rather than to predict phenomena. It honours the participants' right to determine how their behaviours and beliefs are interpreted and to be included in 'the formation of knowledge that purports to be about them' (Lincoln & Guba, 1985, p. 31). It values the use of tacit knowledge and elects to understand phenomena in its natural setting as it is believed that realities cannot be understood outside of their contexts (Denzin, 1971; Erlandson, 1993; Patton, 2002). Qualitative methods are favoured within this framework as they are more suited to recording multiple realities (Lincoln & Guba, 1985).

This study adopted naturalistic inquiry in its purposive choice of participants who were drawn from those AOD workers undertaking the post Graduate Certificate training. As with any

community-based work, the necessity for networks and connections to be mobilised and engaged is paramount. This can be particularly true with marginalised and Indigenous communities. Being an outsider unfamiliar to the community had I not been attached to the Bouverie FFTP and been vouched¹¹ for by my Indigenous colleagues the research would not have been possible. So the convenience sampling method resulted from the opportunity afforded by the training program and my connection to it and depended on the willingness of students to participate. All student participants were AOD workers within roles that provided services to Indigenous clients and came from various communities and service contexts which provided information-rich cases. Opportunistic sampling also occurred when participants invited others within their organisation to speak with me (Neville, Willis, & Edwards, 1994).

A grounded theory method (GTM) (Glaser and Strauss, 1967; Strauss & Corbin, 1994) has been employed to provide explicit guidelines in regards to data collection and analysis and as a means of keeping participants' perceptions and voices central to the process. GTM develops theory through the process of data analysis, rather than using data to test a hypothesis as occurs in the positivist tradition (Creswell, Hanson, Plano, & Alejandro, 2007). Integral to this method is the simultaneous collection and analysis of data, which inform one another in a recursive process. Themes and categories are generated and interrelated to develop a story or theory (Glaser & Strauss, 1967; Strauss & Corbin, 1994).

Though GTM in its original conception (Glaser & Strauss, 1967) assumed a social constructionist approach to the empirical world, it did not take into account how the researcher affected the research process, produced the data, represented research participants and positioned their analysis. This objectivist approach emphasised generality and objectivity rather than relativity and reflexivity (Charmaz, 2008). Constructivist grounded theory (CGT), as espoused by Charmaz (2006, 2008), assumes diversity and multiple realities within particular contexts and is concerned with how power is enacted and accounted for within research. CGT privileges the views and voices of the participants over that of the researcher, this is congruent with a decolonising framework that is sensitive to who controls and mobilises information pertinent to Aboriginal people and who has the right to speak and in what domains.

In keeping with a CGT approach, a working hypothesis can be located within the project's assumptions and position statement and involves the applicability of family-centred counselling approaches for Indigenous community. Initial beliefs, arising from the previous research

¹¹ Endorsed by people known and accepted in the community as a person worthy of engaging with.

undertaken by the Indigenous Program Team were: that the Indigenous AOD sector would differ from the mainstream sector with routine inclusion of family and community members; that the Indigenous service system was crisis-driven and; that there was a high turn-over of staff which related to worker conditions (Perlesz & Proctor, 2009; Latham, 2010, 2011).

Data Collection Processes

Gaining Consent. From an understanding of Indigenous protocol, consent is given to a person rather than to a project or set of questions and this consent implies trust (Smith, 1999). Those seeking to collaborate with Indigenous people and services note that consulting and negotiating is a notoriously slow process which requires trust-building and continuous social interaction processes in order to forge and maintain working relationships (Maclean, Warr, & Pyett, 2008; Phillips, 2003; Waples-Crowe & Pyett, 2005).

Initially, I was introduced to the student training group alongside my field supervisor who was the Indigenous researcher and evaluator from past trainings. I made clear my interest in the area, my professional background and my past associations and relationships. These included being a graduate of the Masters of Clinical Family Therapy at the Bouverie Centre where the current non-Indigenous trainer had been one of my teachers and I had previously worked with the program manager to provide facilitator training in Forum Theatre to service providers. My role as evaluator was discussed and explained as different to my researcher role where I would be asking the AOD students at a later date to participate in a research project in a purely voluntary capacity. I deliberately chose not to ask people to participate in my research at that early stage, deciding instead, in consultation with the trainers and my Indigenous field supervisor, to firstly spend time with the group in order to build relationships before seeking consent (Waples-Crowe & Pyett, 2005).

In order to get to know the group and to build relationships I participated in the first five sessions of the training which were conducted by two Indigenous trainers. These sessions focussed on building cultural awareness and sensitivity through an understanding of the effects of trauma on Aboriginal people and how this can be applied to clinical practice (Frederico, Jackson, & Black, 2010). The exchange of knowledge and experiences during this time, within an atmosphere of respect and trust, enabled the beginnings of relationships to be formed and these provided a platform from which I could begin to request consent from students to participate in the research. The AOD students were approached individually in weeks four and five and all agreed to be interviewed for the research. These requests were made with the knowledge of the

non AOD students, who had been previously informed that the study would be focussing primarily on the experiences of the AOD students. It was restated to the participants that in accordance with university ethical guidelines participation in the research was entirely voluntary, was not a requirement of the training program and would not influence in any way their involvement in the training program, their employing agency or in any future dealings with the Bouverie Centre.

Another aspect of my dilemma surrounding consent was delineating my roles to the students (refer Figure 5). In my role as educator I delivered presentations that centred on the problematic history of research with Indigenous people and this facilitated discussions about research, its harms, its benefits and what constituted ethical and decolonising practices across a range of domains. In each of these presentations I emphasised in what capacity I was addressing the group, what was required of them and opportunities were provided for questions and clarifications both within sessions and afterwards through phone and email. Further discussion of the learning and outcomes of this process will be provided in Chapter 9.

The managers of the workers involved in the study were informed of my research firstly by their employees. They were then sent emails by myself informing them of the research and requesting their participation in two rounds of interviews, the first to be conducted at commencement of the training and the second after the training had been completed. Their permission was also sought to conduct interviews on site or at other suitable locations (refer Appendix A). Participants were asked to give both verbal and signed consent and were supplied with Plain Language Statements (refer Appendix A) which made clear the purpose of the research as well outlining that the data would be fully de-identified with any details of participants masked to protect anonymity.

A sample of questions was sent to all participants for their feedback and input prior to the first interview being conducted. A sample of the questions which were sent to AOD workers prior to the interviews are listed here:

- What approaches do you think are the most useful when working with Indigenous communities affected by substance misuse?
- What prompted your manager to release you to do the post Graduate Certificate in Family Therapy?
- How did you think it might benefit the clients and families you work with?
- How are families included at this service?
- What gets in the way of that?

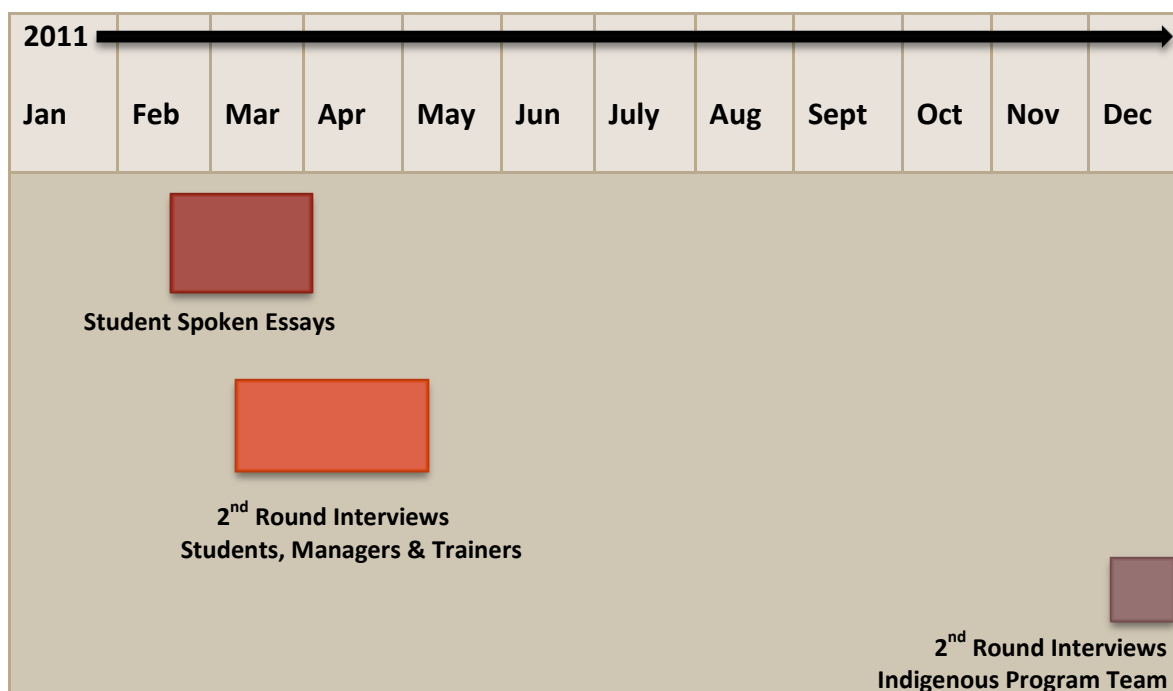
- Who's doing this work well in the area of Indigenous substance misuse?
- What changes to policy are necessary in the Indigenous AOD area?
- What will support you to utilise the skills you are learning? What might get in the way of that?

Spoken Essays. The student Spoken Essays that were part of the curriculum requirements for the post Graduate Certificate in Family Therapy were equivalent to the three thousand word essay required within the mainstream GCFT. The students were interviewed by the Indigenous Program Manager regarding their systemic understandings and practices. After these interviews were transcribed by administrative staff at the Bouverie Centre, they were forwarded to the students for review and editing. Permission was gained from all but one of the AOD students to include de-identified material from these essays in this thesis.

Figure 2: Interview Timeline 2010



Figure 3: Interview Timeline 2011



Journal Writing. In addition to the data collected through interviews a reflective journal was also utilised which recorded assumptions and beliefs and tracked how various experiences impacted upon them. The use of the journal to locate and track researcher bias is consistent with a CGT approach as it provides a way to explicitly integrate the researcher's views in the interpretation of data.

The Interview Process. A sample of questions were sent to participants prior to interviews in order for them to prepare and understand what the process would be like. Potential participants were informed that the interview would be conversational in style where they could direct the interview towards areas of particular interest and concern to themselves and that they were free to answer questions to the degree that they felt comfortable and that they would have the opportunity to view the transcripts after the interview where they could add or subtract from their answers.

In the first round of interviews the Indigenous co-researcher accompanied me to all of the sites though chose to sit in on only half of the interviews and in the second round of interviews through discussion with my Indigenous Program colleagues it was decided that there would be great benefit in having the Indigenous co-researcher more fully participate in interviews by sitting in on all interviews and choosing particular interests and lines of inquiry herself during the interviews in order to build capacity and to gain greater perspective.

The second round of interviews occurred whilst the workers were in the second year of the three year Training Program. Prior to these interviews being conducted a schedule of questions was once again emailed to the participants. However, congruent with the CGT approach these questions were particular to each individual and centred on developing a more fulsome understanding of what they had volunteered in their first interviews as well as asking for their comments regarding areas of concern and interest expressed by other interviewees. In this way the interviewees were involved in the construction of the emerging themes and design of the study. The following is an example of questions asked in the second round of interviews:

- Last time you spoke about being in a process of working out who you are and how you operate at work. I'm wondering where you might be up to with this?
- You spoke about wanting to take more risks, be honest and stand up to clients at times. What effect has trying out any of these things had on you and your clients?
- What does family therapy mean to you?
- How do you deal with the negativity that comes with change?
- How do you work with things that you can't change in families' lives like deaths through addiction?
- You said that your motto as a worker is 'there is a way around everything'. How is that coming through in your work now?

Table 3: Interviews

Interviewed	Total Number of participants	Indigenous	Non- Indigenous	Number of interviews	Type of Interview	Interview location
AOD students	6	4	2	10 (comprising 6 in round 1, 4 in round 2)	Individual	Employing organisation (AOD workers)
	5	3	2	5	Individual Spoken Essays	
Managers (AOD students)	5	1	4	7	Individual Group	Site of employing organisation
Colleague (AOD worker)	1	1	-	1	Individual	Site of employing organisation
Trainers (Family Therapy Training Program)	2	1	1	2	Group	Bouverie Centre
Indigenous Program members	5	3	2	5	Individual	Bouverie Centre
	5	3	2	1	Group	Bouverie Centre
Totals	29	16	13	31		

Interviews' duration was between 1-2 hours, with eighty percent being transcribed by the researcher and the rest by a professional transcription service, made possible by a research assistance grant. The spoken essays were transcribed by administration staff at La Trobe University.

Background to Interviewed Workers, Managers and Services

AOD Worker Profiles¹². All of the students interviewed were employed as AOD workers employed in positions where they worked with Indigenous clients. They comprised of a manager, an alcohol and drug diversion worker, an outreach worker and three AOD counsellors. The workers regularly included families in their work, with the outreach worker as an exception and provided counselling interventions in amongst casework and administrative duties. The workers possessed a Diploma level qualification and a Cert IV in Alcohol and Other Drugs with two of the workers holding an undergraduate degree and all were highly experienced having worked in the AOD field for over five years, one of the workers was in their thirties with the rest of the workers being in their forties or fifties. Four of the interviewees identified as Indigenous with two born in Victoria and two interstate. The other two non-Indigenous workers had standing in the Indigenous community and their organisations considered that increasing their capacity would be beneficial for the community.

The second round of interviews post training two of the students declined to be interviewed, one of whom had been unable to complete the course and felt ambivalent regarding the training and the other cited that they felt they had contributed enough to the research process up until that point though they agreed for the transcripts of their Spoken Essays to be utilised in the research. The AOD colleague interviewed in the first round of interviews was unavailable to be interviewed during the second service visit.

Manager Profiles. Interviews occurred with a range of management staff. The AOD workers were asked to identify a person in a position of authority in their organisation who was supportive of them doing the post Graduate Certificate in Family Therapy. This approach was chosen in order to build on the strengths existing in services and to focus on the people who could provide the most encouragement to the workers and who could support the development of career paths. It was thought that if the profile of the training was raised through the visits and interviews at the services that this may result in an increase in acknowledgement and recognition of worker skills. By interviewing managers it was also hoped that additional information could be gained regarding the perceived benefits of the workers undertaking the training and what relevant skills, if any were being accrued.

Interviewees included: a CEO of an ACCO, a clinical manager, a clinical coordinator, a drug and alcohol services manager and a primary healthcare services manager.

¹² The backgrounds of some of the students are described here whilst changing identifying features in order to protect anonymity.

These managers came from backgrounds in psychology, social work, youth work and drug and alcohol. All of them had some understanding of systems theory and family therapy and had agreed to release their workers to attend the training and supervision required to meet the course requirements for the FTTP.

Two of the managers were interviewed on two separate occasions as indicated in Table 2 whereas two other managers were unavailable to be interviewed a second time as one could not be contacted and another had left the service shortly after the first interview. All participants were sent a copy of their transcripts of their interviews to be altered or added to.

Profile of Services. Four services were involved in the research which accounted for all of the agencies in which the students were employed. The Indigenous Training Team had previously consulted with these agencies regarding the commitment required by the students and the services to complete the GCFT. Three of the services were Aboriginal controlled and one was a mainstream community health service¹³.

The mainstream organisation referred to in this study is a large community health service with over sixty program areas. The service is located in rural Victoria and had previously been involved in family inclusive training which had been well supported by management. Recently the service had expanded to include Indigenous specific programs which had initiated the employment of Aboriginal staff. Aboriginal people had prior to this accessed the service though there had been no services designated specifically for them.

Of the three Indigenous services, one included in its service provision AOD rehabilitation as well as outreach and support services which were located across the state.

Another of the Indigenous services is located in an urban area and has a long history of providing culturally appropriate health services to Aboriginal people and the final ACCO is located rurally with a rapidly expanding range of programs which receives both state and commonwealth funding.

¹³ In order to protect the anonymity of the services some of the identifying details have been changed though it is endeavoured that sufficient contextual information remains.

Table 4: Health Service Interview Sites

Site	Population	Geographical area	Partner/stakeholder
1	30,000	Rural area	Mainstream health service
2	90,000	Large rural area	ACCO
3	56,000	Rural area	ACCO
4	4,000,000	State capital	ACCO

In 2006, around one-third (32%) of the Aboriginal and Torres Strait Islander population lived in major cities of Australia, 43% in regional areas and 25% in remote areas. The total population of Victoria is 4,932,422.

Table 5: Indigenous Population Victoria

Indigenous Population - Victoria	
Aboriginal	27,068
Torres Strait Islander	2,218
Both Aboriginal & Torres Strait Islander	855
Total	30,141
Indigenous population as percent of total Victorian population	0.62%

Source: Australian Bureau of Statistics, 2006 Census.

Data Analysis and Interpretation

Data analysis has been described by grounded theorists Strauss and Corbin (2008), as the interplay between the researcher and the data and where synthesis occurs (Morse, 1994). This involves moving from individual perceptions to a composite stage of understanding where commonalities of experience and meaning are revealed.

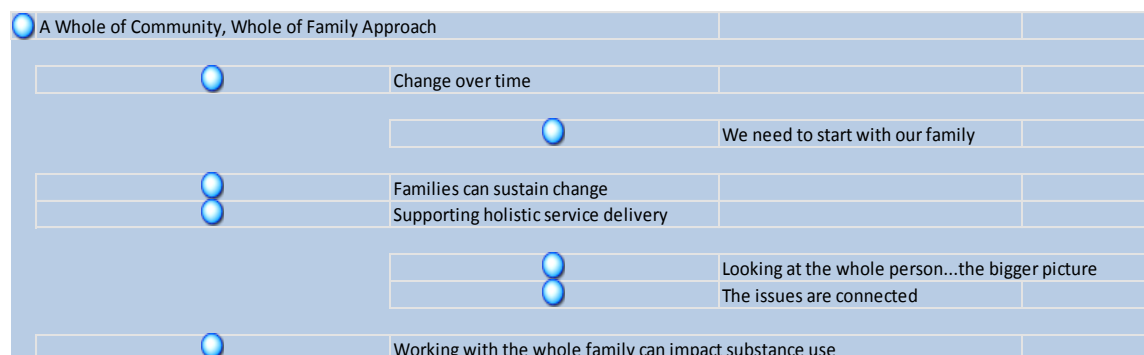
In order to do this, the interviews were transcribed producing a large amount of unstructured data. One of the major strengths of grounded theory is that it provides tools for analysing this vast amount of data. The computer programme, NVivo (Richards, 1999) was employed to manage and organise the data and provided an efficient way to write and attach analytic memos to transcripts. Constructivist grounded theory provides a means of 'naming segments of data with a label that simultaneously categorizes, summarizes and accounts for each piece of data' (Charmaz, 2006, p. 43). Utilising line by line coding meant that an extensive and wide range of

codes were generated in order to allow emergent concepts to appear (Corbin & Strauss, 2008). As this process involves the interpretation by the researcher in the construction of codes certain other interpretations were sought through membership in a peer research group comprising of members external to the Bouverie Centre. To this group I brought data for discussion and comment regarding coding and analysis.

The large amount of initial coding provides the 'analytic scaffolding' as Charmaz has noted (2005, p. 517) on which to build theory. The initial codes were structured through the use of focussed coding where categories and themes emerged, moving the research closer to a more abstract theoretical framework (Charmaz, 2006).

The larger codes under which the data was were grouped included: Family Therapy Training for AOD Workers, Was the Training Culturally Appropriate and Relevant?, Family Therapy Training and the Workforce Development of Drug Service Workers in the Field of Aboriginal Substance Misuse, The Black and White Approach and the Indigenous Program and the Researcher Journey. Under each of these codes were several levels or branches of additional codes. This aspect of coding Glaser (1998) has called labelled coding which progresses to concepts and then to categories. A larger section of the coding is available in Appendix B.

Figure 4: Chapter 4 coding sample from NVivo



The process of identifying and structuring the coding enables a constant comparative method which is discussed by grounded theorists as a means by which to attain theoretical saturation (Charmaz, 2003; Corbin & Strauss, 1990; Glaser & Strauss, 1967). Charmaz (2006) describes saturation as being when no new theoretical constructs emerge from the data. In this research the 'saturation artefact' was reached during the second round of interviews despite the small sample size. This could have been for several possible reasons including: the homogeneity of the sample, the tendency of the participants to be enculturated into a shared voice borne from their shared training experience and from working in similar AOD contexts with an Indigenous focus.

Rigour and Trustworthiness. Positivist research has particular criteria for its assessment including reliability and validity and these criteria have been applied to qualitative studies albeit in a modified way, to account for the differing goals in these types of research. Qualitative methods seek to find categories of meaning that relate to smaller sample sizes whereas quantitative studies use categories taken from existing theory which they apply in a standardised way to larger sample sizes (Morrow, 2005). Though these types of studies differ markedly in terms of their aims and their methods, Lincoln and Guba (2000) and Patton (2002) have formulated parallel criteria for the evaluation of qualitative research that ensure that both rigour and trustworthiness are conveyed. The application of these criteria are outlined here and are also embedded throughout the methodology (Morrow, 2005).

Triangulation of data occurred, through cross-checking across time and context, comparison with written reports and theoretical texts and through utilising a range of methods which were reviewed by different investigators (Lincoln & Guba, 2000; Patton, 2002). I sought feedback for the categories developed through the data analysis from Indigenous Australians through member checking, which was crucial in terms of rigour and decolonising practice. This meant that the analysis and interpretation of data was brought back regularly to the research participants for their input and reconstruction (Caulley, 1994; Hunter & Tsey, 2003). Robyne Latham, Indigenous researcher at the Bouverie Centre acted as my field supervisor and gave regular direction, advice and support. An Indigenous colleague and trainer within the FFTP also accompanied me to interviews and reflected back her observations and thoughts regarding the process. Peer debriefing was utilised with a professional who was experienced in working with Indigenous communities as well as a peer researcher's group at the Bouverie Centre who challenged and tested perceptions and assumptions and gave input on the emerging design.

The credibility of qualitative research can also be demonstrated through prolonged engagement in the field indicating the reliability of findings over time (Lincoln & Guba, 2000; Patton, 2002). In this research, engagement with the AOD workers occurred over a twelve month period, over eight months with their managers and two years with the trainers and Indigenous Program Team. There was participation and facilitation over the course of the eleven-month training program and two visits to each of the services employing the students.

Ethical Considerations. Though my position as a non-Indigenous researcher creates particular dilemmas, limits and possibilities, it does not preclude a critical reflection upon my role or on an ability to engage in practices, which seek to undermine or challenge constructions of power and privilege. Though it is necessary to situate the research and the researcher in a particular time

and place it needs to be done in ways that avoid 'endless self-criticism and empirical nihilism' as this would weaken the study in terms of its aims and outcomes for the community (Naples, 2003, p. 24; Schratz & Walker, 1995). A reflective and accountable practice could be considered as more useful in providing a collective and an individual assessment of the process (Naples, 2003).

Central to Indigenous ways of knowing is a collective rather than individual consciousness (Hazlehurst, 1994). In methodological terms this meant that decisions regarding the research were made collaboratively along with the Indigenous co-researcher and Indigenous field supervisor and that I was not seen or perceived to be operating alone and without accountability. Though there was a fundamental discrepancy in knowledge about research, family therapy and AOD clinical experience between myself, my Indigenous colleagues and the students, discussions provided a means by which it could be broached, including deconstructing language in order to find meaningful terms that could be shared and engaged with and taking time to ensure consensus was reached around the use and purpose of the research. An attention to process and collective decision-making was considered paramount as the research was dependent on the participants' cultural knowledge, expertise and ongoing consent (Grant et al., 2008; Pyett, 2000).

The spirit and integrity of the research (NHMRC, 2006) was congruent with the research previously conducted by the Indigenous Program at the Bouverie Centre (Latham, 2010; Perlesz & Proctor, 2009). The Program Team had been successful in engaging Indigenous Child, Family and Health workers (CFH) in culturally sensitive training for two years which was demonstrated by high retention rates and ongoing requests for the training both nationally and throughout the state of Victoria (Latham, 2012). The networks and learning of past research were built upon to ensure the integrity of research relationships and that appropriate decision-making processes were adhered to within the communities who stood to benefit.

The value of reciprocity (NHMRC, 2006) was sought to be enacted in this research through directly benefitting the lives of Aboriginal people by involvement in bridging the health gap for Aboriginal people and the knowledge gap for those working in the field of Aboriginal substance misuse. Decolonising and demystifying the methodologies involved in research enacted reciprocity through the feedback of information to the community. This knowledge sharing or knowledge transfer took the form of feedback sessions in the training, reports and a forum presentation where those involved in the research had the opportunity to connect with other

people and ways of thinking that had resonance for them (Pyett, 2000: Reason, 1994: Tandon, 1988).

Roles Undertaken Through the Research Process

Many researchers note that it is necessary for researchers to make themselves useful to the community with which they seek to work, by undertaking roles outside of that of researcher (Phillips, 2003; Pyett, 2000; Smith, 1999). This serves to engender a spirit of collaboration and goodwill and enables the community to witness the integrity and qualities of the researcher. Phillips describes this as being 'genuine and giving of my time and attention' and that he found it important 'to lend a hand' (Phillips, 2003, p. 15). It is also necessary to share the theories and processes which construct knowledge (Smith, 1999) which was achieved through mentoring relationships with Indigenous colleagues and discussions with the students undertaking the post Graduate Certificate in order to build research capacity (Onemda, 2008: Rigney, 1999: VicHealth, 2000). Other roles I have undertaken within this study have included program evaluator, community forum facilitator, educator, editor, co-writer, de-briefer, report writer and advocate.

Figure 5: Roles Undertaken

Role	Responsibilities	Outcomes
Training Evaluator	Administered pre and post questionnaires and weekly session evaluation forms to all students undertaking post Graduate Certificate. (N.B these questionnaires and evaluations are not included as part of the research data). Monthly feedback sessions to students and trainers regarding evaluation.	Report to Department of Health (DoH) Mental Health, Drugs and Regions. Co-written with non-Indigenous senior trainer.
Educator	Three two-hour sessions on research and evaluation within the post Graduate Certificate building research capacity of students.	Increased profile of benefits of research and evaluation. Student's reflection on culturally appropriate models of evaluation.
Community Forum Facilitator	Three-day workshop, facilitation and director of Forum Theatre event based on the 'Theatre of the Oppressed' techniques. Included as part of the post Graduate Certificate course requirements occurring at the end of the training and designed to highlight and celebrate the systemic understandings as well as the challenges surrounding the work of Indigenous AOD and Social and Emotional Wellbeing workers.	Community Forum with students, community members and stakeholders. Managers, colleagues, family, friends, funding bodies and Bouverie staff in attendance.
Researcher	10 interviews with AOD students undertaking	Research summary to

	FTTP, 1 interview with an Aboriginal AOD colleague and 7 interviews with the students' managers. 8 Interviews with trainers and Indigenous Team members. 7 Service visits to ACCOs and mainstream services employing interviewees. Attendance at 4 research Cooperative Inquiry group (CIG), and 2 Project Advisory Groups. Data analysis including 5 Spoken Essays and feedback to participants.	community. Presentations to community, the AOD sector and the Department of Health. Conference presentations. PhD thesis and Journal publications.
Mentor	Mentoring Indigenous researcher, Indigenous Program, Bouverie Centre. Supporting roles: editor, co-writer, de-briefer, advocate. Mentoring Indigenous trainer and cultural consultant as co-researcher. Mentorship of Indigenous graduate of Metro training into my role as Community Forum Facilitator (see Chapter 9)	Publication of reports. Research and evaluation presentations (Indigenous Program). Research capacity building. Facilitator capacity building. 6 monthly reports. Presentations. Journal publication.
Indigenous Program Team member	Attendance at Team meetings, Team planning days. Support with funding submissions, reports, advocacy, journal articles. Media liaison, event co-ordinator.	Reports, Journal articles, media release.

The following chapters reflect the findings obtained through the data analysis and methodological approaches outlined in this section.

Chapter 4 The Use of Family Therapy as an Approach to Substance Misuse in Aboriginal Communities

In this chapter emphasis has been placed on allowing the voices of the research participants to speak. This is consistent with a decolonising research methodology which avoids interpretation by the researcher. The perspectives of the researcher on what the data presents will be discussed in greater detail within the discussion chapter to follow.

This chapter responds to the research questions by demonstrating the consistency between family therapy and alcohol and drug work with Aboriginal clients from the perspectives of both Aboriginal and non-Aboriginal drug service workers. In the first round of interviews with the drug service workers and their managers, there was a consistent enthusiasm for the inclusion of families in the treatment of substance misuse and for the professional recognition a postgraduate qualification could afford. What emerged through the prolonged engagement with the drug service workers was a shift in thinking around what type of family involvement could be of most use. This included extending people's practice to working with multiple family members in the room (or other venue) together. From the outset workers believed in holistic and systemic approaches as most efficacious for working with Aboriginal people but over time workers developed a commitment to utilising systemic work within the family and community alongside casework and crisis interventions.

There is scant literature on which counselling interventions are the most useful for work with Aboriginal substance misuse nor how they can best be applied. Within the Alcohol Treatment Guidelines for Indigenous Australians (DoHA, 2010) cognitive behavioural therapy, grief and loss counselling, narrative therapy and couples and family therapy are recommended in order to broaden the range of interventions available for Aboriginal people. The National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009 also suggested family therapy approaches be adopted. There are no accounts from those in the position to implement interventions on how they can be applied. There are lead programs such as in the Northern Territory the Council for Aboriginal Alcohol Program Services Inc. (CAAPS) that involve the whole family in the recovery of those in residential treatment (Strempel et al., 2003) though details of the application of family interventions is scarce. Literature that makes mention of the inclusion and involvement of families in treatment is most often within the sphere of residential treatment rather than within brief or secondary prevention. It is unclear how

programs adapt methods for use with Aboriginal people. This is where this and the following chapters make their contribution.

Narrative therapy has been used to good effect with Aboriginal populations utilising collective approaches (Denborough, 2008; Denborough et al., 2009) and in work with individuals (Bacon, 2007; White, 1997). Narrative approaches are often favoured because of their ability to respect, acknowledge and build upon cultural practices and strengths. Mehl-Madrona's (2007) work is similar to this approach in that it explicates how family and community need to be part of a systemic solution for maintaining the health and wellbeing of individuals though his work doesn't include the application of particular therapeutic interventions that address the functioning of family systems. This chapter builds on the argument for the efficacy of systemic interventions for substance misuse and for health and wellbeing interventions more broadly with specific attention to how the interactions amongst family and community members can be intervened with therapeutically.

Any therapeutic approach to substance misuse needs to take into account that some Aboriginal people are hesitant about being involved in therapy as they may be unsure about how an approach originating from outside their culture could appreciate their history, social and cultural context (Dudgeon & Ugle, 2010; Pattel, 2007; Walker & Sonn, 2010). Within journal entries during the research process it was documented that having the word family in the title 'family therapy' implied to the Aboriginal workers an approach that could be respectful and acknowledging of Aboriginal approaches to health. Conversely the word therapy had negative connotations for many people, though over time the ability of family therapy, or family healing to work with Aboriginal people was affirmed.

One of the Aboriginal trainers in the Indigenous Program, who is also a past graduate of the training, claimed that *'family therapy makes sense because it is a white meets black way'*. A shift in perceptions occurred over time for the Aboriginal workers, from a scepticism surrounding the benefits of therapy for Aboriginal people to an appreciation of how family therapy could provide therapy in a culturally congruent way. For the non-Aboriginal workers this transition was not as marked as they held greater belief in the possible value of family therapy for their clients from the outset though they were unsure how they could best adapt it to their work context.

The following data analysis will exemplify, from the perspectives of Aboriginal workers, managers and staff from the Indigenous Program, how substance misuse is experienced by many Aboriginal people, some of the explanatory models for its cause as well as outlining current and previous approaches to treatment that include the ways in which family therapy can provide a

useful means of intervention. Efforts will be made to address the context of substance use as it informs how family therapy can be applied and understood to be culturally relevant.

The Significance of Family

Family was perceived by workers and their managers as significant in terms of how Aboriginal people perceived themselves and a motivation and/or constraint to change for clients. This was consistent from the first to the second round of interviews.

A collective sense of identity. The workers and managers interviewed stressed the centrality of family and community to Aboriginal people and felt that the inclusion of families in the treatment of substance misuse was culturally appropriate. As one manager commented, *'(Aboriginal) people don't see themselves as individuals but as part of the community or part of a family group'* and,

If you separate out the individual from the family (in treatment), you are not doing justice to the Aboriginal person. Because their family is so intrinsically a part of who they are, you can't separate out the two.

Non-Aboriginal manager

Participants felt that including families in treatment made sense for their clients as it reflected a collective sense of identity and met with the expectations of their family and community. The practice of working with families and communities to find solutions to problems was not new for the AOD workers and as one Aboriginal worker put it *'that's how we work anyway, we work with families not with individuals'*.

As a motivation and a constraint to change. Family members were perceived to impact greatly on each other's perceptions and behaviours and as *'families keep operating after services are closed'*, so pragmatically it was important to work with those in a position to exert the most influence. Workers and managers recognised that families can provide motivation and reasons to change as well providing constraints to decreasing substance using behaviours. As one manager commented,

Workers may see their clients for maybe one hour a week and the rest of the time they are connected to family and to other people...unless they understand the dynamics that operate in their family and community they are not really doing anything with them...so understanding the family, understanding the connection and understanding, how that operates is really important to creating sustainable change.

Those interviewed across the journey of the research were unanimous surrounding the centrality of family to treatment for Aboriginal substance misuse which indicates that any intervention in this field needs to be able to consider and address family connections, needs and constraints to change.

Perception of the Problem

Substance misuse was perceived by workers and managers as symptomatic of people dealing with a multitude of issues including a lack of resources and services, transgenerational trauma resulting in heart and soul sickness and a lack of appropriate skills and training for drug and alcohol workers in the field of Aboriginal substance misuse. Over the course of the research the perception of the problem increasingly emphasised the effects of trauma on substance misuse and the need for appropriate training.

Workers and managers commonly conceptualised substance misuse as symptomatic of other issues such as transgenerational trauma and frequently located it in relationship to the social determinants of health.

Drugs and alcohol are just the icing, just the surface underneath that there's a multitude of issues there's housing and there's money, there's lack of confidence, there's abuse, there's neglect that's going on underneath that so unless you can get to that, you can't fix them, but if you don't deal with that drugs and alcohol are going to be the issue.

Aboriginal AOD worker

A lack of access to resources and appropriate services. One worker expressed frustration about the limited efficacy of her outreach position without the availability of appropriate services to address people's basic needs such as housing as well as culturally appropriate detoxification and rehabilitation facilities.

D&A workers are band-aids, like we are there to deal what happens as a result of the issues, like if they get in trouble, like they have to go to court or go to gaol, not to work on what's really going on.

Aboriginal AOD worker

Though some workers are able to refer clients and families on to specialist workers, not all are able to do so,

I can't say [to a client], I'll get you a sexual assault counsellor or a grief and loss counsellor, I can't take them around there, you can't do that. So you have to swap hats and if you are down by the river bank and under a tin humpy you can't go and get those fellas.

Aboriginal worker

Transgenerational trauma. Other problems emphasised arising from transgenerational trauma and forced separation of families, were issues around identity and belonging.

I think that disconnection from land, disconnection from culture, disconnection from language, disconnection from what it is about being an Aboriginal person, is like taking the soul or ripping the heart out of somebody, because if you do that you die.

Aboriginal AOD worker

Heart and soul sickness. This heart and soul sickness caused a sense of despair which could fuel the misuse of alcohol and drugs. A sense of identity and belonging was also cited as a reason to drink or use drugs. One Aboriginal worker recounted how their family member, when asked why he spent much of his time in the park drinking explained, *'that's where my friends are, that's where my people are, that's what it's about'*. Other workers spoke about substance misuse as a form of protest which purposely alienated them from a society which had previously been the cause of trauma for Aboriginal people and which continued to be discriminatory.

A lack of skills and training to address complex issues. What is evident in a number of interviews is that throughout the course of the training, workers gained awareness that a narrow focus on drug and alcohol issues does not provide opportunities for sustainable change and that drug and alcohol use, though a problem in itself, is indicative of other issues. The findings of this research, in contrast to other literature in the field suggest that holistic interventions are required to address the range of issues which inform and reinforce the problem and these interventions need to include family and community.

Early on in the training, a common belief of workers and managers was that in order to effectively treat substance misuse, drug and alcohol workers needed to have the capacity to address related issues such as mental health, sexual abuse, family violence, trauma and grief and loss.

Drugs and alcohol might be the reason why people come to see you but the reality is it's always going to be a generalist counselling position, it always will be. And yes you are dealing with drug and alcohol dependence but that's as a result of trauma, or it's a result of other life experiences, it's not the cause.

Non-Aboriginal manager

As the Training progressed, workers identified that the complexity of the work and the issues that were confronted, whilst making the work interesting and challenging also increased the need for appropriate training,

You do need to have lots of tools in your tool bag to be able to pull out at the appropriate time with a particular need...you do need to have a really good understanding of these areas as well and for me that is what makes the role really interesting and rewarding.

Non-Aboriginal worker

Addressing Intergenerational Trauma Within the Context of Family

In order for the effects of transgenerational trauma to be addressed in the treatment of substance misuse participants stressed the need for: family to be part of recovery, early intervention for children of parents with substance misuse and the need for family and community to be involved in the provision of treatment in order for a sense of safety to be maintained. This became more clearly articulated throughout the participants' journey and examples of this are described below.

Part of recovery is family

If there's been trauma in the family, it is not just one person who's been traumatised, it's been the whole family who's been traumatised and I just think that part of recovery is family, with community I guess if they can get out in the community and they can make it work and when someone finishes their rehab, it's not just like putting a bandaid on the cut, you are actually treating the whole family.

Aboriginal worker

The participants articulated that the effects of intergenerational trauma are experienced by all Aboriginal people and so to heal from this trauma the family needs to be involved. As an Aboriginal Team member from the Indigenous Program at the Bouverie Centre summarised, healing needs to occur in the context of the family because of *`all that has happened in the past*

that has caused the disintegration of the family, the intergenerational trauma that has caused that fragmentation...murders, deaths, illnesses all of that’.

Early intervention for children. Though a particular family member may be presenting with substance use issues the causes and effects are experienced by all. A research participant told how he believed that by strengthening the family system, symptomatic behaviours were also likely to decrease for the children of parents with substance use issues,

And with the children...I'm always into early intervention and even if there has been drug and alcohol or attachment issues there's always the possibility for early intervention, then we can work on those families and the child has a really good chance of basically coming through that and of coping as an adult and having healthy attachment through their life.

Non-Aboriginal manager

We really stick together. An Aboriginal worker described how her family had adapted in order to survive removal from their traditional lands and the forced separation of families. The following describes the legacy of those practices for her family today,

I've only got two non-Aboriginal friends in my whole life and I think that's really strange I should have and more, but because I didn't think I could be good enough for it or I was content in that bubble. And I look at Renee at her school as well and she has a lot of Aboriginal friends and she's gone that way and she has non-Aboriginal friends as well. It's like when people say I'm going out for coffee with my girlfriend and I think, I never do that, I go out with my cousins, my friends - I've got Koori mates, I don't catch up with my girlfriends - I'll have to do that and see what that's like! It's a strange world where we are protected. It comes down to historically, like the mission days like they stuck together because they were protected and like my grandparents weren't removed because they all stuck together you know they were all at risk of that, but my grandmother moved off the mission and you know got away from that and they were protected from that and like us kids were protected because we always stuck together and no one ever moved away or did anything out of the norm and we really stuck together. So that's really the guts of it, is that we really stick together.

Aboriginal worker

This quote indicates areas that need to be considered when working with Aboriginal people including the way families are engaged and the need for people to maintain connection to engender a sense of safety.

A Whole of Community, Whole of Family Approach

'We need to have families on board for real change to occur'

Non-Aboriginal manager

Participants spoke of the need to include families in treatment because families can sustain change and as participants indicated that family functioning could impact upon substance use.

Families can sustain change. Community and family are seen as interchangeable as *'everybody in the community is family'* (non-Aboriginal worker). Workers and managers spoke of how they saw the inclusion of family in treatment as necessary in order for sustained change to occur.

Past experience has shown me that when you start working with someone who is having problems within the family, the whole family needs to be seen at some stage. Otherwise whatever work you do with the individual has no real effect because they go back home to where the problem is.

Non-Aboriginal worker

An Aboriginal worker gave a particular example where she expressed how important it was for her to *'be available to listen and to open doors for his family because they are going to be his family for the rest of his life'* (Aboriginal worker). As without the ability to address the issues in the family that surround the client's substance use any interventions which she performed would most likely be transient.

Those interviewed felt that family therapy enabled open conversations where families could begin to work on common goals together, this would be more effective than working on individual goals which could dissipate energy for change. An Aboriginal worker expressed this belief in the following way,

The benefit of that then is everything is out there in the open and you ensure that the family is all striving for the same goal and to make the same change. Cause if one member of the family wants one thing and someone else wants another, that doesn't suit, then you have to come to an amicable decision and make sure everyone is on the same wavelength.

Aboriginal worker

Family functioning can impact substance use. An Aboriginal worker noted how it was common for multiple family members to have issues with substances and so she found it

most beneficial to address substance use as a family issue in order for change to occur. This worker, increasingly as a result of the training, debated with other professionals about the need to include family in treatment.

Even the courts are understanding more that for you to be able to fix the client up, it's not just about fixing them up I can send them away to a detox or a rehab but when they come out they are coming back out to what they left, they are going to relapse and I have to get in and work with the families and identify what the abuse is.

Aboriginal worker

Another Aboriginal worker found that his clients were drawn away from their own rehabilitation treatment due to family issues which could derail their own recovery,

Because I've seen people leaving early and going back to the same thing because sometimes the partner is drinking or they have their own issues. And the partner is trying to sort their life out, but then they go back and others aren't...

Aboriginal worker

It was thought that through working to improve family relationships that some of the impetus to use substances could be lessened.

Supporting that conversation [between family members] you would hope that, maybe there wouldn't be immediate change but you would expect that the functioning in the family will be effected. And if all that is happening and even if the substance use is still occurring it is at a decreased level.

Non-Aboriginal manager

Workers found that working with multiple family members could make their work easier as the family were a valuable resource which could provide creative solutions to difficulties,

Sometimes clients will skew stories - having the other family members there helps to get a balanced picture about what's going on. The family helps to moderate the story and they can also support the client too. They know what the issues are with the client and they can sort it out themselves. For me as a worker that's been a huge relief because I've always felt it's the client and myself in this collaboration and it puts a lot of pressure on me, whereas bringing the family in spreads some of that responsibility so that the family's now helping to find solutions, not just the client with me. This is empowering for them and less work for me!

Supporting Holistic Service Delivery. Two of the managers interviewed had a strong understanding of how family therapy fits into a model of service that is holistic in the way it engages and treats clients. These managers reportedly had gained this view as result of their previous training and experiences in the field where systemic approaches to health appeared the most effective. Three of the four managers interviewed were non-Aboriginal which makes the emphasis of the following quotes more reliant on the voices of non-Aboriginal people.

Managers described a system which is flexible, where workers are able to respond to the needs of their clients by providing assistance during a crisis and then being able to either refer them to other aspects of the service or explore how the current condition may be influenced by other factors. They therefore supported looking at the whole person and the bigger picture, how issues are connected and workers' need to be reflective.

Looking at the whole person...the bigger picture.

It might be the crisis appointment that gets them in the door that connects them to other services. The crisis is important to deal with, but looking at the whole person is more important because sometimes that stops them getting into crisis.

Non-Aboriginal manager

A systemic approach involves not focussing solely on the problem as it presents but what surrounds the problem that helps to create and maintain it. Effective service delivery means 'looking at systems theory and the big picture and it jacks me off when people just look at the problem, they just concentrate on the problem and I think, look at the whole big picture!' (Non-Aboriginal manager).

The medical model you see the individual, you see the diagnosis, you see the treatment which is all related to that one individual, so changing that focus I think is where we are headed as we are talking about systemic change....Family therapy is going to change the way we do things around here as some of the services we have here are very individualised like medical or physiotherapy, they are very much in the old way of working...talking about chronic disease for example, you know that's not just about looking at the individual it's about looking at the risk factors, at the environment and where they're at, which includes the family. So...even if someone comes to the doctor here it may be that the illness is result of other issues.

Non-Aboriginal manager

The workers concurred with these views and expressed how, for healing to occur in the communities where substance misuse exists, a whole of community approach is required that involves individual workers coming together to provide an integrated service. *'For long-term healing, many people need to be involved'* (Aboriginal worker).

Through the service system working together in a more integrated way, possibilities for clients could be opened up in regards to treatment that was tailored in regard to their context. An Aboriginal worker recounted how that since doing the FTTP the court had,

Referred me a case, a major case that is going to end up in the County Court and I have had to go back to the roots of all this and go deep and the family have been happy to engage in therapy and counselling rather than to see her go to gaol for a long time, because what she did holds a maximum term of 17 years...but if the magistrate can see why exactly she did what she did, they may be open to a different avenue

Aboriginal worker

The issues are connected. This holistic and systemic way of practicing also fits for the research participants in terms of Aboriginal ways of being in the world and they highlighted some of the difficulties Aboriginal people have in accessing appropriate services;

There is a very strong connection to emotional and spiritual health and the connection to the physical as well. So someone might come in with headaches and it might be presenting physically but it has an emotional component as well. So people are very happy to make those connections.

Non-Aboriginal manager

The connection between drug and alcohol issues and other concerns had become increasingly evident to one drug and alcohol worker her since doing the training;

And it's getting more and more so that when I go and work with that client I don't just think about them with the D&A issues. And sometimes it's not D&A issues, it might be with the whole family, it might be other issues and I'll work with it even though I'm not supposed to.

Aboriginal worker

Change over time. Significantly, both workers and managers commented on how, by not seeing problems in isolation, presentations can be decreased as the interlocking nature of problems are addressed. These comments represent change over time in the workers' views of drug and alcohol issues and how to address them,

It might just be that Mum's not coping with the kids and so she's presenting with D&A issues because she's smoking a whole heap of Yarni [cannabis] to help her get off to sleep at night and then she's got depression and anxiety and whatever so they keep re-presenting with the same issue so if you can work with her and the family and address some of these issues you are going to get a lot less presentations. So you are starting to address some of the family issues that are contributing to that person being unwell. So I see my skills as helping people to get off that merry-go-round and presenting in crisis a lot of the time. It's about helping them to solve their own problems and help them deal with it as a family, so they don't get so worn down that they end up back at the doctor's surgery.

Non-Aboriginal worker

We don't do that well, it's not in our mandate and they say, you can read between the lines, but it's not great. So I've always been pushing, saying we have to look at systems theory, look at family therapy look at the big picture of the client and not just at D&A but at the whole gamut.

Non-Aboriginal manager

An example of the way that the workers have understood and put into practice family therapy ideas is when the worker is able to be flexible in how she approaches the presentations she encounters in her work. She describes how she responds to the issues as they are presented and seeks to understand how they interrelate,

A fifteen year old son is booked in to see me and the mother comes in and for the whole session is in tears, so then I say to Mum you need to come back and see me on your own and so then I've picked her up as well and now through my family therapy training I bring them back in together. So I work with both of them individually on their issues which of course are connected and then I bring them both back in to work together. So previously I wouldn't have said to Mum you need to come back in to see me.

Non-Aboriginal worker

Family therapy in this context is about the worker being able to hold a systemic lens up to whatever problem is brought to them. Rather than family therapy providing the answers to all issues it is seen as a useful lens which can work well within a holistic model of practice. *'Having an understanding of family therapy means you can connect other therapies to it'* (Aboriginal worker).

We need to start with our family. Workers recognised the need to be self-reflective in order to function within a collaborative and flexible structure. Workers saw the need to understand and apply family therapy ideas to their own families;

I rang my Mum and said, in this course it's about healing ourselves, healing our spirits...and we need to start with our family and I need to do it here first because I go out in the field and I've been doing it for years and I said this is different type of healing and we need to do it.

Aboriginal worker

Family Inclusive Residential Treatment

Workers and managers frequently expressed frustration about the ways in which services were structured and funded, this extended to the functioning of residential programs for substance misuse where family work was frequently not privileged. The workers interviewed had cause to refer clients to such programs and two of the workers worked within residential facilities.

For residential treatment to be effective, workers and managers felt that connection to family, changes to the home environment and the ability to address relationship difficulties had to be prioritised for clients whilst in treatment.

Connection to family. The workers and managers interviewed affirmed that residential treatment which did not include family was not culturally appropriate and that connection to family needed to be maintained ideally through the provision of family units as well as through the sharing of information between the facility and the family. It was suggested that family need to be included as part of treatment planning.

My brother went and we weren't allowed to know his progress and like we want to support him in whatever he needs to do to help him recover and that ain't gonna work for blackfellas.

Aboriginal worker

The success rate [of people in rehabilitation] is really dependent on that connection to family and community and when the person is three hours away that is so much lessened...The person who is three hours away has much more of a struggle in terms of them getting where they are headed because they don't have the family at a close distance where they can see them, where they can visit them. In my view Indigenous community put their family and community above all else and even above their individual

need sometimes, you know sometimes they sacrifice their individual need for the sake of their family.

Non-Aboriginal manager

Changes to the environment. There was also the understanding expressed by workers, that a period away from home, whilst offering respite for some individuals would be unlikely to affect sustained change if other family and community members who were part of their home environment were not also involved in treatment,

Yeah that's great and then sending 'em back to where everything is all right, back to their family where there's drugs and alcohol. You've done nothing - you've sent 'em on a holiday!

Aboriginal worker

Some workers commented that the service system had too much of a focus upon getting clients into detox and rehabilitation rather than understanding the cause of the substance use and how it functioned in a person's life. Workers believed it would be more efficacious for the family context to be addressed that was maintaining the substance misuse.

As one manager noted that if the family is separated from the person in treatment then it would be useful that,

Whilst the person is away the worker continues to see the family and makes the connection and enables the change that needs to be occurring whilst the person is away...because you can do as much detox and rehab as you like but if the environment is the same and you come back into the same family structure and the same pressures you had before, you most likely will fall back into a relapse.

Non-Aboriginal worker

Addressing relationship difficulties. Two of the workers involved in the delivery of residential services commented on the fact that many of those seeking treatment had relationship difficulties which needed to be addressed for them to benefit from the care they were receiving. *'With alcohol and drug issues there are a lot of problems and if couples have always drank and drugged together if they stop they won't know each other!'* At times family concerns caused distress and distraction for clients so that they would leave treatment before its completion. The efficacy of engaging partners and families in treatment was evidenced by comments like

There's often lots of problems between partners, between couples, they worry about what's happening with their kids at home or what's happening with their partner; the relationship could be based on a rescuer, or two people using together, the dysfunctional system breaks down, the roles are changed for the children...you know Mum or Dad were using and now they are not, so there is a whole different dynamic. And as a moral responsibility we need to look at that, ethically we need to prepare the family for our clients to go home.

Non-Aboriginal manager

Systemic Approaches to Working with Aboriginal Clients with Problematic Substance Use

All participants spoke of the impact of the Training and family inclusive work on their professional practice and beliefs about what type of service delivery would be most useful for their clients. Workers and managers increasingly over time described the need for systemic work with Aboriginal people to include flexible service delivery with a team of workers who could prepare people for therapy and provide support work.

A team of workers. A number of workers stressed the necessity for outreach and support worker roles in order for clients to be able to be ready and able to attend therapy. This could take the form of workers being able to see the client where they feel most comfortable either in the home, down by the riverbank or some other venue. This degree of flexibility was thought to be very important to engagement and practically it was felt that due to the degree of chaos and disorganisation in some family's lives it wasn't realistic to expect families to be able to attend regular appointments in an office based environment.

Family therapy does that but it would need a lot of people out there doing it and a lot more support workers on the ground to link in and support the (family therapists) with all the issues that are going on because quite a lot of those families here are really in chaos, there's quite a lot of chaos, so housing's not working and D&A is an issue and there's DV and kids aren't going to school. It's that whole knock on effect – it needs a team, a team of workers around that to help put some of those things in place.

Aboriginal worker

Preparing for therapy. Considering the degree of trauma and current level of crisis for families, some workers felt that it would be necessary for work to be done individually to develop trust and relationships with clients in order to prepare them for family work. Family sessions on their own would be insufficient to deal with the numerous issues encountered.

Everyone needs to get taken care of before you can have constructive ongoing therapy. You know the families need a lot of supports in place...I can imagine if those other supports aren't in place then it would be a nightmare, everyone would be too sick to get to first base.

Aboriginal worker

Support work. Some of the relationship strengthening that workers identified as important happened when transporting clients to counselling sessions. Spending time with them pre-session and talking about the current crises or issues of concern was important so that when they arrived at therapy they were able to address cycles of behaviour which may be perpetuating current crises.

Repairing the Rupture - the Importance of Relationship

The importance of developing a strong therapeutic relationship with family members was frequently stressed by participants. It was emphasised that Aboriginal clients need to be able to develop trust with a person before they are able to share their stories which could be developed through self-disclosure, by workers extending themselves in their roles and through thoughtful adaption of therapeutic approaches.

Developing trust through self-disclosure. The importance of trust was often invoked by workers in the context of a history of trauma, where Aboriginal peoples' trust had been violated. Workers spoke of different methods which they employed to gain the trust of their clients including self-disclosure about their own experience of the issues that the family was struggling with. This had the benefit of *'talking from somewhere that they can understand'* (Aboriginal worker) and helped to lessen shame and decrease the power imbalance between the worker and the family.

I prefer to be on the same level as somebody and no matter how young they are really. I'm sure they've got enough mothers and Aunties who pull 'em up. And some clients demand how they sit with you any way. Sometimes they are going to see you as an Aunty and that's just how it is because that's what they are looking for.

Aboriginal worker

Self-disclosure was also utilised by workers when revealing their own feelings arising in context of the work. This was used therapeutically to improve client insight into how their behaviour

impacted upon others, to increase intimacy and improve the capacity for healthy relationship patterns.

There's a way around everything. A number of the workers felt that for them to engage their clients, they needed to show authenticity and genuine care by extending themselves, working outside of work hours and stepping outside of their designated roles in order to be responsive and useful. It seemed important for some people to demonstrate that they were not bound by the system which was perceived as oppressive to their clients. This meant at times stepping outside of the policies and procedures which guided their service. As one Aboriginal worker stated, *'My motto is "there's a way around everything" and that can make it difficult for some managers because they have their rules and regulations and I don't really give a shit about that stuff'*. This particular worker expressed a strong ethical position around the need to be of service to clients and wouldn't broach deviations perceived to interfere with that ability.

Fearing rejection. Workers also spoke about how they felt it was necessary to extend themselves because, as they were a part of the community in which they worked, they feared possible rejection or other ramifications regarding the decisions they made around the provision of services.

In lots of ways I know I avoid, because I know that person is hurting...and I suppose there's a fear of rejection that I have to face.

Aboriginal worker

Applying therapeutic approaches. The therapeutic approaches within the family therapy training which workers took up with the most enthusiasm were narrative therapy, structural and transgenerational approaches. Narrative therapy is widely accepted as a respectful way of allowing people to tell their stories and is favoured due to its focus upon the skills, strengths and resources of families and communities.

Having the trust and confidence of the family. No matter what the framework or model of family therapy utilised, participants stressed that building a trusting relationship with the family was essential before adapting a model to make it culturally appropriate,

If you do pure CBT [cognitive behavioural therapy] you will lose the client. It's got to be culturally appropriate, it's got to be integrated and it's got to be right for the client and

even more difficult when you are working with a family because then you have to have the confidence of the whole family.

Non-Aboriginal manager

Adapting therapeutic approaches. Approaches to treating substance misuse utilised frequently in mainstream treatment such as brief interventions with a motivational interviewing component were thought to be able to be made more culturally apt by including family in the provision of the intervention.

The particular importance of building relationships through acknowledging the importance of family and culture are themes which are common throughout the research and appear to be reflected in participants' engagement with the training.

Family Therapy as a Strength-based Approach

I am great believer in strengths-based practice...I like my clients to say what will work for them. I like them to drive their own process and what I often say to my clients is, "I can open the doors but you have to walk through them".

Aboriginal worker

The participants identified that family-therapy embodied strength-based approaches which were believed to be the most suitable for working with Aboriginal people in order to empower families to drive their own process and know that they can contribute to their community despite the difficulties they may be experiencing.

Empowering families. Family therapy was seen to focus on empowering the family to find and implement solutions to their own problems. Participants' spoke of the critical importance of Aboriginal people controlling the direction of their own lives and that counselling approaches need to support people to find their own voice. As one of the trainers explains,

To work with family therapy approaches, which are strength-based, is very respectful of families. It builds on what is working for families and it is not in any way saying "we have the answer and we are going to tell you...". The families have the solution and we are going to help you peel back the layers and allow you to choose your own solution...The family therapy approaches we are teaching the students are ways of empowering families.

Aboriginal trainer

This quote is reflective of the applicability of family therapy as an approach as it can build upon the resources of the family so that they are able to make the changes that they are seeking.

We don't have to be perfect to contribute. Workers discussed how they would seek out the strengths of the individuals and families even when their lives were chaotic.

When you start talking about the positives or some of the strengths it's a real change in people, because they probably never been told that was a strength, because lots of their behaviour is so over the top that those strengths get lost because people just focus on the drama...that makes people feel good about themselves, and lets them feel like they can achieve, they can give you something you know, that they're not just sitting there taking and being burdens.

Aboriginal worker

It was thought that focussing on client strengths helped to develop positive self-perceptions which could create an environment where people were more likely to make choices that perpetuated healthier cycles of behaviour.

Because their lives are messy and there's lots of things that aren't working, doesn't mean you can't focus on those strengths, or you know, that you have to be perfect to be OK, none of us are...we don't have to be perfect to contribute.

Aboriginal worker

No one drives me. One worker shared some of her own struggles in order to decrease the power differential and to promote a sense of efficacy. *'Indigenous people like to drive their own car and drive their process, exactly like me. I drive my own process, no one drives'.* (Aboriginal worker). This was supported by one of the trainers who expressed that Aboriginal people were denied a sense of efficacy and so are less likely to engage with a process in which they feel they are being told what to do, *'like mission managers' (Aboriginal trainer).*

Aboriginal People Attending Therapy and Counselling

There are a number of experiences and beliefs held by the interviewed workers and reportedly by their clients which they stated had an impact on Aboriginal people attending family therapy sessions and counselling more generally. These include people's need for assistance to attend sessions, the complexity of individual clients and families, dealing with shared histories, workers as figures of authority and perceptions regarding the purpose and usefulness of therapy.

Assistance to attend appointments. Workers felt that it was unlikely some Aboriginal people could attend appointments without assistance due to experiences of trauma that leads them to present as distressed, angry and disorganised.. One Aboriginal worker described this;

There are clients where the clock is just irrelevant and they are having a meltdown so you have to have that hour up your sleeve just in case...They always seem to need to do that [debrief about the current crisis] before they can sit with one of the professionals.

And I get to talk to [the psychologist at the service], that if she has raged all the way in I can tell him and he can prepare for that. We work really well together. Sometimes the problem is that [the psychologist at the service] gets caught up with the day to day dramas so he doesn't get to work on the other stuff, so that's what we need to work on.

Aboriginal worker

This was a familiar story recounted by workers where it was necessary to attend to a client's current crisis before they were willing or able to attend their counselling appointment and address some of the predisposing factors that had them in the current state of distress. Many workers believed that therapeutic work was of value but recognised that some clients required a lot of time and resources for changes to occur. This finding accords with the participants' sense of the importance of relationship building and trust that has been previously described in this chapter.

Complexity and shared histories. One Aboriginal worker remarked that convening a family therapy session for multiple family members who may all be experiencing difficulties would greatly increase the degree of complexity and each of the family members may require individual work for such a session to be possible.

One worker described how she had experienced,

Real resistance from the individual to have their family involved and as the counsellor it is really easy to see if only if we could get them in the room together we could really sort out a lot of this stuff. But there are trust issues entrenched.

Non-Aboriginal worker

For one of the workers who had grown up in the community where she now worked, seeing more people from a family meant increased levels of connection and history with the family. This worker felt that it could be necessary to address some of these shared histories and to clear

the air otherwise she imagined that a barrier to doing productive work could be present. This created some reticence and caution for her when approaching family work as it required more of her personally, to take a greater risk and make herself vulnerable through talking about perceptions of past issues.

A figure of authority. Some workers preferred not to hold a title which indicated they were a counsellor or therapist as they felt that by doing so they ran the risk of being perceived as thinking of themselves as expert, better than and separate from their community,

I think that's why it's important to be really clear at the start to say 'I'm not an expert, at all'

Aboriginal worker

JS: Would you call yourself a therapist or a counsellor or something else?

Aboriginal worker: Nuh, I hate that

JS: So what would you call yourself then...?

Aboriginal worker: 'I'm Auntie nothin' ... um, I'm not sure about that yet

Workers and managers also described how the perceptions of the authority of workers held by community often did not match with the role they saw themselves fulfilling. For some families they felt that the worker would or should give advice, be directive and be able to ensure they were provided with a range of services to meet their needs.

Being a figure of authority in a service, especially if the worker was non-Aboriginal, could trigger experiences of fear and concern amongst clients where there had been traumatic experiences of services such as the Stolen Generations. An Aboriginal trainer from the Indigenous Program commented that non-Aboriginal people in health services needed to be aware that for some Aboriginal people they represented a perpetrator of past abuse where authority had been abused.

Assumptions about therapy. Other barriers to Aboriginal people accessing family therapy, it was noted, were clients' fears that information divulged about their relationship to their children might be shared with child protection. Other perceptions included counselling being 'a white thing' (Aboriginal worker) and not an Aboriginal way of addressing issues. One Aboriginal worker voiced community perceptions about how it could be seen as a luxury to be able to talk about issues rather than deal with basic pressing needs, that counselling wasn't thought to be useful and further to that was shameful as it signified a family that was failing.

Connection to the person rather than to the position. In one service the manager described how some of the Social and Emotional Wellbeing workers had few clients as they were yet to demonstrate their usefulness to those in the community. It was believed that demand was created through word of mouth in the community about the effectiveness of a worker. As one participant described, *'They just see you as the person that can help. They don't have a label' and 'it's about the connection they have to the person rather than to the position'* (Non-Aboriginal worker). This worker and their manager felt that it was through a worker's ability to deal with crises that trust was developed which then enabled conversations about other areas of concern such as the function of a person's substance use.

Dealing with barriers. Workers described how they dealt with some of these barriers by spending time and developing relationships with people in the community in other contexts so that when people came into contact with the service they would more likely accept a referral to a worker with whom they were familiar.

I have no doubt if the doctor said, 'Why don't you see the counsellor? People would say "I don't need counselling"'. Could you imagine if you said, family therapist? No way, they'd run a mile. But if you are out and about and say "why don't you go and see Marie? Remember she was the one who came out fishing with us?"

Non-Aboriginal manager

One worker described how a client was referred to her without really being clear what her position was or for what they were being referred for her. This revealed the how this doctor avoided recommending that a client see a counsellor and also the trust that referred client had in the doctor and their recommendation.

The other day I had this guy and I gave him this spiel about confidentiality and then asked him why he'd come and he said he didn't know. And I said, "how did you get here?" And he said, "on the bus" and I said, "no", and he wasn't being facetious and I said, "no, what got you here sitting in this chair today?" and he said, "I saw that new young doctor and he said I should come and see you". So I said, "OK, so tell me what's going on. So you've got a few issues..." and then it all kind of came out. But it made me think about it, if the doctor would have said, "I want you go and talk to a counsellor or speak to a therapist" that person probably would have run a mile. It's just, "come on in and have a yarn and see what we can do to sort it out".

This quote also gives a sense of what the worker perceives is necessary to engage clients which includes a relaxed, straight forward approach.

Demystifying therapy. Many workers felt that part of their work was demystifying what family therapy and counselling was, what happens in the room, what sort of support the therapist could provide and how families could benefit from it in order to counter the view that it's a '*white thing*' or that their '*family is stuffed*' or has '*no hope*'. These fears and concerns, workers said, needed to be assuaged in order for people to be able to benefit from any type of therapeutic intervention. Some participants believed that a lack of understanding around what therapy is can also run alongside a toughness or resiliency to dealing with hardship,

I think that a lot of people accept life for what it is rather than thinking, "I am under so much pressure I need to go and talk to someone about it"... Like I think it is a hard connection for people to make because people think, "that's what other people do, they go and complain about their lives and talk about their problems when they have got everything...and "I've got more things to do than to sit around talking about my problems, I need to do something about it. Like I need to go and get a food voucher. Like I don't have time to talk to you about how I feel about that!"

Aboriginal trainer

A reticence about the appropriateness or efficacy of counselling approaches in Aboriginal services is reflected in their tendency towards crisis driven service provision and most likely reflects some of the beliefs and concerns previously expressed. One worker offered that, in the rehabilitation services with which he was associated, management held the view that counselling was not necessary because clients could talk to the support workers at the unit. This belief implied an unstructured way of addressing therapeutic issues which would be unlikely to involve the routine inclusion of families.

Summary

Within this chapter, drug service workers, their managers and family therapy trainers have described the importance of family and community in addressing an individual's substance misuse because of the significance of Aboriginal people coming from a collectivist culture where problems are viewed systemically and individual treatment is not culturally appropriate.

Workers report that their current experience indicates that for a person with serious substance dependence the degree of difficulty in sustaining change is too great when the environment in which they reside contains a high degree of substance use and relationship difficulties. Though rehabilitation centres can provide a respite from difficult home circumstance, if the issues which are contributing to the substance use issues at home and in community are not addressed workers report that sustained change is unlikely. For some clients, substance misuse and other high health-risk behaviours are considered to be part of their Aboriginal identity so to re-enter an environment that reinforces those beliefs and identity constructs does not bode well for change.

Culture and community are seen to be valuable for Aboriginal people in order to find healing around problematic behaviours, though there are currently aspects of culture that serve to maintain problematic substance use. Workers stressed that it was possible to work with families to effect the positive benefits of culture and community on substance using behaviours which could create sustained change.

As has been discussed in this chapter if substance misuse is understood to arise in a context of intergenerational trauma and is socially determined, then interventions which can address trauma and work with the context in which the problem occurs are likely to be effective. As family therapy can work with a range of issues that are associated with substance misuse it has been seen to be particularly applicable to this area.

Holistic approaches to health are favoured by the workers and their managers and they have experienced family therapy as being congruent with Aboriginal approaches. As family therapy seeks to draw out the strengths of families to address their own problems and is respectful of what practices workers and families may usefully employ, it has been seen to provide a culturally acceptable framework in which to address complex issues. Family therapy is described as a bridge between Aboriginal and non-Aboriginal approaches to health and offers ways to work with more than one person in the room systemically.

Family therapy was also perceived as providing a means in which to integrate service provision for Aboriginal clients. Those interviewed did not believe that the medical model was able to address the complex issues impacting Aboriginal health. It was recognised that though a client may present with a particular issue it was most likely being informed by the emotional and spiritual domains of a person's life. Workers believed that family therapists, if integrated within health services, could usefully work across programs and services to address the relational aspects of presenting problems. Through creating an environment that supports healthy

practices both physically, emotionally and spiritually client families and community could stand to benefit.

This chapter is important in articulating from worker perspectives how best to conceptualise working with families living with problematic substance use:

- Aboriginal people come from a collectivist culture so that the treatment of individual issues, including substance misuse needs to occur in the context of the family and community.
- Family and community are affected by and affect substance misuse so they need to be included in interventions as they will either support or constrain change.
- Strength-based family interventions can effectively address substance misuse by incorporating the healing aspects of culture and community.
- Relationships with family and community need to be strengthened in order to provide the continuity of care which rehabilitation services and other healthcare services cannot.
- Transgenerational trauma impacts Aboriginal families and communities and is a predisposing factor for substance misuse as people seek out means to ameliorate the effects of trauma.
- Trauma can best be dealt with in a relational context through family interventions.
- Family therapy can act as a bridge between Aboriginal and non-Aboriginal approaches to health and offer ways to work systemically which are respectful of both knowledge systems.
- Family therapy is a holistic approach to health that could provide a means in which to integrate service provision for Aboriginal clients.

Chapter 5 Family Therapy Training for AOD Workers

This section will primarily give voice to perceptions from AOD workers and their managers about the impact of the family therapy training on the workers. This will cover the skills that the workers developed during the training and how they could be usefully applied in their work with substance misuse in Indigenous communities. In order to contextualise the impact of the training attention will be paid to the pre-existing skills and qualities of the workers which allow them to successfully negotiate the difficult field of Aboriginal substance misuse.

Paradies (2007) has argued that racism can be internalised so that people take on feelings of inferiority. It may be that Aboriginal workers are more prone to stress due to high workloads and to the effects of racism incurred personally and professionally (Duraisingam et al., 2006; Gleadle et al., 2010). The data in this section speaks of how the knowledge and systemic understandings in the training course built the confidence of workers which improved their ability to advocate for their clients and to take up more senior positions.

Worker confidence can be linked to a sense of mastery and control which Anderson (2007) has identified as a protective factor that can offset social stressors such as racism. Malin (2003) has also highlighted that educational attainment and better employment prospects can enhance self-esteem for disadvantaged groups, though this is dependent on the educational environment being inclusive and positive.

As has been discussed in Chapter 2, there are a number of factors which may cause and maintain substance misuse. Through seeking to address these factors some of the skills that can be useful for workers in the field of Aboriginal substance misuse are defined. A number of authors have identified the connection between substance use and trauma in Aboriginal communities (Atkinson, 2002; Hunter, 1990; Phillips, 2003) and in mainstream populations this has also been identified, along with unresolved grief and loss, as a major cause of substance misuse (Coleman, 1991; Coleman et al., 1986; Erikson, 1976; Herman, 1992). The findings in this chapter outline how the workers' understanding of trauma through the family therapy training was increased and thence which approaches and skills they perceived could be used to address it.

International literature stresses the importance of working with trauma in the context of family and community (Shalev, 2007; van der Kolk, 2007a). Mehl-Madrona (2007) and local authors (Brady, 2004; Denborough, 2008; Van Der Sterren et al., 2006) highlight the need for family and community to be involved in health interventions in order to enact and reinforce narratives that can sustain change. The participants throughout the research also reinforce how family and

community are central to healing processes and describe in this chapter the ways in which the training enables such processes.

The relevance of strengths-based interventions for Aboriginal communities have been emphasised (Pattel, 2007; Roe, 2000; Vicary & Andrews, 2000; Whiteside et al., 2006). They are seen to be important as they are congruent with a valuing of autonomy in Indigenous communities (Brady, 1995b; Hazlehurst, 1994) and because they enable a sense of mastery and control to be developed which can offset a range of other risk factors (Anderson, 2007). The workers document how they perceive and apply strength-based approaches with their clients within the context of family therapy interventions.

Within mainstream literature, Liddle and Rowe (2006) have emphasised how interventions which improve social and cultural supports, including family are of particular value for adolescents who misuse substances. Other authors speak of particular skills which are useful in this field such as managing conflict and effective communication (Liddle, 2004; Templeton et al., 2005). These skills are spoken of by the workers interviewed as being part of the training along with a number of other important skills.

There is little reference in current literature as to the personal skills and qualities that are most advantageous for workers to possess in the field of Aboriginal substance misuse and workers and managers discuss this area within this chapter. Importantly, workers also outline the difficulties they encounter when working in communities of which they are a part. They discuss how they currently manage issues and some of the skills in the family therapy training they believe could be useful despite their struggles to implement them. Logan and Bakos (2011) have accounted for some of the challenges which Aboriginal workers in the field of dual diagnosis experience in their communities and this chapter will add to and extend this discussion.

Some people within the Aboriginal population are suspicious of mainstream training programs (Gleadle et al., 2010) and what value they could add to cultural knowledge and practical experience of working in community. However others, such as Hazlehurst (1994), have recognised the need for workers to build upon and extend their knowledge and skills in the field of substance misuse. The workers and managers involved in this research believed that the students had been able to learn a range of useful skills that were being demonstrated in their work practice.

Critical to the success of the Training Program was that students felt that their pre-existing skills were acknowledged. The respect that was shown for the students' skills and cultural understandings helped to create a culturally safe place in which the students could extend their skills and learn a new language to describe their practice. This is further explored in the next chapter.

Worker Pre-existing Skills and Values

Our students already have a PhD before we get to work with them...it's in culture!

Aboriginal Team member

The skills and values that the workers possessed, identified by themselves and their managers, will be outlined here in order to understand the types of workers drawn to undertake the family therapy training, the position from which students interpreted and connected with the course material and what changes occurred over time.

Cultural Knowledge. Though not all of the workers interviewed were Aboriginal, they were all employed in Aboriginal positions and had been endorsed¹⁴ by the communities for which they worked. They brought with them varying degrees of cultural knowledge particular to their communities and were eager to share their experiences of what they found useful. The non-Aboriginal workers sought to increase their cultural understanding of Aboriginal clients and displayed a willingness to be challenged as well as to share and explain their practice.

Aboriginal workers stated that they were '*working cross culturally all the time*' (Aboriginal worker) as they needed to employ different languages and ways of behaving so that they could engage both the systems around their clients and the community. Workers and managers asserted that the common cultural understanding between Aboriginal workers and their clients greatly increased their ability to connect with and make their clients feel at ease and this made these workers a great asset to their services.

I won't tell you lies. Other useful skills and qualities that were discussed by participants included a strong and forthright approach. This was articulated well by one of the workers who subscribed to a direct method of dealing with clients so that they were aware of the likely consequences of their actions and were party to any decisions regarding possible referrals.

¹⁴ The Aboriginal community decides whether a particular worker is working well with that community and whether they wish resources to be allocated for their professional development.

I make an agreement with my clients, that you don't tell me lies and I won't tell you lies...I'm upfront, I'm straight out there and I tell them what's expected of them and I always tell them if they fail to comply with their court orders I'm mandated to report them and there'll be a warrant sent out for their arrest.

Aboriginal worker

Participants spoke about the importance of being able to advocate strongly within the service system in the best interests of their clients and make decisive calls around what was necessary to create non-threatening environments for families to participate in decision making.

Using some of your own experience. A number of the workers spoke of sharing parts of their own stories with clients in order to minimise shame or embarrassment and the client because,

Using some of your own experience, some of your own realisations can help because you're giving people the opportunity to see that you can make mistakes.

Aboriginal worker

Self-disclosure, participants believed, could help to relax clients so that they did not feel as if they were being judged too harshly. One worker described how she would sometimes say to her clients *'there's nothing you've done that I haven't done!'* (Aboriginal worker). Another worker explained that the clients he worked with found it difficult to trust workers who had not *'walked the walk'* and that it was important to,

Just be normal. Don't come out with all the big words or make it too technical so they get lost in it. And be really honest and connect through your honesty and build up the trust because their trust has been broken.

Non-Aboriginal worker

Life experience and knowledge passed down from family and community members helped workers in dealing with the presentations which they encountered,

A lot of it is my own experience and looking at other people's lives and talking to old people and sitting down with old people. There were times when they would sit all the kids down and they would talk about different things, so it's like a teaching thing, but it's done in a fun way.

Aboriginal worker

This was particularly important when sharing knowledge of the working with strong emotions and the effects of trauma on children. One worker who had worked with foster carers and had fostered children herself, described her experience and the learning which had been passed down from her mother as enabling her to work with difficult behaviours and support adolescents to negotiate what it meant for them to be Aboriginal,

I think for Aboriginal kids in care and Aboriginal adolescents in general I think they hit this point when they are going through all this stuff and they have this realisation that, "Hey I'm an Aboriginal and what does that mean to me?". And there are all these things going on around you and you don't understand it...I know it happened to me...it was almost like this extra responsibility that I had.

Aboriginal worker

Commitment to community. A number of the workers described a passion for learning which was coupled with a strong commitment to their work. For some Aboriginal workers they '*had to work in their community*' in order to give back their knowledge and skills and that they described how they were willing to extend themselves in order to make a difference in their clients lives,

If I can open the doors for these people to have a better life, then I will. If I have to go out and see them every day and go and see them for breakie, I'll go and have tea with them I'll go and have everything with them, I will, I'll do it if it makes a better outcome for them.

Aboriginal worker

Managers recognised that prior to the training their Aboriginal workers had skills which were highly sought and the qualification made them even more valuable. Managers were aware that workers could receive greater remuneration in other services however they chose to continue in their current roles because there's '*such a commitment to their community and they could go elsewhere but their passion overrides that*' (Non-Aboriginal manager).

Changing Attitudes to Training

This section accounts for some of the changes to perceptions, understandings and skills of workers over the course of the training. The following quote is taken from an interview one month after the training was completed and follows up on a comment made by the worker two months into the training;

JS: You said last time that you hadn't learnt new things but got more certain about what you know.

Aboriginal Worker: Well I've changed my mind about that as I've got a few more new pointers up my sleeve and I do. I changed the whole way I go about doing things, now when I go and see a client on their own, not even the whole family, I have changed my whole approach to the way I engage.

This quote supports comments made by previous participants in the FFTP surrounding the impact of the training on workers (Latham, 2010, 2012). Workers often commence the training with a fair degree of wariness and scepticism about the possibilities and usefulness of the training. As the course progresses graduates report learning a new language to articulate their practice, that their confidence around their practice increases and that valuable new skills are learnt (Latham, 2010, 2012). As the Indigenous Program Manager noted, students who had previously completed the training started off saying that,

"It's about time you all recognised that we've been doing that already" but it's not where they are at the end of the training. We know to be true that they are much more family focussed and family inclusive but now at the end of the course they say, "we can do some things differently and that by staying in the program it has allowed us to see how we can do some things differently". That is very different than "we have become white family therapists who have done the training" but "we are black family therapists and you have allowed us to change our way of thinking about how we do this" and that's about relationship [between the students and the trainers] and that over time I've had to come to trust that that means something to them.

Indigenous Program Manager

Increased Skills in Working with Families

Though many workers, prior to commencing the training, included families in their work, the way they did so altered as a result of the training. Though not employed primarily in clinical roles, workers had occasion to include counselling within their roles which spanned outreach, counselling and casework, drug diversion, support worker and management positions. At the start of the training none of the workers viewed themselves as family therapists. Over the course of the program a change in professional identity was tracked, as some workers began to call themselves family therapists whereas others, whilst feeling more competent to work therapeutically with families, were not comfortable with affording themselves that title. This

shift in identity occurred despite most workers not changing their work roles during this time. This appeared to happen once the training was completed.

Increasing confidence. A few months after the final interviews were conducted, one non-Aboriginal worker changed from a drug and alcohol counsellor to a generalist counsellor position, two Aboriginal workers took on team leader positions outside of the drug and alcohol field and another Aboriginal worker became a manager at a youth rehabilitation centre. The workers attributed these changes to their increased confidence to perform such roles and the recognition their qualification afforded them within their organisations.

Shift from family work to therapeutic family work. The following section demonstrates that a significant change occurred in the workers' practice. This was a shift from family inclusivity towards therapeutic practice with families. This change in practice also reveals a change in understanding about how to work with families. Further discussion as to what enabled this transition will be covered in the section pertaining to support of workers both within their service and within the service system more broadly. The discussion here will centre on the changes in practice regarding how families could be engaged therapeutically and changes to how work with families was conceptualised in terms of interventions for substance misuse.

Common practices reported by workers prior to the family therapy training, for including families in treatment of substance misuse, was to hold centrally how important family were in enabling sustained change to occur. Workers related how they would endeavour to be as helpful as possible when family members contacted them regarding a loved one's treatment whilst remaining within the bounds of confidentiality. If consent from their primary client was obtained they would on occasion see family members individually to discuss the family members' concerns. If consent was not obtained the worker would then only speak generally about the service but not provide information regarding a specific individual. Family meetings would occur as a result of clients bringing a family member along for support, incidentally at home visits or as a result of special requests made by the client or workers to discuss a pressing concern. As one worker stated, *'Kooris, wherever we are, we might predominately work with the individual but we work holistically with the family'* (Aboriginal worker). This quote highlights how family sessions were not a routine part of this worker's practice though families were always considered and worked with.

The skills associated with family therapy training include a systemic understanding of the interlocking nature of issues for families and communities and the specific skills for working with more than one person in the room (or other venue) when implementing family interventions.

The shift from family inclusive practice to more therapeutic interventions containing family will be explicated from the perspectives of student/workers, managers and trainers.

Changes to the Way Families Were Included in Treatment

The FTTP increased worker understanding around the benefits of family therapy, improved confidence in conducting family sessions and of the types of approaches that could be utilised when working with a family system to address symptomatic behaviour.

Hearing all the voices in the room. What altered for workers was how they positioned themselves in relationship to their client and what they perceived their role was during a family session.

Prior to the training, if I had of had more than one person in the room I would have been aligned with the client. It would have been clear, this is my client and we are here to work on this person's issues...I'm learning much more now that it's more important that we hear all the voices in the room and how they're all connected.

Non-Aboriginal worker

Confidence to bring more people in. Workers described how they actively sought out ways to include the family in their work whereas previously this contact had been more ad hoc.

Since I started doing the family therapy training that has really given me the confidence to bring more people into the room...I'm really encouraging it now. Whereas if I have someone sitting there and it's just that one person I might ask them, "Who's significant in their lives?" And I might even bring it up and say, "How do you think it might be if you brought your partner in and we talk about this together?" Like with this woman who was really going off about the kids and I said, "How would you feel if we actually brought the kids in and we all sat down together and had a chat about it?" - they all jumped at it!

Non-Aboriginal worker

This worker had the support of her manager to flexibly respond to her clients and during the course of the research her position changed from a Drug and Alcohol worker to a generalist counsellor. Participants also spoke of the increased frequency which they saw family members together with one describing how, since she had begun the training, services were referring to her whole families for treatment. Others conveyed that colleagues were now often referring families to them for counselling as well as seeking them out for secondary consultation.

Helping people understand the way families evolve. The ability of workers to understand the context in which an issue has arisen improved. Workers reported that after the training they had greater awareness and skills to see individual clients as part of a family and community which needs to be actively engaged in the therapeutic process. By developing curiosity about family relationships, workers stated that they have been better able to disrupt cycles of blame and shame by assisting families to better understand the factors that impact on a problem.

Helping people understand the way families evolve, given the environment and the situation you know, rather than trying to tell them how to do things, I think to give them a deep understanding of how and why things are the way they are now. And then they might be able to work out for themselves what they need to do to shift or to change the situation.

Aboriginal worker

By including the perspectives of family members and understanding the context of problems, families are seen by the participants as a resource, which can be drawn on to find solutions so that workers need not be directive in their approach. Many workers related that they are better able to maintain client engagement and that family therapy skills enable this through an increased ability to observe and listen attentively, be respectful and tailor approaches to individual and family needs.

Looking at the Bigger Picture

As a result of the training managers noted that workers were able to situate problems within a broader context, separate the problem from the individual and to plan systemic interventions.

Everything has a context now. A non-Aboriginal manager commented that change was evident in the worker's focus and perception of an individual's issues,

You are putting things in a context now, whether it's motivational interviewing or family therapy or whatever, you can identify whatever it is you are doing and everything you are doing has a context.

Non-Aboriginal manager

An appreciation of how problems are interconnected within families has led to an increased ability to situate problems in relationship to other systems as well. Through the training the

workers have been increasingly interested in understanding the frameworks surrounding problems. A manager, noting the impact of the training on a worker in her employ, said that it had '*got her thinking outside of the square*' so that she had access to a greater range of possibilities when conceptualising what may be happening for a client which could lead to more effective tailored interventions. The worker described the change to her work practice in this way;

I talk a fair bit about the relationship between them and their wife, and even though it's including the drug and alcohol stuff I'm finding that the family stuff is being brought in more. I also talk about their childhood and how things happened way back. When I first started doing this, some of the clients said "Oh, no-one's really gone into that before".

Aboriginal worker

Workers were spending more time understanding the history of people's problems as well as seeking out information from Elders and others within the community. Through developing more detailed understandings of problems, workers sought specific interventions which unfolded through discussions around the significance and meaning families eschew from what is happening in their lives.

Separating the process from the individual. Increased systemic understandings have also been useful for those workers in management roles so that they're better able to understand what may be happening for their staff and deal with their staff needs as effectively as their clients.

My staff would probably say I'm giving better advice and listening more...I'm more patient with staff and situations that arise. The link between the training and being more patient is understanding dynamics and processes; it's separating the process from the individual. You understand that this person's a result of this process.

Aboriginal worker

The ability to implement change, whilst keeping staff engaged in the process, was spoken of by one worker-manager as a skill she had learnt in the training. She believed that the training had also enabled her to work with upper management around how change was managed in the organisation.

With complex families you have to start off with a team. An increased appreciation for the how systems operate to support or constrain change has also translated into perceptions from workers on how services can best respond to families who are struggling,

[With] some of these real complex families you have to start off with a team...if a young man is angry and you get supports in for him you know the mother is going to be in a much better place...that's what it's got me thinking about, about what else needs to happen for long-term healing.

Aboriginal worker

Workers articulated that working within a team to collaboratively address issues that a family faced, relieved some of the pressure they experienced and could provide better outcomes for families. Though working across Indigenous and non-Indigenous services can pose challenges, workers spoke of an increased openness to developing professional relationships. The confidence to develop these relationships and to advocate for clients within the sector will be further discussed in the confidence and recognition sections which are to follow.

Negotiating Confidentiality

An issue for many AOD workers when considering working with families is the issue of confidentiality. The training was helpful in providing a forum in which to discuss how confidentiality could be respected along with the need of clients to receive sustained support during and after treatment. Participants changed their views of confidentiality, as the following quote indicates.

This training's helped me to realise it's not a breach of confidentiality to be including family in treatment, so that's been a big change for me...In my previous training it was always, you can't speak to the partner. Whereas using the family therapy model, it's getting everyone in the room so we all know what's going on, that there's no hidden agendas and we are all working towards the same goals.

Non-Aboriginal worker

Confidentiality was identified as a key feature in the work with AOD clients, in order to build trust and an effective working relationship. To alter from the belief that work with a client needs to be protected is a major departure for many workers and within the context of Aboriginal health has added significance. As many workers are acquainted with the family members of their client, it is more difficult to maintain client privacy. One worker recounted how, for her,

professional and personal boundaries didn't really exist among those with whom she worked because *'it's not like they [clients who are community members] ever leave your life'* (Aboriginal worker) and for this reason,

If you make mistakes you have to be willing to own it and you have to have that conversation with the client and the family and say how you don't think you handled a situation the right way, you may have mentioned something too sensitive, and remember they are not strangers, if they don't know you they know your kids and other relatives.

Aboriginal worker

Workers related how community members sometimes pressured them to reveal information about their client. The training has allowed the workers to better address client confidentiality, responding to questions from family members and utilising the care and interest of family members to support the work.

My mindset, as far as confidentiality went was whatever was discussed between me and the client was strictly between me and the client, to the extent that even if a partner rang up and asked me for information about the client I would have said something like, "I'm sorry I can't give you that information..."

Non-Aboriginal worker

Due to the past history of trauma of Aboriginal people, workers were particularly sensitive to issues of trust with their clients and worked hard to develop a strong therapeutic relationship. One worker was careful to always address confidentiality with his predominately male clients directly by asking *'Is there stuff we can talk with your wife or your kids and then he can give his permission'* (Aboriginal worker). Previous trainers of the post Graduate Certificate noted that *'Indigenous people are intensely protective of confidentiality'* (Aboriginal trainer) and that this would extend to case presentations and role-plays within class where they would rather use their own family situations as examples. This increased their personal vulnerability, but guarded against potential breaches to the privacy of a family in the community. Workers commented that within group supervision in their workplaces that they were mindful not to present certain cases because of the relationships colleagues may have with their clients.

The issue of confidentiality within a community setting had a number of added dimensions for workers and the Training Program had an impact on the workers becoming more confident in this area of their work.

Dealing with Difficulties in Family Sessions

Workers' means of addressing some of the difficulties and dynamics present in family sessions which can impede progress included managing conflict and strong emotions, working with those resistant to the process and affording sufficient respect to Elders.

Managing conflict and strong emotions. Prior to the training, a barrier for many workers when considering family work was the fear that conflict would develop in sessions that they were not confident to manage and that this would be detrimental to family relationships. The workers noted that in the AOD field, blame was a common feature and that through the training they had gained a systemic way of managing strong emotions which could enable a safe environment to be maintained.

Dealing with the resistant person. These skills also extended to being able to contain dominant personalities within a session and to find ways of encouraging those more reticent to have a voice.

Through doing the training I feel much more able to tackle, to deal with the resistant person in the room. Whereas I wouldn't have known where to go before with that, but this Training is giving me the confidence.

Non-Aboriginal worker

Respecting Elders. Taking responsibility for the process could be made more complex for workers in the community when there were Elders present who would usually be deferred to. However, in the context of a family meeting workers felt it was necessary to find ways of both respecting their authority, challenging when necessary and making space for other perspectives. Other skills that workers considered were necessary to employ in such situations will be further discussed in the section 'Working in Community'.

Strength-based Approaches

Workers frequently spoke of the value of strength-based approaches in their work and that the training had increased their repertoire of interventions, with solution focussed and narrative therapy holding particular resonance. Focussing on client strengths helped to encourage and support longer-term change and relieved pressure for workers.

People are more than their problems. Workers emphasised that through locating individual and family strengths, a positive environment was created in which difficult issues could be discussed. One worker described this process. He used,

Problem-free talk and getting to know about them as a person, because that's something that I always do first. When I start off a session I say, "Before we get into this I just want to know a little bit about you because I believe that people are more than the problems or worries they have".

Non-Aboriginal worker

Through utilising solution focussed approaches that had been learnt during the training, workers collaborated with clients to set achievable goals, *'so they can see that they are winning, that things are changing'* (Aboriginal worker).

They can cope better. Though engaging families in therapeutic work can be very challenging, those interviewed felt that it was a way in which to promote longer term sustainable change that was not reliant on service involvement.

Sometimes it creates more pressure [working with families], but again I mean if you can teach people how to find their own solutions...it gives people the confidence to then have a go themselves which means they can cope better and so they are not on your doorstep all the time and feel more confident to work it out for themselves, so yes definitely it relieves pressure for me!

Non-Aboriginal worker

It is centring her. An ability to implement solution focussed approaches with families has also supported workers to more clearly discern where to best apply their energies and workers have appeared more contained and not as extended in their roles.

She is focussing more on working with the client and the family rather than trying to fix everything. It is centring her a bit which has been good for her, rather than before she used to think she had to put out all the spot fires around the family as well.

Non-Aboriginal manager

Working with Trauma

The ability of workers to address the effects of trauma on their clients was witnessed through perceiving the impacts of trauma along with the ways trauma could present symptomatically and be treated, including the creation of a safe therapeutic environment.

Understanding the impacts. Though many workers agreed that knowledge about the intergenerational effects of colonisation was key to understanding factors which led Aboriginal people to misuse substances, the ways in which trauma impacted upon family relationships was less well known and was an area in which workers became more cognisant of as a result of the training.

Before this [training], when I heard the word trauma, I would think of road trauma, but when you break it down into individual, family, transgenerational and community trauma it's then you start to realise how trauma can not only just affect individuals, but the family and the community.

Non-Aboriginal worker

Creating safety. Managers observed how their workers involved in the training were now able to track traumatic legacies through the generations and respond by paying particular attention to the creation of a safe therapeutic environment.

Viewing almost any behaviour you encounter with much less fear. An appreciation of how trauma could impact on mental health was useful for workers to contextualise behaviour that in the past had them feeling 'out of their depth' (Aboriginal worker).

If you have some knowledge on how past traumas can present themselves in people you view almost any behaviour you encounter with much less fear and you are in a better position to help somebody through that moment...This training caused me to reflect on some of my clients and certain behaviours or reactions they present with to situations that appears out of character or "over the top". If I have not heard their whole story and I am not aware of unresolved traumas they may have experience, my thoughts in the past have sometimes been that the client is mentally unwell or they are having a psychotic episode.

Aboriginal worker

Through this increased understanding of how trauma can affect behaviour the worker recounts how her capacity was increased in being able to respond to their clients therapeutically. Other

workers spoke of being able to view symptomatic behaviour in children and young people with a trauma lens which could prevent a pathologising of behaviour to a more treatable approach that was understood in terms of the family.

Professional Boundaries

For workers who are a part of community and who are intimately connected with the lives and stories of their clients, the risks associated with the work are increased as are the possible consequences for the worker themselves. The topic of boundaries was one which frequently presented itself throughout the training and one which the students reflected upon within the context of their work with families and within their service. Some of the areas where workers and managers believed professional boundaries could be instituted to benefit the outcomes for families and for workers were: holding the process in sessions, finding the courage to challenge behaviour, being more focussed within sessions on where change could occur and taking less responsibility for a family's issues.

Challenging behaviour. The difficulty for workers exercising boundaries in their work with fellow community members was expressed in the following way;

I've sort of allowed, I don't know if you'd call it bad behaviour but I've allowed some pretty unacceptable behaviour whereas I know now that if I'm to be effective as a therapist...if I'm to work properly with families then I have to be able to get past some of those areas where I get stuck.

Aboriginal worker

They'll try to keep the old me that they are comfortable with. Though the workers recounted how there had been a personal cost to them in allowing certain behaviours there was also concern regarding how setting different boundaries could be received.

If it doesn't turn out, how I'm gonna feel with the response?...The realisation that the family may not want to come back because they see a different side of you and they don't want that and they'll try to keep the old me that they are comfortable with.

Aboriginal worker

You have to have courage to adopt new ways of working. There is clearly a degree of ambivalence on the worker's part about adopting new working methods and there is a lot at stake in terms of professional and personal relationships with community members.

I'm always feeling like, you know protecting 'em and I don't want them to feel any more pain. So I don't want to be that person who's gonna challenge them because they've got enough challenges, because it's about trusting the love or the friendship to take a risk and step outside of my comfort zone and be honest with them and I haven't done that yet and there's been lots of times where I have been so close, but I won't...I want to have more courage. You have to have courage to be a good worker.

Aboriginal worker

I can really only be here for this long. One way a worker described how she had begun to intervene in the process of sessions more actively by containing clients who tended to impart large quantities of emotional content which could leave the worker feeling drained and not very useful.

It's about being honest with them too and saying "I can really only be here for this long, so, what are the main things we need to work on today?"

Aboriginal worker

She's not responsible for everything. These changes were noticed by managers also. One non-Aboriginal manager spoke of how her primary hope for the worker undertaking the training was for the worker to be able to set and hold to boundaries with her clients, primarily so the worker felt less stressed and able to manage her workload but also to increase her efficacy. The manager reflected on the change she had observed in the worker's practice as a result of the training.

It's her feeling that she's not responsible for everything. Like if there's a client with umpteen family members around them and there are one's that don't want to do anything at the moment, then being able to leave them and focus on what she can do and her feeling that she is accomplishing more and having better outcomes with the family. And from my point of view, she's a lot less stressed.

Non-Aboriginal manager

The complexity of the work that research participants were involved in and their high caseloads, community expectations and the degree of personal responsibility workers assumed all reportedly impacted on worker stress. What the training supported workers to do, in order to reduce the stress they experienced in their roles, was to devise interventions that included the

family and community context, work in collaboration with colleagues and other services and use a greater range of strength-based approaches.

Worker Confidence

An increase in worker confidence has been one of the biggest impacts of the training including workers recognising the skills they already possessed prior to the training, being more outspoken about the needs of families and an increasing willingness to take on challenges and embrace change.

We have the skills. As the training revealed that many of their pre-existing approaches could be located within family therapy frameworks, workers stated that they felt acknowledged and assured that their practice was benefitting their clients.

The realisation that we have skills that we are unaware of, it was empowering to have that validated. It made me feel more confident about what I have been doing and how to move forward.

Non-Aboriginal worker

I am more outspoken. Worker conviction around what could most benefit families in service provision was reportedly boosted through attending the training and this has translated into workers advocating more strongly for their clients,

Since doing the family therapy training I am probably a little bit more confident, I think more carefully about what I say and how I say it because you learn more about your own behaviour and how it can impact on a family. I've just changed positions where I work from a Drug and Alcohol counsellor to Team Leader of another program, so the increase in confidence has helped me through the process of adjusting to a new position. I am more prepared to challenge myself and I am more passionate about healing. I am also more outspoken about what needs to be done to help a family.

Aboriginal worker

Managers consistently commented how the workers were more self-assured as a result of the training and that they were able to articulate their practice to their colleagues and other services with greater clarity.

Her confidence keeps getting bigger and bigger, prior to that you could see it in her work but now you can see it in the team...bringing up families or talking to other workers about families and what might work in a particular situation.

Non-Aboriginal manager

Champions of change. Though when they began the training workers were already highly skilled in their roles, more than half had not completed tertiary training and only one had a tertiary qualification in counselling. Receiving a postgraduate qualification also had an effect on the organisations in which workers were employed as the workers became role models and as one manager described '*champions of change!*'. Workers feeling more confident in the skills they bring to their service has led to an increasing willingness to take on new challenges. Since the training a number of the workers have stepped up into management roles, others have begun to run group programs and training for health workers and graduates wish to fulfil the requirements to become a registered family therapist.

Self-reflection, Personal Growth and Development

Workers commented that the course created a space in which they could reflect on their own lives which helped them to realise how their actions and reactions had been shaped. The family therapy course gave insight into their own family's patterns, how to perceive these patterns in a non-blaming way and how they could better communicate and influence family members.

It's nobody's fault. A family therapy lens was described as offering a non-critical way to understand behaviour,

When we realise how we raise our own children, we do that just cause that's what my Mum did, or that's what my Dad did that, and you're kind of conditioned you know, and it's sort of nobody's fault...I think with family therapy, the course, I had lots of them realisations. You know when you're given the knowledge, or the opportunity to think about your own life and suddenly a sort of light goes on, "Oh, that was why!"

Aboriginal worker

Communicating with and helping my family. Workers spoke about implementing what they perceived as family therapy skills in their own families,

The course has been really helpful for me communicating with and helping my family, I'm doing things that I wouldn't have done before and it's helping. That's really rewarding. It's also been helpful at work for the same reasons.

Aboriginal worker

Students conveyed that the insight that they developed into their own families helped them to better understand and conceptualise what was happening for the families they worked with and to do so more empathically.

Working in Community: Strengths and Constraints.

Aboriginal workers who had grown up in the community in which they worked, illustrated how they needed to manage the added complexities that arose through their connections in community. The past history that they or their family members have had with clients, presented challenges as well strengths on which to draw. The training led the workers to reflect on what types of family involvement could be most useful. Workers identified some of the skills from the course which could be applied to increase their efficacy including being transparent and reflecting on how the work impacted upon them therapeutically.

Workers and their managers believed that the skills acquired through the family therapy training were useful in helping them manage the complexities of working and living in community and of maintaining personal and professional boundaries. However not all of the workers felt able to apply them.

One worker felt particularly vulnerable in this area of her work and found that she needed to utilise a range of skills in order to be able to negotiate a working relationship around,

Stuff that happened when you were a teenager that people still carry, dramas, "like I remember when you stood up at an AGM"...and different things like that and different political battles that people have...it's not like you can just go into a person's home, you have to clear the old baggage out because they might still be hanging on to it and you may need to go over the whole thing, you know. Because of that you never have a new start, it's very unlikely that you do. Sometimes you're sitting there talking to a lad and when he starts talking you think, I know everyone he associates with and who did something to him...it just makes it such a different working style than mainstream.

Aboriginal worker

You have to admit your own mistakes. These factors are at variance to the demands of most mainstream workers as their personal lives are exposed to a greater scrutiny and Aboriginal workers may need to provide explanation for their behaviours or decisions.

You're working with young people whose mother's you know intimately, sister girls, you are considered as almost Aunties to their children. So if you make mistakes you have to be willing to own it and you have to have that conversation with the client and the family and say how you don't think you handled a situation the right way, you may have mentioned something too sensitive, and remember they are not strangers, if they don't know you they know your kids and other relatives.

Aboriginal worker

Workers reflected how the family therapy training emphasised the value of transparency and how a 'one down' position could minimise the power differential between workers and families.

One worker described the difficulty in challenging people on their parenting whom she knew well. She would at times defer responsibility for such encounters to workers less connected with the family or during the session would attempt to keep the focus on the parents' desire to help their child. Delicacy and skill is required to manage such situations to decrease shame and fears surrounding confidentiality within the community.

Who wants to be in there when they realise "oh" ... it's uncomfortable, you almost have to admit your own stuff, your own mistakes as a parent so that they know we're not here to point the finger.

Aboriginal worker

I don't feel I can talk about how things impact on me. Workers recounted how there were times when they received personal attacks from clients or backlash surrounding the behaviour of relatives and though they might feel hurt or 'betrayed' they would endeavour to act in a professional manner. Their roles constrained how they would respond and required particular skills, which they had gained in the training, to manage the conflation of the professional and the non-professional aspects of worker's lives by clients,

At work I'm different, I act different, I don't feel I can talk about how things impact on me in work hours, you can't afford to do that...you'll forget their sickness or their struggle if you start...if you took everything personally you wouldn't survive and I might have a cry and a debrief but you have to get over it quickly otherwise you wouldn't survive.

Aboriginal worker

This worker illustrated what many of the workers spoke about regarding the complexity and vulnerability that comes with dual/multiple relationships in community.

Summary

The chapter presented how the Aboriginal AOD workers perceived the family therapy skills that were gained through the training program in relationship to their work. In the first round of interviews, some workers were sceptical of what the training could usefully provide and emphasised that the knowledge was already familiar and that including families was already a routine part of their practice. Some of this scepticism can be seen in the context of family therapy stemming from a non-Aboriginal tradition and the history of colonisation where non-Aboriginal knowledge systems have been privileged.

Over time, the perspectives of workers changed with respect to what they felt they had gained from the training program and they acknowledged the ways in which the course had built upon and extended their practice. Some of the factors accounting for this change include the time trainers spent deconstructing family therapy ideas and linking them to the pre-existing knowledge and the practices of the workers. This process incorporated adult learning principles where the training started where the students were currently located in order to more easily scaffold new ideas whilst demonstrating respect for the cultural knowledge and abilities of the workers. This enabled the necessary degree of cultural safety to be engendered so that students could begin to learn and extend skills in working with families.

One of the significant changes to how workers' viewed their work with families was how they positioned themselves. Prior to the training many workers spoke of aligning with their clients in family meetings whereas through the training, people understood the value of demonstrating understanding and empathy towards all family members and from there enacting systemic interventions in relationship to the particular cycles of problematic behaviour. Workers reported being much more confident in being able to work with multiple family members and multiple agendas and hence were more likely to invite family members to attend family meetings at their services.

Workers particularly valued gaining knowledge about the intergenerational effects of trauma on family relationships and how substance misuse could be understood as a symptom of this legacy. Though workers were well aware of the effect of colonisation on Aboriginal people the degree of understanding regarding its relational impacts was much enhanced through the training. As trauma can disempower individuals and communities, workers appreciated the strength-based approaches that were detailed in the training and how they could enhance the long-term sustainability of interventions.

The particular constraints for Aboriginal AOD workers in working with families were addressed in the training with attention to the skills required to manage conflict in family meetings as well as how to negotiate confidentiality with clients so that a strong therapeutic relationship can be preserved and enhanced through family work.

As community members, Aboriginal workers often have shared histories with their clients which can make their professional relationships more complex when they deem that challenging family members could be helpful. To support this, workers believed in transparency and a degree of self-disclosure which was discussed in the training program. However, some Aboriginal workers found the degree of vulnerability they felt in the work because of their status as community members had them reticent to implement some of the skills and resources that were promoted during the training.

The family therapy training encouraged a systemic view of problems which participants had applied to both their workplace culture and the systems surrounding their clients and families. These skills enabled a greater ability to advocate and navigate the systems in which the workers and their clients were involved.

Workers and managers articulated that:

- Substance misuse is a symptom of the trauma that many Aboriginal people have experienced both within their lifetimes and transmitted transgenerationally as a result of colonisation and the dispossession of lands.
- Trauma needs to be addressed in the context of the family as all family members are affected.
- Family therapy training provided workers with skills in managing conflict and negotiating confidentiality which were seen to be important when providing family interventions where substance use was problematic.
- Workers appreciated the strength-based nature of family therapy as it aligned with their belief in these approaches for dealing with Aboriginal people and those who had experienced significant trauma.
- Prior to the training, many workers spoke of aligning with their clients in family meetings, whereas through being exposed to family therapy interventions workers appreciated the value of demonstrating understanding and empathy towards all family members and from there enacting systemic interventions in relationship to the particular cycles of problematic behaviour surrounding substance misuse.

- Family therapy training provided a systemic understanding of the problem of substance misuse. This led workers to reflect on themselves and their role in maintaining boundaries and professionalism when dealing with fellow community members. Workers spoke of how it could be a struggle to not respond reactively to the crises their clients faced and to attempt to provide solutions. However workers felt that a more therapeutic response would be to promote the efficacy of families and to minimise their sense of responsibility for client outcomes. This approach workers and managers felt would also lessen the personal toll workers experienced and could better sustain them in their demanding positions.
- The systemic understanding evident in family therapy was also transferrable to the workplace where skills were enhanced in management and supervision and workers felt better able to advocate and navigate the systems in which they and their clients were involved.

Chapter 6 Was the Training Culturally Appropriate and Relevant?

The following chapter explores the cultural appropriateness of the Family Therapy Training Program, as perceived by workers, managers and the Indigenous Program staff. In order to be effective for the drug service workers, the course needed to be culturally relevant, both in its content and in the way it was delivered. This chapter will firstly chart the significance to the students of undertaking postgraduate education within a mainstream institution. This will provide the context for the training's cultural relevance as well as demonstrating the need for workers to participate in postgraduate education. The chapter will also include some of the barriers faced by the Aboriginal students in accessing education and the ways the Training Program addressed these obstacles in order to engage the students and provide cultural safety. Participants' reflections on the principles and methods guiding the delivery of the training through the 'Black and White Approach' will be outlined, along with the ways these processes impacted on non-Indigenous students' cultural awareness.

The need to increase access to tertiary education for Aboriginal students has been well documented (Andersen et al., 2008) and though there is no literature that speaks specifically about the need for postgraduate training in family therapy for Aboriginal drug service workers, there is literature that provides a context for understanding the significance of the training's approach and its ability to engage and retain Aboriginal students (Behrendt et al., 2012; Biermann & Townsend-Cross, 2008; Harris & Malin, 1997).

Culturally appropriate and relevant education for Aboriginal people can be perceived as 'a social justice issue which impacts on social, political and economic inequality' (Andersen et al., 2008, p. 3). The participants of this Training Program recount what made the training accessible to them which makes this analysis part of an important contribution to the field of Aboriginal education.

The ability of the FFTP to engage and retain students is reflected in the table below.

Table 6: Enrolments and Completion Rates for Indigenous and non-Indigenous students in the first 5 cohorts of the post Graduate Certificate in Family Therapy: 2008-2013

Cohort	Indigenous enrolments	Indigenous Graduates		Non-Indigenous enrolments	Non-Indigenous Graduates		Total enrolments	Total Graduated	
	N	N	%	N	N	%	N	N	%
Shepparton (2008-2009)	10	10	100	-	0	0	10	10	100
Ballarat (2009-2010)	7	7	100	4	2	50	11	9	82
Gippsland (2010-2011)	12	10	84	5	4	80	17	14	82
Metro (2010-2011)	8	6	75	2	2	100	10	8	80
Mildura (2011-2012)	5*	5	100	6	5	84	11	10	82
Eastern Metro (2012)	11	9	82	4	3	75	15	12	80
TOTAL	53	47	88.7%	21	16	76.2%	59	51	86.5%

* 4 Aboriginal workers enrolled but did not commence the training due to deaths in community and loss of jobs at the ACCO (MVAHS-Robinvale). One deferred her enrolment.

Some of the barriers identified for Aboriginal Australians accessing tertiary education have been identified as a lack of support from family (ABS, 2010b; Andersen et al., 2008; Hossain et al., 2008), financial considerations (ABS, 2010b; Andersen et al., 2008; Hossain et al., 2008; Toombs & Gorman, 2010), acknowledgement and understanding of Indigenous knowledge and culture within training programs (ABS, 2010b; Rigby et al., 2010) and racist attitudes (Hossain et al., 2008; Rigby et al., 2010).

This chapter describes the Indigenous pedagogy which was adopted within the Training Program and how it was received from the participants' perspectives. This is of significance because this is an area that has been under theorised (Biermann & Townsend-Cross, 2008). The findings

identify elements important to creating a culturally safe learning environment. Elements noted previously by Australian authors include having Indigenous staff employed across the university, effective support systems (Andersen et al., 2008) and culturally appropriate teaching (Kippen et al., 2006) as being of great importance.

The 'Black and White Approach' to training that is reflected on by participants in this chapter can be seen within a history of 'both-ways' learning that was first articulated at Batchelor College (McConvell, 1982). This approach involves both Aboriginal and non-Aboriginal people learning about each other's knowledge system in order to facilitate the possibility for a genuine exchange occurring within what is a predominately white, academic system.

The learning styles that were utilised within the Training Program and accounted for within this chapter emphasise kinaesthetic or 'hands on' learning (Clapham et al., 1997; Main et al., 2000; Waples-Crowe & Pyett, 2005; White, 2005) after a period of observation and demonstration (Hughes et al., 2004; Main et al., 2000) where the skills taught have application to the students' lives (Clapham et al., 1997; Main et al., 2000; White, 2005). Incorporation of the Black and White Approach into this postgraduate training program in family therapy is unique both nationally and internationally. This chapter makes an important contribution to the field of Aboriginal education where much of the research conducted about Aboriginal learning styles has been done at the level of primary and secondary education, rather than tertiary (Hughes et al., 2004).

Attitudes and Beliefs about Education

I've got an education through the non-Indigenous system and it wasn't a positive experience, but why I sit here today and my commitment was to prove that I could do this and achieve something that is not easy to achieve as an Indigenous person in a university with 30-40,000 students there and being the only blackfella.

Aboriginal trainer

Previous experiences of mainstream education. The Aboriginal workers who were interviewed commonly recounted how previous mainstream educational environments had been culturally unsafe. Workers explained that what was being taught often had minimal relationship to their own experience and so they needed to spend extra time deconstructing or unpacking what was being learnt in order to make sense of the content. At times the students found the course content and comments made in class incorrect or racist and this would pose a dilemma for them. They spoke about the need to decide whether to contest what was being spoken about and put themselves in the position of cultural educator, which also brought with it

a degree of risk, or let the comment go unchallenged. These difficulties created a state of vigilance in the students, which prevented them from being able to relax and concentrate on learning.

Being in a minority within a class was spoken of as burdensome for workers as they were often asked for an Aboriginal perspective on issues. They felt ambivalent about providing this as they did not represent all Aboriginal people and that they also wished to be recognised for other aspects of themselves,

Like you are Aboriginal before you are anything else and they will identify you and that "Oh it's one of the Aboriginal students asking a question" rather than one of the students asking a question.

Aboriginal trainer

Everything I have learnt has been through practice through watching and learning. Workers spoke of difficulties with the mode and style of learning within previous mainstream education. Many identified as coming from an oral tradition through which they had learnt about life from their families and community. To be assessed on their ability to write felt like a very 'white way of learning' and this created some conflict for people who felt that more respect needed to be given to Aboriginal ways of knowing,

Everything I have learnt, it's been orally, verbally, through teachers through practice through watching and learning and that's the process for blackfellas and that's where I get torn and at the end of the day this is the process [in mainstream education] in which things will happen, whether we want it to be or not. So we have to adapt whether we want to or not. And then I'm torn and I think, why should we?!

Aboriginal worker

It just comes naturally. A couple of the workers were doubtful at the beginning of the training as to the degree to which anyone could learn communication and interpersonal skills through training and that even when people did have a high level of education, it did not always translate into an increased capacity to do the work,

There is no training or courses to complete, you just interact with other families the way you would with your own. Therefore having a degree or a lot of training is kind of foreign to Indigenous people, doing the work is an organic process, it just comes naturally.

Aboriginal worker

An Aboriginal person will stay in a job if they are given the right support. Though it was clear throughout the interviews that mainstream education often failed Aboriginal people, the experience of Indigenous specific training had not always been positive as it was viewed as too 'dumbed down' (Aboriginal worker) to be of use. However, the need for culturally appropriate, practical training was evident. One Aboriginal worker expressed the belief that the high turnover of staff within the Indigenous AOD sector was a result of insufficient and inappropriate training opportunities for new workers,

Aboriginal people are in jobs they do not know how to do and which they are not supported to do. They are given these assessments that they have never seen before and they are told they have to do an assessment report and they have never had any report training in their life and they panic...An Aboriginal person will stay and stick at a job if they are given direction and if they are given the right support.

Aboriginal worker

Despite the ambivalence many of the Aboriginal workers held towards education it was recognised that in order to fulfil more senior roles Aboriginal people needed to achieve the necessary qualifications. For this to be accomplished it was necessary for them to,

Not only having access to educational opportunities, but supported access to actually fulfil it. So not just, "here's a course for you, now go off and do it", but "here's the place and the necessary support to compensate the disadvantage, disadvantage through no fault of your own".

Aboriginal manager

Challenging Previous Experiences

A number of the Aboriginal workers were surprised about how their perceptions of higher education had changed through the Training Program. An Aboriginal worker, after having been very ambivalent about attending a few months after the Training, commented that,

Now that I'm doing family therapy training I'm thinking about doing the Master's.

Aboriginal worker

Another Aboriginal worker was surprised that she had completed the course and that she was now looking for ways to utilise her skills,

I have been surprised the most by the positive change in me - I didn't think it was there. I'm really striving to go ahead and complete it.

Now that I have done the training it is like where to from here and how can I use these skills so that they don't just become something I did in my mid-life crisis and I'm in my 50s now and fancy doing this in my 50s!

Aboriginal worker

Maintaining Respect in Two Worlds

Even being an educated blackfella can mean you've already gone white.

Aboriginal Team member

Issues surrounding what some aspects of the Aboriginal community perceive as acceptable forms identity can act as a constraint for community members in receiving an education and so are important in contextualising the experience of Aboriginal workers (ABS, 2010b; Andersen et al., 2008; Hossain et al., 2008). The following data reveals the struggles and strategies workers implement in order to maintain their professional identity and their status within the community. Achieving certain markers of success like gaining a tertiary education can be seen as *'trying to be white'* or that that person may not know what it is like to struggle and there can be an ambivalence about being part of a system that has been a source of oppression for Aboriginal people.

Trying to be white. The educational and professional aspirations of workers are at times in conflict with what the achievements signify to their community. One worker expressed how she had been deeply ambivalent around receiving an education throughout her life as she had thought, *'what is that gonna do for me? I'm Aboriginal'*. For her being Aboriginal did not include building a career or being academic but rather as a young person she had rather envisioned getting married and having children as that was what she felt was expected of her.

Receiving an education can risk being viewed by others in community as someone who is, *'trying to be white'* or in some way trying to separate themselves out from community.

That is why people pull out of study and don't go to university because they don't want to lose their connection to community because it can be seen as that, that you are a flash black and I know that I copped a lot of that when I went to school, when I wasn't going out on the weekends drinking and studying but I had a very strong family at the same time. It's such a hard, hard thing for an Aboriginal person to be respected in both worlds.

Aboriginal trainer

The limits surrounding acceptable expressions of Aboriginal identity were described by the participants as being narrowly prescribed, as one of the workers articulated. She had felt within her family that it was important to appear modest and humble. For her parents they,

Could have brought this really beautiful house but they didn't because it was too flash for them so, "Nah, nah we're just blackfellas and no one is going to visit us if we lived in a place like that".

Aboriginal worker

Workers were often thoughtful when considering the legacy that had been transmitted to them and about what they wished to pass on to their children regarding how they chose to express themselves and what they wished to achieve.

Does that mean I'm not Black enough? The dilemma for Aboriginal workers was described by one of the Aboriginal trainers. She described how for her issues of identity posed challenges because her background was significantly different from others identified within the Aboriginal community,

I had an upbringing, with the usual privileges of the middle class. Even though my family is as dysfunctional as the next, my life was not as disrupted as some (Aboriginal people) and sometimes I think, 'does that mean I'm not Black enough because I haven't lived through that?'

Aboriginal Team member

The perceived difference in experience and upbringing had required her to deeply consider her place in community and how she could maintain her Aboriginal identity without conforming to certain norms of behaviour. She described that it had taken her '25 years to feel comfortable about my fit in community'.

You have to remind them that you're actually struggling too. Another issue that workers were sensitive to in order to maintain connection to their communities, was to not create distinctions between themselves and their clients that could exacerbate a sense of separateness or difference,

I just hate the title therapist, 'cause to me, straight away you're not on the same level as the family...(I prefer) health worker, who's got some experience in helping families with their issues

Aboriginal worker

The following quote describes the need for workers, at certain times, to address what their position represents to those they work with,

It's like you've got this squeaky clean life...that you've kicked all these goals, but sometimes you have to remind them that you're actually struggling too, that you've got similar problems. There can sometimes be that resentment that you're managing to hold a job, they forget, it doesn't mean that everything's grouse, you know, they can be that nasty...and you have to remind them.

Aboriginal worker

To have employment, an education, to own expensive cars or 'nice' houses can all be eschewed as trappings of the white world which, for some of the workers, raised the challenges surrounding what it means to be a good Aboriginal community member.

Being part of the system. To maintain a professional and community self can sometimes create a dissonance in how workers portray themselves as described by a non-Aboriginal manager,

There is a real disconnect between the way Aboriginal people are in their roles...and it's not about passion and it's not about not wanting to do their jobs but there is a disconnection between what they actually do and how they see themselves. So when you talk about being passionate about your job, it has to be close to your heart, to who you are. If you have this disconnect between, who they are at work and who they are in their community then you are never going to see that passion and drive because people don't see what they do as being part of who they are.

Non-Aboriginal manager

This manager described how he saw part of his role as supporting workers to be more fully themselves at work and to take greater ownership for their roles though he was surprised to hear from an Aboriginal trainer that ACCOs were perceived by many to be based on white structures,

You talk to any one Aboriginal person, they have a story of being a part of the system and a very new system that's been here a short period of time but has had a tragic impact.

Aboriginal trainer

The participants spoke of the experience of being associated with the system, where in the eyes of some of their community they had '*gone white*' which made it difficult for some workers to commit fully to their roles.

In light of the history of Aboriginal people's experience of education and the service system, the achievements of these particular workers in gaining a post Graduate Certificate in Family Therapy is even more remarkable, as they demonstrate the courage and the ability to walk between two worlds.

The Black and White Approach

Structure of the Course. In order to make the training program culturally safe and relevant for the students, changes had been made to the structure of the course and the pedagogical approach was also significantly altered. This section will describe how the changes made impacted on the students and their ability to engage in the process and with the course material. Further discussion as to the evolution of this educational approach and that of the Indigenous Program will be left to a following chapter.

Critical to the cultural safety for the group was the employment of an Aboriginal cultural consultant and trainer whose primary role was to attend to the cultural needs of the students and support the translation of course materials into a form that was recognisable to those in the group. The Aboriginal trainer also provided support and safety to the non-Aboriginal trainer by acting as a bridge between Aboriginal and non-Aboriginal worlds.

The group was smaller than a regular university class with a maximum of fifteen per group. In this cohort there were eleven students who attended the twenty-six weeks of the training and nine who completed all the requirements for the award. The smaller group size meant that more attention could be paid to group processes and the trainers described the experience as more like a '*supervision group*' which made it '*more intense*'. It also contributed to a greater exchange of experience and learning amongst group members, which was consistently reported as a highlight for the students. The course was held off campus which helped to create a more relaxed environment that promoted closer relationships,

This has been much more personal than going to university and that's been important to me...being away from the university is good because when you're at the university you have everyone that's going to university every day and they're in their circle of friends. Whereas we've been meeting up quite a lot.

Aboriginal worker

The way that the course was taught was significantly different from the mainstream program. The degree of experiential learning was greatly increased so that trainers structured their teaching around a *'practice, theory, practice'* model rather than *'the western idea of theory, practice, theory'*. In keeping with the increased emphasis upon practice, the written component of the course was decreased in order to respect the oral tradition of the Aboriginal students and to favour knowledge gained through experience. Assessments included a Spoken Essay and a community presentation rather than a two thousand and three thousand word essay as well as a reflective journal and two written assignments (see p.5).

Acknowledgement. The trainers within the Indigenous Program were aware of their need to acknowledge the traditional owners of the land on which the training was being held. From this starting point, respect was extended to respecting the student's knowledge and experience of working in community. The trainers recognised that they could not privilege western ways of approaching Aboriginal health over the worker's own experience as it would be a colonising practice which would result in disengagement. Consultation with the communities in which the students worked was an essential aspect of this acknowledgement process,

We acknowledge the traditional owners of the land, pay respect to those people because that's about getting permission to be here on this land to talk about what you want to talk about, whether it's here in Victoria or New South Wales or whatever, it's about acknowledging that history and paying respect to that, which gives you permission to visit, to be a part of this land and share that experience

Aboriginal trainer

Another aspect of acknowledgement is that trainers in the Indigenous Program have learnt that they need to be more flexible around the rules of academia in order to account for community responsibilities and the impact of Sorry Business. The trainers have witnessed that each of cohorts undertaking the training suffered personal losses and tragedies at a higher rate than in other training groups they had experienced.

Acknowledgement and respect for Aboriginal people underpinned the training and was seen to be vitally important as *'the subtext of the space creates the possibility'* (Indigenous Program Manager).

The Training Team

I found the combination of having an Aboriginal and Non-Aboriginal facilitator a nice balance and it shows a mutual respect does exist for both cultures. Some people may be a bit uncertain having a non-Indigenous facilitator but it would depend on the skill of the

facilitator and how they manage this. The non-Indigenous facilitators we had were really great and I don't believe anybody had an issue with it.

Aboriginal worker

Having an experienced non-Aboriginal trainer and an Aboriginal trainer and cultural consultant with family therapy and group work skills has been an important feature of the training model and of what has been coined the 'Black and White Approach'. The advantages of having an Aboriginal and non-Aboriginal trainer has been perceived by participants as important in enabling cultural translation of the course materials, creating another level of safety by having two facilitators attend to group dynamics and in demonstrating how Indigenous and non-Indigenous people can respectfully work together. Having trainers with therapeutic skills was believed to facilitate attunement to the group and the trainer's ability to manage their own responses.

A cultural translator. It was frequently commented on, by both the students and the trainers, that a 'cultural translator' was a significant enabler of a culturally safe learning environment. One of the ways the cultural consultant helped to achieve this was to prompt the non-Aboriginal trainer to provide examples or unpack language that was being used to relate more directly to the students' experience. An Aboriginal worker commented that the Aboriginal trainer *'was like a cultural translator, she translated at that community level so we'd understand it more'*.

Another level of safety. Having two trainers enabled more attention to be paid to group dynamics and group processes which intensified the training experience and the ability of the students to stay engaged with what was being taught. As one trainer describes it,

If you were a sole trainer and having difficult group dynamics I think it would be much harder and I think you can't process it the same way, as there is simply only one of you. And I think what happens in the group, is they see this dynamic going on between the two people and that creates another level of safety and that has the trainers feeling safer and that translates to the group feeling safer. And they can throw anything on them (the trainers) and they look at each other and around we go and they think, "These two are up for anything!" And in this way it is highly containing and you can't get that, well I can't imagine, I wouldn't even try to get it on my own.

Non-Aboriginal trainer

A partnership between two cultures is a possibility. Through having both a black and white trainer collaborate in the delivery of the training, culturally sensitive practice was

modelled to the students. Though the trainers come from very different backgrounds and have different approaches to teaching they were able to negotiate a method of teaching which can speak to both of Aboriginal and non-Aboriginal cultures. It was observed by an Aboriginal member of the Indigenous Program that,

It was important to the participants that they saw that was a possibility, that a relationship and a partnership between two cultures was a possibility to achieve better outcomes for communities.

Aboriginal Team member

My experience as a clinician has been equally important as my experience as an educator. An Aboriginal trainer noted that though the non-Aboriginal trainer needed to have some understanding of Aboriginal culture it was more important that the trainer was attuned to what was happening in the room and was able to sense changes in students' responses. The trainers needed to listen and observe carefully what was happening in the room and be willing to respond in useful ways to challenges made by the students. Rather than focussing on moving through the curriculum attention needed to be paid to not '*losing the students*' in the process. The high degree of commitment required in this type of training was noted by the Aboriginal trainer about her non-Aboriginal colleague who '*puts herself out there for everyone and makes herself available and to ask questions and challenge*'.

An advantage of having trainers who have backgrounds in family therapy is that they are highly skilled in being able to attend to safety in the room and attune and deal with the students and their own emotional responses-- when they feel challenged, they are able to manage their own feelings of '*fear and excitement and anxiety*' and if they have unwittingly offended that they know the value and importance of repairing any breaches to safety or relationships. A previous trainer in the program noted that '*my experience as a clinician has been equally important as my experience as an educator*' as '*every time I have felt personally wounded I have put myself in the position of therapist*'. This has meant that emotional responses can be worked through and that the trainer is able to contextualise the experience in order to preserve the educational environment. A previous non-Aboriginal trainer observed that,

It's the same dynamic that I do in therapy - I do it when I sense that I've lost them at some point, that I have used jargon in a way that leaves people estranged from the meaning. Ensuring that I constantly check in that students are walking with me

(It's) important to have the confidence to know that "getting it wrong" means that they are voicing "what they would like to do".

Non-Aboriginal trainers also noted that without the support of their Aboriginal colleague they would find it more difficult to maintain their role as educator in the face of the various difficulties presented by the students. The Aboriginal trainer ensures that their co-trainer keeps the material relevant and if they have been culturally insensitive unintentionally supporting them to make reparation. A previous non-Aboriginal trainer noted that it was through the cultural consultant's courage and '*uncompromising attitude*' that made it safe for her as she knew that '*that this guy is not going to be pushed over or compromised*' around his community receiving a high standard of education.

Aboriginal and non-Aboriginal people in the group. Previously through consultation with a number of Aboriginal communities and services, it was decided that for optimum learning and privileging cultural safety for Aboriginal workers the composition of the group should include two thirds Aboriginal people and one third non-Aboriginal workers who had the endorsement of the Aboriginal communities in which they worked (see p. 5, 74-75). In this cohort, three out of the eleven were non-Aboriginal and one of these workers originated from an Indigenous culture outside of Australia.

We have learnt a lot from one another. Having both Aboriginal and non-Aboriginal students in the Training Group, for this student group, provided greater opportunities for learning as people had particular areas of expertise and approaches to their work which made it '*richer and more interesting*' (Aboriginal worker). Not only were there the cultural differences between Aboriginal and non-Aboriginal students and staff, the Aboriginal students were also multi-cultural as they originated from different clans and language groups and they worked with diverse communities throughout the state of Victoria. The particularities of working in these various communities was shared and the mixed composition of the group became a strength over time,

At the start it was difficult having Aboriginal and non-Aboriginal people in the group, not difficult, but it was like 'Oh OK, what are these people doing here?' Once you got to know those people and their roles in community and what they did, it actually broke down barriers for us.

Aboriginal worker

Aboriginal group members affirmed the right of non-Aboriginal people to be undertaking the training as they believed that the community would benefit through improved worker practice

and they commented that they had also experienced an enriched learning environment as a result,

It is fascinating to learn how non-Indigenous people think about things, so we have learnt a lot from one another.

Aboriginal worker

The course enabled worker practices to be challenged and for dialogue around the choices workers made to be understood which facilitated a process of cross-cultural awareness,

By the end of it we had reached the point of mutual respect and yes it was challenging in that respect but there was many positives and I loved being there because I got to hear Aboriginal stories and perspectives and that really helped me when I deal with Aboriginal people.

Non-Aboriginal worker

A number of students commented that as Aboriginal and non-Aboriginal people frequently worked together in their organisations the training was serving to improve understanding about how to work together.

We develop tolerance and understanding in the classroom. I have learned so much from my classmates about Aboriginal ways of doing things, their learning styles and work practices, which has enabled me to think more creatively about how we work in our organisation. I'd like to think that Indigenous students have also learnt from non-Indigenous, to develop an appreciation for our differences and also our similarities. Having that understanding and appreciation supports our journey together.

Non-Aboriginal worker

The relationships that had developed as a result of the group process was significant for those in the group as,

We have developed a sense of justice and unity. I believe the connections that we have made in this class will be ongoing and that life friendships have been formed.

Aboriginal worker

A Bridge between Aboriginal and non-Aboriginal Systems of Knowledge

A number of elements were perceived by participants as being of significance to the Black and White Approach. This included respecting: community over individual learning, the stories of the

workers about education, and the community and professional experience of participants. Workers commented that the trainers had been able to create a safe learning environment where a two-way exchange of knowledge occurred through a process of deconstruction and reconstruction.

I will take it back to community. Central to the workers' approach to learning was their commitment to the communities they served. There was a strong ethic present of needing to pass on the knowledge learnt to their colleagues, their families and those in community,

If I learn something new I will take it back to community and share that. It's like a process of consultation.

Aboriginal trainer and past student

The trainers, in respect to the groups preferred way of learning, sought to democratise the knowledge by decentering themselves so that the expertise was held by the group,

We as Aboriginal people believe that any one of us is not the expert...we will go and collect the knowledge and gather the information and bring it all together but we actually don't own it, we will share that information.

Aboriginal trainer and past student

The ethic of sharing information and focussing upon the success of the group over that of the individual helped create a more conducive environment for learning. An Aboriginal trainer, who had been both a student within the post Graduate Certificate, which had an Indigenous focus, and the Master of Clinical Family Therapy was able to articulate her experience of the difference between the mainstream and the Black and White model':

In the Grad Cert you feel like you are doing it together and with each other, whereas in the Masters you feel like you are on your own and that you are rowing your own boat.

Aboriginal trainer and past student

What will keep us feeling safe. The importance of creating a safe learning environment was reiterated by both trainers and students. As one trainer noted, for Indigenous students there was a '*greater need to deliberately attend to their safety as they have had many past experiences of where there was a lack of safety*'. This attention to safety provided a firm foundation from which the students learnt and appeared to contribute to the likelihood that the students would be retained till course completion. Safety was viewed as an ongoing process by the trainers that needed to be regularly revisited and referred to throughout the training. Students commented that the environment was:

Really friendly where no question was a stupid question; we put those rules in at the start so it made the group more interactive with each other, we didn't laugh at a person because they didn't understand something...Group norms, rules were set out also around what will keep us feeling safe and how we were going to support each other, it was really important.

Non-Aboriginal worker

Time was taken to listen to the experiences of the student's past history of education and their fears and presumptions about the Bouverie Centre and La Trobe University. It was believed that this approach served to privilege the educational process as it was important to,

Take the time in the beginning sessions to engage and establish a working relationship, and the rest will work quickly! First five to six weeks, you really need to make sure that you haven't lost them. It parallels therapy where if you don't engage them in the beginning, you lose them.

Non-Aboriginal trainer

The importance of developing safety for the group was used to model how to discuss safety within family sessions. When difficult group dynamics arose the trainers would endeavour to make the connection to how workers would deal with similar issues within a family meeting. This served to both normalise the group processes and deepen the learning for students.

They have learnt through stories. Trainers spent time understanding what the student's previous educational experiences had been and drew a systemic connection between their personal learning, familial and political contexts. This highlighted how people's belief in their academic abilities could be affected by teachers, families and community expectations. These conversations also served to inform the trainers as to what methods would be most amenable to student learning,

Because a lot of them haven't had the formal education...they have learnt through stories and that's how they pass on their learning to other people, through stories.

Non-Aboriginal trainer

Personal stories were privileged in the learning environment because *'there is so much experience there it would be disrespectful not to include'* (non-Aboriginal trainer). It was then up to the trainers to locate the relationship between the stories, the theme under discussion and family therapy concepts. This validated the workers' practice, enabled them to identify how they

were already using aspects of family therapy which sustained emotional engagement in the group and created a deeper connection to what was being learnt.

A shared learning experience. Given the Indigenous cultural emphasis on family and community, Aboriginal students were respected as family inclusive workers from the beginning of the training by the trainers and after a teaching topic was introduced the trainers would ask the group what was already known about the area. Adult learning principles were adopted so that it was assumed that the students knew and practiced aspects of what was being discussed and what was being taught was a second language to describe what was already known.

When I first started the course I anticipated learning a lot about the Western model of family therapy. But I did not get that feeling that we were there to be taught the Western way of doing things. It was a shared learning experience between mainstream and Indigenous workers. We were introduced to a lot of different mainstream theories but it was more to broaden our knowledge of how mainstream do things and how they give terms to different styles of working.

Aboriginal worker

Importantly the trainers were open to learning from the group and to participating in two-way learning which marked respect for the experience and cultural expertise in the group,

The tutors approach wasn't to dictate, it was very much open to 'how do you think that will fit working with Aboriginal families?' so they were very open all the time. It gave the impression that they really wanted to learn from the students, not just that the students were learning from them. It was very much a two-way exchange and to me that was quite unique

Aboriginal worker

There have been really key learnings from the [Aboriginal trainer] and some the [Aboriginal students] and all of them but those have really stuck out, as times when I've thought, "Oh my god of course! How could I have not seen that!". So it's been those moments when you really get that you just don't know and being able to sit with that.

Non-Aboriginal trainer

Deconstructing and Reconstructing. Another perceived key component of the Black and White approach was the deconstruction of theoretical concepts. This was done through interrogating the theory in terms of '*ethics, pragmatics and the assumptions*' (Non-Aboriginal

trainer). The language used to describe the theory would be broken down and refigured and documented to express the same concepts but in a language which workers would feel comfortable using with the families with whom they worked.

Trainers instituted the practice of creating two sets of slides that both contained the course content but which were expressed in different ways. Firstly, slides were presented which described mainstream theoretical concepts and the group talked about their understanding of these. From this discussion a second set of slides was constructed which described the same concepts but in language which has greater meaning and resonance for the group. Both sets of slides are then emailed to the workers at the end of the training day. This process has been found to be very powerful as students witness their understanding and experience being acknowledged and given authority (Latham, 2010, 2012). Through having access to both sets of slides the workers are free to use the language that best suits the context in which they were working. Workers spoke about being more aware of how mainstream language can be utilised effectively within Department of Health meetings and in other mainstream services where workers need to advocate for their clients. The use of the vernacular enabled the students to '*recognize and own*' (Non-Aboriginal trainer) what is being described as well as making the concepts more vivid and elevating the group's knowledge. An example of this was when the students in the Metro cohort decided family healing, rather than family therapy, best described the way they worked with families as they felt that the word therapy carried too many negative associations for themselves and their clients.

Through this process the trainers took responsibility for connecting the course material to workers' experience. As an Aboriginal staff member noted,

It's up to the lecturer to put the time into make those bridges to think, this is my problem not their (the students') problem...it's the teachers job to work out what people can do and then raise the bar.

Aboriginal Team member

Unlike earlier delivery of the Black and White Model, the Metro training team found that spending too much time behind the computer, capturing the deconstruction and reconstruction process disconnected them emotionally from the students as '*sometimes the conversations are so engaging it feels like you would miss something*' (Non- Aboriginal trainer). This particular training team maintained the technique to a lesser degree than previous trainings, but were always sure to situate the knowledge being discussed, its context and for whom it had been derived in order to open up a dialogic space with the students. The Aboriginal trainer observed of her colleague that,

You are always saying you are coming from mainstream and I think you pull it out of them and encourage them to say how it is for them.

Aboriginal trainer

The discussion generated around worker experience created a powerful group process which is what the non-Aboriginal trainer identified as what *'seems to be what they are learning most from. More than the concepts it is more the process of taking apart and refiguring'*. The degree of perceived emotional engagement of the group and its importance to learning was commented on by the non-Aboriginal trainer;

I'm just learning that about myself lately, that I learn more when I am emotionally tuned in. What it makes me think about too when someone else in the group said, the training process "was more about learning with our hearts than our heads" and I think that sums it up well.

Non-Aboriginal trainer

Non-Aboriginal Student Learning

Being non-Aboriginal workers in the minority culture led to some important learnings. The Training Program was useful in imparting skills and understanding to the non-Aboriginal students around working with Aboriginal families. What the non-Aboriginal participants spoke about was an increasing ability to relate more empathically to Aboriginal people, to be more consultative in approach and to know when to not take challenges personally.

I can relate more empathically. As the texts and theories that formed the basis for the course materials were derived from non-Aboriginal sources, cultural learning occurred through the discussions, case studies and role plays that centred on Aboriginal families and communities. The perspectives of non-Aboriginal group members on what they had experienced as effective approaches for working with client families greatly informed what was learnt.

It (the training) gave me some new insights into Aboriginal culture because some of the information that was shared by the other students was new to me...It was quite revealing and fascinating, and useful because now that I have some of this cultural knowledge I can relate more empathically.

Non-Aboriginal worker

The knowledge that was gained by the non-Aboriginal workers enabled them to more strongly advocate for their Aboriginal clients and to better understand the barriers to treatment that they face.

I get quite despondent at times about this, especially when advocating for clients who are on their healing journeys and the mainstream system that they depend upon has so little understanding of their struggles. The mainstream system can be so punitive! I think it's vital, that if we want to make any difference at all for Aboriginal people that mainstream get on board and get more information - It's definitely a knowledge which comes from doing that journey with Aboriginal people.

Non-Aboriginal worker

It's the way in which you do something. A significant learning for the non-Aboriginal workers was the necessity to employ a consultative approach with their Aboriginal colleagues and to respect their cultural expertise.

Completing the training has changed the way I work with my Indigenous peers. I listen more to the way they believe problems need to be tackled and I consult with them more often to find solutions. I'm learning to see things from their perspective and gaining a greater understanding of the issues as they see them. I have learned to adjust my dominant culture thinking to be more curious and less "know all"! I have developed a greater respect for the lived experiences of Aboriginal people, their resilience, their tolerance and the expertise that they possess about their culture. I'm learning that as a non-Indigenous worker I need to work in partnership with my Indigenous peers, to build trust in their communities and to support each other.

Non-Aboriginal worker

One worker described that she had learnt that if she attended to the proper cultural protocols when working in Aboriginal community she was likely to accomplish more because, *'it's the way in which you do something, it's not the actual tasks but it's how you do it'* that makes the difference. This is significant learning because it has been the processes implemented by many non-Aboriginal people and institutions that have served to exclude and discriminate against Aboriginal people.

I had to toughen up and stand up. Throughout the course of the training, non-Aboriginal worker practices were challenged and at times Aboriginal students expressed strong opinions around the cultural appropriateness of approaches adopted by their fellow students. One non-Aboriginal worker spoke about what it was like to be challenged:

There is great diversity in Aboriginal communities and even within the class...it was good for me to realise you can't generalise about a whole race of people, so it was good it stopped me having those stereotypes.

This worker also articulated the experience of other workers when she said,

Just because I am non-Aboriginal doesn't mean I can't have a voice, as that was how I was feeling...and I'm so eager to do it the right way for Aboriginal people that it kind of almost sucked out my essence as I was giving away myself in order to always trying to please...I had to toughen up and stand up, but I couldn't have done it without the support of other Aboriginal people on my team who said, "hold on, that's not right and you are right in what you are saying" and that made it OK.

Non-Aboriginal worker

This worker concluded that there were times when she needed to respect her own practice and judgement as long as she had support from members of the community who knew her practice well.

Aboriginal students also offered reassurance to the non-Aboriginal group members and supported them to be able to frame responses to their work in a systemic way. Non-Aboriginal workers became less defensive and took critical comments less negatively over the course of the training, recognising that a negative reaction need not always be taken personally as it could be *'about the system or because I represent a non-Aboriginal side and there is anger towards non-Aboriginal people, not me per se'* (non-Aboriginal Worker). This knowledge encouraged resilience in the non-Aboriginal workers so that they were not disheartened when their approach was not automatically acknowledged.

Summary

This chapter has highlighted both the context in which the Training was delivered and the ways in which the students perceived it to be culturally relevant. The prior educational experiences of the students and attitudes to education within their family and community were seen to influence access and engagement with training opportunities. The workers within this study demonstrate how it is possible to maintain integrity and respect in both Aboriginal and non-Aboriginal worlds though constraints exist and their reflections highlight the skills gained and the dilemmas that are faced.

Aboriginal students who participated in the research described how their previous experiences of mainstream education had been poor and that due to the lack of cultural safety and attendance to modes of learning and assessment that were culturally congruent, they had difficulty in engaging with the course material. The participants indicated that the trainers were

attentive to these past histories and sought to adapt the course in such a way as to be able engage and retain students in learning. Without a culturally sensitive approach being employed, no matter how potentially effective the family approaches being conveyed were, their ability to be implemented in the workers' context would have been greatly diminished. One of the significant successes of the Training Program was to create a bridge between Aboriginal and non-Aboriginal systems of knowledge and to discuss the similarities and abilities of both to benefit Aboriginal families and communities.

Workers identified a significant barrier to educational achievement present within their community, which was a narrowly prescribed version of Aboriginal identity that eschews mainstream society and its markers of success, including involvement in higher education. For workers to maintain respect both within Aboriginal community and in their professional roles was an ongoing difficulty. That the workers in this Training Program had found a way to navigate these alternate worlds, making them leaders within their communities and workplaces, added particular significance to their journey.

Gaining an education that provided relevant skills was described as a challenge by Aboriginal AOD workers, whether the course was provided by a mainstream or Aboriginal training provider. Some courses designed for Aboriginal workers were described as too 'dumbed down' to be useful or alternatively mainstream courses failed to be inclusive of Aboriginal students or provide the necessary support to address disadvantage.

The post Graduate Certificate in Family Therapy held cultural safety at its core in order to address the needs of students. Respect for the considerable experience of the workers was privileged over mainstream education qualifications in order to meet the entry requirements for a postgraduate course. Assessment processes were altered to acknowledge the Aboriginal workers oral tradition and practice knowledge through experiential assessments which minimised the written requirements of the course. The course was provided off campus in an intimate setting which students found less intimidating and the class size was reduced so that increased attention could be paid to group process.

The Black and White Approach, as developed by the Indigenous Program, includes an Aboriginal and non-Aboriginal trainer who enter into a dialogic process with the students, deconstructing and reconstructing mainstream ideas in light of their applicability and resonance for the students' work. This approach enabled a high degree of cultural safety to be maintained, creating an environment conducive to learning which retained students at higher rates than in many other training programs.

The Black and White Approach modelled a respectful cross-cultural way of working together where alternate knowledge systems and approaches to service provision interacted for mutual benefit. Knowledge sharing and discussion amongst the trainers and the Aboriginal and non-Aboriginal students provided a rich learning environment where workers were able to extend their knowledge and appreciation of each other's cultural practices. The workers felt this was important as it was necessary for them to work across both Aboriginal and non-Aboriginal service systems in order to provide the best outcomes for their clients.

- One of the significant successes of the Training Program has been to create a bridge between Aboriginal and non-Aboriginal systems of knowledge and to discuss the similarities and abilities of both to benefit Aboriginal families and communities where there was the problem of substance misuse.
- Workers faced considerable challenges in maintaining respect in their communities and in their professional contexts. The participants in this study were particularly adept at navigating these alternate worlds which highlighted their leadership abilities within their community and workplace.
- Without a culturally sensitive approach being employed, no matter how potentially effective the family approaches being conveyed were, their ability to be implemented in the worker's context would have been greatly diminished.
- The Black and White Approach utilised in the Training Program was found to create a culturally safe learning environment which engaged and retained students at higher rates than in many other training programs.
- Mainstream family therapy concepts were found to be applicable for the work of drug services in the field of Aboriginal substance misuse once they had been deconstructed and reconstructed in light of their applicability and resonance for the workers.
- The Black and White Approach was perceived as modelling a respectful cross-cultural way of working together where alternate knowledge systems and approaches to service provision interact for mutual benefit. The workers felt this was important as it was necessary for them to work across both Aboriginal and non-Aboriginal service systems in order to provide the best outcomes for their clients.

The following section will detail the Aboriginal AOD workers experience of what workplace support enabled them to utilise their family therapy skills and the opportunities and constraints to their career development.

Chapter 7 Family Therapy Training and the Workforce

Development of Drug Service Workers in the Field of Aboriginal Substance Misuse

The following chapter explores the significance of the training in terms of workforce development for drug service workers in the field of Aboriginal substance misuse and the ways the training impacted upon the services in which they are employed. The analysis contained in this chapter answers the research questions by demonstrating the need for the training and its usefulness for the alcohol and drug workers who undertook it and the extent to which the workers have been able to implement their family therapy skills. To contextualise the usefulness of the training as a workforce development strategy, the constraints to supporting and recognising the skills and qualifications of workers are outlined. Suggestions for changes within the service system are also proposed from the perspectives of workers, their managers and members of the Indigenous Program. These include principles and practices that would support family interventions within a service model that develops the strengths of workers, families and communities.

The need for Indigenous drug service workers to have access to a greater range of education and training opportunities has been articulated by a number of authors (Gray et al., 2004; Roche et al., 2013; Roche & Pidd, 2010; Rose, 2008). Though there has been shown to be a pressing need for culturally appropriate training for this workforce there is a lack of knowledge as to what constitutes effective training. This chapter contributes to understanding which factors, from training participants' perspectives, made the training relevant and to what extent the training could be implemented in the workers' professional context.

There is reportedly a lack of career pathways for drug service workers in the field of Aboriginal substance misuse, which the provision of appropriate education and training could serve to address (Gray et al., 2004; Phillips, 2003; Roche et al., 2013; Roche & Pidd, 2010). Many workers have not completed training involving counselling skills and, as Phillips (2003) has noted, without such training workers are not equipped to deal with the level of complexity that they often face. Many workers resort to 'in-house' and 'on the job' training where recognised qualifications are not provided. This makes movement into more senior roles more difficult (Gray et al., 2004). Where the data presented in this chapter contributes to the literature in the field is in detailing the advanced skills obtained through the post Graduate Certificate and how

the participants' perceive that these skills can be applied within an environment where barriers for the workforce development of drug service workers exist.

Several authors cite the importance of adequate remuneration of workers in this field and how currently workers do not receive salaries which accord with workers in similar roles in mainstream organisations or in other sectors (Duraisingam et al., 2006; Duraisingam et al., 2007; Gray et al., 2004). Though equitable remuneration is an important social justice issue which impacts on staff retention, additional means of acknowledgement of these workers are less accounted for within the literature. This chapter highlights participants' views on other methods by which acknowledgement and support can be attained which may impact on staff retention and wellbeing.

The Importance of Education and Training for Drug Service Workers in the Field of Aboriginal Substance Misuse

Participants spoke of the importance of education as a means of empowerment and as a way for workers' to acquire the necessary skills to acquit their roles in the AOD field.

Being educated gives empowerment to the people that you work with and the communities that you live in. The ability of education to empower individuals and communities has been a source of inspiration and motivation for those in the Indigenous Program. This knowledge motivates those in the Program to deliver the training and support the implementation of workers' family therapy skills in the workplace. One Team member, in previous research about the Training Program expressed how the provision of culturally relevant training benefitted the community surrounding a graduate;

"There's nothing more dangerous than an educated blackfella". And when I say that that's about how being educated empowers not only you as the person being educated but it gives empowerment to the people that you work with and the communities that you live in. That's what education is about.

(Perlesz & Proctor, 2009, p. 8)

Another member of the Indigenous Program described how educational empowerment was manifest through the creation of a platform on which people could make changes that enhanced their options and possibilities in life.

I come from a strong education background, both of my parents were teachers, my mother was a Phys. Ed. teacher and my father was a principal of a high school. So I've come from a background that says that education brings freedom, education brings

choice. Education is the most important thing you can give to a child...give them an education and you give them a choice about how they live their life...

Aboriginal Team member

The significance of a training program that provides cultural safety and relevance cannot be underestimated:

It's about more Aboriginal people getting nurtured because non-Indigenous people can get it any time they like and Blackfellas can't.

Aboriginal Team member

Learning the necessary skills. Though all of the workers interviewed had brought significant experience and skills to their positions they also recognised that it was beneficial for them and their colleagues to acquire further skills to augment and extend their knowledge. An Aboriginal trainer within the Indigenous Program noted that there was still a high degree of ex-substance users working in the field and, though they could draw on their own personal experience, they often did not have knowledge or experience to enable them to draw on other interventions. Further to this, an Aboriginal worker postulated that the reason for a high turnover of staff in the Aboriginal AOD sector was because many workers did not possess the necessary skills to acquit their roles. These included a lack of the written and administrative skills and the networking capacity to facilitate appropriate referrals. It was remarked that workers can be placed in positions for which they are not qualified or confident to deliver which can be disempowering and leave workers feeling inadequate and incompetent. An Aboriginal worker describes a specific context where;

They have dropped him in to do something that he isn't qualified for, doesn't have the skills for, but they give it to him so they can tick another box that says an Aboriginal is running the training.

Aboriginal worker

This practice, it was believed, discouraged people from taking on new roles or extending themselves after having had such an experience.

The Need for more Aboriginal Family Therapists, Clinicians and Workers within Mainstream and Aboriginal Controlled Organisations

A number of reasons were stated by participants as to why Aboriginal people needed to be more visible within health services including being in positions of power to exercise greater choice for

their community and providing culturally relevant and accessible services. Despite this, there is also benefits to having some services provided by non-Aboriginal workers who are not community members.

Access to roles where they can have a voice. The need for more Aboriginal people to be in positions of power and influence in the field of Aboriginal health was a common theme within the research. It was recognised that in order for this to occur, Aboriginal workers needed to be given appropriate recognition for their skills and experience and have access to relevant training opportunities.

(Until) we who have the power, privilege and entitlement seek to have people who are Black take over our roles there will be no Closing the Gap. So that our students get access to the roles within their organisation where they can have a voice, whether that is within mainstream or Indigenous orgs and within DHS.

Non-Aboriginal Program manager

A similar sentiment was echoed by an Aboriginal manager. He had experienced a paucity of Aboriginal people in senior or clinical positions and expressed that;

I'd love to see more Aboriginal people be qualified and knowledgeable and skilled-up...And not to say anything about non-Aboriginal people working here, but to have options so they [Aboriginal people] can work here or any mainstream place...to be in equal standing as other professionals to respond to families, that will bear some good outcomes.

Aboriginal manager

You can see that people are more comfortable talking to an Indigenous person.

There is general belief and recognition amongst workers and managers that Aboriginal people are most effective in helping Aboriginal families and communities work through the struggles that confront them as, *'Indigenous people feel more comfortable working with Indigenous people'* (Aboriginal Worker) and *'The more Aboriginal therapists we have the sooner we can work through all these issues in the community. It will make a big difference'* (Aboriginal Worker).

When considering that connection to culture is a protective factor in regards to substance misuse, it follows that Aboriginal workers and therapists are those who can best understand issues around Aboriginal identity and ways of connecting to culture. As one worker explained;

If you've grown up in care with non-Aboriginal carers to try and find that [connection to culture] from a non-Aboriginal counsellor, it ain't gonna happen. And you can't get that from NAIDOC week or special outings it's something that's inside you.

Aboriginal worker

Though a worker's Aboriginality creates increased opportunities for connection, safety and understanding with their clients it is not a given as one manager noted;

That's personality as well and we had an Indigenous male worker and it's not the same [his ability to engage with clients] but you can see that people are more comfortable talking to an Indigenous person.

Non-Aboriginal manager

Confidentiality can be an issue. Having non-Aboriginal workers employed to provide services to Aboriginal people, however, has some benefits. Workers and managers explained that confidentiality can be an issue for some clients when speaking to a professional who is also a member of their community and that for some it is preferable to speak to someone whom they do not know as this can reduce shame and embarrassment. This issue is discussed in more detail within the sections 'Working in Community', and 'Maintaining Respect in Two Worlds'.

Making all services more accessible and inclusive. Those interviewed felt that mainstream services needed to be more inclusive and welcoming of Aboriginal people. Within the context of AOD treatment it was recommended that increased numbers of Aboriginal people need to be employed in services including reception staff, withdrawal nurses, AOD and mental health counselling. This would also have the benefit of creating a more collegial and culturally safe workplace for Aboriginal staff members.

The Indigenous Program manager believed that cultural awareness had yet to be achieved in mainstream services. She reflected that;

I don't know in the mainstream world or in the wider world, both black and white are we yet at a point that Indigenous Australians can feel comfortable walking into a mainstream agency and know that they will be treated equal, and feel equal.

Non-Aboriginal Program manager

Many of those interviewed judged that in order for the health outcomes for Aboriginal people to begin to approach that of other populations, all services needed to be made accessible to them. An ACCO manager was ambivalent about the successful growth of his service because,

I never wanted this to be a one stop shop because part of reconciliation is getting people out in the general community and that people realise that Aboriginal people exist and they have certain ways of doing things and that they need to accommodate that in their practices as well. So having this one stop shop, is like no-one ever has to deal with Aboriginal people outside of this service, so it wasn't a very attractive thing for me.

Non-Aboriginal manager

Support and Recognition

There are systemic constraints to workers receiving adequate recognition for their family therapy qualifications. This originates from the way services are funded and administered and a racist legacy of marginalising and discrediting Aboriginal people's knowledge and expertise. Recognition was perceived by participants as being demonstrated through possibilities for career advancement, adequate remuneration and reasonable workloads. When this did not occur high staff turnover resulted.

Lack of career development, low wages and an unsustainable amount of work.

An Aboriginal manager recounted some of the reasons for the poor retention rate of workers within the Aboriginal AOD sector;

I could easily name a dozen people at other ACCOs who have left because of lack of career development, low wages and the amount of work that was unsustainable...for the sake of their well-being they have to leave.

Aboriginal manager

For many Aboriginal workers in the health field there is a lack of incentive to increase their qualifications as they do not receive an increase in remuneration. Aboriginal workers explain that;

It's the way it's funded they don't really allow for growth and you know you get a job and you can do all the training you want or whether it's certified or not it doesn't change how you are paid or how you are recognised in that role.

Aboriginal worker

Many workers and managers reported inconsistency in pay rates for Aboriginal workers between mainstream and Indigenous organisations and that the demands of their work were not commensurate with how they are remunerated;

For me it's the harsh reality that to work with an Aboriginal organisation I have to accept I am going to get a lower wage than if I was employed in an equivalent mainstream service and also the challenges are different, more complex and then you are probably going to have a bigger case load.

Aboriginal manager

Workers reported that disparities in pay rates between identical and similar positions also resulted from funding originating from various government departments and coming under separate awards.

All that burn-out has a lot to do with that. A lack of recognition has an effect on worker satisfaction with their roles and one worker postulated that people leave the sector because;

The knowledge they have and all the skills we have that aren't recognised that aren't acknowledged. And I think all that burn-out has a lot to do with that. The non-recognition of skills.

Aboriginal worker

Aboriginal workers spoke of the need for their colleagues to receive adequate recognition especially those who had spent years in the sector but still did not possess a minimum qualification of a Certificate IV. Without this qualification people's self-esteem and perceived value in the sector could be diminished, making it harder for people to move across services. An Aboriginal worker observed that;

They always set the bar too high for Indigenous people to get recognition. Do you know at the last Telkaya¹⁵ meeting, how many people who have done their Cert IV and there was a hundred of us?...4!

Aboriginal worker

An Aboriginal worker expressed that the decreased possibilities for career advancement served to marginalise workers. As there was a shortage of Aboriginal workers with both the experience and qualifications to acquit roles within the sector, it was important to recognise and adequately support and them.

¹⁵ Telkaya is a Koori Alcohol and Other Drug Network which convenes for two days quarterly for professional development and networking in the state of Victoria.

There are no jobs. Many ACCO's are not funded for family therapy programs, hence, there are not the positions available to employ graduates as family therapists. An Aboriginal Team member conveyed that whilst consulting with a number of ACCOs he had experienced reticence from management to support the training program because *'there are no family therapy positions in place and so whilst there is the training, there are no jobs, so that is a constraint from a community perspective'* (Aboriginal Team member).

Family therapy could provide a central component of care for complex families experiencing the effects of transgenerational trauma across a number of domains. An Aboriginal worker describes how family therapy can create space for families to understand the effects of trauma on parenting practices and child behaviour;

Teaching parenting skills, teaching people how to cope...because what I see coming through here is a direct result of transgenerational knock on, of someone who has picked up the same coping style as Mum or Dad. So what I have noticed, in the few family therapy sessions I have practiced on, it's been really interesting for them to realise there are these patterns that are contributing to the dysfunction [in their child]...It would need a lot of people out there doing family therapy and a lot more support workers on the ground to link in and support the family therapists with all the issues that are going on. Because quite a lot of those families here are really in chaos...so housing's not working and D&A is an issue and there's DV and kids aren't going to school - it's that whole knock on effect, it needs a team.

Aboriginal worker

Many of the workers undertaking the training are not employed in counselling positions and the Aboriginal organisations in which they are employed do not offer identified counselling services. This makes it difficult for managers to support their workers to see families in order to practice their family therapy skills. The Indigenous Program manager outlines some of the limitations;

You have to create new positions and they don't have the funding for it and it isn't part of the tender and it would have to sit somewhere and if you talk to the CEO from a large ACCO, there is nowhere for it to sit and they often don't even have counsellors and they outsource to non-Indigenous counsellors and therapists.

Non-Aboriginal Program manager

Tenders submitted by managers for AOD and other health programs often do not include family counselling or therapy positions nor do they adequately factor in the need for professional development of workers. For workers to be supported to complete further education, tenders

need to include the cost of back-fill for workers and the clinical supervision in family therapy for workers who have completed the training. The Indigenous Program manager recognises that;

They (ACCOs) are not funded for family therapy work and so it is about educating the funders and working with them when they write their tenders for the next five years of funding to make sure they get a family therapy program, which is going to be complex and difficult.

Non-Aboriginal Program manager

Without the support for the training program from Aboriginal organisations a vicious cycle is created where government departments are reticent to provide recurrent funding for the program and without workers continuing to graduate from the course the profile and credibility of the course is eroded.

Career Pathways. In order to increase the value of the qualification within the service system, an alternate pathway within the Australian Association of Family Therapy (AAFT) was sought for Indigenous graduates of the Program to gain clinical membership within the Association. Graduates need to complete an additional 26 days of approved training along with 50 hours of clinical supervision in family therapy. Those graduating from the mainstream post Graduate Certificate would not be afforded this opportunity and would need to have completed a further two years within a family therapy postgraduate program along with the 50 hours of clinical supervision. This initiative, though valuable, does not immediately provide graduates with recognition as qualified family therapists on completing the course. This can be a source of disappointment for graduates as their qualification is not automatically recognised within a counselling or psychotherapy association.

Mainstream graduates of family therapy training also experience a lack of funded family therapist positions in which to utilise their skills, though the barriers facing the Indigenous workers graduating from this training are perceived by participants as greater.

In order to enact the values and beliefs underpinning the training as a workforce development strategy the Indigenous Program at the Bouverie Centre employed a past graduate of the training program as a family therapist, cultural consultant and trainer. This position is just one of two family therapist positions in which graduates from the program have been employed¹⁶. Graduates from the cohort that this research is focussed on have progressed their careers with

¹⁶ Another graduate of the training program is employed on a part-time basis at and ACCO as a family therapist.

three graduates moving into team leader and management positions. This signals recognition from within their agencies for the workers' ability to work systemically.

Qualifications and Worker Skills. Significant cultural change needs to occur within both the mainstream and Aboriginal service systems to enable Aboriginal workers to chart career paths in family therapy. Some of the changes that need to occur from participant perspectives are regular clinical supervision, recognition for worker qualifications and Indigenous education to be of a high standard.

Clinical supervision. Though most of the workers interviewed felt supported by management, what was commonly lacking in regard to their continued professional development was the provision of clinical supervision in family therapy. In most services this could not be provided in-house as others in the organisations did not hold family therapy qualifications. Workers explained that;

The supervision is more on the D&A side and it is pretty good. I'd still prefer someone who's worked within this family therapy.

Aboriginal worker

I've had none - I mean in their policy and procedures we're supposed to have clinical supervision every two weeks!

Non-Aboriginal worker

Degrees are the yardsticks. Many workers interviewed reported that they were often questioned about their qualifications, particularly in mainstream services and government departmental meetings and it was felt that this served to undermine the workers' right to advocate for their clients and assert their professional judgement;

If they [Aboriginal workers] don't have that piece of paper they can get talked down to, like doctors can. I don't say what I've done, but then someone will say, "He's a counsellor" and they'll say, "I didn't realise - where did you train?" and I'll say "James Cook University" and their whole attitude changes...

Aboriginal worker

...especially when I worked with Aboriginal kids in foster care because I had a white manager and she was constantly questioning me about the things that I had done. And me not really understanding why she was doing that, but feeling like she was undermining me all the time...and it is very much about not having any qualifications.

Aboriginal worker

These quotes highlight the racism and discrimination that Aboriginal workers regularly experience, as well as the increasing focus within mainstream society upon qualifications. A number of workers stressed that they would not have undertaken the training unless it was university accredited because of their prior experience of completing training programs that afforded no recognition within the sector. For the majority of workers who did not already possess an undergraduate degree in social work or psychology, the qualification held particular significance.

Without Aboriginal workers trained at university level, it is unlikely in this current climate that workers will receive the recognition for their skills, expertise and outcomes with their clients. As an Aboriginal Team member noted; *'Degrees are the yardsticks of employment in our society, good bad or indifferent that's the way it is'.*

Lowering the bar is a measure of the lecturer not the student. Some Indigenous specific courses have, according to Aboriginal workers and Aboriginal members of the Indigenous Program lowered course standards in order for students to more easily attain qualifications. When this occurs, qualifications are devalued as graduates find they are not equipped with the skills and knowledge anticipated as accruing from a training program.

Indigenous Program staff and workers stressed the need for Indigenous-specific education to be of a high standard. This requires educational institutions and training providers to take time to institute learning methods that are both culturally safe and relevant. An Aboriginal staff member emphasises:

Lowering the bar is a measure of the lecturer not the student and I've seen Indigenous and non-Indigenous lecturers lower the bar...When I worked at IKE¹⁷...I raised the bar so high and the students just sailed over it.

Aboriginal Team member

¹⁷ Institute of Koori Education, Deakin University.

As this research was conducted during and not long after the formal part of the Training Program was completed¹⁸ a full assessment of whether the training qualification provided the degree of recognition that was anticipated cannot be fully gauged. What is known is that past graduates have reported that recognition for the qualification is inconsistent and that they have encountered the view that the training is not valued as highly as the mainstream post Graduate Certificate in Family Therapy. This could be accounted for by the low regard some hold for the standard of Indigenous specific training and a pervasive difficulty within Australian society in recognising the authority of Aboriginal people.

Educating the System. Participants observed that another constraint to graduates of the Training Program receiving adequate recognition is lack of understanding about what family therapy is and what it can achieve from funding bodies, service management, colleagues and clients. One worker agreed that;

The organisation and staff needs to understand the benefits of family therapy and what that actually means and how that translates to my role of AOD counsellor. Changing the emphasis of my role would need some promotional literature around what I can do and to encourage families to seek that support.

Non-Aboriginal worker

Feedback from some of the ACCOs has been that *'there is a lack of respect for family therapy as they see it as coming from a white perspective'* (Aboriginal Team member). It is possible, through the testimony of graduates, that management at ACCOs could come to understand that Aboriginal workers make a substantial contribution to the content of the training. Through the incorporation of their knowledge and practices into the educational process, the family therapy training becomes a *'white meets black way'* (Aboriginal Team member). When utilised by Aboriginal workers who have completed the training, family therapy can be perceived as embodying a family healing, holistic approach which has cultural relevance and significance for Aboriginal organisations and communities.

Family therapy is going to change the way we do things around here. The majority of managers interviewed possessed a systemic understanding of how health issues develop and are maintained and they expressed a desire to have family therapy approaches influence service delivery;

¹⁸ The training program comprises one year of formal training and two years of supervision to support the implementation of the students' family therapy skills.

Family therapy is going to change the way we do things around here as some of the services we have here are very individualised like medical or physiotherapy, they are very much in the old way of working. The medical model you see the individual, you see the diagnosis, you see the treatment which is all related to that one individual. So changing that focus I think is where we are headed, as we are talking about systemic change...that's not just about looking at the individual, it's about looking at the risk factors, at the environment and where they're at, which includes the family.

Non-Aboriginal manager

Training in family inclusive practices, coupled with an understanding of a social model of health, were recommended by managers to improve intake systems so that appropriate referrals could be made to address the individual's context and support systems. A manager explained that;

I've always been pushing to include families across all programs...You have to be realistic about what can you do, but even if it's about the clinicians asking a few questions about the clients support systems in the family and then they can refer to the counselling team if they need to. There's things, like in podiatry where people can't get their feet right because of problems in the family. I used to see a woman taking her husband in a wheel chair and I'd think, I know what you are thinking! I wonder how she's coping, whether she gets depressed? A whole myriad of things - who picks up on that?

Non-Aboriginal manager

If services were to become more family inclusive, program managers believed that a culture more conducive to the employment of family therapists would be the result. However, as this was not current practice a dilemma existed for the Indigenous Program and for the services employing the graduates. The workers wish to have the opportunity to practice their skills with families at their services and also be paid more in recognition of their increased qualifications. The services realise that they are at risk of losing their workers to other programs unless they can provide adequate recognition either through increased opportunities to work with families, pay increases, changes to job description, a way to count the work statistically or other professional opportunities for them to chart a career path. The Department of Health is also aware that many AOD positions are funded to a lesser extent than comparable positions in other fields of health and that the demand for Aboriginal workers possessing a high degree of skill and qualifications is great. So the maxim is train them, but not too much as otherwise they will leave the sector. This poses a difficulty as the AOD workforce is requiring a higher minimum level qualification and the stated aims of current AOD policy will have difficulty in being achieved

without a workforce who possess a range of skills to deal with the complex clients requiring AOD services.

Worker Recognition within the Service System

Participants in the research reported that worker recognition for their ability to implement family interventions needed to occur through management seeking to provide opportunities for their graduates to utilise their skills. Participants also felt they needed opportunities to demonstrate to their colleagues their ability to undertake family work.

If she wants to go with it, we have to support her. Within the constraints of service structures managers had, for the most part, sought opportunities for their workers to practice their family therapy skills and explore with their colleagues the possibilities for family interventions within their services. These managers had invested significantly by allowing workers to attend the training and by agreeing to be interviewed. However, this commitment had not always translated into satisfactory opportunities for skill development as determined by previous graduates (Latham, 2012). It should be noted that of the four managers interviewed, only one was Aboriginal. This reflects the lack of Aboriginal people in senior and management positions.

Workers from the Metro cohort were employed in services across the state of Victoria in contrast to prior trainings where the training was located within a particular community where workers familiar with each other and their services. The diversity of locations from which the Metro cohort was drawn decreased the impact of the training in some regards as there were less workers from each of the services making it more difficult for the workers to advocate and support each other around their skill development. A manager expressed that;

The support is probably one of the biggest concerns I have is that she [Aboriginal worker] isn't isolated as the only family therapist here and that others need to come on board...And being able to fully establish it and cement that into our core business, as right now we don't really have the resources to do it.

Non-Aboriginal manager

Within all the services, it was reported that managers played an active role in recruiting and encouraging staff to do the training. In one instance a worker was told she needed to get a counselling qualification and she chose family therapy training over other generalist qualifications. In the other participating services managers had actively encouraged particular

workers whom they believed could benefit from undertaking the training. One manager expressed that;

If you can see a little twinkle in the eye you really need to pick up on that and reinforce it. Not pandering to their egos but let them think about it and say, "Yeah, you can do it!"

Non-Aboriginal manager

They've have been very supportive from the start and if it hadn't have been for my manager I wouldn't have done it.

Aboriginal worker

Management selected workers for whom they already had a high regard and wished to retain at their service. The high demand for skilled Aboriginal staff increased the need to provide opportunities for professional development and a degree of flexibility in worker roles to enable them to utilise their skills.

Because she has been studying it she does need the opportunity to put it into practice. If she wants to go with it we have to support her.

Non-Aboriginal manager

We were talking about stats and how that [family work] is recorded and sometimes that does and sometimes doesn't fit for her program but she is quite happy to put it under our counselling, consultancy and continuing care (CCCCs) program.

Non-Aboriginal manager

In order to document the effect of utilising family interventions with AOD clients, management recognised that they would need to implement their own evaluative methods as current reporting requirements would not capture the effect of incorporating family interventions into treatment. This represents a major constraint to the incorporation of family therapy into AOD practice.

In another service, the training of workers in family therapy skills coincided with a wish to provide clients with more opportunities for therapeutic interventions. Two workers had completed the training from this service though they had disparate experiences surrounding the degree of support they had been afforded. One reported that there had been encouragement and opportunities for him to implement his family therapy skills whereas the other staff member had felt hampered in his attempts.

It is up to the students to actually prove they have the capacity. Referrals and support for the incorporation of family interventions at services could also be enhanced through graduates promoting the benefits of family work. Two of the managers were also keen to establish in-service training where workers would have a forum to discuss the training, how it related to their work and applications for family interventions across the service. An Indigenous Team member stressed that;

It is up to the students to actually prove to their communities that they have the capacity and the capability to do family therapy work...and that is going to take time.

Non-Aboriginal Program manager

Over the course of the research a significant shift occurred for this non-Aboriginal worker regarding the respect she had amongst her colleagues;

I have noticed that the GP's and other clinicians make more referrals to me for generalist counselling as well as AOD work. And my AOD colleague who questioned my counselling credentials when she first started is now suggesting that she will be referring families to work with me. It's become accepted within the Social Emotional Wellbeing team that if someone's got family issues they refer them to me.

Non-Aboriginal worker

Her role also changed from that of being a drug and alcohol counsellor to being called simply 'the counsellor'. The rationale for this change was that a more generic title could decrease shame or embarrassment for people who wished to access the service but were concerned about the stigma attached to substance misuse. It also reflected an increase in credibility for the worker and their ability to attend to the complexity of issues surrounding substance misuse. The worker explained that;

My colleagues are really able to define my role and their role and if it is counselling, that quite clearly goes to me, whereas that wasn't happening before...The clinical team, the doctors and nurses with no hesitation are referring clients...and I don't know perhaps they have more faith in my ability to do it.

Non-Aboriginal worker

It is not known if the kudos and respect afforded to this worker would have occurred if she had been Aboriginal, as in previous cohorts Aboriginal workers tended to receive less recognition and opportunities for advancement than their non-Aboriginal counterparts (Latham, 2012). In this training however, three of the four Aboriginal workers participating in the research received

promotions whilst they were undertaking the course and the other worker had increased her profile within the sector and was now receiving referrals that involved family work.

Both Aboriginal and non-Aboriginal participants commented that they had experienced an increase in requests for secondary consultation from within their service and had on occasions conducted family meetings alongside their colleagues from other programs.

Within the broader service system workers had experienced increased referrals from a range of agencies. One worker stated, that she was now being referred '*whole families for treatment*' (Aboriginal Worker) and another worker had found that his knowledge and skills were being recognised across a number of forums;

I have had acknowledgement from DHS workers that I have learnt things in the course and that my new skills and knowledge are valuable to them. I go to Corrections with a client...his children have been fairly traumatised and they were just having a normal counsellor seeing the children. I suggested, "Why can't we get family therapists in to do family therapy with them?" That was tabled and is now going to go ahead. I've also had a couple of people come out from DHS and we were talking about children and I started talking around trauma and family and it really opened their eyes up. One of them has experience with trauma and they told me that they could see I was learning a lot in the course.

Non-Aboriginal worker

Though workers appreciated the increased recognition, along with it also came added responsibilities for it was observed that '*the reward for good work you do is more work*' (Aboriginal worker). One worker found that;

People are always asking, "Can you do this or have a look at that?" And that's happening constantly at work now. Like recently I had to organise a detox tour and discussion and had to facilitate that. Like I'm already getting all these extra things put on me.

Aboriginal worker

Impact on Service Culture

The research processes were seen to impact positively on workplace culture and, according to managers, workers who had undertaken the training contributed positively towards workplace culture through acting as role models for other staff and by advocating the needs of families.

It has really got us all thinking about really where to from here. According to one worker, a factor that was important in increasing the profile of the training was the research visits made by the co-researcher and myself.

I really feel that without that it wouldn't have had this kind of focus at all and OK I've gone off and done the training and I've got my Certificate and I've come back and well just that nothing would have changed. The fact that you've both come twice and you've followed up and done the research and it has really got us all thinking about really where to from here and what has been the impact of doing the training and it has really helped to keep the spotlight on it.

Non-Aboriginal worker

A champion for change. Managers noted that workers participating in the training were a positive force within their organisations and acted as role models for other staff. As one manager illustrated;

When she comes back from the training she is pumped up about it you know?! Well, that just filters down to other staff members and then what she ends up doing and she doesn't even realise, that she becomes a champion for change within the organisation. Because other people think, "I'd like to do that!". And it's about up-skilling the staff so they can not only provide a better service, but so they get something out of it. And being a better human being and that they are contributing members of society rather than just coming to work and doing a job and getting a pay packet. And they value what they are doing and I think once you get a staff member who really loves what they are doing and values what they are doing, they are easy to manage, that's my agenda!

Non-Aboriginal manager

Workers graduating from the program have also reportedly proposed changes to service delivery and have initiated conversations around the importance of services increasing their investment in cultural programs, including men's and women's groups that build social support and create environments conducive to change. One worker highlighted a program which she believed could serve to build community and engage clients with counselling and family work;

A men's group and they would go fishing and then one of the health workers would go and they would just sit down and they might have a yarn about some of the issues they were having or sexual health issues. So I have thought about trying to get a fishing group going as part of relapse prevention get them out get them connected. So I would imagine

just being part of the group and just having a yarn with them about different things that might come up. Like if they had problems with their family, I would say, "Well I could sit down with you and your family".

Non-Aboriginal worker

It was perceived by managers that as a result of participating in the training, workers took a greater pride and ownership of their roles which increased worker satisfaction and efficacy.

Seeing the individual as part of a greater community. One of the managers working at an ACCO had noticed the increasing frequency of a worker advocating the needs of the families. This meant for him that he had an ally in increasing the services awareness of family and community needs. He expressed,

...that sense of importance around connecting other people to the individual, like it is ingrained in her [the worker's] thinking now to see the individual as part of a greater community and that is really important I think in creating sustainable change within the environment, within the community, within the family.

Non-Aboriginal manager

Summary

This chapter has discussed the impact of the training as a workforce development strategy and the mechanisms within the service system that constrain and enable career pathways for Aboriginal AOD workers. The influence of the training has been experienced through changes to workplace practice and culture and workers have contributed to discussion and reflection on the capacity of services to respond to the needs of families. Attention to the capacity of workers to utilise family therapy skills within the workplace has highlighted barriers within the broader service system and suggestions have been made as to changes that could better serve the needs of workers and their clients.

A common area of concern for the AOD workers participating in the research was the lack of recognition they and their colleagues received within the public health field for the cultural knowledge they possessed and the practice wisdom they had developed over years of providing health services to Aboriginal people. As many workers in the Aboriginal AOD field did not have formal qualifications, their ability to move freely between Aboriginal and non-Aboriginal organisations and command senior positions, exercise authority and receive adequate remuneration was greatly restricted.

The postgraduate qualification was seen by the AOD workers as an acknowledgement of their authority in their current roles and as a means to further career pathways. Workers agreed that culturally appropriate and relevant training needed to be more readily available for their colleagues, in order to equip workers for their roles, extend their skills and work systemically across Aboriginal and non-Aboriginal service systems.

The effectiveness of the family therapy training as a workforce development strategy for Aboriginal AOD workers was hampered by a number of issues. Family therapy is not widely known or understood within the Aboriginal service sector so that the social and emotional wellbeing factors it can usefully address, including AOD issues, are not fully appreciated. This means that the graduates and their managers are often in a position of needing to educate in order for recognition to be afforded to their clinical skills. Secondly, many ACCOs do not have funded clinical positions so a good deal of flexibility is needed by management in order to provide graduates with opportunities to practice what they have learnt. Clinical supervision is often not provided so that workers wishing to progress their family therapy skills towards clinical membership within AAFT are constrained.

Within ACCOs and mainstream organisations there are very few family therapy positions, so graduates are unlikely to take up such roles on the completion of training. What has occurred in previous cohorts and also with the Metro group, has been that some of the graduates' systemic understandings are recognised in terms of increased responsibilities and promotions into senior and management roles, but not recognised formally within changed position descriptions.

Another constraining factor for the graduates implementing skills acquired in the Training Program is that family work is often not counted within reporting systems. This means that managers and workers need to balance program targets with the desire to work with families.

Managers reported that workplaces were positively impacted through having workers trained in family therapy. The graduates were utilised more frequently for secondary consults and some who had previously limited experience presenting at in-services or conferences, had gained the confidence to do so. Another positive impact which was noted was the enthusiasm for family therapy and the training program which appeared to improve the workers' overall satisfaction with their roles and acted as a source of inspiration for other staff members.

- Workers perceived a lack of recognition within the public health field for the cultural knowledge they possessed and the practice wisdom they had developed over years of providing health services to Aboriginal people.

- The postgraduate qualification was seen by the AOD workers as an acknowledgement of their authority in their current roles and as a means to further their career pathways.
- Workers and their managers agreed that culturally appropriate and relevant training needed to be more readily available for their colleagues so that they were better equipped for their positions through having their skills extended and increasing the ability to work systemically across Aboriginal and non-Aboriginal service systems. Family therapy training was thought to be effective in this context.
- The effectiveness of the family therapy training as a workforce development strategy for Aboriginal AOD workers was hampered in a number of ways:
 - Family therapy is not widely known or understood within the Aboriginal service sector so workers often need to educate their services and the systems around them in order for recognition to be afforded to their clinical skills.
 - Many ACCOs do not have funded clinical positions nor do funded family therapy positions exist in Aboriginal organisations and are rare in mainstream services so career pathways are not established.
 - Management need to exercise a good deal of flexibility in order to provide graduates with opportunities to practice what they have learnt in the training program.
 - Family work is often not counted within reporting systems meaning that workers balance their desire to conduct family work with high caseloads and the need to meet targets.
 - Clinical supervision in this environment is often not provided so that workers struggle to find the support to progress their skills and meet the requirements for registration the national body for family therapists (AAFT).
- Though the opportunities for the AOD graduates to take up family therapist positions are limited, their systemic understandings have been recognised in terms of increased responsibilities and promotions to senior and management roles.
- Workplaces were positively impacted through having workers trained in family therapy with managers recounting how workers:

- were utilised more frequently by colleagues for secondary consults.
- had gained in confidence to present at in-services and conferences.
- workers' overall satisfaction with their roles appeared to improve as a result of the family therapy training.
- workers were a source of inspiration for other staff members.

Chapter 8 The Black and White Approach and the Indigenous Program

This chapter will focus upon the journey of the Indigenous Program through the development of the Training Program and the model for collaborative practice with services and amongst its Team members. Previous discussion has shown the ways in which the training team collaborated with the students through the 'Black and White Approach'. Now attention will shift to how this approach was supported by practices within the Indigenous Program. The underpinning principles which serve to guide the work of the Indigenous Program relate to the research questions through explicating how collaborative processes can be developed within Aboriginal health and education to deliver family therapy training and family based interventions. The collaborative processes are of interest more broadly as they reflect a crucial component of reconciliation including the capacity of mainstream organisations to build and maintain relationships with Aboriginal organisations. The example of the Bouverie Centre's Indigenous Program is of particular significance given that the Bouverie Centre, prior to receiving funding to provide training for Aboriginal healthworkers, was a mainstream organisation with a limited record of providing services to Aboriginal people.

When considering the ways that partnerships can occur between Aboriginal and non-Aboriginal people, the Royal Commission into Aboriginal Deaths in Custody made clear how the right of Aboriginal people to exercise maximum control over their lives was necessary to improve their health outcomes (Johnston & RCIADIC, 1991). For this to be evident within the 'Black and White Approach' (as it pertains to relationships between Team members and other organisations) the authority of Aboriginal people needs to be exercised within all decision making which affects them.

The 'Black and White Approach' can be seen to have its antecedents in 'both-way' learning where both Aboriginal and non-Aboriginal knowledges are respected and drawn upon (McConvell, 1982) and where a genuine exchange can occur (Dudgeon & Fielder, 2006). This type of learning and exchange can occur within education and also across organisations, communities and between individuals. This chapter contributes to accounting for the way this learning and exchange can be enacted between people and services.

A cross-cultural way of working has been described by Woods (2000) as *Malparara*. In the context of the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council in South Australia a non-Aboriginal person who possesses certain professional skills works alongside a senior Aboriginal person who has the understanding and cultural knowledge surrounding the

needs of Aboriginal communities. The relationship facilitates the delivery of projects and services and locates Aboriginal people centrally in the design and implementation of the work with non-Aboriginal people providing necessary skills, knowledge and navigation of mainstream systems (Woods et al., 2000). The Black and White Approach similarly involves Aboriginal and non-Aboriginal people working side by side and this chapter elucidates how within an urban setting those employed in a non-Aboriginal service sought to develop and maintain such relationships. This is of great importance as effective partnerships can enable Aboriginal advancement in a contemporary Australian context.

Program Development

The Program's development reflects how support was gained at a grassroots level for the program. This was gained through the commitment and support of Aboriginal Team members and from the executive level at the Bouverie Centre who demonstrated a capacity to listen and respond to stakeholders.

Garnering grassroots support. Concerns by both Aboriginal and non-Aboriginal organisations surrounding the desirability of a mainstream organisation receiving money for the training of Aboriginal healthworkers provided difficulties, initially, in garnering support for the Program. Prior to the Indigenous Program being formed issues were present surrounding the need to consult and include Aboriginal people in decision making when there were no Aboriginal staff members employed at the Bouverie and limited relationships existed between the Bouverie Centre and Aboriginal organisations. However, there had been a partnership between the Indigenous Gathering Place, Footscray and the Bouverie Centre to provide an outreach family therapy program for twelve months immediately prior to the development of the Program.

In recognition of the difficulties in getting the Program started, the then director of the Bouverie Centre recruited the current Indigenous Program manager to consult with the Team. The describes how,

I was drawn into the Program when [the Director of the Bouverie Centre] asked me to do it because of the action research component, as I'd previously been able to get the Breaking Through Project up and running in what is a pretty difficult environment, schools...he seemed to think my hubris was right, that somehow you could translate that capacity for grassroots support to something else that could be difficult to get grassroots support for.

Indigenous Program manager

The Indigenous Program Manager's expertise in being able to harness support for a project that had not been initiated from within Community translated to the convening of an Advisory Group composed of Aboriginal and non-Aboriginal people from the field of Aboriginal health and education and the forming of a partnership with the Take Two Aboriginal Team. Take Two exists within Berry Street, a mainstream organisation in partnership with the Victorian Aboriginal Child Care Agency (VACCA). The Team Leader of the Aboriginal Team at Take Two was recruited to act as cultural consultant and, as an Indigenous man with respect from many quarters of Aboriginal community, the Program began to assume some semblance of credibility.

I owe it to community and you put the effort into meeting with me and listening. A Bouverie Centre staff member was teamed with the Team Leader from Take Two to deliver what was initially a Certificate in Family Therapy to Aboriginal workers in Shepparton. The Bouverie Centre staff member had extensive experience as an educator and family therapist but had not worked in the field of Aboriginal education. On commencement of the training she encountered a steep learning curve requiring an alternate approach to teaching, and the level of qualification needed to increase if the workers were to remain engaged in the process. It was the ability of the then Indigenous Program manager and other Bouverie Centre staff to respond to the needs of the students and the Advisory Group which generated a commitment from the Take Two Team Leader. The current Indigenous Program Manager recalls,

It was the conversations he [Team Leader Take Two] had with the Bouverie staff member and trainer and that we three had together, and my memory of it was that he said, "because I owe it to community to make this work and because you put the effort into meeting with me and listening to what I think needs to be done, we'll give it a go". So the first two nightmare sessions happened at the end of 2007 and we met over January and he was willing to stay with the commitment to the group, not to us but to the group...and over the three months between December and March...we had managed to get La Trobe [University] to agree to make it a postgrad and the Bouverie trainer and I met with the Take Two Team Leader and agreed on another way of teaching – and it worked. So once the Bouverie trainer began teaching in this way then the Take Two Team Leader became a student, because once it was a postgrad he wanted to get the qualification and by then he was absolutely committed and he was both a student and a consultant in the training

Indigenous Program Manager

Having gained a level of support from the students and from the newly recruited Team Leader from Take Two for the direction of the training other Aboriginal staff members were employed

including an Indigenous researcher and, a year later, an Aboriginal consultant, trainer and emerging family therapist. The non-Aboriginal members of the Team had learnt valuable lessons in consultation, collaboration and the need to listen and respond to the needs of Aboriginal stakeholders.

We don't need a piece of paper. The ability of the Team to weather difficult conversations and challenges to their approach and then to find a way to attend to the needs of the workers and the university was critical to the Program. A non-Aboriginal Team trainer conveyed that,

When I went to Shep [Shepparton] they [Aboriginal workers] said, "What are you delivering?" and "What will we get at the end of that?". And it's the first time for me...and for Bouverie, it was pretty humbling... and they said, "We don't need a piece of paper". So basically they couldn't see the point of coming for ten weeks and on the spot I said "Well you could do the Graduate Certificate"...and they said "What does that mean?". "That you have to do 26 weeks" and they said "Oh no we haven't done anything like that"... and I started selling the idea of a Grad Cert course and that, "you could do exactly what mainstream students do but this is an Indigenous mob so we'd have to adapt it to an Indigenous curriculum and we could do that together". And it was really hard to walk that line of how to be relevant to an Indigenous community but also to (meet the requirements of a post Graduate Certificate)...there was a lot of anxiety about it...(the writing requirements) and we did a lot of thinking about it ...and a colleague at another university said to me "You can do a spoken essay and you can say these are the areas you need to cover and they can see a transcript and make any changes" and that seemed like a really good idea...

Non-Aboriginal trainer

The changes to the assessments tasks that were to be part of a culturally relevant post Graduate Certificate in Family Therapy for Aboriginal Child and Family Workers needed to be agreed to by La Trobe University. It took the then Research Program Manager's knowledge of the university system and ability as an advocate, to argue for equitable access to education for Aboriginal people. The amendments were agreed to within a relatively short period of time in order to begin the training as agreed with the Shepparton cohort.

His passion has really made a difference. The commitment displayed by the Program staff to find a way to deliver a recognised university award course in a culturally relevant way was supported by the new director of Bouverie Centre who came to the position in

2009. He gifted his office, which was located centrally within the Bouverie Centre, to the Indigenous Team. The significance of this gesture was felt by an Aboriginal Team member;

We asked the Director of the Bouverie Centre for his office and he didn't bat an eyelid he didn't even have to think about it. He just said, "that's a great idea, here's \$2,000 to get the furniture". It was a huge metaphor from him, it was more than that...we needed a place where we could all be together as we were all over the place and part-time.

Aboriginal Team member

The support from the executive level of the organisation helped to garner commitment from those in the Team as;

His [Director of the Bouverie Centre] backing us and his respect, his passion has really made a difference, because if the top person isn't there, forget it! And that it's important that the head person doesn't think they know what it's like to be an Aboriginal – because if you're not, then you don't!

Aboriginal Team member

The commitment that the Aboriginal workers have made. Having Aboriginal members of the Team possessing belief in the integrity and usefulness of the Program has made the difficulties encountered worth enduring as the current Indigenous Program Manager explains;

What kept me in there...was [the Aboriginal trainer's] confidence in me and his confidence in us as a Team and his commitment to doing the training, and that continues to keep me here, mainly the commitment that the Aboriginal workers have made to this particular agency. I would find it very hard to walk away...but because of the commitment they have made and I now know what a huge commitment it is – huge!

Indigenous Program Manager

It has been recognised that without the support of Aboriginal members of the Team it would not have been possible to engage Aboriginal organisations in consultations about the training:

I reckon if [the Aboriginal trainer] wasn't as respected as he is, there would be no way we would be invited into any of these organisations, it's about the respect they have for him not about anything that we did. The thing that we did was to engage with [the Aboriginal trainer] and he then has vouched for us and then our training has vouched for us and the students have vouched for us and now the [new Aboriginal trainer] and that is where we have got our credibility.

It's because she is a family therapist and because he does so much behind the scenes. It has been both the experience and skill of the educators along with knowledge and connection to Aboriginal community that has helped students to maintain their substantial commitment to the training. As an Aboriginal Team member explains,

[The non-Aboriginal trainer] is a highly skilled trainer: I've seen her time and time again get a clumsily asked question and reframe it and up the stakes in such a way as to get to what was underpinning it and you can see the pride in the student to say, "Yes, you got it!" and "I feel proud now that I asked that question" because usually their experience has not been that. Now that's a highly skilled person doing that, not every trainer could do that...it's because she is a family therapist and then the fact that [the Aboriginal trainer] will say "something is going off...I'm not happy, something's wrong"...he does so much stuff behind the scenes...you watch what he does, he'll go up to people and say "you want a cigarette?" And you know he's asking them something, and then they'll walk off together.

Aboriginal Team member

The trainer's experience of family therapy informs their way of teaching and though family therapy includes a diversity of interventions, common to these approaches is a belief in the strength of families to resolve their own issues. This has helped to create a collaborative environment conducive to learning. An Aboriginal Team member identified that,

It's also something about the way family therapy goes about questioning people about their life which is inherently respectful and non-intrusive and because of the history of Aboriginal people, we are highly tuned to anything that is disrespectful, the slightest whiff and we are out of there.

Aboriginal Team member

This respectful approach apparent in the Training has also been evident in the consultations with the Aboriginal community. Though the Program's foundations were initially unstable, the capacity of the Team to listen and adapt to feedback from students, Aboriginal Team members and community have enabled a successful Program to be built. The ability to be responsive, the skill of the Team members and the demonstrated commitment to delivering a high quality Training Program are all vital components of the Program's sustained success.

Underpinning Principles and Practices

The respectful processes that have developed within the Team elucidate certain principles and practices that may have relevance within other organisations seeking to engage Aboriginal and non-Aboriginal workers in collaboration. Some of these include adopting a consultative approach, being willing to admit mistakes and learn from them, not making assumptions about Aboriginal knowledge or Aboriginal perspectives, acting with humility as well as knowing when to stand your ground and not be apologetic and building the capacity of Aboriginal people to take up leadership roles.

We not I. The Black and White Approach, which is central to the Training Program is also present within the operation of the Team. A clear directive from Aboriginal Team members has been that when the Program is represented publically it is important that there is always an Aboriginal person involved, whether they are from the Team or a past graduate of the training. The knowledge that is imparted within a presentation is developed in consultation with both Aboriginal and non-Aboriginal Team members and recognises the contribution of Aboriginal people. The Indigenous Program manager explains consultation processes surrounding decision making;

Constant and time intensive...And if you speak, you are clear about who you are speaking for and you never speak without checking in with the other...I can say anything about the university and the management of the Team and responsibilities in my role. And I have to be clear with an Aboriginal Team Member and she will ask, "Why you are going on your own?" And I'll say, "It's about management and my role, about my responsibilities, it's at that level. And any decisions that come out of those meetings I will bring back and anything that affects you, I will consult"- I've had to learn that.

Non-Aboriginal Program Manager

This need for collaboration and consultation parallels a collective approach to decision making prevalent in Aboriginal community. The thinking surrounding Team processes is 'we' not 'I', which has provided challenges for the non-Aboriginal Team members who are less familiar with operating in this way. There have been occasions when people have misconstrued what knowledge and experience they are able to speak of without consultation. The Team has learnt that endorsement regarding the Program's output and direction cannot be assumed but needs to be actively sought through continuing discussion. Though at times these discussions have been challenging, it's recognised that they also provide a level of safety as if mistakes are unintentionally made by non-Aboriginal staff, their colleagues will alert them to it so that the

impact on relationships both within the Team and more broadly in the Aboriginal community will be minimised.

Someone is always there. Strong working relationships have been built which have contributed to the sense that *'someone is always there...and I think it has made it feel safe for me as well'* (non-Aboriginal trainer). Other Team members have expressed a sense of relief in being able to share responsibility for decisions across the Team. As a non-Aboriginal trainer expressed, *'I became aware that I was not alone in this and that I have felt that very, very much in this project'*.

The uncomfortable space is the one that you learn from. Part of the Team's ability to work together is a result of the commitment of the Aboriginal members in giving feedback regarding the structure and direction of the Program and the non-Aboriginal members being able to listen and adapt when these challenges are made. For the Indigenous Program Manager,

One thing that I have appreciated with [two of the Aboriginal Team members], or everyone really... you've come and said, "this is what I'm thinking and this is what is upsetting me", you haven't not said it cause it would be easy to not say it and just walk away.

Non-Aboriginal Program manager

Though the non-Aboriginal members of the Team were highly regarded within the family therapy field, respect in Aboriginal community was not immediately forthcoming, it needed to be earned through an ability to examine assumptions and be flexible in regard to group needs. The non-Aboriginal staff members have remained teachable when their educational practices, which have been highly effective in a range of other contexts, have been contested. A non-Aboriginal trainer relates;

I had many moments of thinking I'm too old!...At this stage I should be basking in my glory of everything I say is brilliant rather than everything I say I have to think about - I don't like this position! So I have to struggle with that myself, you know I spent all my early years thinking I know nothing and finally I think maybe I know something and then I'm back down the bottom of the longest snake in the snakes and ladders!

Non-Aboriginal trainer

Trainers spoke of a deskilled phase with their teaching where they experienced a greater sense of vulnerability than in previous training contexts. Another Team member in a non-training role also conveyed that it has been important for her to be;

Open to taking the hits and taking the criticism, asking the questions about what it is we could be doing differently so that it doesn't happen next time and not being guilty that you got it wrong. Like, you have to make mistakes to learn...it's like that Michael White definition of the liminal space; that the uncomfortable space is the one that you learn from and it's to be celebrated, not to be run away from.

Non-Aboriginal Program manager

There's a great humility about what they don't know. An Aboriginal Team member explains that part of what has made her position a viable one is the respect that has been afforded to her concerns. She is both generous and firm surrounding her expectations of her colleagues and asserts that;

I don't mind if people make mistakes. I'm really direct with [the Indigenous Program Manager], I'll say to her we have to get on top of this...and she will respond...It's important that there's no assumption that they [non-Aboriginal staff members] do know [what it's like to be Aboriginal]. But there's a great humility about what they don't know and that's important to me and so then it's workable.

Aboriginal Team member

You've got to stand your ground. Whilst being teachable and humble is important within the Team, being apologetic or unsure of one's professional authority is not productive as has been conveyed to the Indigenous Program Manager;

If you talk to any of our students they'll say...the worst thing you can do is apologise for being white, [you need] to say what you want, to tell them to "pull their heads in, you've got it wrong", to stand your ground, to be upfront. So I've lost my fear of doing it wrong...I have had enough feedback from people that say, as long as you are not deliberately out to harm or manipulate, then all you can do is be upfront and if you don't know something you ask...then laugh about it later.

Non-Aboriginal Program manager

Two core values. The commitment and belief in the central tenants of the Program have served to unify and sustain the team as an Aboriginal Team member identifies,

One of the core reasons there has been resilience, is that as a Team we have a belief in family therapy being a very good methodology for working with Indigenous families and a belief that education brings choice...I think those two core values we probably all hold.

Aboriginal Team member

I want an Aboriginal person in my role. Another commitment all members of the Team possess is around the need to build the capacity of Aboriginal workers to exercise an authoritative voice within their field and to step into senior and management positions. Within the Team this responsibility is evident through a past graduate of the training being employed as a family therapist, cultural consultant and trainer at the Bouverie Centre and the Indigenous Program manager has also expressed that;

What motivates me now is...that I want an Aboriginal person in my role and that it is built into my role obsolescence and that I be a mainstream consultant to the Program...Because even in Indigenous agencies and certainly in mainstream they [Aboriginal people] are not in management roles and they should be and we should be supporting them to do that.

Non-Aboriginal Program manager

What Sustains Team Members

Through the application of the principles and practices above, Team members found that the rewards from engaging in the work included intense personal learning and satisfaction from knowing the benefits accrued by the students undertaking the Training Program.

How much I learn about myself, is so rich. Team members have needed to participate in deep reflection and steep learning curves, both professional and personal. The rewards for this degree of engagement have included greater Team support and tremendous opportunities for learning. As a non-Aboriginal trainer describes it;

How much I learn about myself...about my own abilities, my own capabilities about everyone and people's families and cultures...is so rich!...Like even on a low key day...the learning that I get to do about myself and our world and these great people and all of the students, and so for me that is what is very sustaining.

Non-Aboriginal trainer

What it means to the students to have had a positive learning experience.

Another significant factor influencing the engagement and dedication of Indigenous Program staff is the feedback received from graduates regarding their experience of the Program. It creates;

An informed sense of responsibility to the students and what it means to the students to have had a positive learning experience and to have completed the course at that level

and to have had conversations with experts, with white people in positions of power and privilege where they haven't felt patronised - that's been the feedback.

Non-Aboriginal Program manager

Dealing with Program Challenges

Some of the challenges that the Program has faced have been wrought whilst negotiating what constitutes adequate consultation and the time it takes to receive recognition within the Aboriginal health and education sector. Team members have sought to adopt a constructive approach to difficulties and avoid slipping into a deficit model where people from Aboriginal or non-Aboriginal cultures are viewed as essentially more or less competent or where cultures fit into a binary model and are pitted in opposition to one another. The non-Aboriginal trainers also experienced particular challenges and expressed how they had addressed them.

Bouverie needs to take on Blackfella way. The lack of recurrent funding, amidst important outcomes achieved and the enthusiastic support of students and graduates has been a source of frustration for the Team and has created a sense of insecurity and instability. The need to chase funding opportunities from a range of sources as well as deliver the training and supervision has stretched resources. It has meant that adequate time has not been devoted to building partnerships with Aboriginal organisations, nor maintaining relationships once they have been established. This somewhat crisis-driven aspect to the Team's culture has concerned Aboriginal members of staff who suggested that *'Bouverie needs to take on Blackfella way'* and that *'Bouverie's culture of "can do" doesn't work'*. They have argued that there needs to be a greater acceptance around the time it will take for the Program to gain recognition and that a more systemic perspective is needed. Aboriginal staff members have suggested that their familiarity with the experiences of recognition and support being denied them, and their people, has enabled them to bide their time and take a broader view of current circumstances.

The Aboriginal members of the Team appear more optimistic around the possibilities for garnering recurrent funding and long-term support for the program. An Aboriginal Trainer stressed that, *'I hope you [Indigenous Team members] are in for the long haul because it is a long haul to get that recognition, it is a long battle'*. He has expressed that because of the commitment he has witnessed in the Team, he anticipates that the Program will endure until it receives permanent funding. In contrast, other non-Aboriginal members of staff have felt that, *'we are very vulnerable and it feels that we could be torn apart by funding at any time and it all feels very tenuous'*.

Consultation. What constitutes adequate consultation amongst staff members has been an ongoing issue as there have been times when Aboriginal staff members have not felt that their opinions and advice have been adequately sought, or respected, and they have been unwilling to repair damage to relationships with Aboriginal organisations that have resulted from actions which they had not endorsed. In the first years of the Program, before the Program's culturally sensitive processes had been established, Aboriginal staff at times felt their presence was tokenistic and they distanced themselves from aspects of the Program's history in order to preserve their sense of professional integrity in community.

At other times, Aboriginal staff have displayed a high degree of respect and trust in the abilities of their non-Aboriginal colleagues, though this also provoked some anxiety and uncertainty. As a non-Aboriginal trainer recalls,

When I was teaching in Ballarat there was a big block of time when [the Aboriginal trainer] wasn't there...and it was very unsettling for me...and I was driving to Ballarat and I get a call from [the Aboriginal trainer] and he says, "Just letting you know that I won't be there"... "Oh OK" ...so there I am thinking, "Shit ...what do I do?" And he said, "You'll be right mate!" And I thought, "She'll be right - is that enough?". So I rang him back and said, "What am I supposed to do?" And he said, "What do you want a PhD in cultural consultancy now?" and I said, "Do you think I'll be all right?" and he said "You'll be fine".

Non-Aboriginal trainer

Avoiding binary definitions. The question of how to respect differences in experience, history and culture whilst avoiding binary definitions so as not to split along racial lines, or to position a culture or a people as possessing fixed traits, has been a consideration within the Team. Team members have been mindful not to work within a deficit model where any culture is seen as lacking, but rather to be aware of how all members add value through their particular experiences and understanding.

A non-Aboriginal trainer herself provided an example of eluding a fixed categorisation as either Black or White. Having being born in Malaysia she was part of an Indian minority who were pejoratively called 'Jungle people' and she describes how as a young person, prior to immigrating to Australia, she identified and associated with other ethnic minorities. Though the non-Aboriginal trainer is familiar with the experience of being a 'second class citizen', she has also worked in a mainstream institution for twenty five years and is aware of her privileged position in Australian society. Her background and experience represents how binary definitions of black and white do not adequately account for those in the Team, yet are used to represent

experience and history within Aboriginal community rather than Indigeneity, experience of marginalisation or persecution.

An Aboriginal Team member who identifies as a Namatji woman did not grow up within Aboriginal community and was born into a privileged home which valued education. It was in adult life that she learned of her Aboriginality and sought to understand how this knowledge had meaning and significance for her. Despite having worked hard to identify her place and responsibilities within Aboriginal community, some would exclude her from their definition of Aboriginal because of her upbringing and educational achievements. Others in the Team have come from Irish, Italian and Jewish backgrounds where they have experienced minority status and a sense of not feeling a part of the dominant culture.

Expressing grievances constructively. During a group interview it was highlighted how difference had been negotiated in the Team. What I found remarkable was the restraint with which Team members spoke about difficulties they had experienced during their time in the Program, despite a number of invitations to contribute to the discussion. The ability of people to contain their grievances and find ways to express them constructively could be another factor contributing to the Team's ability to sustain itself. During my three years with the Team, I frequently noted how they were generally good humoured and generous with one another, tended not to take things too personally and adopted a systemic approach to difficulties as they arose.

As a result of individual commitment and shared purpose, people are willing to tackle the significant hurdles towards permanency for the Program and tolerate disagreement in the Team in order to share in the satisfying work and encouragement from the workers to achieve, what all experience as, the incredibly worthwhile goals of the Program.

Challenges for the Trainers. Those non-Aboriginal Team members who conducted the training faced particular challenges when teaching a cohort of students who were new to them including: knowing how to maintain respect for the learning environment, knowing when and how to challenge student ways of working and working with student groups where dual relationships were common.

Respect in the learning environment. Through a desire to respect Aboriginal worker practices, the non-Aboriginal trainers have been tentative at times to address the culture of the group. For instance, a non-Aboriginal trainer recalls how during the training mobile phones seemed to be constantly ringing and she was getting a bit distracted and one person in the group said, *'We haven't always had mobile phones you know, would you like us to turn them off?'*

(Aboriginal worker). The non-Aboriginal trainer could see the humour in the situation which confronted her ideas about what constituted respect in the learning environment.

Maybe I am subtly imposing a way of working on you? At other times the non-Aboriginal trainer noted how she was unsure as to the degree to which she could challenge the group. On one occasion, despite her wariness the non-Aboriginal trainer addressed the tendency towards adopting a directive approach;

I said it's not about finding solutions for your clients, it's another way of approaching it...and they were very excited by it and they had the experience of the client coming up with the answers. And then I got anxious because every mob I had worked with had said, "Our job is to find solutions for our clients, because they are marginalised it is up to us to advocate for them and find solutions for them". And I was teaching them not to find solutions but to sit down and have a chat and I was saying to the group "Maybe I am subtly imposing a way of working on you" and I got emails from them...and they said they are learning.

Non-Aboriginal trainer

Trainers spoke of an increased need to make overt their thinking, dilemmas and decision making processes with the students. This increased their own sense of vulnerability but also had the effect of deepening engagement both for themselves and for the students.

Dual relationships. The boundaries commonly present within a mainstream educational setting were contested within the training. One of the non-Aboriginal trainers commented that;

What challenged my prejudices...as an educator, is the fact that in every group there have been family members in the same group...and a mainstream white way of thinking would be to say, that's problematic to put a mother and a son and a nephew in the same group, it's problematic to put an Auntie and a daughter-in-law in the same group, a husband and a wife in the same group. But in every group we've had those kind of combinations and from my experience, it hasn't been a problem.

Non-Aboriginal trainer

The non-Aboriginal trainers were familiar with dual relationships being discouraged amongst students or between staff and clients within mainstream educational settings and organisational environments. However the trainers saw the need to be flexible and respond to the students' alternate working environments. The boundaries prevalent in mainstream organisations do not exist to the same degree within ACCOs, where it is common for family members to also have

professional relationships and for workers to have history and connection to many of the clients with whom they work (refer chapter 4). For the workers, the training experience paralleled their work environments where they frequently navigated professional and personal boundaries amongst family and community.

This chapter has discussed the challenges and strengths of the Indigenous Program at the Bouverie Centre and the principles that underpin the Black and White Approach within the Team's processes. Despite considerable external challenges, the Team has been sustained through a unity of purpose and through the encouragement and support of the Aboriginal workers who have been involved with the Training Program.

Summary

The journey of the Indigenous Program Team towards the development of the family therapy Training Program including the post Graduate Certificate in Family Therapy for Aboriginal health, child and family workers was discussed in this chapter in order to inform an understanding about how the training was received by the students and their understanding of family therapy as a mode of intervention. Family therapy interventions were reinscribed and adapted by the workers undertaking the course, alongside the Indigenous Program staff and in so doing represented to many workers a '*white meets black way*' that could be usefully applied to work with Aboriginal families.

The collaborative model that enabled this synergy between Aboriginal and non-Aboriginal knowledge systems, is important to account for. The Black and White Approach developed by the Indigenous Program can be seen to imbue the ideas espoused within the family therapy training program, the pedagogical practices it employed, the relationships between Team members and the research process undertaken in this thesis. This chapter seeks to explain the conditions under which this method arose as it could usefully inform other adaptations of non-Aboriginal approaches to Aboriginal health, their teaching, cross cultural practices within teams and services and collaborative research processes. This understanding supports the transferability of the thesis findings to other domains and increases its contribution to the field.

A collaborative, consultative approach was borne out of the necessity initially to engage Aboriginal staff for the Indigenous Program. Once credibility had begun to be established through the imprimatur of respected Aboriginal members of staff and those on the Advisory Group, opportunities for developing relationships with Aboriginal organisations and recruiting workers for the Training Program could commence. Though consultation and collaboration was initially not always in evidence, the Team learned to consult, acknowledge and pay respect to the students as First Australians and for their cultural knowledge and expertise in working with

Aboriginal people. By consulting with the students cultural safety was engendered and knowledge was exchanged in ways that felt equitable.

The personal and collective commitment of Team members has enabled challenges to educational and organisational practices within the Team to be negotiated productively. Aboriginal Team members have been willing to make challenges due to their belief in the value of family therapy as an approach for Aboriginal families and as a means of workforce development for Aboriginal workers. The Team's unity of purpose has created a constructive learning environment and an ability to resolve difficulties. Team members have learnt the importance of a collective approach to decision making and all decisions affecting the Team are discussed. Presentations are reviewed by Aboriginal and non-Aboriginal staff members to ensure the values and knowledge within the presentations adequately reflect all members of the Team. Though intensive, this consultative process is central to the functioning of the Program and is paralleled within the training program and in the process of working with Aboriginal families therapeutically.

- The Black and White Approach developed by the Indigenous Program can be seen to imbue the ideas espoused within the family therapy training program, the pedagogical practices it employed, the relationships between Team members and the research process undertaken in this thesis.
- The Black and White Approach involves two-way, collaborative learning. It is intensely consultative and seeks ways to honour the voices of those who hold knowledge regarding Aboriginal approaches to healing and health as well as respecting non-Aboriginal approaches to education, research and working with families.
- Within the Indigenous Program, the Black and White Approach is central to its functioning. This involves collaborative decision making which is built upon a belief in the value of family therapy as an approach for Aboriginal families and belief in the post Graduate Certificate in Family Therapy as an effective workforce development strategy for Aboriginal workers.

Chapter 9 Researcher Journey

The analysis contained within this chapter will contribute to answering the research questions by locating processes that enable collaboration and the sharing of knowledge between Aboriginal and non-Aboriginal people in the delivery of family based interventions and family therapy training. The particular context is through my participation in the research and by tracking the impact of the diversity of roles that were undertaken and how they shaped the research journey.

As a researcher utilising a qualitative design method, it is important to record and explore what arises as part of the research process. As a family therapist I am also interested in exploring what constitutes no go zones, secrets and unspoken laws and rules. Recording thoughts and reflections in the context of this research was also used as a way to give voice and meaning to experience which enabled me to continue on what was at times a lonely and challenging journey. The strength of my responses had me wondering about how others managed similar experiences and feelings. Such feelings I imagined caused people to disengage from the field which represented a loss of knowledge, skills and possibly good will. I hoped that by researching and understanding my own and other's responses that a contribution could be made around what people had found to be sustaining practices working in the field of Aboriginal health and education. As a result, after I had been engaged in the research for over a year I began asking individual Team members, both Aboriginal and non-Aboriginal, how they coped and framed experiences of being 'growled at'¹⁹ and having their integrity questioned (refer Chapter 8).

When commencing the research I was aware of the novel by J.M Coetze (2000), 'Disgrace' which had resonance for me. The book depicts post-apartheid South Africa and relays how the ledgers that have been accrued as a result of the institutionalised racist practices of the past need to be balanced, not only through changes to laws and institutions but also on an individual level. The steps towards restitution occur in Coetze's account through white South Africans weathering attacks and losses as a result of being a recipient of privileges accrued at another's expense. To be silent, to not retaliate, constitutes an acknowledgement of the original crime and enables the ledger to be squared. The Coetze book could be seen to be a critique of the limited effectiveness of the Truth and Reconciliation Commission as retribution continues to be enacted when material and emotional inequities still exist. I saw parallels in Coetze's book with the inequities

¹⁹ An Aboriginal colleague explained to me that it's traditional to be 'growled' at. That when anyone has business on another's land they go before the Elders and state their business and where they are from. The Elders may then ask questions and make a decision whether that person is allowed in. ACCOs too will often refuse services to people from other lands. They will ask why that person has come and what they may be attempting to dodge back home. The person may be sent back to deal with whatever situation they are avoiding out of respect for other's laws and so that the local community does not buy into any politics.

experienced by Aboriginal people in Australia and a discourse surrounding a price that needs to be paid without complaint by white Australians.

The data informing this chapter is drawn from journal entries made throughout the research process. The challenges and opportunities that are highlighted contribute towards an evolving set of principles and practices which may have application in other settings including other non-Aboriginal researchers and those seeking to create partnerships between Aboriginal and non-Aboriginal people and services.

This chapter reflects on the principles of ethical research with Aboriginal people as applied in the context of this research. These principles include research with Aboriginal people that: benefits their lives, privileges Aboriginal voices, enacts reciprocity and equity, builds capacity, acts upon research outcomes and then feeds them back to the community in meaningful ways (NHMRC, 2006; Onemda, 2008). Though these principles seem unambiguous and straight forward, journal entries reveal the difficulties enacting them as well as what was useful in enabling these principles to be utilised beneficially and realistically within a challenging context.

Pyett (2000) and Mahood (2012) have reflected on the expectations of researchers and other workers when working with marginalised communities. Pyett (2000) has indicated that considerable time and resources need to be committed in order to ensure people's participation and equity in research processes. Maclean et al (2008) have also problematized what equality means within a society that privileges particular skills and knowledges and how this can mean that non-Aboriginal researchers may be blind to the significance and depth of contributions made by Aboriginal participants. The data presented within this chapter explores what equality can mean within research processes with Aboriginal people and how assumptions and interpretations of equality can be challenged and new concepts developed.

Hazlehurst (1994) has contested that, fundamentally, any move forward in Aboriginal affairs needs to involve Aboriginal empowerment so Aboriginal and non-Aboriginal people working together in Aboriginal health and research is of great significance when it involves capacity building. Smith (1999) has posited that an existing constraint for non-Indigenous researchers is a tendency towards positioning Indigenous people as disorganised or in some way not up to the task of being full participants in research, this then allows non-Indigenous people to take control. My own struggles and consultations with Aboriginal advisors around what constituted adequate participation of those involved in the research and where and how control, authority and decision making was shared provide a valuable contribution to the discussion of Indigenous participation and equity in research. This research highlights how the principles of ethical

research can be applied in the field and the dilemmas that are presented when theory meets practice.

A number of authors (McIlwaine, 1998; Waldegrave & J.T.T., 2003) have emphasised the need for those working with marginalised populations, including Aboriginal people, to adopt fluid non-essentialising positions. Rigid understanding or positioning of the other, Thiele (2005) claims, can elicit white guilt (Maddison, 2011) which can result in non-Aboriginal people taking up responsibilities outside of their domain. This can include 'doing for' or 'speaking for', which has those from the dominant culture walking ahead instead of alongside their marginalised colleagues (VACCA, 2008).

Pyett and Walker (2004) have identified how non-Aboriginal workers can be put off from engaging in Aboriginal affairs and undertaking research out of a misguided cultural sensitivity and for fear of doing the wrong thing and of not being welcome. Waldegrave et al (2003) have discussed how such responses can serve to undermine accountability and responsibility by non-Indigenous people and that cross-cultural engagement needs to be negotiated. My own experience prior to undertaking this research attested to some of these responses and concerns and reflections centre on how some these issues can be re-visioned and/or addressed (see also Chapter 8).

Virginia Goldner (1998) has written on the tendency of people, when experiencing extreme ambivalence, to split ideas and people into good and bad rather than tolerate and recognise competing, contradictory perspectives. There were times in this research when I experienced this phenomena through a desire to make expedient decisions on behalf of those with whom I was working rather than to stay with a time consuming and difficult collaborative process. A dilemma is explored in this chapter surrounding taking up authority where it has been divested and continuing to consult and commit to process. McIlwaine (1998) has written about the importance, when working with people from different cultures, of building relationships which are characterised by respect, equality and compassion rather than being stuck in binary definitions of each other's culture, qualities and values. This can be a challenge when, as Cowlshaw (2006) has observed, betrayal and abuse afforded by the colonisers can render a lack of trust and suspicion. McIlwaine (1998) has commented that it is not enough for the person from outside of community to be trustworthy. In order to counter suspicion this trustworthiness needs to be demonstrated. My own experience attests to how there were times when my intentions were questioned and where I needed to demonstrate my integrity and credibility and draw on various qualities and processes to maintain relationships.

Experiences of transference and counter-transference²⁰ with research participants is not confined to Aboriginal and non-Aboriginal subjects, as Gregory Phillips (2003) has recounted. As an Aboriginal man conducting research in his community, Phillips (2003) found that such exchanges could undermine the goals of research and that a strong support team was necessary to aid a reflective process whereby dynamics could be addressed and purposeful action can be taken. Mahood (2012) has written about some of the pitfalls that can be encountered by non-Aboriginal workers in Aboriginal communities when adequate support is available and reflection is limited. She details positions which non-Aboriginal people take up as a result of their own anxieties and ideals, and observes that, under pressure, their strengths and weakness can become exaggerated. For some, this entails an overheated sense of responsibility for past and present issues which can lead to dependency, failure and disappointment. Other authors, such as Rose (1992) in her work with Aboriginal communities, recognised that it was not necessary to say yes to all requests in order to forge relationships and that saying no at times was necessary to form relationships that included give and take. My own journey regarding what responsibilities I undertook, the default positions that were triggered in myself and others and how relationships were effected and developed are features of the following chapter.

In order for researchers working with Aboriginal communities to maintain integrity within research processes, whilst being primarily accountable to research participants, Rix et al (2014) has suggested that a relational lens needs to be applied. Perceptions by the research participants about how the research was conducted according to Rix et al (2014) need to be considered when assessing research outcomes. My reflections on how research in this context can be assessed builds upon this work and recounts a number of ways in which ethics in research practices can be understood and implemented.

Roles Undertaken

As outlined in the methodology chapter (see p. 80-81) I undertook a number of separate yet interlocking roles in relationship to the research participants. Broadly, these can be defined as the researcher of the questions embedded in this thesis, a trainer and evaluator of the post Graduate Certificate in Family Therapy, research mentor and Forum Theatre Facilitator within the Training Program. The additional roles played include: assisting the Aboriginal researcher in her report writing, desensitising participants in the Training Program to research practices and

²⁰ *Transference* is the phenomenon whereby people unconsciously transfer feelings and attitudes from a person or situation in the past on to a person or situation in the present. *Countertransference* is the response that is elicited in the recipient by the other's unconscious transference communications.

exposing them to research processes that were more respectful and acknowledging and conducting Forum Theatre.

Figure 6: Diagram of Roles Undertaken



Some of these roles grew out of my engagement with the research, others were part of being embedded in the Program eg. Forum Theatre Facilitator. Engaging in these roles and activities served to pave the way for the research to be conducted. These different roles provided a diversity of experience with which to understand the field and helped to develop the research questions. The diverse roles undertaken also provided an increase in complexity for the research as it was necessary to frequently delineate the parameters of my roles to those involved in the post Graduate Certificate in Family Therapy, Metro cohort (see p. 79) in order to maintain ethics in the research processes (NHMRC, 2006).

The strategies for managing the difficulties that were encountered regarding the diversity of roles will be tackled in this chapter though firstly attention will be drawn to my engagement with the Indigenous Program at the Bouverie Centre. My relationships with Team members provide a critical context for the research as they provided the foundation upon which the research questions began to emerge.

Building Relationships in the Indigenous Program Team

Through reading in the area of research and collaborative practice in Aboriginal health, as well as my own desire to make a contribution to the field, I sought out ways to engage the Team and for people to get to know me through my work. I expected to do a considerable amount of unpaid

work to build relationships and to enact reciprocity (NHMRC, 2006; Phillips, 2003). One of the first ways I sought to do this was through sharing my knowledge of the mainstream AOD field, which was designed to establish my credibility and add to the knowledge base of the Team as they frequently worked with Aboriginal AOD workers within the Training Program. I conducted a formal presentation for the Indigenous Program Team, which centred on how family therapy ideas had been taken up within the sector and what the constraints and discourses surrounding family and collaborative practices were. The presentation was well received and acted as a springboard to discuss the similarities and differences between the mainstream and Aboriginal AOD sectors.

Though familiar with a number of people in the Team, as my supervisors held the positions of Program Manager and Team Leader some of the other Team members I was less acquainted with and was unfamiliar with the Program's culture and processes. In consultation with my supervisors, and consistent with Grounded Theory methodology the decision was made to situate myself within the Team and from that position participate and observe. This meant that I would attend Team meetings and planning days, spend days in the Team's office working and contribute skills and knowledge where appropriate. This approach was undoubtedly successful as well as providing significant challenges.

As an outsider, my assumption on commencing the research within the Team was that I would be supported in my endeavours partly due to the imprimatur of my supervisors. I believed that their commendation along with my integrity, enthusiasm and persistence would give me sufficient cache to become an insider with integrity.

Another belief was that I would be able to speak to Indigenous and non-Indigenous people holding senior positions in the field and they would help to orientate me to an area where I had some knowledge (see p. 1-3) but sought assistance to contribute to meaningfully. I hadn't expected that these connections would be easily made and anticipated that I would need to persist to be granted audience with people who were often stretched, however I wasn't prepared for the resounding silences to repeated attempts to organise contact with key figures. This growing knowledge was destabilising as I saw that the personal qualities I relied on, such as integrity and enthusiasm, were not going to be immediately valued inside or outside of the Program and that I would have to adopt alternate methods. It became apparent that 'the field' that I most needed to cultivate was the Team and that it was there that I needed to adopt a 'learner's mind' (Swantz, 2008), build my credibility and so gain the introductions and endorsements which would enable the research.

It was suggested by my supervisor early on in the process that I would contribute to the Team and the field simply through my presence, though my own anxiety and desire to contribute drove me at times to over extend myself. This experience attests to how hard it is to establish a working relationship with research participants, engage them in research processes and for multiple roles to be understood.

A Cross-cultural Way of Working Together

An important part of my learning journey is exemplified through the development of a way of working cross-culturally which involved working side by side, consulting, privileging process, ownership and satisfaction, trialling collaborative methods and challenging notions of equity.

Side by Side. A significant contribution I made to the Team was my work with the Indigenous Researcher in assisting her with the writing of a report (Latham, 2010) on the outcomes surrounding a particular training cohort. Together we developed a way of working where we would sit side by side and I would ask questions and record the Indigenous Researcher's knowledge and reflections as well as pose alternate ways of expressing the ideas and structuring the knowledge. This cross-cultural way of working resembles Malparara (Woods et al., 2000) and was also employed with Aboriginal colleagues when co-presenting at conferences (Latham & Sundbery, 2010, 2011; Sundbery & Boundy, 2013; Sundbery, Coade, Proctor, & Moloney, 2010; Sundbery & Dwyer, 2012; Sundbery, Freeman, Kelly, & McIlwaine, 2011; Sundbery, McIlwaine, & Kelly, 2010) and co-writing articles (Dwyer & Sundbery, in press; Sundbery, Boundy, & Griffin, 2012; Sundbery, Proctor, & Latham, 2011).

Other collaborative methods. This process for working together with Aboriginal colleagues evolved through trialling a number of other collaborative methods which proved less effective. For instance, it was not useful to suggest preparation be done prior to meeting together, nor to send a draft of ideas for comment, criticism or alteration as too much preparation would silence my Aboriginal co-worker(s) and leave me feeling frustrated about the amount of work I had contributed. What was most effective was to do minimal preparation for meetings but to schedule longer meeting times so that familiarity and trust could empower my co-workers to become involved in the co-creation of work.

I would come to the meeting with a few questions and areas of interest in mind which would be offered after connecting informally and then inviting my colleagues to share thoughts and ideas. From there, the work would develop whilst I recorded thoughts and ideas on computer, writing it up and meeting a number of times afterwards to discuss alterations. When I failed to adopt

this approach, conversations were less generative and had less a sense of collaboration, ownership and equity.

The privileging ownership and satisfaction with the process. I observed my impulse to want to move through processes more quickly or to take charge when I felt I had more knowledge about a particular subject or process, as a form of colonisation. Though there could be good intentions on my part regarding the possible outcomes of the work, the process itself would be inequitable unless I was willing to privilege process over product and take the time to ensure a sense of ownership and satisfaction regarding what had been contributed.

Refiguring notions of equity. My own sense of equity was challenged at times when I was contributing more time to projects associated with the research, in terms of researching, planning or writing, than my Aboriginal colleagues. How I came to reconcile this was through understanding that my colleagues were offering their imprimatur for the work and their knowledge of their community and without this contribution the work would have been seriously flawed. I also recognised that for them the stakes were higher in terms of their personal and professional reputation in community and that collaborative work was not a simple transaction in terms of hours spent on a project but rather a person's contribution occurred at a number of levels, all of which I may not be privy to. I came to understand that I needed to enact a greater sense of generosity than I might in other contexts and to accept that I was operating in a different economy which required different types of investment.

Consulting. This way of working extended to privately and publically consulting on what were small and relatively straight forward decisions to ones which had greater significance. It was not assuming to know what would be considered culturally appropriate or what direction my colleague was wishing to go. This meant challenging taken for granted approaches or knowledge and asking for clarification and input regularly.

Aboriginal colleagues leading. I was cognisant of always having my Aboriginal colleague/s speak first at conferences and lead forums in order to convey a decolonising approach where Aboriginal authority was respected and Aboriginal ownership of knowledge was conveyed.

Feedback. The feedback received from those attending conferences and forums where I co-presented with Aboriginal colleagues was universally positive with no negative feedback levelled either during or after the presentations. This was in contrast to other presentations I observed without an Aboriginal co-presenter, which received challenges during their delivery. Comments, when presenting to an Aboriginal audience, centred on how the presentations were

`warm' and `well-pitched', reflecting `a partnership and equality' and interest was expressed around the continuing development and outcomes of the research. This feedback provides testament to the learning journey which was undertaken and the successful development of means of working cross-culturally.

Learning from Challenges

The need to develop collaborative, respectful relationships with the Aboriginal Team members was apparent as their support and imprimatur was necessary for the research to proceed. It was also recognised at the outset that there was the possibility that no Aboriginal AOD workers would agree to participate in the research. I became increasingly aware of the historical constraints operating as many Aboriginal people had experience of research not benefitting them. As a result the research was vulnerable to having support withdrawn at any time.

A number of other challenges were encountered during the research including the effects of trauma on inter-personal relationships and a lack of authority. These required alternate perspectives to be cultivated through a process of reflection and support by Aboriginal and non-Aboriginal colleagues.

A lack of authority. Though the processes involved in working collaboratively on projects presented challenges around equity of contribution, what was more difficult for me was when I felt I could make no contribution to a situation, event or project, or none that could be accepted or acknowledged. I frequently experienced situations where I felt invisible, dismissed, left standing, not invited, looked through and around. Initially when these incidents occurred I was curious about my own and others' responses. But as the experiences persisted I became less curious and sought ways to protect myself through minimising exposure to situations where I could not define an expressed purpose or recognised role. Though it felt intensely personal being ignored or dismissed I knew that it was a frequent challenge for participant-driven collaborative researchers. I also understood these experiences to be partly occurring as a result of my position as a white researcher, that being white in Aboriginal community can be difficult and creates instant suspicion in some quarters. Within the Team, I had limited power and mostly undertook unpaid work which can be undervalued.

The above experiences caused me to reflect on the degree to which my experience paralleled that of Aboriginal people in mainstream society where contributions are not sought or acknowledged, at times are actively denied, with a resultant sense of not belonging and self-worth and esteem affected.

Support and feedback. What I fell back on during dark times in the research process was my belief in the my integrity of the research, the positive feedback I received from my supervisors, Aboriginal members of the Team and other Aboriginal participants who all reassured me as to the significance of the research and my integrity within it.

I also needed to engage all my support systems to enable me to persevere during times when it felt like there was little reward for the work I was doing and where I needed to cultivate alternate perspectives.

The effects of trauma on inter-personal relationships. My learning is not complete in this area but I have come to understand that in this field I will not be liked or respected by a greater percentage of people than in other contexts and that there is a portion of the Aboriginal community who prefer not to work with non-Aboriginal people. I understood over time and through the support of my Aboriginal colleagues that this can be because of what a white person represents. Intergenerational trauma and hypervigilance can be triggered surrounding perceived threats to safety increasing misunderstandings, negativity and suspicion. I also came to appreciate that I was not alone in my experiences and to place it within a broader context. Aboriginal colleagues recounted to me how they also experienced the effects of intergenerational trauma as lateral violence within Aboriginal community and that for them they had less opportunities to disengage than I as an outsider.

My Role as an Evaluator and Trainer

In order to develop relationships and engagement with the research and to enact reciprocity in the role of researcher, I sought to enhance the capacity of the emerging family therapists in the Training Program to conduct research and evaluation. It was negotiated with the Indigenous Program Manager and the trainers of the Metro cohort that I would come into the Training Program for three two hour sessions to discuss research and evaluation.

I and the Training Group gained significant learning throughout the research and evaluation sessions with them. However in order to remain within the limits of the ethics clearance obtained I will confine myself to my own reflections on the process. When speaking about research I was told by my field supervisor and Indigenous Researcher in the Team *'Don't bring up white research issues unless they do'*. During the first session I didn't mention the word research, due to its negative associations preferring instead to refer to evaluation. I asked the group, *'How do you know that you are doing a good job, both on an individual and organisational level?'*. I was mindful to firstly highlight the expertise and knowledge of the workers and the processes

they already utilised. I chose to not impose too tight a structure on the sessions as I felt that this would stifle conversation and engagement with the topic.

By week three I estimated that I had gained sufficient trust to be able to touch on the history of research and a context had been developed to speak of decolonising research practices which were useful to and respectful of Aboriginal people. I also held the somewhat lofty hope that the group would be able to create an evaluation tool with which to measure the effectiveness of their work with families. When discussing the history of research I contrasted colonising research practices to decolonising approaches and had the experience of being 'growled' at. I mentioned a justification for not ceding control of research to Aboriginal people was the perception that Aboriginal people did not have a developed critical faculty because this faculty was not valued culturally. Some Aboriginal people in the group became upset and I too agreed that the nature of the ideas were unacceptable. Later I was to learn that a number of people in the group had taken offence and had queried my intentions and my position in relationship to the ideas posed. I clarified my intentions once I became aware of the breach and made reparation to the group and to the individual most affected, however the hurt feelings persisted. This rift caused considerable pain for myself and others and I felt misunderstood and cast in the role of oppressor. Seeking to learn from the experience, I consulted my Aboriginal colleagues who suggested that it was unwise to mention colonising ideas no matter how they were framed, that I needed to factor in what as a white person I represented to Aboriginal people and that at times people's trauma backgrounds would determine their responses rather than what I might do to ameliorate any harm. As it is not possible to control all these influences I learnt that I needed to anticipate strong reactions and deal with them as expeditiously as I could.

Building Research Capacity

In my work with the Training Group I sought to build interest in research and evaluation as well as the capacity to conduct it purposefully around the effectiveness of family interventions in their work contexts. Building capacity was understood to be part of conducting ethical research with Aboriginal people (NHMRC, 2006), however it was not formally evaluated and observations here are limited to journal entries.

In the Training Program. At the beginning of the training sessions there was a considerable disparity in people's understanding of what constituted useful evaluation in their services. At one end of the continuum workers believed that a client's satisfaction with the service could be measured by their continued engagement and through a lack of complaint, whereas others in the group informally evaluated by asking whether a session was on track and whether clients were getting what they wanted or expected out of the work. Some others were

keen for research to be conducted more formally into what were known to be effective interventions for their clients as currently there was not a strong evidence base on which to draw in order to attract funding.

Though there was general agreement reached on the usefulness of research to people's work, it did not translate into group members wishing to take on the role of researcher themselves. To have achieved such an outcome, significantly more time would need to have been devoted to the project. In this context it was not appropriate to do so as the primary focus of the research was to understand how family therapy interventions and training was perceived by the drug services workers.

In the Indigenous Program. In other contexts I achieved mixed results in building research capacity with my Aboriginal colleagues. With the Indigenous Researcher in the Team I was successful in developing research skills through working on various research tasks together including discussion around the forms in which research could be presented back to community and the direction of further research within the Team. We co-presented at a conference and a forum (Latham & Sundbery, 2010, 2011) where past graduates of the Training Program, their managers and representatives from La Trobe University and the Department of Health were present. However, my colleague decided after three years that she did not want to continue in a research capacity within the Team and moved on to a Senior Project Officer and Strategic Development Position. This decision was made through the acknowledgement that Indigenous research required a high degree of commitment and involvement which she needed to dedicate to her art practice.

I also undertook to mentor another Aboriginal Team member around research processes. Through this relationship I sought to increase my knowledge and understanding of alternate perspectives on the tasks we undertook together and I envisaged that the relationship could provide a level of cultural safety for those involved in the research and for myself. Through negotiation with the Program Manager and my Aboriginal colleague it was decided that together we would conduct the interviews with those participating in the research and travel to the services where the participants were situated. We discussed the purpose and processes associated with the research and how the data could be generated and analysed. My colleague previously did not have a background in research and through this experience she had an experience of how research could be an intervention that had positive benefits for both the agencies and individuals involved. We also presented at two conferences together (Sundbery, Freeman, et al., 2011; Sundbery, McIlwaine, et al., 2010) around the findings of the research and collaborated around the content and mode of presentation. My colleague was relatively new to the family therapy field, was completing a Master's qualification and as research was not central

to her role she was not able to continue with further research projects after our work was completed.

Though the literature is clear about the need for Aboriginal people to be the primary drivers of research in their communities (NHMRC, 2006; Onemda, 2008) and for a greater percentage of researchers in the field of Aboriginal health to be Aboriginal, I found limited interest in taking up leadership roles in research amongst my colleagues, research participants and the Training Group. Though I desired to build the capacity of Aboriginal people to take up research positions so that they controlled the knowledge pertinent to them, the reality was that the negative history of research in Aboriginal community continued to act as a powerful obstacle in some instances. When working with my Aboriginal colleagues in the Indigenous Program the complexity of their roles made it difficult for them to locate research as essential. This experience raises questions around what may be needed to create a context for emerging Aboriginal researchers in Australia and it is evident that the work of the National Indigenous Research and Knowledges Network (NIRAKN)²¹ and other endeavours need to be supported.

How the Research Questions Evolved

This section tracks the changing nature of the research question and the factors that influenced my understanding of what approaches could be most useful in eliciting rich, pertinent data. The research questions developed in response to my understanding of what constituted community control, my experience of the Training Program, knowledge of family therapy within the Aboriginal community and, more broadly, how the Training Program could be used as a way to explore collaboration, reconciliation and as a means of Aboriginal empowerment.

Beginnings. Initially when I was invited to do my PhD with the Indigenous Program it was suggested by my supervisors that the thesis focus upon the training and support needs of Aboriginal alcohol and other drug workers. The data was to be drawn from observation and interviews during the consultation and recruitment phase of the post Graduate Certificate in Family Therapy being delivered to AOD and Social and Emotional Wellbeing workers who were employed to work with Aboriginal people. As a result of the short turnaround time between when I was able to enrol and this phase of the training's development, it didn't prove viable to continue with this particular direction. Had this route been taken, the thesis would have had a greater focus on engagement and the processes for creating partnerships between mainstream and Aboriginal organisations whilst implementing a workforce development strategy.

²¹ NIRAKN is a national, inclusive, multidisciplinary hub and spokes model network of Indigenous researchers at various stages of their careers.

Aboriginal control of the research. Initially I held concerns regarding the genesis of the research project itself as it didn't appear to be initiated from within the community. The literature that I had surveyed surrounding research and collaborative relationships between Indigenous and non-Indigenous people was clear about the need for there to be community ownership of projects (NHMRC, 2006; Onemda, 2008; Smith, 1999). I was concerned that family therapy was a model of intervention that came from a non-Aboriginal tradition and that the training was provided by a mainstream service provider without a formal partnership with an Aboriginal organisation. Though the Program was guided by an Advisory Group containing Aboriginal Elders and others important in the field I still held misgivings about the degree to which it was defined from and within Aboriginal community.

Reservations drove me to better understand how Team members conceptualised the aims and aspirations of the Program. Through reflecting on these conversations I appreciated that community approval for the activities of the Indigenous Program was evident in the overwhelmingly positive community response to the training and support provided. This signified a shift in my thinking where I was more informed by what Aboriginal community members deemed as significant and meaningful to them rather than measures that had been derived externally. From this vantage point I was aware that though the Program could be critiqued for its various deficits it also needed to be assessed in terms of its intentions, its ability to consult and respond and the benefits that had been derived for Aboriginal people, as defined by those in the community.

Though I knew that the research needed to be rigorous in its critique of all aspects of the study, personally it was vital that there was an alignment between my values and the Program's goals and aspirations. Conducting research on a venture which I was ambivalent towards would have been valid but not something to which I could dedicate a significant portion of time.

The suitability of family therapy to Aboriginal community. Another significant shift in the direction of the research came through realising that many government, Aboriginal and mainstream agencies were not aware of the benefits of family therapy as an intervention. This led me to focus more keenly on contributing to the discussion surrounding the suitability of family therapy as an approach for Aboriginal substance misuse and how it related to Aboriginal concepts of health and wellbeing. I was mindful that the discussion would not be centred on highlighting the benefits of including families in treatment, as it might have been if the study was dealing with a mainstream population. In this context it was understood that Aboriginal people were from a collectivist culture where family and community were included routinely in care and problems were understood systemically. The purpose of family therapy as an approach then

would be to build on the skills workers already had in including families in treatment so that they had a greater range of culturally congruent interventions available to offer families.

A model of collaboration explored through family therapy training. A premise of the Training Program was understood to be that Aboriginal and non-Aboriginal systems of knowledge can work together to address the complex area of Aboriginal health. A focus for this study grew from this premise to include how different peoples and cultures can work together in an environment where there has been significant trauma and a history of fractious relationships. As both the mainstream and Aboriginal health systems are intertwined, I believed that finding ways to evolve approaches to Aboriginal health could be beneficial for Aboriginal people.

Concerns I held surrounding the possibility of family therapy ideas colonising the practices of the workers were allayed by those undertaking the post Graduate Certificate who assured me that Aboriginal culture was constantly evolving and that they were able to adapt ideas that were significant to their context. The study of the Training Program I considered could pose a model of collaboration between disparate cultures and knowledge systems that was based on respect and mutual learning of Indigenous Program staff, myself as researcher and those Aboriginal workers and health services involved in the post Graduate Certificate in Family Therapy.

Workforce development and the empowerment of Aboriginal people. What was being offered through the training, along with a greater access to a range of appropriate interventions was a pathway for Aboriginal workers towards becoming respected leaders both within the mainstream health system and within their communities. Through gaining a postgraduate qualification workers could have greater access to senior clinical and management positions. The training then offered the possibility of supporting the empowerment of Aboriginal people within services to take up leadership positions in Aboriginal and mainstream health.

An individual process of reconciliation. As part of exploring models of collaboration, I became interested early in the research process in what it would take to reconcile in the fields of Aboriginal health, education and research. I wished to understand the personal barriers for non-Aboriginal workers to engaging in partnerships with Aboriginal people. I was cautioned by my supervisors to avoid too great a focus on the experience of non-Aboriginal people as this could potentially diminish the potency of the experiences of Aboriginal people in the thesis. With this in mind I held to the belief that some consideration of these constraints and how they were managed would be valuable in explicating constraints to reconciliation in the systems and structures surrounding individuals, communities, services and governments.

Introductions

When presenting myself to the Training Group I adopted suggestions made by the Indigenous Team in order to demonstrate cultural sensitivity and increase the likelihood that my various undertakings would be supported. Firstly, an Aboriginal Team member introduced me to the group and explained my connection to the Team and my roles. I explained how the research I was conducting was in partnership with the Aboriginal Researcher in attendance who had been part of the research within the Team for some years. I spoke about my background and connections to the Team along with my interest and passions in relationship to the research area. I explained that the research's primary aim was to inform the mainstream health system about working with Aboriginal families where substance use was an issue and how Aboriginal AOD workers and their development, was critical to this achievement. I made overt how my position as a white researcher was a tricky one and wondered whether it was OK for me to ask questions if I didn't know certain things. I also recognised that I would make mistakes and hoped that I would be pulled up on them as I wished to learn and not cause offence whenever possible. I mentioned that as the research area pertained to the AOD sector I would be asking those working in that area if they were interested, on a voluntary basis, to talk with me about their work. I chose not to use the word interview and opted for 'having a talk' or 'a yarn' in order to make the process less formal and signalling a desire to connect with those spoken with.

It was three weeks into the training before I approached the AOD workers about their interest in participating in the research. By that time we had all been involved in 'Yarnin' up on Trauma' training²² which was part of the Training Program and it had been recommended I attend in order to increase my cultural awareness. Spending this time together I felt would enable group members to get to know me and so be better able to make an informed decision about whether to be involved in the research or not.

Is it OK for me to be doing this work? After I had commenced the research I decided, along with my supervisor, to ask those I interviewed whether they thought it was OK for me to be doing this work. This question was to ascertain what the workers understood the purpose of the research to be as well as an assessment of the perceived validity of the topic and my role within it. In response to this, a worker replied she perceived that the research would support more Aboriginal people into family therapy positions and would raise the profile of Aboriginal ways of working with families, so for this reason it was OK for me to be doing this work. Similar responses were gained from other research participants. This had the effect of freeing me up to

²² Yarnin' Up on Trauma training is part of the post Graduate Certificate in Family Therapy offered to Aboriginal healthworkers.

do the various research tasks, as I had the imprimatur of those involved and the knowledge that the work was perceived to be of benefit to Aboriginal people.

Worker Responses to the Research

The research process afforded benefits and outcomes to those involved as participants and opportunity was taken during interviews for participants to assess the research and my role within it.

Benefits to visiting services. When interviewing workers at their services, time would be spent informally making personal connections before beginning to focus on particular areas relevant to the research question. One worker described how *'it was nice to be listened to for a change'* as she was often in the inverse position and received minimal supervision. She took the opportunity to ask for clinical advice regarding clients and we would discuss various approaches that we had implemented both within our own families and in our professional work.

Another worker appeared *'buoyed up'* during the conversation about her work and that the opportunity to express her views seemed to represent an acknowledgement of her skills. This was gratifying as I had consciously undertaken to position workers as experts in their field with a wealth of knowledge to impart about how to work in the field of Aboriginal substance misuse.

Another worker felt that as a result of mine and my co-researcher's visit to her service, greater respect and collaboration had been generated between her and her work mate. We had taken the advice of the worker to interview her colleague and she expressed that;

I think that you talked to [an Aboriginal colleague] previously and...there was a definite change in her view about what I do after you came up

Co-researcher: Now she knows how to include you in her ideas...

Worker: She can see a role for me in her ideas and it's more inclusive of me.

Non-Aboriginal worker

The worker also felt that;

Just you being here has made a huge difference to me...It's got us asking questions...I wouldn't have sent the email to everyone and told them about what I'm doing. I think the fact that you've come up here and kept the spotlight on it has been really helpful. I think I thought about it after your first visit and you speaking to the CEO and raising the profile of family therapy; putting the spotlight on it helped him to start to thinking about my role and a role for the future of family work here.

Constraints to the Interview Process

Though responses to the interview process were positive, participants sometimes exercised a degree of caution and formality, which was perceived to stem from a desire to protect individuals and services from negative evaluation and a degree of unfamiliarity with a process perceived as arising from a western paradigm.

Perceived judgement or evaluation. When conducting the interviews I observed that people enacted a degree of caution when talking about best practice and what worked well in terms of clinical interventions and workforce support and service provision. This caution I took to be a result of participant's concern as to how the findings of the research could position them in their community and through discussion with participants this perception was confirmed. Participants stated that it was important to not to be seen to be placing any practice or service as better than, as it would not be humble nor diplomatic within the highly political environment of Aboriginal health. I assured participants throughout the research about the goals of the research and the rationale behind what I was asking and why.

A heightened concern surrounding possible negative assessments being made of worker performance surrounded interviews with managers. I invited workers and managers to be interviewed together in the hope that relationships and knowledge would be built around how family work could enhance practice in the service. Workers stated that they felt a high degree of discomfort and concern about being involved, with only one co-interview occurring and commonly chose to give their managers 'freedom to say whatever they wanted about me' (see Chapter 8).

A degree of formality. I often left interviews feeling that I had failed to elicit the answers I was looking for to some of the questions I had asked. This could have been a result of a lack of clarity in questioning, a use of language which highlighted disparities in education and experience and a power differential. There was at times a degree of formality which I could not shift and a sense that the workers felt they were being assessed in some way. I had conveyed that participants exercised full editorial control over the interview transcript but despite this, participants perhaps assumed that they would spend minimal time reading transcripts or making amendments or additions. This intensified the need to not disclose information that may be perceived poorly by community members.

A narrative approach? On reflection I think that I could have asked fewer questions and asked instead for people to tell a story in response. This may have enabled people to feel

more open and included a broader range of their experience. However, in one of the interviews this was precisely what happened and little of what was spoken was able to be included as it did not pertain to the research questions. It's possible that a more sophisticated approach to a narrative method of interviewing may have better aligned with my wish to create a less formal environment and provided answers to the research questions.

A western paradigm. It was obvious at times that I was speaking a different language and doing something stemming from a western paradigm. This was evidenced in one of the interviewee's comments;

Non-Indigenous or mainstream workers like to have terms or to be able to identify evidence of good practice so they analyse how things are done. Whereas I just do it because it is something I have always done, it is simply an extension of my life. There is no training or courses to complete, you just interact with other families the way you would with your own.

Aboriginal worker

Though this quote reveals a critique of my approach at other times alternate views were present which could fluctuate around the degree to which training and research was esteemed.

Forum Theatre Facilitator



Though not formally a part of the research, my role as Forum Theatre Facilitator and mentor, provided significant outcomes which interacted with, and informed, the research. These roles served to build relationships with those workers and communities associated with the Training Program, enhance my knowledge of the field and enact ethical principles outlined in the methodology section.

Figure 7: Forum Theatre with the Gippsland mob 2010

I took on the role of Forum Theatre Facilitator in 2010 and was immediately interested in recruiting an Aboriginal person from within the Training Program to take over my role as I felt that this would be in keeping with the capacity building aims of the Training Program. The Forum is a significant component of the Indigenous Program's post Graduate Certificate in Family Therapy and is based on methods adapted from the Brazilian theatre director Augusto

Boal (2008). This method involves representatives from the community coming together to generate an interactive performance which highlights the problems that they are struggling with. Community members are invited to attend the Forum Theatre event and are involved in enacting possible solutions to these problems within an interactive performance.



Figure 8: Forum Theatre Performance

As part of the post Graduate Certificate training, a Forum Theatre event has been incorporated into the curriculum and constitutes part of the course requirements. Students demonstrate their systemic understandings gained through the Training and apply them to the context of their work. The Forum is also an opportunity to highlight and celebrate the skills and accomplishments of the students within their community.

When considering that Augusto Boal's method (2008) seeks to place control for community problems in the hands of those communities, having an Aboriginal graduate of the training mentored as a facilitator was fitting and congruent with the Black and White Approach espoused by the Indigenous Program.

Mentoring. I was intrigued to learn that a student in the Metro training had a background in using drama in community contexts and had completed a performing arts degree at the Institute of Koori Education (IKE), Deakin University. Through my conversations with her during the training I felt she had the depth of skills both in family therapy and theatre to be a facilitator of the Forum. We managed to secure funding for her to be mentored into the role of facilitator through the Jeff Lipp Innovation Fund²³. It was anticipated that she would be able to use Forum Theatre methods in a variety of contexts to empower communities to address complex issues.

The relationship between myself and my colleague who was being mentored involved a considerable investment of time to develop the necessary trust, equity and understanding through which to facilitate a process, which was very challenging. After two experiences of the Forum my colleague suggested that, due to its demanding nature, facilitation was '*a two person job*' and that she would prefer not to be sole facilitator but rather co-facilitate with me into the

²³ Dr. Jeff Lipp, psychiatrist and family therapist, was a key member of the Bouverie Centre between 1987 and 1997. The Jeff Lipp Innovation Fund was created in 2010 from a donation by the Lipp family in memory of their son, brother, brother-in-law and uncle.

future. I acceded to this as I had enjoyed sharing the role and could see the value of continuing with a Black and White Approach within this aspect of the Training Program. An account of my colleague's experience of Forum Theatre can be located in Appendix C.

As part of developing our working relationship, my colleague and I presented together at the National Indigenous Drug and Alcohol Committee (NIDAC) Conference in 2012. The presentation focussed primarily on the findings of the research but also sought to embody ethical research practice through member checking, consultation and reciprocity. A newspaper article appeared in the Koori Mail (refer Appendix C) which spoke to my engagement with and endorsement by community for the research and for the work of the Indigenous Program. Other feedback received about our presentation was that people recognised a sense of partnership and equity between us. This spoke to the work we had both put in to collaborate and of my colleague's ability to integrate the knowledge contained within the Training and the research.

Forum Theatre Outcomes. Though hard to quantify, outcomes of the Forum Theatre events can be seen to have manifested in a variety of ways. Participants have reported that the Forum Theatre process has been instrumental in healing long standing rifts between community members, through harms being acknowledged and reparations made. Greater respect and opportunities have been afforded to workers as a result of representatives from their services and communities attending the Forum Theatre event. Participant's confidence to perform and articulate their work was evidenced particularly by one training cohort who were so pleased with their performance that they decided to restage it at the Australian Family Therapy Conference. This was significant as the audience was mostly non-Aboriginal and many of the group had not attended or presented at such a conference previously. The group commented that they felt satisfied with the process and outcome of the presentation with one participant saying that they 'wished it could have gone on for ever!'. Others in the group commented that the presentation was only possible because of the support of all those in the Team.

An increase in confidence around performing and presenting knowledge was cited as the reason that one participant was able to be part of writing and performing in television commercials aimed at preventing men's violence. Others who had been involved in the Forum Theatre process have described it as a transformational experience, which revealed and clarified their sense of purpose and passion in their work.



Figure 9: Forum Theatre with the Gippsland mob 2010

Those participating in the Forum Theatre events have remarked that my facilitation of the process has contributed to the success of the presentations. They have commented that my respect for the traditional owners of the land is crucial to engaging the group and that my belief in the process and in the group's ability to generate a quality performance enables them to stay with the process. From my own perspective, I believe that keeping an unerring eye on what the group wants to communicate is key to achieving a result which they can own and feel proud of. Within the process, challenges are rolled with whilst maintaining the focus on what needs to be achieved. It is necessary to hold strongly to what my role requires of me and make difficult decisions when necessary to keep the process on track. The need to stand strong is magnified in

this context as the Forum Theatre process is a course requirement. It generates a high degree of anxiety due to its compulsory nature and through the need to perform in front of community. The workshopping process to performance is relatively short and a large amount of commitment from the group is required. Support from my Aboriginal colleagues has encouraged and reminded me that people naturally resist doing something which at times is very challenging and that it is important not to drop the high standard that has been set.

Lessons Learnt

Some of the most significant learning I experienced during my research journey was about how to respond to the challenges that were posed and how to create safety for myself and my Aboriginal colleagues. I needed to reflect on the constraints that can exist for non-Aboriginal people becoming involved in collaborative relationships with Aboriginal people, consider what I could represent, stand strong, develop respectful relationships and utilise writing as a way to learn from challenges.

Constraints to collaborative relationships between Aboriginal and non-Aboriginal people. Given that it is critical for both for Aboriginal and non-Aboriginal people to work together to tackle the problems and inequities that exist within Australian society (Maddison, 2011), I was interested to reflect on what had previously led me to limit my degree of involvement in Aboriginal issues. One of the reasons I identified was an intergenerational legacy of shame and guilt which manifested as a disconnection from the reality and responsibilities associated with the history of Aboriginal dispossession in Australia. Another was how this legacy could couple with a belief in self-determination for Aboriginal people where the role of white people is to step back to make way for Aboriginal people to take up their rightful space in society. This version of self-determination can act as a rationale for not entering into relationships with Aboriginal people whether that be either on an individual, service or institutional level. This can perpetuate a black and white divide with Aboriginal people not afforded access and equity across all aspects of Australian culture and institutions (Maddison, 2011; Waldegrave & J.T.T., 2003).

What I can represent. Aboriginal colleagues advised me to consider what it was I may represent to an Aboriginal person in terms of past and current racial abuse and what privileges I enjoyed as a result. Knowing that I could be seen not as an individual but rather as a perpetrator of inequities was important for understanding the variety of reactions and projections that I encountered. It was helpful to view strong reactions and misunderstandings through a trauma lens where negativity and fear serve as protective defences against a sense of powerlessness, rage, worthlessness and inadequacy (J. Herman, 1992; van der Kolk, 2007b). When reactions are

viewed systemically, opportunities are opened up to respond constructively rather than reactively.

Standing strong. During times when queries arose about my or others intentions or methods, I observed that it was useful to apologise immediately for any offence taken and ask how things could be handled differently. It was seen to be important to not take criticisms to heart and give in to a sense of hopelessness as it was more productive to stand strong and weather the storms in the knowledge that others in the Aboriginal community had endorsed the aims and methods of the research and other activities associated with it.

Knowing that as a white person I could be viewed with suspicion, I learnt that when opportunities arose to express a position surrounding issues pertinent to Aboriginal people it was important to make my beliefs overt. If I withheld my bias I could be wrongly assessed and my ability to proceed with the work would be effected.

This learning was engendered through seeking out support and understanding from my colleagues in the Indigenous Team, research participants and friends familiar with the field. This enabled me to find ways to sustain my involvement when the going got tough.

Respectful relationships. The importance of support from Aboriginal colleagues I found was essential and needed to be cultivated through mutual commitment to the work and everyone gaining through the relationship. This, I realised, takes time, patience and a willingness to connect on a variety of levels so that agreement can be reached on how each person's contribution will be acknowledged.

When co-work is presented publically the Aboriginal person needs to lead which respects their authority and right to endorse and give voice to approaches in Aboriginal health.

Writing through the difficulties. Another important means of centring myself in the work was to continue to write throughout the research process and amidst difficult circumstances. When I was able to do this, a sense of direction and control resulted so that situations could be looked at more purposefully in terms of, what data they were providing and what learning was being derived.

Summary

This chapter has charted the learning and outcomes associated with the various roles that I inhabited during my journey with the research. As these roles informed one another and effected my interpretation and understanding of the research findings they have been detailed. As I had not previously worked in the field of Aboriginal health and education I was not known

by the participants or by a number of the Indigenous Program Team members. The possibility of engaging participants in the Training Program with the research, rested on the imprimatur of those in the Indigenous Program so it was necessary to spend considerable time cultivating those relationships by embedding myself in the Team and making myself useful. Time was also spent with the Training Group so that they could get to know me and understand the aims of the research before committing to be involved.

Through endeavouring to enact ethical research practices it was necessary to build relationships and partner with Aboriginal people. Through this process I learnt what it meant to consult and collaborate in working relationships with those participating in the research. I learnt to work alongside my colleagues by respecting Aboriginal people's right to speak first in regard to issues directly affecting them and I deferred to their authority on matters of content, whilst contributing my knowledge and opinions surrounding the style and structure of written work and presentations. This manner of working was perceived as equitable and collaborative.

At times I felt challenged about the amount of time that I was contributing to projects in order to engender working relationships, though I came to appreciate that I needed to broaden my perspective to acknowledge the substantial contribution my Aboriginal colleagues were making in terms of trust, their personal reputation in community and their cultural knowledge and endorsement.

In my desire to enact reciprocity in the research process I sought to build capacity in research processes within the Indigenous Program and with those participating in the Training Program. Though effective collaborations were established, I was not successful in inspiring others to take up research leadership roles in the short term. However, a greater understanding of the processes and benefits of research for Aboriginal people did occur.

I had harboured concerns during the early stages of the research around some of the processes adopted by the Indigenous Program, my research topic and the usefulness of a non-Aboriginal approach as an intervention for Aboriginal substance misuse (family therapy). These concerns were addressed throughout the research journey, through posing questions to Team members, other research participants and through reflecting on my own experiences.

The research process afforded benefits to the research participants as they identified that it had helped to raise the profile of family work in their agencies. Participants also commented on the interview process itself as being of value as it revealed perspectives that were productive for them in conceptualising their work and its direction.

The other roles I undertook during the research, particularly that of Forum Theatre facilitator and mentor, achieved outcomes for the project participants, even though they did not directly inform the research findings. Participants recounted transformational experiences and a sense of pride and accomplishment from their participation in Forum Theatre which had enabled them to take risks in other areas of their work, especially in regards to advocacy, performance and presentations.

My personal journey offered me important learning about how to affect collaborative relationships in the field of Aboriginal health. This learning was engendered at times through intense and difficult experiences, though this granted me a degree of sensitivity as to what is required for cultural safety and equity to be afforded both for myself and for my Aboriginal colleagues.

Through my journey with the research I learnt what it meant to consult and collaborate in working relationships with Aboriginal people. The following represent a set of principles and practices that were developed:

- To spend substantial time getting to know people personally and building relationships before asking anything of them.
- Not to rush processes to achieve outcomes but to spend as much time as possible working through what was deemed necessary so that my colleagues were satisfied with what was produced.
- To work alongside my colleagues by respecting Aboriginal people's right to speak first in regards to issues directly affecting them.
- Deferring the final authority to my Aboriginal colleagues regarding the content of presentations, reports and articles whilst focussing my contribution around how best to structure and articulate the knowledge.
- When I felt challenged by what I perceived as an unequal time investment in a project, I took a broader view to acknowledge the substantial contribution my Aboriginal colleagues were making in terms of their cultural knowledge, their trust in me and the project and how their personal reputation in community was at stake when they endorsed any project or put their name to a piece of work.

- A significant amount of time was spent participating in knowledge transfer around research which achieved an increased understanding by the participants about research processes and of the benefits of research.
- The research process afforded benefits to the research participants as it revealed perspectives that were productive in conceptualising their work and its direction and by visiting services and interviewing staff and management, the profile of family work was raised.
- Other positive outcomes for participants which resulted from activities outside of the research process included; the recounting transformational experiences as a result of participating in Forum Theatre; and a sense of pride and accomplishment which had enabled them to take risks in other areas of their work especially in regards to advocacy, performance and presentations.

Chapter 10 Discussion

Through this thesis the voices of Drug Service workers employed in the field of Aboriginal substance misuse and their managers have clearly expressed a rationale for a systemic approach to substance misuse which also has broader implications for the delivery of health and education programs. Family therapy was shown to have the ability to engage participants in interventions that they found meaningful to their work contexts.

Family in the Provision of Treatment for Aboriginal Substance Misuse

Within the literature there is often mentioned the need to include family in the provision of treatment for AOD issues people (DoH, 2010; MCDS, 2006; Novins et al., 2011; Wilson et al., 2010). However there is little description of what these interventions entail or the different levels of family engagement that can be employed. In this context, this research is significant in providing a compelling account of the positive impact of family therapy interventions and their implementation within the field of Aboriginal substance misuse.

The way the workers perceived family therapy was gained to a great degree through their experience of the family therapy training program and so it isn't possible to separate the relevance of family therapy from their experience of the training. All of the workers, however, did have a significant history working in the field of Aboriginal health and substance misuse. As such, they brought with them a great deal of knowledge and expertise both culturally and professionally. As interviews were conducted early on, and then immediately after the first year of the Training Program, workers had opportunity to extend their pre-existing interventions and implement new practices so that this study also contains accounts of the particular benefit and relevance of family therapy to their work.

This study has indicated the receptivity of the participants to the use of family interventions in the treatment of Aboriginal substance misuse and their experience utilising them over a short time period. Other studies have found that interventions embraced by communities are the most effective in addressing substance misuse (Brady, 2004; Gray et al., 2000). So there are promising signs regarding the relevance of family therapy in the Aboriginal community.

A number of factors account for the uptake of family therapy by the workers and their managers. Those participating in the study held the pre-existing belief that including family in Aboriginal AOD treatment was a necessary part of service provision. So family therapy appeared to them a common sense approach to substance misuse as well as to Aboriginal healthcare more generally. These views are congruent with what is known in the literature to constitute Aboriginal concepts of health (Hunter, 1993; VACKH, 2009). Since the late 1980s in Aboriginal

health policy, service provision has been broadly defined in holistic terms (Hunter, 1993; VACKH, 2009). A holistic view of health encapsulates social, emotional and cultural wellbeing with an emphasis on Aboriginal people exercising control over the various domains of their life (Johnston & RCIADIC, 1991; NAHSWP, 1989). The research participants emphasised that family therapy, through its focus on systems and the context of problems, provides an inherently respectful and inclusive means of addressing a range of health concerns including substance misuse.

This research contributes to the field through emphasising how Aboriginal culture places a high premium on maintaining connection to family and community, so by including families in treatment the interconnected nature of relationships can be respected and knowledge held about how to best to address problems that exist in community, can be drawn on.

Another reason for including families in AOD treatment noted by workers, was that substance misuse often occurs in the context of family relationships where a number of family members have substance use issues. Hence, in order to intervene in the environment where the problem occurs, families need to be involved.

The workers believed that strength-based interventions were the most useful for their clients. This aligns with the views of others working in the field of Aboriginal health (Pattel, 2007; Roe, 2000; Vicary & Andrews, 2000; Whiteside et al., 2006). What this research contributes is the belief in family therapy as a strength-based intervention by participants, which could serve to rebuild family and social supports affected by transgenerational trauma. Workers viewed substance misuse within the context of trauma and the social determinants of health and believed that addressing these causes would be most effective when seeking to intervene around substance misuse. By perceiving the substance use and problematic relationship patterns through the lens of trauma, workers experienced this framework as providing a non-blaming means of approaching the problem. They learnt that family members could be released from the cycles of blame and shame that served to perpetuate the problematic behaviour. Family therapy interventions were also experienced as being able to build upon the positive aspects of culture in sustaining decreased problematic drug and alcohol use and the family's sense of mastery and control in their lives.

As a result of the family therapy training, both workers and their managers stated that workers had an increased capacity to apply interventions that empowered clients, families and communities. The ability to respond therapeutically rather than with crisis responses, was found to be important in enabling workers to offer interventions that supported families to find their own solutions to problems. This provides a new contribution to the literature around workforce development in the Aboriginal substance misuse field. Managers also noted that worker stress

had decreased through workers affording greater responsibility to clients for the outcomes of their work together, whilst focussing on building strengths which would sustain them and their communities.

Other possible applications. Family therapy was found to provide insight around how a range of other health interventions could benefit from the inclusion of family in their delivery and the means to purposefully do this. The participants in the research explored the possibility of extending the skills acquired in the family therapy training to a range of settings and applied to different levels of treating substance misuse from brief interventions to counselling and therapy. Workers and managers cited that a coordinated approach across all aspects of health and wellbeing was a current priority in service delivery and that the systemic understanding inherent in family therapy training and approaches offered a means through which this could be implemented.

Family Therapy Training Access and Participation

Through interviews with the workers involved in the Training Program, it was evident that the way they had been engaged with family therapy ideas was of great significance considering the low access and participation in higher education by Aboriginal people (ABS, 2009). Throughout the study culturally appropriate processes being enacted was found to be critical to enabling any type of engagement, either in the family therapy interventions, the training or research.

Effectiveness of the Black and White Approach. The research found that the Black and White Approach that underpinned the Training Program provided collaborative principles to consider when implementing interventions and policies in the field of Aboriginal health. Those working in Aboriginal affairs (Gray, Stearne, Wilson, & Doyle, 2010; Hazlehurst, 1994; Phillips, 2003) have long suggested that adequate consultation is required for any endeavour affecting Aboriginal people, though this approach is not often taken. Programs and policies remain partially fulfilled, under-utilised or not engaged with. Though this study focuses on a small cohort of participants within a very particular context, the principles embedded within it could be applied in other contexts when partnerships need to be formed between Aboriginal and non-Aboriginal services.

One of the reasons why this particular pedagogical approach underpinning the family therapy training had meaning and resonance for these participants, both Aboriginal and non-Aboriginal, was its ability to create a safe learning environment where the workers were able to relax sufficiently to take in new information. Trainers were aware that due to the history of trauma and some of the participants' negative prior educational experiences, greater attention needed

to be afforded to group processes. The focus on building a collaborative learning environment with minimal focus upon didactic presentations of material was in keeping with Paulo Freire's dialogic model of education where the knowledge of participants is placed centrally in the process (Freire, 1970) and with models of Indigenous education (Gray et al., 2004; Waples-Crowe & Pyett, 2005; White, 2005). Knowing that, for those with a history of trauma, hypervigilance can prevent the taking on of new knowledge (Levine, 1997), the research demonstrated the importance of privileging safety over other aims and objectives so that learning is enabled.

An indication of the success of the Training Program as evidenced through the high retention rate of Aboriginal students (89%) and the satisfaction of the students with the course content and its delivery is noteworthy considering the relatively low completion rate of Aboriginal students in higher education (50%) compared to around 75% for other students (Dept. of Education, 2002). The achievement of a postgraduate qualification marks these workers out as leaders in their communities through their ability to traverse both professional and community domains whilst maintaining respect in both. As there is a lack of Aboriginal people in senior clinical and management positions, the ability of the family therapy training and the postgraduate qualification to support the professional development of drug service workers in the field of Aboriginal substance misuse is significant.

Family Therapy Training as a Workforce Development Strategy

Best practice in Aboriginal health determines that Aboriginal people need to hold positions which direct the choice and application of health interventions in their communities (Australian Government, 2013; Johnston & RCIADIC, 1991; NAHSWP, 1989). In order for Aboriginal AOD workers to be empowered to progress into leadership positions, ongoing opportunities are needed and clear career paths need to be developed (Australian Government, 2013; Department of Education, 2013; Hunter, 1993). By having Aboriginal workers in positions of authority the likelihood of culturally relevant services being delivered for Aboriginal people is increased, thus potentially improving service access (Brady, 2007).

Acknowledgement and recognition for workers. Inadequate recognition of the workers' professional experience and cultural knowledge around how best to work with Aboriginal people was often cited by Aboriginal workers as a constraint to their professional development. Literature accords with this perception, specifically around the inadequate remuneration that workers in this field receive (Duraisingam et al., 2006; Duraisingam et al., 2007; Gray et al., 2004). The workers spoke of how the training increased the level of respect for

them in their workplace, where they were more frequently sort out for secondary consultations around clinical issues and how to work effectively with families.

Workers were also asked to present at in-services regarding family work and four of the six interviewed moved into more senior clinical and management roles during the course of the training. It was found that workers had become 'champions of change' and 'role models' for other workers and community members since commencing the training. Managers observed that workers possessed the language and greater authority to advocate for the inclusion of families in treatment and for the use of family therapy as an intervention in Aboriginal substance misuse.

Other suggestions to afford greater recognition to workers included: position descriptions that included capacity to undertake family work, adequate remuneration with rates commiserate with non-Aboriginal organisations and other sectors, meaningful professional development opportunities, and opportunities for workers to share their knowledge within the health sector.

Barriers. A difficulty regarding the use of family therapy training as a workforce development strategy is that family therapy is not widely known or respected, especially within the Aboriginal AOD health sector (DoHA, 2010; MCDS, 2006; Strempel et al., 2003). Workers reported that many people were unaware of how family therapy could be useful as an AOD intervention or how it could deal with a range of other complex issues surrounding substance misuse. In this context, workers spoke of the need to be able to articulate to their colleagues the rationale for family interventions in Aboriginal Health and demonstrate how it was proving to be useful.

A significant constraint cited by the workers for progressing their careers was the lack of clinical and family therapist positions, particularly within Aboriginal organisations. The workers highlighted that within the AOD field less respect is accorded to them in comparison to those working in other sectors such as mental health. Substance users are often marginalised in society and within service provision and this is paralleled in the low status afforded to the mainstream and Indigenous AOD fields and reflected in the low remuneration for its workers (Duraisingam et al., 2006; Duraisingam et al., 2007; Gray et al., 2004). The research highlighted the particular barriers within the Aboriginal AOD field including stigmatisation of clients and workers, heavy workloads, restrictive reporting requirements and lack of workplace support such as clinical supervision. These provided difficulties in attracting and retaining qualified staff (Gray & ANCD, 2010; Roche & Pidd, 2010).

Aboriginal workers spoke of the difficulty of maintaining respect in both worlds and that as Aboriginal community members and professionals there existed considerable complexity.

Workers spoke of the perception held by some in the Aboriginal community that to invest in career development was to be perceived to have 'gone white'. The workers recounted how even within Aboriginal controlled organisations there was ambivalence expressed about moving into clinical or management roles as they could then be perceived as representing authority which held negative associations for some community members. They noted that working in mainstream organisations also presented a significant challenge for Aboriginal people as those organisations could be seen to denote the colonial past and present containing racist structures and practices that discriminate, or at the very least ignorantly enact white privilege. To be employed or hold positions as leaders within these structures was discussed as potentially legitimising an inequitable system where government has power over and holds the resources of Aboriginal people.

As there is little research on the legacy of trauma in regards to Aboriginal leadership this could be an area of future research. In the context of this research, participants highlighted the need for a collaborative environment where those in the Aboriginal community have a sense of control and are given sufficient choice about what structures and interventions they wish to incorporate. By so doing greater opportunities exist for Aboriginal people to move into leadership positions.

Participant Recommendations

Recommendations made by workers and managers regarding workforce development and general improvements to the sector included:

1. Flexible funding arrangements to allow family therapists to be employed to work across a number of programs providing specialist treatment, education and secondary consultation. These positions would serve to connect and integrate programs, which is congruent with departmental policies aimed at service integration (DoH, 2012).
2. Increased access to accredited, culturally safe and relevant training that acknowledges the prior experience and cultural knowledge of Aboriginal people. eg. Take the time to demonstrate Dadirri (deep listening) in order for relationships to be built and developed through showing respect to Aboriginal knowledge systems.
3. Training intake staff in family inclusive practices so that appropriate referrals can be made to accommodate the individual's context and support system.
4. Rehabilitation and detox facilities need to include family programs so that changes made during treatment can be sustained and so that a sense of connection is maintained amongst family members. Family programs need to address the environment where the

problem is maintained and the needs of the family ought to be taken into consideration. When family members are unable to travel to rehabilitation and detox facilities, Skype or video conferencing facilities are needed to maintain connection and support.

5. Increasing service investment in cultural programs, including men's and women's groups which build social support and create environments conducive to change.
6. Increased counselling and mental health services that address high prevalence disorders such as anxiety and depression.
7. Changes to the reporting system to reflect work done with families. Though family inclusive practice is included within departmental policies, there is not an adequate way for the work to be counted and within many services the work remains invisible. Those interviewed suggested broadening the focus of what is considered a successful outcome for AOD treatment to include improved family functioning.
8. Reporting requirements need to take into account the diverse locations in which workers operate so that targets are not static between workers with smaller catchment areas and workers who need to travel longer distances to see clients.
9. Improvements in the service systems' ability to respond to crises especially in rural areas where Aboriginal people frequently ended up in police cells overnight and in some cases psychiatric wards rather than detoxification or dry-out facilities.
10. Mainstream services need to be more inclusive and welcoming of Aboriginal peoples. Within the context of AOD treatment it was recommended that increased numbers of Aboriginal people need to be employed as reception staff, withdrawal nurses and in AOD and mental health counselling positions.

Participants in the study recounted the difficulties Aboriginal people encountered when utilising mainstream services and in accessing a full range of AOD interventions. In order for Aboriginal and non-Aboriginal people to work together in providing access and equity in substance misuse service provision, this research has demonstrated that collaborative processes need to be privileged. The ability to traverse knowledge systems and cultural practices so that a sense of equity is created has been shown throughout this research to take considerable time and investment. Though resource intensive, this mode of working has been shown to be beneficial and can provide guidance on how services can work to deliver a range of AOD interventions in a culturally relevant way which could be transferred to other domains of health, education and research.

Acknowledgement and respectful collaborative relationships

When reviewing the research findings, the acknowledgement of Aboriginal people's country, culture, transgenerational trauma, history, skills and expertise was seen to underpin the possibilities for family therapy as an intervention for Aboriginal substance misuse and the usefulness of family therapy training and qualifications for Aboriginal workforce development. Acknowledgement provided the necessary first step towards engagement of Aboriginal workers and organisations (Onemda, 2008; Waldegrave & J.T.T., 2003; Waples-Crowe & Pyett, 2005).

Acknowledgement is also a part of healing from trauma (Herman, 1992) and operates within a process of forgiveness and reconciliation. Acknowledgement is the critical first step towards forgiveness then followed by reparative action (Herman, 1992). From this vantage point it appears, from the perspective of the research participants that non-Aboriginal people are still at this first step. It can be extrapolated that as a nation this is also true where non-Aboriginal people struggle to acknowledge the effects of colonisation, the need for constitutional recognition of Aboriginal people, land rights and self-determination economically and socially. The conversations with research participants did not focus on the broader processes of reconciliation so this study did not frame the experiences of the research participants in this light, however this could be a subject of further research. The experiences of Aboriginal and non-Aboriginal workers could be considered in terms of the individual and collective steps towards reconciliation within the implementation of health interventions and in educational settings.

A focus of this study has been on the necessary components when building relationships between Aboriginal and non-Aboriginal people in the context of Aboriginal health, education and research. It is clear from this study that acknowledgement enables relationships, which provides the foundation for the implementation of interventions. At times the need to hold centrally the difference between Aboriginal and non-Aboriginal knowledge systems and identities represented a conflict for myself and the participants. Essentialising notions of what can be defined as Aboriginal or non-Aboriginal identities can enable exclusion and for power to be operationalised in service of those in positions of power (McIlwaine, 1998; Waldegrave & J.T.T., 2003). Though critical theory conflates discourse surrounding Whiteness and Indigeneity (Cowlshaw, 2006; Kowal & Paradies, 2005; Paradies, 2006) it did not inform the methodological framework in this research. The focus was on privileging the voices of the participants within frameworks that respected and honoured their experience as represented through the research. Discussions around the difficulty in maintaining respect in Aboriginal community whilst engaging in the trappings of success in non-Aboriginal culture, did occur though did not extend to broader consideration of how conceptions of difference and identity served Aboriginal people.

In the Indigenous Program, though members did not neatly fit into a black or white category as they include a variety of different ethnic and cultural groups, it was observed that those in the Team spent little time problematising fixed categories of identity. This could be accounted for through the commitment of the Team to acknowledging difference as the students and workers perceived it and of pragmatically jettisoning whatever was not useful in building relationships and enabling a safe and productive educational environment. Difference, though central, was held lightly by Team members and respect was engendered for the ways alternate knowledge systems could approach education and family work in the context of Aboriginal health.

Another way of framing the need to respect and acknowledge difference is that Aboriginal people have been in the position of needing to adapt to other cultures in order to survive. Participants spoke of how Aboriginal people have inhabited a marginalised position in Australian culture and so to create a sense of equity and to seek to right an inequitable ledger, it is the responsibility of the non-Aboriginal people and systems to adapt to Aboriginal culture and ways of operating. In this context the research demonstrated the need for mainstream organisations to become more culturally respectful in the provision of services for Aboriginal people rather than requiring Aboriginal people to change to fit institutional structures (Smith, 1999).

Considerations Regarding the Research Outcomes

The multiple roles which I undertook during the course of the research provided a rich context from which to better understand the lives and experiences of the research participants, though they also constrained my reflexivity surrounding the Indigenous Program Team and the Training Program due to my embeddedness.

A consideration that may have impacted on the research was that managers who supported their staff to attend the training and participate in the research, invested program resources in the belief that the training would improve capacity and benefit staff members and their service. The workers attending the training also invested considerable time and effort into completing the training. The participants in the study demonstrated openness to family therapy concepts and practices in the first instance and professionally had an interest in adopting family therapy within the Aboriginal health sector. There were no participants interviewed that decided that family therapy was not a 'hand in glove' fit when working with Aboriginal substance misuse. However, if the experiences of family therapy approaches of those interviewed were not favourable, it is unlikely that services or workers would have continued to support the Training or family therapy as an approach.

Another factor influencing the data was my involvement with the Indigenous Program during the research process because I was regarded by many of the participants as part of the Team providing the training. I presented and workshopped ideas on research and evaluation, evaluated the training and facilitated the Community Forum over the last three sessions of the Training Program. There could have been a 'halo' effect regarding what participants chose to convey surrounding their experience of the Training Program and utilising family therapy in their work, enhancing the homogeneity and positiveness of their responses. This was mitigated against through relationship building and transparency regarding the research processes as discussed in Chapter 3 (see p. 77-81).

Directions for Future Research

Possible directions for future research could centre on: the role of delineating difference in the delivery of health, education and research projects with Aboriginal populations; the means by which Aboriginal people navigate the complexity inherent in maintaining professional and community respect; the effects of trauma on Aboriginal leadership; and the processes required for reconciliation to occur individually, programmatically and organisationally.

Conclusion

The experiences of drug service workers in the field of Aboriginal misuse, as evidenced within this research, have highlighted how family therapy can provide empowering strength-based interventions for Aboriginal families experiencing problems associated with substance misuse. Participants have perceived family therapy training as providing a therapeutic way of working that is effective in sustaining them in their work and which enhances their opportunities for professional advancement.

This research has highlighted how the strengths and possibilities inherent in Aboriginal culture must be held within a dialogue about any approach to Aboriginal health knowing that Aboriginal culture is continually evolving and incorporating new knowledge and practices. The distance between different knowledge systems and approaches to health and education is the dynamic liminal space that provides the possibilities for change and reconciliation. The research demonstrated a framework that can provide two-way learning where collaboration is wrought and leadership forged across the fields of health, education and research.

The importance of including families in Aboriginal drug and alcohol treatment in order for change to occur at an individual level speaks to the complexities and tensions that take place in the space in-between Aboriginal and non-Aboriginal collaborations. This research has demonstrated how family therapy can contribute towards addressing these tensions. The complexities and challenges that the participants encountered when undertaking the family

therapy training, including issues around identity, difference and stepping outside of community norms and expectations can also be seen to impact the engagement of Aboriginal people with treatment for substance misuse.

This research's translation into providing direction for organisations and government around drug and alcohol policy, particularly in regards to the release of funds to support the recruitment, retention and professional development of Aboriginal workers will contribute towards benefitting the research participants. Consultation and endorsement by the drug service workers who participated in this study will be a necessary part of translating the research into action in order to provide informed, educated and collaborative approaches to support much needed change and a healing within the Aboriginal community.

Appendix A Ethics Informed Consent Forms

1. Informed consent forms for individual interviews and spoken essays of Indigenous drug and alcohol workers.
2. Informed consent form to interview Indigenous drug and alcohol workers in the workplace.
3. Informed consent form for Managers and Employees.



Form One

LA TROBE UNIVERSITY HUMAN ETHICS COMMITTEE

PLAIN LANGUAGE STATEMENT

FOR INDIGENOUS DRUG AND ALCOHOL WORKERS

Student Researcher: Jacqui Sundbery (La Trobe University, Bouverie Centre)
j.sundbery@latrobe.edu.au

Co-Researchers: Dr Kerry Proctor (La Trobe University, Bouverie Centre)

Program manager, Indigenous Project Team, k.proctor@latrobe.edu.au

A/Prof Amaryll Perlesz (La Trobe University, Bouverie Centre)

Research manager, a.perlesz@latrobe.edu.au

Project Title: Engaging Indigenous alcohol and other drug workers in culturally appropriate family inclusive training.

Hello, my name is Jacqui Sundbery. I am a family therapist who has worked in the drug and alcohol field for the past nine years. Over the last two and a half years the Bouverie Centre has been funded by the Department of Health to provide culturally appropriate training to Indigenous child and family workers. Many Indigenous health workers have found this training useful and now further funding has been granted to extend the training to Indigenous drug and alcohol workers. I am interested in your perspective on what the training and support needs are of Indigenous alcohol and drug workers in Victoria and how workforce development could be strengthened in this area.

I am doing this research as part of my study towards a university qualification, a Doctor of Philosophy at La Trobe University and am part of the Indigenous Project Team at the Bouverie Centre.

To find out different perspectives on this topic I would like to have a conversation with you about decide how best to utilise the knowledge and expertise in this area to benefit Indigenous drug and alcohol workers. I will be having conversations with people at convenient locations and with permission these conversations would be recorded and used to better understand the needs of Indigenous workers.

If you are happy to be included in the project I would really appreciate your contribution, however you are free to choose to not to take part and your involvement in the project will not advantage or disadvantage you within your workplace or if you are involved in any of the training provided by the Bouverie Centre. You will be given a written consent form to sign and the results of this work will be regularly fed back for your comment and direction. I undertake to keep you informed regarding all stages of the project either by telephone, by mail or by email. With your agreement before finalising the use of your interview transcription, I will consult you in regards to its accuracy and whether you want to add or change it.

You have the right to withdraw from active participation in the project at any time and further, the right to require that all traces of your participation be removed from the project records, provided that this right is exercised within four weeks of the completion of your interview for the project. Please feel free to ask any questions during your participation in the project

The information you give may be included in a thesis, presented at conferences and published in journals and with your permission the findings will also be forwarded to the Department of Health with the intention of better meeting the workforce development needs of Aboriginal health workers. At no time will your name or other identifying information be used. The results of the project will be made to you at any time on request.

As a participant your anonymity is guaranteed within any written information through the use of pseudonyms and by omitting any information that may identify you. If you choose to withdraw at any time from the research your information will not be used and you can request that it be returned to you. All material will be in my possession, password protected on my computer and within locked premises until the research is complete. After that time it will be archived at the Bouverie Centre in a locked filing cabinet for a period of five years after which time it will be destroyed.

If you have any complaints or questions that the investigator has not been able to answer to your satisfaction, you may contact the Secretary, Research Services, La Trobe University, Victoria 3086 Tel: 03 9479 1443 e-mail; humanethics@latrobe.edu.au

I hope to have the opportunity of talking with you and if you would like to discuss this project further please approach me and I will be happy to do so. You may also want to contact my supervisor Dr Kerry Proctor 0421 444 237, e-mail k.proctor@latrobe.edu.au

Thank-you

CONSENT FORM

I _____ have read the plain language statement and agree to be part of the research project as it has been explained. I understand that interviews may be audio recorded for use solely as part of this research project and at any time I'm am free to withdraw my consent to participate from the project and have my information returned to me.

Signed _____

Date _____

Should you have any concerns about the conduct of this research project, please contact Barbara Doherty University Human Ethics Committee (UHEC) (03) 9479-1443
humanethics@latrobe.edu.au

CONSENT FORM

I _____ have read the plain language statement and agree to be part of the research project as it has been explained. I understand that my spoken essay that was part of the Graduate Certificate in Family Therapy may be used solely as part of this research project and at any time I am free to withdraw my consent to participate from the project and have my information returned to me.

Signed _____

Date _____

Should you have any concerns about the conduct of this research project, please contact Barbara Doherty University Human Ethics Committee (UHEC) (03) 9479-1443
humanethics@latrobe.edu.au



Form Two

REQUEST FOR PERMISSION TO INTERVIEW

INDIGENOUS DRUG AND ALCOHOL WORKERS IN THE WORKPLACE

Student Researcher: Jacqui Sundbery (La Trobe University, Bouverie Centre)
j.sundbery@latrobe.edu.au
Co- Researchers: Dr Kerry Proctor (La Trobe University, Bouverie Centre)
Program manager, Indigenous Project Team, k.proctor@latrobe.edu.au
A/Prof Amaryll Perlesz (La Trobe University, Bouverie Centre)
Research manager, a.perlesz@latrobe.edu.au

Project Title: Engaging Indigenous alcohol and other drug workers in culturally appropriate family inclusive training.

Hello, my name is Jacqui Sundbery. I am a family therapist who has worked in the drug and alcohol field for the past nine years. Over the last 18 months the Bouverie Centre has been funded by the Department of Health to provide culturally appropriate training to Indigenous child and family workers. Many Indigenous health workers have found this training useful and now further funding has been granted to extend the training to Indigenous drug and alcohol workers. I am interested in gathering different perspectives on what the training and support needs are of Indigenous alcohol and drug workers in Victoria and how workforce development could be strengthened in this area.

I am doing this research as part of my study towards a university qualification, a Doctor of Philosophy at La Trobe University and am part of the Indigenous Project Team at the Bouverie Centre.

To find out different perspectives on this topic I would like ask your permission to invite Indigenous drug and alcohol workers in your employment to have a conversation about how best to utilise the knowledge and expertise in this area to benefit Indigenous drug and alcohol workers. I will be having these conversations with people at convenient locations and if workers from your organisation are interested in being part of the study I would appreciate permission to interview them at your workplace. These conversations would be recorded and used to better understand the needs of Indigenous workers.

If you are happy for me to contact AOD workers at your organisation I would really appreciate it, however you are free to choose to not have your workers take part. If your organisation chooses not to participate, your involvement in the project will not advantage or disadvantage anyone within your organisation or employees who are involved in any of the training provided by the Bouverie Centre.

The information received from the interviews may be included in a thesis, presented at conferences and published in journals and the findings will also be forwarded to the Department of Health with the intention of better meeting the workforce development needs of Aboriginal health workers. At no time will employee's names or other identifying information be used regarding your organisation. The results of the project will be made available to you at any time on request.

Employee's anonymity is guaranteed within any written information through the use of pseudonyms and by omitting any information that may identify them or your organisation. If your employees choose to withdraw at any time from the research their information will not be used and they can request that it be returned to them if they exercise this right within four weeks of the completion of the interview for the project. You also have, at any time the right to withdraw permission for employees to be part of this project and for the use of the organisation's premises for interviews. Please feel free to ask any questions during the course of this project.

All material generated from the interviews will be in my possession, password protected on my personal computer and within locked premises until the research is complete. After that time it will be archived at the Bouverie Centre in a locked filing cabinet for a period of five years after which time it will be destroyed.

If you have any complaints or questions that the investigator has not been able to answer to your satisfaction, you may contact the Secretary, Research Services, La Trobe University, Victoria 3086 Tel: 03 9479 1443 e-mail; humanethics@latrobe.edu.au

I hope to have the opportunity of talking with Indigenous alcohol and other drug workers at your organisation and if you would like to discuss this project further please approach me and I will be happy to do so. You may also want to contact my supervisor Dr Kerry Proctor 0421 444 237, e-mail k.proctor@latrobe.edu.au

Thank-you

CONSENT FORM

I _____ have read the request and agree for the researcher to contact Indigenous alcohol and other drug workers in my employment. I am aware that interviews may be audio recorded for use solely as part of this research project.

I do /do not (please circle) consent for interviews to be conducted at my organisation's premises.

At any time I am free to withdraw my consent for my employees to participate in the project and for the workplace to be used to conduct interviews.

Signed _____

Date _____

Should you have any concerns about the conduct of this research project, please contact Barbara Doherty University Human Ethics Committee (UHEC) (03) 9479-1443
humanethics@latrobe.edu.au



Form Three

LA TROBE UNIVERSITY HUMAN ETHICS COMMITTEE

PLAIN LANGUAGE STATEMENT FOR MANAGERS AND EMPLOYEES

Student Researcher: Jacqui Sundbery (La Trobe University, Bouverie Centre)
j.sundbery@latrobe.edu.au
Co- Researchers: Dr Kerry Proctor (La Trobe University, Bouverie Centre)
Program manager, Indigenous Project Team, k.proctor@latrobe.edu.au
A/Prof Amaryll Perlesz (La Trobe University, Bouverie Centre)
Research manager, a.perlesz@latrobe.edu.au

Project Title: Engaging Indigenous alcohol and other drug workers in culturally appropriate family inclusive training.

Hello, my name is Jacqui Sundbery. I am a family therapist who has worked in the drug and alcohol field for the past nine years. Over the last 18 months the Bouverie Centre has been funded by the Department of Health to provide culturally appropriate training to Indigenous child and family workers. Many Indigenous health workers have found this training useful and now further funding has been granted to extend the training to Indigenous drug and alcohol workers. I am interested in your perspective on what the training and support needs are of Indigenous alcohol and drug workers in Victoria and how workforce development could be strengthened in this area.

I am doing this research as part of my study towards a university qualification, a Doctor of Philosophy at La Trobe University and am part of the Indigenous Project Team at the Bouverie Centre.

To find out different perspectives on this topic I would like to have a conversation with you about decide how best to utilise the knowledge and expertise in this area to benefit Indigenous drug and alcohol workers. I will be having conversations with people at convenient locations and with permission these conversations would be recorded and used to better understand the needs of Indigenous workers.

If you are happy to be included in the project I would really appreciate your contribution, however you are free to choose to not to take part and your involvement in the project will not advantage or disadvantage you in your workplace. You will be given a written consent form to sign and the results of this work will be regularly fed back for your comment and direction. I undertake to keep you informed regarding all stages of the project either by telephone, by mail or by email. With your agreement before finalising the use of your interview transcription, I will consult you in regards to its accuracy and whether you want to add or change it.

You have the right to withdraw from active participation in the project at any time and further, the right to require that all traces of your participation be removed from the project records, provided that this right is exercised within four weeks of the completion of your interview for the project. Please feel free to ask any questions during your participation in the project

The information you give may be included in a thesis, presented at conferences and published in journals and with your permission the findings will also be forwarded to the Department of Health with the intention of better meeting the workforce development needs of Aboriginal health workers. At no time will your name or other identifying information be used. The results of the project will be made to you at any time on request.

As a participant your anonymity is guaranteed within any written information through the use of pseudonyms and by omitting any information that may identify you. If you choose to withdraw at any time from the research your information will not be used and you can request that it be returned to you. All material will be in my possession, password protected on my computer and within locked premises until the research is complete. After that time it will be archived at the Bouverie Centre in a locked filing cabinet for a period of five years after which time it will be destroyed.

If you have any complaints or questions that the investigator has not been able to answer to your satisfaction, you may contact the Secretary, Research Services, La Trobe University, Victoria 3086 Tel: 03 9479 1443 e-mail; humanethics@latrobe.edu.au

I hope to have the opportunity of talking with you and if you would like to discuss this project further please approach me and I will be happy to do so. You may also want to contact my supervisor Dr Kerry Proctor 0421 444 237, e-mail k.proctor@latrobe.edu.au

Thank-you

CONSENT FORM

I _____ have read the plain language statement and agree to be part of the research project as it has been explained. I understand that interviews may be audio recorded for use solely as part of this research project and at any time I'm am free to withdraw my consent to participate from the project and have my information returned to me.

Signed _____

Date _____

Should you have any concerns about the conduct of this research project, please contact Barbara Doherty University Human Ethics Committee (UHEC) (03) 9479-1443
humanethics@latrobe.edu.au

Appendix B Copy of NVivo Data Coding from Chapter 4

A Whole of Community, Whole of Family Approach			
		Change over time	
			We need to start with our family
		Families can sustain change	
		Supporting holistic service delivery	
			Looking at the whole person...the bigger picture
			The issues are connected
		Working with the whole family can impact substance use	
Aboriginal People Attending Therapy and Counselling			
		A figure of authority	
		Assistance to attend appointments	
		Assumptions about therapy	
		Complexity and shared histories	
		Connection to the person rather than the position	
		Dealing with barriers	
			Demystifying therapy
Addressing Intergenerational Trauma Within the Context of the Family			
		Early intervention for children	
		Part of recovery is family	
		We really stick together	
Family Inclusive Residential Treatment			
		Addressing relationship difficulties	
		Changes to the environment	
		Connection to family	
Family Therapy as a Strength-based Approach			
		Empowering families	
		No one drives me	
		We don't have to be perfect to contribute	
Perception of the Problem			
		A lack of access to resources and appropriate services	
		A lack of skills and training to address complex issues	
		Transgenerational trauma	
			Heart and soul sickness
Repairing the Rupture - the Importance of Relationship			
		Applying therapeutic approaches	
			Adapting therapeutic approaches
			Having the trust and confidence of the family
		Developing trust through self-disclosure	
		There's a way around everything	
			Fearing rejection
Systemic Approaches to Working with Aboriginal Clients with Problematic Substance Use			
		A team of workers	
		Preparing for therapy	
			Support work

Appendix C Publications, Conference Proceedings and Media Arising From This Research

Dwyer, J. & Sundbery, J. (in press) An Inspiring Journey with Forum Theatre and Aboriginal Community.

Murray, E. (2012). Family Therapy Winning Favour, Conference Told. *The Koori Mail*, Wednesday 13 June, 36.

Sundbery, J., Boundy, F., & Griffin, D. (2012). How Family Therapy is Making a Difference for Indigenous AOD Workers. *DrugInfo Newsletter of Australian Drug Foundation's DrugInfo service., Responding to the needs of children and families experiencing drug and alcohol problems*(10(1)), 7,8.

Sundbery, J., Proctor, K. & Latham, R. (2011). Empowering Indigenous Family Workers by Degree. *Australian Philanthropy, Indigenous Philanthropy*, December (80), 23-24.

Empowering Indigenous family workers by degree

Reflections on the impact of the post Graduate Certificate in Family Therapy¹ that is being provided to Indigenous child, family and health workers through La Trobe University. By **Jacqui Sundbery**, PhD candidate, **Dr Kerry Proctor**, Indigenous Program Manager and **Robyne Latham**, Indigenous Researcher at the Bouverie Centre².



Graduates of the post Graduate Certificate in Family Therapy 2008-2011.

The Indigenous program at the Bouverie Centre³ has made an impressive contribution towards closing the health and education gap for Indigenous people since its inception in 2007. Many of the graduates of this training program report that prior to this training program their experiences of education had been discouraging (Latham, 2010). These experiences are reflected in the low uptake of university education by Indigenous Australians where they account for only 0.5 per cent of university places whilst representing 1.9 per cent of population over 15 years of age (ABS & AIHW, 2008). What makes this training model different is its accessibility; the training is provided in community, so that the university comes to them; the model of education is 'safe and empowering' so that the considerable skills and knowledge of the students are built

upon; places within the course are sponsored; and supervision is provided for two years post training to support the implementation of family therapy skills. Within this context, this flagship program has delivered in 2011, 14 per cent of all Indigenous students graduating with a post Graduate Certificate and 4 per cent of all Indigenous postgraduates nationally (Projected figures based on DEEWR, 2011).

Since 2008, 41 students have graduated from the Graduate Certificate in Family Therapy with an Indigenous retention rate of 89 per cent. This is remarkable considering the poor retention rates of Indigenous students nationally, where fewer than one half of the Indigenous students who enroll in higher education can be expected to complete their program of study (Australia. Dept. of Education & Training, 2002).

"Indigenous Australians prefer approaches to healthcare that include social, emotional, cultural and spiritual wellbeing and that recognise that gains in any area affect the whole person, their family and community."

Along with increasing the capacity of Indigenous workers and providing access to post graduate education, this program is equipping graduates with the necessary academic credentials to move into senior clinical and management positions (Latham, 2010). Though there is a wealth of experience

regarding working with families within the community, there has been a lack of recognition and acknowledgement of these skills and this qualification goes a way towards addressing this. As one graduate noted,

"While I believe I'm effective in what I do my confidence falls down big time when I'm questioned about my qualifications. This training and the qualification that comes with it has validated my many years of experience. I will finally have that piece of paper!"

Graduate, 2010

Indigenous people are more likely to access services that are staffed and managed by Indigenous service providers so it is important to support Indigenous workers to be employed in these much needed services (Whiteside, Tsey, McCalmana, Cadet-James, & Wilson, 2006). Significantly, 49 per cent of graduates are now undertaking increased clinical duties with families and 16 per cent of graduates have taken up senior positions in mainstream agencies (Latham, 2010). These graduates are cited as 'champions of change' within their organisations and are involved in increasing understanding of the central role of families in achieving positive health outcomes (McIlwaine & Sundbery, 2011).

Indigenous Australians prefer approaches to healthcare that include social, emotional, cultural and spiritual wellbeing and that recognise that gains in any area affect the whole person, their family and community (Garvey, 2008; O'Donohue, 1999). Family therapy, with its strong grounding in these principles, provides useful tools for Indigenous workers in addressing a range of issues including trauma, violence, mental health and drug and alcohol issues.

Graduates working in Indigenous community understand that,

"If there's been trauma in the family, it is not just one person who's been traumatised, it's been the whole family...and I just think that part of recovery is family...they can make it work...it's not just like putting a bandaid on the cut."

Graduate, 2010



Systemic understandings, gained through the Graduate Certificate are useful for workers when navigating the systems that they and their clients need to utilise. Recently, a network of Indigenous family therapists has developed to advocate on behalf of Indigenous workers and community to provide culturally appropriate service delivery.

The Indigenous program is supported through partnerships between La Trobe University; Philanthropic funding bodies such as The Myer Foundation, R. E. Ross Trust, JT Reid Foundation, Fouress Foundation; and short term contributions (2008-2011) from State and Commonwealth Government-OATSIH, DHS, DoH, and the DEECD. The philanthropic partners are currently supporting the Indigenous program, with transitional support as they endeavour to secure long term funding. ■

1. Family therapy is primarily a commitment to 'systemic practice', involving a focus on relationships, process, context and meaning. One can work 'systemically' with individuals, couples, various formations of family members, organisations or other groupings (Lowe, 2004).
2. The Bouverie Centre, Victoria's Family Institute is a unique public institute located within La Trobe University's Health Sciences. The Bouverie is publicly funded with the majority of funds emanating from Victoria's Department of Human Services as well as philanthropic organisations.

3. Training is conducted in partnership with Take Two, Berry Street, and in consultation with an Advisory Group comprising Indigenous and non-Indigenous representatives from the participating Aboriginal Community Cooperatives (ACCOS) and mainstream organisations working with Aboriginal families.

ABS, & AIHW. (2008). *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008* (Vol. AIHW cat.no. 21). Canberra: ABS.

Australia. Dept. of Education, S., & Training. (2002). *Achieving equitable and appropriate outcomes: Indigenous Australians in higher education*. Commonwealth Department of Education, Science and Training. Canberra: Dept. of Education, Science and Training.

DEEWR. (2011). *Higher Education Report 2009*.

Latham, R. (2010). *Post Graduate University Award Certificate in Family Therapy Training for Aboriginal Child, Family and Health Workers: Report on the second training cohort Ballarat 2009*. Melbourne: Bouverie Centre, La Trobe University.

McIlwaine, F., & Sundbery, J. (2011). *Family Therapy Training and Support of Aboriginal Mental Health and AOD Workers Working with At Risk Families in Aboriginal Community Settings - The Metro Cohort*. Melbourne: Bouverie Centre, La Trobe University.

Whiteside, M., Tsey, K., McCalmana, J., Cadet-James, Y., & Wilson, A. (2006). *Empowerment as a framework for Indigenous workforce development and organisational change*. *Australian Social Work*, 59(4), 422-434.

How family therapy is making a difference for Indigenous AOD workers

Jacqui Sundbery, PhD candidate, The Bouverie Centre*, La Trobe University;
 Francie Boundy, Koori Alcohol and Drug Diversion Worker, Sunraysia Community Health Services Ltd; and
 Di Griffin, Counsellor, Albury Wodonga Aboriginal Health Service, Victoria.

Family therapy Indigenous alcohol and other drug (AOD) workers and graduates of The Bouverie Centre, La Trobe University Postgraduate Certificate in Family Therapy, are finding that including family therapy approaches as part of their work practice offers many benefits to adults who use AOD and their families.

Since 2008, 41 students have graduated from the Postgraduate Certificate in Family Therapy with an Indigenous retention rate of 89 per cent. Family therapy is primarily a commitment to "systemic practice", involving a focus on relationships, process, context and meaning. One can work "systematically" with individuals, couples, various formations of family members, organisations or other groupings.¹

"By working more inclusively with families, alcohol and other drugs become less of an issue as clients and their families work together."

— Indigenous AOD worker

Incorporating the family** into service delivery for AOD issues makes sense as Indigenous Australians prefer approaches to healthcare that include social, emotional, cultural and spiritual wellbeing. They recognise that gains in any area affect the whole person, their family and community.^{2,3} Family therapy, with its strong grounding in these principles, provides useful tools to address a range of issues associated with substance misuse such as trauma, mental health, parenting and attachment issues.⁴

As one worker noted:

"If there's been trauma in the family, it is not just one person who's been traumatised, it's been the whole family ... and I just think that part of recovery is family ... they can make it work ... it's not just like putting a bandaid on the cut."

Responsibilities to family are often given as reasons why Aboriginal and Torres Strait Islander (ATS/I) people with alcohol issues alter their drinking behaviour. Some of these motivators to change are:

- needing to looking after family
- caring for children
- wanting to see grandchildren grow up.⁵

This sense of care and concern for family can be mobilised when workers are dealing with clients struggling with parenting.



Figure 1. Members of the Indigenous Family Therapy Network.



Figure 2. Graduates and trainers of the Postgraduate Certificate in Family Therapy 2011.

* The Bouverie Centre, Victoria's Family Institute is a unique public institute located within La Trobe University's Health Sciences. The Bouverie is publicly funded with the majority of funds emanating from Victoria's Department of Human Services as well as philanthropic organisations.

** Family for Aboriginal and Torres Strait Islander people includes blood and non-blood relatives.

By taking time to understand the context of problematic substance use, alternate ways of understanding can be opened up. An Indigenous AOD worker explains,

"It might be that Mum's not coping with the kids and she's smoking a whole heap of Yarnidi [cannabis] to help her get off to sleep at night and she's got depression and anxiety. She keeps re-presenting with the same issue [to the doctor's surgery], so if you can work with her and the family to address some of these other issues you are going to get a lot less presentations."

Positive family functioning is a key social determinant of health and resources committed to improving family relationships are an effective investment. International evidence illustrates that family interventions decrease childhood risk factors which have been linked to risky substance use later in life.⁶

"We can work with families so that the children have a really good chance of coming through and coping well as adults and having healthy attachments throughout their life."

— Indigenous AOD worker

By seeking to understand how substance misuse occurs in a particular context, family therapy provides opportunities to strengthen family resources to address substance misuse and to improve parenting and attachment in ATSI communities.

References

1. Lowe, R D 2004 "Family therapy: A constructive framework", London: SAGE
2. Garvey D 2008 "A review of the social and emotional wellbeing of Indigenous Australian peoples: considerations, challenges and opportunities," *Australian Indigenous Health Bulletin*, 8, pp. 1–29.
3. O'Donoghue L 1999 "Towards a culture of improving Indigenous health in Australia," *Australian Journal of Rural Health*, 7, pp. 64–9.
4. McIlwaine F & Sundbery J 2011 *Family therapy training and support of Aboriginal mental health and AOD workers working with at risk families in Aboriginal community settings — The metro cohort*, Melbourne: The Bouverie Centre, La Trobe University.
5. Brady M 2004 *Indigenous Australia and alcohol policy: meeting difference with indifference*, Sydney: University of NSW Press Ltd.
6. Wilson M, Stearne A, Gray D & Saggars S 2010 "The harmful use of alcohol amongst Indigenous Australians, at www.healthinfonet.ecu.edu.au/alcoholuse_review (accessed 27/04/2012).

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NIDAC conference speakers on family therapy Jacqui Sundbery, left, and Joanne Dwyer.



Daniel Morrison, Joseph Wallam and Margaret Beattie at the NCP national cancer prevention information.



The Wadjuk Dancers perform for delegates.

Family therapy winning favour, conference told

By ELIZABETH MURRAY



A NEW trend in the treatment of alcohol and substance addiction under which family members

participate in therapy is gaining support with communities and social workers, the NIDAC conference has been told.

Jacqui Sundbery, a researcher at the Bouverie Centre at Latrobe University, says family therapy creates a safe, supportive environment with the help of families and communities, that recovering addicts can return to after treatment. She has been studying its effectiveness.

She said there was a shortfall in research on the effectiveness of current therapies for Indigenous people.

Her new research shows many Aboriginal Australians are not utilising treatment services, and are waiting to get help until their conditions are acute and chronic.

Joanne Dwyer, from Victoria Aboriginal Health Services, helped to present the new research at the conference.

She said family therapy was about helping families solve their own problems and deal with them together, to prevent relapses.

"The therapy involves talking through issues that affect the whole family," she said.

"Family therapy is a space

where everyone gets a chance to speak and families find their own solutions to their problems.

"The role of the therapist is just to ensure that everyone is respected and gets to have a voice and that's regardless of age, and sometimes that means managing conflict within the family."

Research also found almost 90 per cent of Indigenous post-graduate students of family therapy completed their studies, where the retention rate for other higher degrees was only 50 per cent.

Course

Ms Sundbery said the course was designed specifically for Indigenous alcohol and other drug workers, who comprise two-thirds of all students.

Ms Dwyer said workers spoke about traditional rehabilitation as a band-aid approach, and commented that when family connections and support were not maintained, relapse became more likely.

Workers also noted that if clients moved back into the same old environment, they would be less likely to stick with rehabilitated behaviours.

She said clients felt family therapy improved their chances "because they've already discussed, as a family, what changes are necessary to make a home for the person to remain well".



Panelist Nadine Highfield.



An Inspiring Journey with Forum Theatre and Aboriginal Community

This article tracks the journey of Joanne Dwyer a Gunditjamara woman from Victoria who is the Team Leader of Koori Kids, Victorian Aboriginal Health Service. She has worked with the Forum Theatre methods of Augusto Boal in the context of workshops with Aboriginal child, family and health workers completing a post Graduate Certificate in Family Therapy (The Bouverie Centre, La Trobe University). This model provides a creative means for collaboration and cooperation amongst those participating and the wider community. The benefits of this process will be discussed along with other possible applications within Aboriginal services and community.

Forum Theatre was developed by Augusto Boal (2008), a Brazilian theatre director who worked with communities to explore complex problems and to rehearse possible solutions. Through this process, interested members of the community decide what issues they'd like to explore and where they'd like changes to occur. Over a number of days, theatre exercises and games are used to awaken the senses, open up possibilities and explore the potential of the group. Scenes or small plays are devised which portray the issues back to the community in powerful and challenging ways. The interactive performance, or Forum Theatre event involves inviting community members to participate in trying out alternate ways of dealing with the situations they witness and then discussing their effectiveness. An example of this is when a group decided to focus on how the service system overlooked the needs of young people when numerous workers pursued their particular agendas. An audience members stepped into the scene and took over one of the roles, then the scene was replayed whilst they explored how the voice and the cultural needs of the child could be privileged. A discussion followed about the benefits and obstacles to the change proposed and how the needs of the young person and the community could be better served.

The power of this process is generated through empowering communities to express and give voice to their issues. Implicit is the belief that communities possess all the necessary knowledge to address the problems they face. Augusto Boal was greatly influenced by the educationalist Paulo Freire (1996) who believed that the transformation of communities and individuals could best occur through dialogue.

The dialogic process, evident in Forum Theatre is also present within the post Graduate Certificate in Family Therapy²⁴ which I completed in 2010. The training program is provided nationally to Aboriginal child, family and health workers through the Bouverie Centre, La Trobe University²⁵. It utilises a 'Black and White approach'²⁶ where the training is delivered by both a non-Aboriginal educator and an Aboriginal cultural consultant and trainer. During the program,

²⁴ Family therapy is primarily a commitment to 'systemic practice', involving a focus on relationships, process, context and meaning. One can work 'systemically' with individuals, couples, various formations of family members, organisations or other groupings (Lowe, 2004).

The post Graduate Certificate in Family Therapy is conducted in partnership with Take Two, Berry Street, and in consultation with an Advisory Group comprising Indigenous and non-Indigenous representatives from the participating Aboriginal Community Co-operatives (ACCOs) and mainstream organisations working with Aboriginal families.

²⁵ The Bouverie Centre, Victoria's Family Institute is a unique public institute located within La Trobe University's Health Sciences. The Bouverie is publicly funded with the majority of funds emanating from Victoria's Department of Human Services as well as philanthropic organisations.

²⁶ The 'Black and White approach' is the term initially derived by the Indigenous consultant and Indigenous family therapy students to describe the delivery of a mainstream family therapy curriculum in culturally relevant and sensitive ways.

students' considerable skills and expertise are acknowledged and learning takes place in an environment where cultural safety is privileged. Many of the family therapy approaches are already familiar to Aboriginal health workers but they are language differently. As well as validating and fine tuning worker skills, the trainers participate in two way learning and continually develop the course in response to feedback. The dialogue between theory and practice and the mutual learning between the students and the trainers, creates an environment where people are safe to change and grow. The group I studied with were comprised of Aboriginal alcohol and drug workers and social and emotional wellbeing workers from all over the state of Victoria and we spent 26 weeks together exploring how family therapy could be used with the families we worked with²⁷. In respect of the great deal of experience in the group, rather than written assessments the course had a large experiential component that included role plays, a spoken essay²⁸ and a Forum Theatre presentation.

Though I had had previous experience using theatre in community, I was impressed by the capacity of Forum Theatre to engage community and to bring together diverse people around a common goal. When asked if I was interested in being mentored into the role of facilitator I agreed and along with my co-facilitator and the rest of the Indigenous program at the Bouverie Centre we became inaugural recipients of the Jeff Lipp Innovation Fund²⁹, which has enabled my skills in this area to be developed over the past eighteen months.

Having now co-facilitated Forum Theatre workshops and presentations both within the post Graduate Certificate and with a group of non-Indigenous people, I feel in a position to identify some of the benefits of this process. What I have noticed when working with a mixed group of Aboriginal and non-Aboriginal workers, is that there is often wariness and tensions surrounding each other's work practice. One of the highlights of this process is watching how these tensions are resolved during the workshoping process. This occurs through overtly acknowledging differences and the context in which they have developed. The group needs to identify common issues of concern within their work and find a way in which to present these issues in a way that respects everyone's experience. As the group struggles to come up with a presentation in a relatively short period of time, the stress in the group increases to a crisis point which serves to define and transform relationships. The underlying passion and commitment to working in community is exposed through the challenge and by working together on a common goal. The workshops are plenty of fun and there are lots of laughs though at times people are unsure how it will all come together. However, I believe that without this uncertainty and challenge there would be a less emotional engagement and opportunities for growth. It is a truly creative method where neither we as facilitators, nor the group know what the outcome will be. What I have come to appreciate is that my role is to trust the process and the strength and ability of the group to invent creative ways to tackle the task.

²⁷ Since 2008, 74 Aboriginal child, family and health workers have graduated from the training program with a retention rate of 91% for Aboriginal students. The program is usually delivered in community so that the university comes to the students.

²⁸ This method was suggested by Carol Messer, an educator in both mainstream and Aboriginal contexts. Students narrate answers to an assignment, which are transcribed and given back to the students for editing and then submitted for assessment.

²⁹ Dr. Jeff Lipp, Psychiatrist and Family Therapist, was a key member of the Bouverie Centre between 1987 and 1997. The Jeff Lipp Innovation Fund was created in 2010 from a donation by the Lipp family in memory of their son, brother, brother-in-law and uncle.

I have had numerous personal discoveries about myself, my work practice and my life and have witnessed that occur both for those in the workshops and those attending the Forum Theatre event. It's like a theatrical AGM where people express views and perceptions about the best way forward except there is more time to explore the issues, not only on an intellectual level but experientially. Though people who come to the performance frequently hold strong opinions about the issues presented, they often are not prepared for the effect of seeing aspects of themselves portrayed. I have witnessed the surprise of audience members when they witness how certain practices continue to disenfranchise and marginalise Aboriginal people despite the existence of policies designed to prevent this from occurring. This process can be quite confronting and challenging for people, though it is through this strong emotional engagement that people are drawn into the process and are compelled to participate. They explore the issues from various perspectives and gain a greater appreciation of the impact of people's behaviours and decisions on others. This can create change in the broader community through a ripple effect, where the images and scenarios witnessed continue to resonate for years to come. Forum Theatre powerfully engages the audience and can be used to involve mainstream decision makers and other areas of the service system, in a dialogue about the impact of policy and practices on Aboriginal workers and families.

Forum Theatre could also usefully be employed in Aboriginal controlled organisations as a way to give those in management an opportunity to experience how decisions made at an organisational level effect the workforce and the community. It can show how policies and procedures have been translated throughout the organisation and highlight the areas in which they aren't working. The process can also create a greater understanding across programs about the nature of the work colleagues are involved in and the challenges that they face.

There would also be great value in utilising this process with families who attend Aboriginal Health Services. Some families who have had frequent contact with the service system have become accustomed to getting through counselling sessions without making themselves too vulnerable by avoiding being challenged. This process strips people of their armour and awakens dormant aspects of themselves so that they are able to authentically address their issues. The process of scene creation brings the family together around what unites them as a family. The process is therapeutic, but in an invisible way as the family is focussed on the task at hand rather than consciously working to resolve conflict. By enabling family members to see difficulties from others perspectives, understanding develops and the potential for change is increased. Presenting the scenes to other families within a Forum Theatre event, could magnify the possibilities for change as many of the issues facing Aboriginal families have similar themes which can be connected to the intergenerational effects of trauma and the social determinants of health especially poverty, exclusion and marginalisation.

The creative processes, involved in the making of Forum Theatre can effectively engage all sectors of the community and create opportunities for unity and collaboration in the difficult terrain of Aboriginal health. The pride that I have witnessed develop as a result of this process, along with the coming together of people from different cultures for the benefit of Aboriginal people, speaks to the value and possibilities of this method.

Author Biographies

Joanne Dwyer is an Aboriginal woman and mother of three who is traditionally from Gunditjamara country in the western part of Victoria, Australia. She was raised in inner city Melbourne and recently completed a Bachelor of Arts/Drama and her Certificate in Drug and Alcohol. Joanne worked for several years in sexual health and then as a drug and alcohol worker as part of the Family Counselling Service for several years. Joanne later moved to work in the Koori Kids & Adolescent Mental Health Program where she has been for 18mths. During this time she completed a Graduate Certificate in Family Therapy and is now working as Team Leader in the Koori Kids program.

Jacqui Sundbery is a family therapist and trainer at the Bouverie Centre, La Trobe University. She is currently completing her PhD research into the usefulness of family therapy in addressing substance misuse in Indigenous communities from the perspectives of Aboriginal AOD workers. She also has an arts background where for 20 years she has worked as an actor, artist, academic and community cultural development worker. She has maintained an interest in Forum Theatre since being introduced to it in the 1980s and has used Augusto Boal's methods when working with at-risk young people and Aboriginal child, family and health workers.

References

- Boal, A. (2008). *Theatre of the Oppressed*. London: Pluto.
- Freire, P. (1996). *Pedagogy of the Oppressed*. London: Penguin.
- Lowe, R. D. (2004). *Family Therapy: A constructive framework*. London: Sage.

References

- ABS. (2009). *Schools, Australia, 2008*. Canberra.
- ABS. (2010a). *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Canberra.
- ABS. (2010b). *National Aboriginal and Torres Strait Islander Health Social Survey, 2008*. Canberra.
- ABS. (2011). *Prisoners in Australia*. Canberra.
- ABS. (2013). *Prisoners in Australia*. Canberra.
- ABS, & AIHW. (2008). *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*. Canberra.
- Adams, R., Boscarino, J., & Galea, S. (2006). Alcohol Use, Mental Health Status and Psychological Well-being 2 Years After the World Trade Center Attacks in New York City. *The American Journal of Drug and Alcohol Abuse*, 32(2), 203-224.
- AHMAC. (2002). *Aboriginal and Torres Strait Islander health workforce national strategic framework*. Canberra: Australian Health Ministers Advisory Council (AHMAC).
- AHMAC. (2012). *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*. Canberra.
- AIHW. (2006). *Drug use among Aboriginal and Torres Strait Islander peoples: an assessment of data*. Canberra.
- AIHW. (2009). *Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples*. Canberra.
- AIHW. (2011). *The health and welfare of Australia's Aboriginal and Torres Strait Islander people*. A. I. o. H. a. Welfare. Canberra.
- AIHW. (2013). *Child Protection Australia 2011-12*. Canberra.
- Al-Yaman, F., Van Doeland, M., & Wallis, M. (2006). *Family Violence among Aboriginal and Torres Strait Islander Peoples*. Canberra.
- Alati, R., Peterson, C., & Rice, P. L. (2000). The development of Indigenous substance misuse services in Australia: Beliefs, conflicts and change. *Australian Journal of Primary Health*, 6(2), 14.
- Andersen, C., Bunda, T., & Walter, M. (2008). Indigenous Higher Education: The Role of Universities in Releasing the Potential. *Australian Journal of Indigenous Education*, The, 37(Journal Article), 1-8.
- Anderson, I. (2007). Understanding the processes. In B. Carson, T. Dunbar, R. Chenhall & R. Bailie (Eds.), *Social Determinants of Indigenous Health*. Sydney: Allen and Unwin.
- Atkinson, J. (2002). *Trauma trails, recreating song lines: the transgenerational effects of trauma in Indigenous Australia*. North Melbourne: Spinifex.
- Australian Government. (2013). *Closing the Gap: Prime Minister's Report 2013*. Canberra.
- Australian Government Productivity Commission. (2014). *Report on Government Services*. Canberra.
- Bacon, V. (2007). What potential might narrative therapy have to assist indigenous Australians reduce substance misuse? *Australian Aboriginal Studies*, 2007(1).
- Bamberg, J., Blyth, A., Toumbourou, J., & Forer, D. (2001). Change for the BEST: family changes for parents coping with youth substance abuse. *Australian and New Zealand Journal of Family Therapy*, The, 22(4), 189-198.
- Bartlett, B., & Boffa, J. (2005). The impact of Aboriginal community controlled health service advocacy on Aboriginal health policy. *Australian Journal of Primary Health*, 11(2), 53-61.
- Behrendt, L., Larkin, S., Griew, R., & Kelly, P. (2012). *Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People: Final Report*. Canberra.
- Bell, D. (1983). *Daughters of the Dreaming*. Melbourne: McPhee Gribble/ George Allen and Unwin.
- Biermann, S., & Townsend-Cross, M. (2008). Indigenous Pedagogy as a Force for Change. *Australian Journal of Indigenous Education*, The, 37(Supplementary), 146-154.

- Bin-Sallik, M. (2003). Cultural Safety: Let's Name It. *Australian Journal of Indigenous Education*, 32(Journal Article), 21-28.
- Boal, A. (2008). *Theatre of the Oppressed*. London: Pluto.
- Boyd-Ball, A., & Dishion, T. (2006). Family-centred treatment for American Indian adolescent substance abuse: toward a culturally and historically informed strategy In H. Liddle & C. Rowe (Eds.), *Adolescent Substance Use: Research and clinical advances* Cambridge: Cambridge University Press.
- Brady, M. (1995a). *Broadening the base of interventions for Aboriginal people with alcohol problems*. Sydney, NSW: National Drug and Alcohol Research Centre.
- Brady, M. (1995b). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science & Medicine*, 41(11), 1487.
- Brady, M. (1995c). *The prevention of drug and alcohol abuse among Aboriginal people: resilience and vulnerability*. Canberra: Aboriginal Studies Press.
- Brady, M. (2004). *Indigenous Australia and alcohol policy: meeting difference with indifference*. Sydney: UNSW Press.
- Brady, M. (2007). Equality and difference: persisting historical themes in health and alcohol policies affecting Indigenous Australians. *Journal of epidemiology and community health*, 61(9), 759-763.
- Brady, M., MacKenzie, M., & Alcohol Education Rehabilitation Foundation. (2008). *First taste: how Indigenous Australians learned about grog*. Deakin, A.C.T: Alcohol Education and Rehabilitation Foundation.
- Brook, J., Brook, D., & Pahl, K. (2006). The development context of adolescent substance use intervention. In H. Liddle & C. Rowe (Eds.), *Adolescent Substance Use: Research and clinical advances* Cambridge: Cambridge University Press
- Brown, A., & Brown, N. J. (2007). The Northern Territory intervention: voices from the centre of the fringe. *The Medical Journal of Australia*, 187(11-12), 621.
- Carlson, E. (1997). *Trauma Assessments: A Clinician's Guide*. New York Guilford Press.
- Carson, B., Dunbar, T., Chenhall, R., & Bailie, R. (2007). *Social Determinants of Indigenous Health*. Australia: Allen and Unwin.
- Catto, M., & Thomson, N. (2008). Review of illicit drug use among Indigenous people. *Australian Indigenous Health Bulletin*, 8(4), Article 1.
- Caulley, D. (1994). Notes on the basic characteristics of postpositivist interpretative inquiry. In B. Neville, P. Willis & M. Edwards (Eds.), *Qualitative Research in Adult Education: A colloquium on theory, practice, supervision & assessment* (pp. 3-20). University of South Australia: Centre for Research in Education & Work
- Central Land Council. (2008). *Reviewing the Northern Territory Emergency Response: perspectives from six communities* Alice Springs.
- Charmaz, K. (2003). Grounded Theory. Objectivist and Constructivist Methods. In N. Denzin & Y. Lincoln (Eds.), *Strategies of qualitative inquiry* (Vol. 2, p. 249). Thousand Oaks, CA: Sage.
- Charmaz, K. (2005). Grounded Theory in the 21st Century: Applications for advancing social justice studies In N. Denzin & Y. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* Thousand Oaks, CA: Sage.
- Charmaz, K. (2006). *Constructing Grounded Theory*. Thousand Oaks, CA: Sage.
- Chilcoat, H., & Breslau, N. (1998). Investigations of causal pathways between PTSD and drug use disorders. *Addictive Behaviors*, 23(6), 827-840.
- Chilcoat, H., & Menard, C. (2003). Epidemiological Investigations. In P. Ouimette & P. Brown (Eds.), *Trauma and Substance Use*. Washington DC: American Psychological Association.
- Christie, M. (1985). *Aboriginal perspectives on experience and learning: the role of language in Aboriginal education*. Geelong, Vic: Deakin University.
- Clapham, K., Digregorio, K., Dawson, A., & Hughes, I. (1997). The Community as Pedagogy: innovations in Indigenous health worker education. *Journal of Higher Education Policy and Management*, 19(1), 35-43.

- Clapham, K., O'Dea, K., & Chenhall, R. (2007). Interventions and sustainable programs. In B. Carson, T. Dunbar, R. Chenhall & R. Bailie (Eds.), *Social Determinants of Indigenous Health*. Sydney: Allen and Unwin.
- Clifford, A., & Shakeshaft, A. (2011). Evidence-based alcohol screening and brief intervention in Aboriginal Community Controlled Health Services: Experiences of health-care providers. *Drug and Alcohol Review*, 30(1), 55-62.
- Cloitre, M., Stovall-McClough, K. C., Noonan, K., Zorbas, P., Cherry, S., Jackson, C. L., . . . Petkova, E. (2010). Treatment for PTSD related to childhood abuse: a randomized controlled trial. *The American journal of psychiatry*, 167(8), 915-924.
- COAG. (2009). *National Indigenous Reform Agreement (Close the Gap)*. Retrieved
- Coetze, J. M. (2000). *Disgrace*. London: Vintage.
- Coleman, S. (1991). Intergenerational patterns of traumatic loss: death and despair in addict families. In M. McGoldrick & F. Walsh (Eds.), *Living beyond loss: death in the family*. New York: Norton.
- Coleman, S., Kaplan, J., Gallagher, D., Downing, R., & Cains, C. (1982). *Heroin-A Family Coping Strategy for Death and Loss: Final report 1979-1981*. Washington DC: National Institute on Drug Abuse.
- Coleman, S. B., Kaplan, J. D., & Downing, R. W. (1986). Life cycle and loss-the spiritual vacuum of heroin addiction. *Family Process*, 25(1), 5-23.
- Combined Aboriginal Organisations of the Northern Territory. (2007). *A proposed Emergency Response and Development Plan to protect Aboriginal Children in the Northern Territory: a preliminary response to Australian Government's proposals*. Darwin.
- Commonwealth of Australia. (2008). *Northern Territory National Emergency Response Act 2007*. Canberra: Commonwealth of Australia.
- Corbin, J., & Strauss, A. (1990). Grounded Theory Research: Procedures, Canons, and Evaluative Criteria. *Qualitative Sociology*, 13(1), 3-21.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Los Angeles: Sage.
- Council for Aboriginal Alcohol Program Services Inc. (2012). Retrieved August 6th, 2012, from www.caaps.org.au/
- Cowlshaw, G. K. (2006). Cultures of complaint: An ethnography of rural racial rivalry. *Journal of Sociology*, 42(4), 429-445.
- Creswell, J., Hanson, W., Plano, V., & Alejandro, M. (2007). Qualitative Research Designs: selection and implantation. *The Counselling Psychologist*, 35(2), 236-264.
- Cripps, K. (2004). *Enough Family Fighting: Indigenous community responses to addressing family violence in Australia & the United States* (Centre for Women's Studies and Gender Research, School of Political and Social Inquiry, Faculty of Arts Monash University, Melbourne).
- Cunneen, C., & ATSIC. (1997). *The Royal Commission into Aboriginal Deaths in Custody: an overview of its establishment, findings and outcomes*: ATSIC.
- d'Abbs, P., & Shaw, G. (2008). *Executive summary of the "Evaluation of the impact of Opal fuel"*. Canberra: Department of Health and Aging.
- Denborough, D. (2008). *Collective narrative practice: responding to individuals, groups, and communities who have experienced trauma*. Adelaide, S.A.: Dulwich Centre Publications.
- Denborough, D., White, C., & Wingard, B. (2009). *Yia Marra: good stories that make spirits strong, from the people of Ntaria/Hermannsburg*. Adelaide: Dulwich Centre.
- Denzin, N. (1971). The logic of naturalistic inquiry. *Social Forces*, 50(2), 166-182.
- Department of Education. (2013). *Higher Education Report 2010*. Canberra.
- Dept. of Education, S. T. (2002). *Achieving equitable and appropriate outcomes: Indigenous Australians in higher education* Canberra: Commonwealth Dept. of Education, Science and Training.
- Deyhle, D., & Swisher, K. (1997). Research in American Indian and Alaska Native Education: From Assimilation to Self-Determination. *Review of Research in Education*, 22(1), 113-194.
- DHS. (2003). *2002 Training Program for Aboriginal Alcohol and Drug Workers*. Melbourne.

- DHS. (2007). Dual Diagnosis: Key directions and priorities for service development. *Victorian Government Department of Human Services, Melbourne.*
- DHS. (2008a). *Annual Report 2007-08 - Department of Human Services.* Melbourne.
- DHS. (2008b). *A new blueprint for alcohol and drug treatment services 2009-13 - Client centred, service focussed* Melbourne.
- DHS. (2008c). *Victorian Alcohol Action Plan 2008-2013: Restoring the balance.* Melbourne: Victorian Department of Human Services.
- Dockery, A. M. (2010). Culture and Wellbeing: The Case of Indigenous Australians. *Social Indicators Research*, 99(2), 315-332.
- DoH. (2010). *Koori Alcohol Action Plan 2010-2020.* Melbourne: Mental Health, Drugs and Regions Division, Victorian Government, Department of Health.
- DoH. (2012). *Victorian Health Policy and Funding Guidelines 2012-2013: Part 2 Health Operations.* Melbourne.
- DoHA. (2010). *Alcohol Treatment Guidelines for Indigenous Australians.* Canberra.
- Dudgeon, P., & Fielder, J. (2006). Third spaces within tertiary places: indigenous Australian studies. *Journal of Community & Applied Social Psychology*, 16(5), 396-409.
- Dudgeon, P., Garvey, D., & Pickett, H. (2000). Indigenous mental health across the lifespan. In H. Pickett, P. Dudgeon & D. Garvey (Eds.), *Working with Indigenous Australians: A Handbook for Psychologists.* Perth Gunada Press.
- Dudgeon, P., & Ugle, K. (2010). Communication and Engagement: Urban Diversity. In N. Purdie, P. Dudgeon & R. Walker (Eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health Wellbeing Principles and Practice.* Canberra: Department of Health and Ageing.
- Dunbar, T., & Scrimgeour, M. (2007). Education. In B. Carson, T. Dunbar, R. Chenhall & R. Bailie (Eds.), *Social Determinants of Indigenous Health* Sydney: Allen and Unwin.
- Duraisingam, V., Pidd, K., Roche, A. M., & O'Connor, J. (2006). *Satisfaction, stress and retention among alcohol and other drug workers in Australia.* Adelaide: National Centre for Education and Training on Addiction (NCETA). Flinders University.
- Duraisingam, V., Roche, A. M., Pidd, K., Zoontjens, A., & Pollard, Y. (2007). *Wellbeing, stress and burnout: A national survey of managers in alcohol and other drug treatment services.* Adelaide: National Centre for Training and Education on Addiction (NCETA). Flinders University.
- Duran, B., & Duran, E. (2000). Applied postcolonial clinical and research strategies. In M. Battiste (Ed.), *Reclaiming indigenous voice and vision* (pp. 86-100). Vancouver: UBC Press.
- Dwyer, J., & Sundbery, J. (in press). An inspiring journey with Forum Theatre and Aboriginal community.
- Dwyer, L., & Santikarma, D. (2007). Posttraumatic Politics: Violence, Memory and Biomedical Discourse in Bali. In L. Kirmayer, L. Lemelson & M. Barad (Eds.), *Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives.* Cambridge: Cambridge University Press.
- Erikson, K. (1976). *Everything in its Path* New York: Simon and Schuster.
- Erlandson, D. A. (1993). *Doing naturalistic inquiry: A guide to methods.* Thousand Oaks, CA: Sage.
- Frederico, M., Jackson, A., & Black, C. (2010). *"More Than Words" - Take Two Third Evaluation Report* Bundoora.
- Freire, P. (1970). *Pedagogy of the Oppressed.* New York: Herder and Herder.
- Freire, P. (1996). *Pedagogy of the Oppressed.* London: Penguin.
- Freire, P., & Schor, I. (1987). *A Pedagogy for Liberation: Dialogues on transforming education.* London: Macmillan.
- Gagne, M. (1998). The Role Of Dependency and Colonialism in Generating Trauma in First Nations Citizens: The James Bay Cree. In Y. Danieli (Ed.), *International Handbook of Multigenerational Legacies of Trauma.* New York Plenum Press.
- Garvey, D. (2008). A review of the social and emotional wellbeing of Indigenous Australian peoples- considerations, challenges and opportunities. *Australian Indigenous Health Bulletin*, 8, 1-29.

- Gillepsie, K. (1998). *We've Come a Long Way: An exploration of pedagogy in an Indigenous context* (School of Education, University of South Australia, Adelaide).
- Glaser, B. (1998). *Doing Grounded Theory: Issues and discussions*. Mill Valley, California: Sociology Press.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company
- Gleadle, F., Freeman, T., Duraisingham, V., Roche, A., Battams, S., Marshall, B., . . . Weetra, D. (2010). *Indigenous Alcohol and Drug Workforce Challenges: A literature review of issues related to Indigenous AOD workers' wellbeing, stress and burnout*. Adelaide: Flinders University
- Goold, S., Turale, S., Miller, M., & Usher, K. (2002). *Gettin''em n keepin''em': Report of the Indigenous nursing education working group*. Canberra: Commonwealth Department of Health and Ageing.
- Grant, J., Nelson, G., & Mitchell, T. (2008). Negotiating the Challenges of Action Research: Relationships, Power, Participation, Change and Credibility. In P. Reason & H. Bradbury (Eds.), *The Sage Handbook of Action Research: Participative Inquiry and Practice*. (Second ed., pp. 589-601). Los Angeles: Sage Publications.
- Gray, D., & ANCD. (2010). *Indigenous-specific alcohol and other drug interventions: continuities, changes and areas of greatest need* (Vol. 20.). Civic Square, A.C.T: Australian National Council on Drugs.
- Gray, D., Haines, B., & Watts, S. (2004). *Alcohol and other drug education and training for Indigenous workers [electronic resource]: a literature review* Perth.
- Gray, D., Pulver, L., Saggars, S., & Waldon, J. (2006). Addressing Indigenous substance misuse and related harms. *Drug and Alcohol Review*, 25(3), 183-188.
- Gray, D., Saggars, S., Atkinson, D., Wilkes, E., Couzos, S., & al., e. (2008). Substance Misuse. In S. Couzos, R. Murray, NACCHO & Kimberley Aboriginal Medical Services Council (W.A) (Eds.), *Aboriginal primary health care: an evidence-based approach* (Vol. 3rd edition). South Melbourne, Vic: Oxford University Press.
- Gray, D., Saggars, S., Sputore, B., & Bourbon, D. (2000). What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians. *Addiction*, 95(1), 11-22.
- Gray, D., Stearne, A., Wilson, M., & Doyle, M. (2010). Loss of Local Control. *Of Substance: The National Magazine on Alcohol, Tobacco and Other Drugs*, 8(2).
- Guttman, H. (1981). Systems Theory, Cybernetics and Epistemology. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of Family Therapy* (Vol. II, pp. 41-62). New York: Brunner/Mazel.
- Harris, S. (1990). *Two-way Aboriginal schooling: Education and cultural survival*. Canberra: Aboriginal Studies Press
- Harris, S., & Malin, M. (1997). *Indigenous Education: historical, moral and practical tales*. Darwin: NTU Press.
- Hayman, N. E., White, N. E., & Spurling, G. K. (2009). Improving Indigenous patients' access to mainstream health services: the Inala experience. *The Medical journal of Australia*, 190(10), 604.
- Hazlehurst, K. (1994). *A Healing Place: Indigenous visions for personal empowerment and community recovery*. Rockhampton: Central Queensland University Press.
- Hegarty, T., Smith, G., & Hammersley, M. (2010). Crossing the River: A Metaphor for Separation, Liminality, and Reincorporation. *International Journal of Narrative Therapy & Community Work*, 2010(2), 51-58.
- Henry, J., Dunbar, T., Arnott, A., Scrimgeour, S., Mathews, S., Murakami-Gold, L., & Chamberlain, A. (2002). *Indigenous Research Reform Agenda: Rethinking Research Methods*: Cooperative Research Centre for Aboriginal and Tropical Health
- Herman, J. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377-391.
- Herman, J. (1992). *Trauma and recovery*. New York, N.Y.: Basic Books.

- Holland, C., & Close the Gap Campaign Steering Committee for Indigenous Health Equality. (2012). *Shadow Report 2012 on Australian Governments' Progress Towards Closing the Gap in Life Expectancy between Indigenous and non-Indigenous Australians*. Australia (Book, Whole).
- Hossain, D., Gorman, D., Williams-Mozely, J., & Garvey, D. (2008). Bridging the Gap: Identifying Needs and Aspirations of Indigenous Students to Facilitate Their Entry into University. *Australian Journal of Indigenous Education*, 37, 9-17.
- House of Representatives. Standing Committee on Aboriginal Affairs. (1979). *Aboriginal Health*. Canberra: Australian Govt. Pub. Service.
- Howard, G. (2009). Good Practice Studies In K. Milward (Ed.), *Prevention research quarterly: Prevention of alcohol related harms in Victoria's Koori communities* (Vol. Issues paper no.8). Melbourne: Druginfo Clearinghouse.
- HREOC. (1991). *Racist violence: report of the National Inquiry into Racist Violence in Australia / Human Rights and Equal Opportunity Commission*. Canberra HREOC.
- HREOC. (1995). *Alcohol Report, Racial Discrimination Act 1975: Race discrimination, human rights and the distribution of alcohol* Canberra: Australian Government Publishing Service
- Hughes, P., Williams, M., & More, A. (2004). *Aboriginal ways of learning*. Adelaide, S. Aust: Paul Hughes.
- Hunter, E. (1990). Using a socio-historical frame to analyse aboriginal self-destructive behaviour. *The Australian and New Zealand journal of psychiatry*, 24(2), 191.
- Hunter, E. (1993). *Aboriginal Health and History: power and prejudice in remote Australia*. New York: Cambridge University Press.
- Hunter, E. (2004). Commonality, Difference and Confusion: Changing Constructions of Indigenous Mental Health. *Australian e-Journal for the Advancement of Mental Health*, 3(3), 95-98.
- Hunter, E., & Tsey, K. (2003). Setting strategic directions in mental health policy and practice: the challenge of understanding and addressing the social determinants. *Australasian Psychiatry*, 11(s1), S1-S5.
- Ikin, D. (2008). Stories from the Room of Many Colours: Ritual and Reclamation with People Wishing to Make Changes to Drug and Alcohol Use. *International Journal of Narrative Therapy & Community Work*, 2008(2), 47-59.
- Jacobsen, L. K., Southwick, S. M., & Kosten, T. R. (2001). Substance use disorders in patients with posttraumatic stress disorder: a review of the literature. *The American journal of psychiatry*, 158(8), 1184-1190.
- Johnston, E., & RCIADIC. (1991). *Royal Commission into Aboriginal Deaths in Custody: National reports [Vol 1-5] and regional reports* (Vol. 1-5). Canberra: AGPS.
- Kahn, M., Hunter, E., Heather, N., & Tebbutt, J. (1990). Australian Aborigines and Alcohol: a review *Drug and Alcohol Review*, 10.
- Kahn, M., Hunter, E., Heather, N., & Tebbutt, J. (1991). Australian Aborigines and alcohol: a review. *Drug and Alcohol Review*, 10(4), 351-366.
- Kaner, E. F. S., Dickinson, H. O., Beyer, F., Pienaar, E., Schlesinger, C., Campbell, F., . . . Heather, N. (2009). The effectiveness of brief alcohol interventions in primary care settings: a systematic review. *Drug and alcohol review* 28(3), 301.
- Khantzian, E. (2003). The self-medication hypothesis re-visited: The dually diagnosed patient *Primary Psychiatry* 10(9), 47-48, 53-54.
- Kippen, S., Ward, B., & Warren, L. (2006). Enhancing Indigenous Participation in Higher Education Health Courses in Rural Victoria. *Australian Journal of Indigenous Education*, The, 35(Journal Article), 1-10.
- Kowal, E., & Paradies, Y. (2005). Ambivalent helpers and unhealthy choices: public health practitioners' narratives of Indigenous ill-health. *Social science & medicine* (1982), 60(6), 1347-1357.
- Kulka, R. A. (1990). *Trauma and the Vietnam War generation: report of findings from the National Vietnam veterans readjustment study* (Vol. no. 18.). New York: Brunner/Mazel.

- Langton, M. (1993). Rum, Seduction and Death: 'Aboriginality' and Alcohol. *Oceania*, 63(3), 195-206.
- Langton, M. (2012). Why I continue to be inspired by Pearson *The Australian*
- Langton, M. (2013). *Boyer Lectures 2012: The Quiet Revolution: Indigenous People and the Resources Boom*. Melbourne: HarperCollins Australia.
- Latham, R. (2010). *Post Graduate University Award Certificate in Family Therapy Training for Aboriginal Child, Family and Health Workers: Report on the second training cohort Ballarat 2009*. Melbourne.
- Latham, R. (2012). *Post Graduate Certificate in Family Therapy Training for Aboriginal, Child, Family and Health Workers: Report on the third training cohort Gippsland 2010*. Melbourne.
- Latham, R., & Sundbery, J. (2010). *Hearing Indigenous Voices Through: Participatory Action Research, Theatre for Living and Family Therapy*. Paper presented at the ALARA Participatory Action Research and Action Learning 8th World Congress and 12th PAR World Congress: Appreciating our diverse pasts, comprehending our complex presents, prefiguring our possible futures Melbourne.
- Latham, R., & Sundbery, J. (2011). *Research Overview 2008-2011*. Paper presented at the Indigenous Family Therapy Network, Inaugural Forum 2011, Melbourne.
- Levine, P. (1997). *Waking the Tiger: Healing Trauma*. Berkeley, California North Atlantic Books.
- Liddle, H. (2004). Family-based therapies for adolescent alcohol and drug use: research contributions and future research needs. *Addiction*, 99(s2), 76-92.
- Liddle, H., & Rowe, C. (Eds.). (2006). *Adolescent Substance Abuse: Research and clinical advances*. Cambridge: Cambridge University Press.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills: Sage.
- Lincoln, Y., & Guba, E. (2000). Paradigmatic controversies, contradictions and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research*. Beverly Hills, CA: Sage Publications.
- Lodge, P. S. (2012). *Adult rehabilitation*. Retrieved 3rd August, 2012,
- Logan, G., & Bakos, K. (2011). *Our Healing Ways: Successful strategies for working with dual diagnosis issues Aboriginal way* Melbourne: Victorian Dual Diagnosis Initiative Education and Training Unit.
- Louis, R. P. (2007). Can you hear us now? Voices from the margin: using indigenous methodologies in geographic research. *Geographical research*, 45(2), 130-139.
- Lowe, R. D. (2004). *Family Therapy: A constructive framework*. London: Sage.
- Loxley, W. (2004). *The prevention of substance use, risk and harm in Australia: a review of the evidence*. Canberra: Dept. of Health and Ageing.
- Maclean, S., Warr, D., & Pyett, P. (2008). *Universities Working with and for Communities: Strategies for Collaborative Research and Knowledge Exchange*. Melbourne: U. o. Melbourne. (Policy Signpost #2).
- Maddison, S. (2011). *Beyond White Guilt: The real challenge for black-white relations in Australia*. Sydney: Allen & Unwin.
- Mahood, K. (2012). Kartiya are like Toyotas: White workers on the Australia's cultural frontier. *Griffith REVIEW*(36), 43-59.
- Main, D., Nichol, R., & Fennell, R. (2000). Reconciling pedagogy and health sciences to promote Indigenous health. *Australian and New Zealand journal of public health*, 24(2), 211-213.
- Malin, M. (2003). Is Schooling Good for Aboriginal Children's health? . *CRCATH, Darwin*.
- Man-kwong, H. (2004). Overcoming Craving: The Use of Narrative Practices in Breaking Drug Habits. *International Journal of Narrative Therapy & Community Work*, 2004(1), 17-24.
- Marmot, M. G., Smith, G. D., Stansfeld, S., Patel, C., North, F., Head, J., . . . Feeney, A. (1991). Health inequalities among British civil servants: the Whitehall II study. *The Lancet*, 337(8754), 1387-1393.
- Mayers, N. R., & Couzos, S. (2004). Towards health equity through an adult health check for Aboriginal and Torres Strait Islander people. *Medical Journal of Australia*, 181(10), 531.

- McConvell, P. (1982). Supporting the two-way school. In J. Bell (Ed.), *Language Planning for Australian Aboriginal Languages*. Alice Springs: ALA/IAD.
- MCDS. (2006). *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009*. Canberra: DoHA.
- MCDS. (2011). *National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs*. Canberra: DoHA.
- McIlwaine, F. (1998). *Making Difference Matter: Culture and Identity in the Therapeutic Domain* (School of Public Health. Faculty of Health Sciences, La Trobe University Melbourne).
- McIntyre, J. (1996). *Culture matters: factors affecting the outcomes of participation in vocational education and training by Australian Indigenous peoples*. Broadway, N.S.W: Research Centre for Vocational Education and Training, Faculty of Education, University of Technology, Sydney.
- Mehl-Madrona, L. (2007). *Narrative medicine: the use of history and story in the healing process*. Rochester, Vt: Bear & Co.
- MHDRD. (2010). *Koori Action Plan 2010-2020*. Melbourne: Mental Health Drugs and Regions Division (MHDRD), Victorian Government, Department of Health.
- Mignolo, W. D. (2009). Epistemic Disobedience, Independent Thought and Decolonial Freedom. *Theory, Culture & Society*, 26(7-8), 159-181.
- Miller, R., & Dwyer, J. (1997). Reclaiming the Mother-daughter Relationship after Sexual Abuse. *Australian and New Zealand Journal of Family Therapy*, 18(4), 194-202.
- Morgan, S., & Golding, B. (2010). Crossing Over: Collaborative and Cross-cultural Teaching of Indigenous Education in a Higher Education Context. *Australian Journal of Indigenous Education, The*, 39(Supplementary), 8-14.
- Morrow, S. L. (2005). Quality and Trustworthiness in Qualitative Research in Counseling Psychology. *Journal of Counseling Psychology*, 52(2), 250-260.
- Morse, J. (1994). *Critical issues in qualitative research methods*. Thousand Oaks, CA.: Sage.
- Nagel, T., & Thompson, C. (2008). Motivational care planning - self management in indigenous mental health. *Australian family physician*, 37(12), 996.
- NAHSWP. (1989). *A National Aboriginal Health Strategy*. Canberra: Department of Aboriginal Affairs.
- Nakata, M., Nakata, V., Keech, S., & Bolt, R. (2012). Decolonial goals and pedagogies for Indigenous studies. *Decolonization : Indigeneity, Education & Society*, 1(1).
- Naples, N. A. (2003). *Feminism and Method: Ethnography, Discourse Analysis and Activist Research*. London: Routledge.
- Narayan, K. M., Hoskin, M., Kozak, D., Kriska, A. M., Hanson, R. L., Pettitt, D. J., . . . Knowler, W. C. (1998). Randomized clinical trial of lifestyle interventions in Pima Indians: a pilot study. *Diabetic Medicine*, 15(1), 66-72.
- Nechi. (2012). *Programs*. Retrieved 3rd August, 2012,
- Neville, N., Willis, P., & Edwards, M. (1994). *Qualitative Research in Adult Education: A colloquium on theory, practice, supervision, and assessment*. Adelaide: University of South Australia.
- NHMRC. (2006). *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. Canberra: National Health and Medical Research Council.
- NIDAC. (2013). *Bridges and Barriers: Addressing Indigenous incarceration and health. Revised edition*. Canberra.
- Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, Wild, R., & Anderson, P. (2007). *Ampe Akelyernemane Meke Mekarle: "Little Children are Sacred": Report of the Northern Territory Board of Inquiry Into the Protection of Aboriginal Children from Sexual Abuse 2007*. Darwin: Department of the Chief Minister.
- Novins, D. K., Aarons, G. A., Conti, S. G., Dahlke, D., Daw, R., Fickenscher, A., . . . Centers for American, I. (2011). Use of the evidence base in substance abuse treatment programs for American Indians and Alaska Natives: pursuing quality in the crucible of practice and policy. *Implementation science : IS*, 6(1), 63-63.

- NRHPF. (1999). *Healthy horizons: a framework for improving the health of rural, regional and remote Australians*. Canberra: National Rural Health Policy Forum and the National Rural Health Alliance for the Australian Health Ministers' Conference (NRHPF).
- Ober, R. (2009). Both-ways: Learning from Yesterday, Celebrating Today, Strengthening Tomorrow. *Australian Journal of Indigenous Education, The*, 38(Supplementary), 34-39.
- Onemda. (2008). *We Can Like Research...In Koori Hands: A Community Report on Onemda VicHealth Koori Health Unit's Research Workshops in 2007*. Melbourne.
- Paradies, Y. (2007). Racism In B. Carson, T. Dunbar, R. Chenhall & R. Bailie (Eds.), *Social Determinants of Indigenous Health* Sydney: Allen and Unwin.
- Paradies, Y. C. (2006). Beyond Black and White: Essentialism, hybridity and Indigeneity. *Journal of Sociology*, 42(4), 355-367.
- Pattel, N. (2007). Aboriginal families, cultural context and therapy *Couselling, psychotherapy and health* 3(1), 1-24.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, Calif: Sage Publications.
- Pearson, N. (2007). White guilt, victimhood and the quest for a radical centre. *Griffith Review*.
- Perlesz, A., & Proctor, K. (2009). *Post Graduate University Level Family Therapy Training for Aboriginal Chld and Family Workers - Interim Report*. Melbourne.
- Phillips, G. (2003). *Addictions and healing in Aboriginal country*. Canberra, ACT: Aboriginal Studies Press for the Australian Institute of Aboriginal and Torres Strait Islander Studies.
- Prilleltensky, I., & Nelson, G. B. (2002). Doing Psychology Critically: Making a Difference in Diverse Settings. In: Palgrave Macmillan.
- Pyett, P. (2000). *Undertaking public health research in collaboration with disenfranchised groups* (Faculty of Health and Behavioural Sciences. School of Nutrition and Public Health, Deakin Univeristy, Melbourne).
- Quadrio, C. (1987). Family therapy: what are the basic assumptions? *The Australian and New Zealand journal of psychiatry*, 21(4), 420.
- RACP. (2004). *Illicit drugs policy: using evidence to get better outcomes*
- Raphael, B., Swan, P., & Martinek, N. (1998). Intergenerational Aspects of Trauma for Australian Aboriginal People. In Y. Danieli (Ed.), *International Handbook of Multigenerational Legacies of Trauma*. New York: Plenum Press.
- Reay, M., & Beckett, J. (1964). Aborigines, alcohol and assimilation. In *Aborigines now: new perspective in the study of Aboriginal communities*. Sydney Angus & Robertson.
- Reid, C., & Frisby, W. (2008). Continuing the Journey: Articulating Dimensions of Feminist Participatory Action Research. In *The Sage Handbook of Action Research: Participative Inquiry and Practice*. (pp. 93-106). Los Angeles: Sage Publishing.
- Richards, L. (1999). *Using NVivo in qualitative research*. Los Angeles: Sage.
- Rigby, W., Duffy, E., Manners, J., Latham, H., Lyons, L., Crawford, L., & Eldridge, R. (2010). Closing the Gap: Cultural safety in Indigenous health education. *Contemporary Nurse*, 37(1), 21-30.
- Rigney, L.-I. (1999). Internationalization of an Indigenous Anticolonial Cultural Critique of Research Methodologies: A Guide to Indigenist Research Methodology and Its Principles. *Wicazo Sa Review*, 14(2), 109-121.
- Rix, E. F., Barclay, L., & Wilson, S. (2014). Can a white nurse get it? 'Reflexive Practice' and the non-Indigenous clinician/researcher working with Aboriginal people. *Rural and Remote Health*, 14(2679), 1-13.
- Roche, A., Tovell, A., Weetra, P., Freeman, T., Bates, N., & Trifonoff, A. (2010). *Stories of Resilience: Indigenous Alcohol and Other Drug Worker Wellbeing, Stress and Burnout*. Adelaide: National Centre for education and Training on Addiction (NCETA), Flinders University.
- Roche, A. M., Duraisingam, V., Trifonoff, A., & Tovell, A. (2013). The health and well-being of Indigenous drug and alcohol workers: Results from a national Australian survey. *Journal of Substance Abuse Treatment*, 44(1), 17-26.

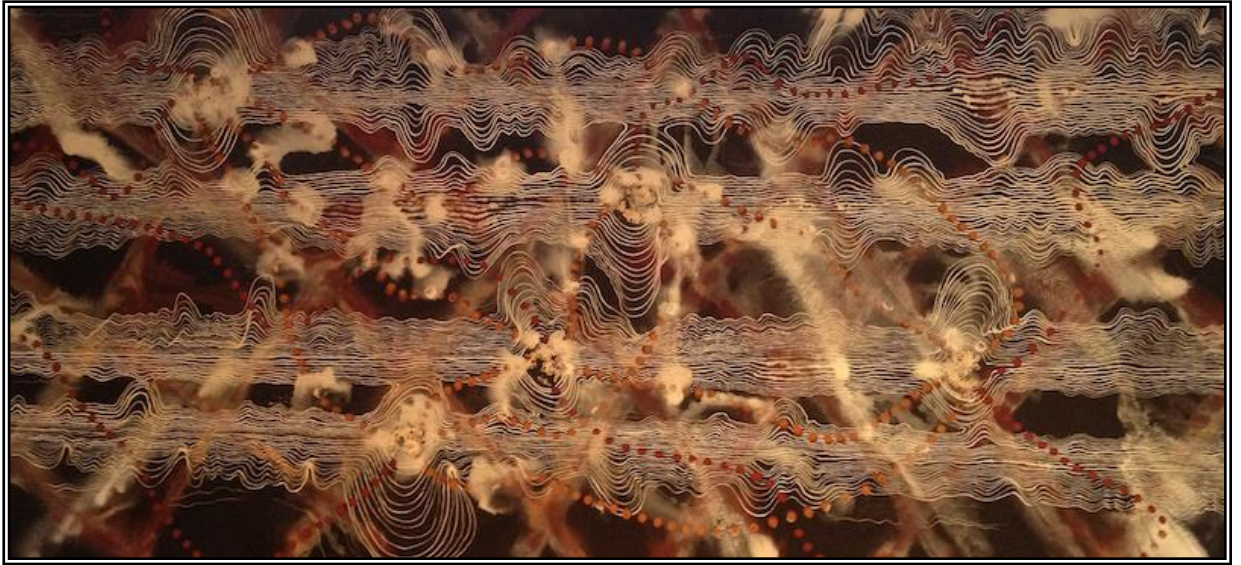
- Roche, A. M., Duraisingam, V., Wang, P., & Tovell, A. (2008). *Alcohol and other drugs, mental health and comorbidity: A training review* Adelaide: National Centre for Education and Training on Addiction. Flinders University
- Roche, A. M., & Pidd, K. (2010). *Alcohol and other drugs workforce development issues and imperatives: Setting the scene*. Adelaide: National Centre of Education and Training on Addiction. Flinders University.
- Roe, J. (2000). Cultural empowerment: Ngarlu - a cultural and spiritual strengthening model. In P. Dudgeon, H. Pickett & D. Garvey (Eds.), *Working with Indigenous Australians: A Handbook for Psychologists* (pp. 395-402). Perth: Curtin University: Gunada Press, Centre for Indigenous Studies.
- Rose, D. (2008). Quality initiatives in the alcohol and other drug treatment sector. *Australian Journal of Primary Health* 14(2), 58-63.
- Rose, D. B. (1992). *Dingo makes us human: life and land in an aboriginal Australian culture*.
- Rose, D. B. (1996). *Nourishing Terrains: Australian Aboriginal views of landscape and wilderness* Australian Heritage Commission.
- Rossingh, B., & Dunbar, T. (2012). A participative evaluation model to refine academic support for first year Indigenous higher education students. *The International Journal of the First Year in Higher Education* 3(1), 61.
- Rowley, K. G., Jenkins, A., Best, J. D., Wang, Z., Brown, A., O'Dea, K., . . . Wang, Z. (2008). Lower than expected morbidity and mortality for an Australian Aboriginal population: 10-year follow-up in a decentralised community. *The Medical journal of Australia*, 188(5), 283.
- Rudd, K. (2008). *Apology to Australia's Indigenous peoples*. Parliament House, Canberra. Presented at House of Representatives 13 February 2008.
- Sackett, L. (1978). Clinging to the Law: Leadership at Wiluna. In M. C. Howard (Ed.), *Whitefella Business: Aborigines in Australian politics*. Philadelphia: Institute for the Study of Human Issues.
- SADoH. (1999). *Iga Warta Principles*. Retrieved
- Saggers, S., & Gray, D. (1998). *Dealing with alcohol: indigenous usage in Australia, New Zealand and Canada*. Cambridge: Cambridge University Press.
- Saggers, S., & Gray, D. (2007). Defining what we mean. In B. Carson, T. Dunbar, R. Chenhall & R. Bailie (Eds.), *Social Determinants of Indigenous Health* Sydney: Allen and Unwin.
- Sayers, B. (1988). Left or right brain: is there a neurological relationship to traditional learning styles. In B. Harvey & S. McGinty (Eds.), *Learning my way: papers from the National Conference on Adult Aboriginal Learning Styles*. Perth: Western Australian College of Advanced Education.
- Schatz, M., & Walker, R. (1995). *Research as Social Change: New Opportunities for Qualitative Research*. New York: Routledge.
- SCRGSP. (2011). *Report on Government Services 2011*. Canberra: Productivity Commission. Steering Committee for the Review on Government Service Provision.
- SCSAC. (2007). *Substance Abuse in Remote Communities: Confronting the confusion and disconnection*. Darwin: Legislative Assembly of the Northern Territory.
- Shahjahan, R., Wagner, A., & Wane, N. (2009). Rekindling the sacred: toward a decolonizing pedagogy in higher education. *Journal of Thought*, 44(1-2), 59.
- Shalev, A. (2007). PTSD: A Disorder of Recovery. In L. Kirmayer, L. Lemelson & M. Barad (Eds.), *Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives*. Cambridge: Cambridge University Press.
- Shand, F. L., & NDARC. (2003). *The treatment of alcohol problems: a review of the evidence*. Canberra: Dept. of Health and Ageing.
- Slattery, G. (1987). Transcultural therapy with Aboriginal families: working with the belief system. *Australian and New Zealand Journal of Family Therapy* 8(2), 61-70.
- Smith, G. H. (2003). *Indigenous Struggle for the Transformation of Education and Schooling*. Paper presented at the Alaskan Federation of Natives (AFN) Convention, Anchorage, Alaska, U.S.

- Smith, L. T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. London: Zed Books Ltd.
- Smith, M., & McLaren, P. (2010). Critical Pedagogy: An Overview. *Childhood Education*, 86(5), 332.
- Stanton, M. D., & Todd, T. C. (1982). *The family therapy of drug abuse and addiction / by M. Duncan Stanton, Thomas C. Todd, and associates ; foreword by Salvador Minuchin*.
- Stewart, S. H., Pihl, R. O., Conrod, P. J., & Dongier, M. (1998). Functional associations among trauma, PTSD, and substance-related disorders. *Addictive Behaviors*, 23(6), 797-812.
- Strempel, P., Saggars, S., Gray, D., & Stearne, A. (2003). *Indigenous Drug and Alcohol Projects: Elements of best practice*: Australian National Council on Drugs.
- Sundbery, J., & Boundy, F. (2013). *How family therapy is making a difference in the treatment of substance misuse in Aboriginal community* Paper presented at the Broadening the Focus, VAADA Conference Melbourne.
- Sundbery, J., Boundy, F., & Griffin, D. (2012). How family therapy is making a difference for Indigenous AOD workers. *DrugInfo Newsletter of Australian Drug Foundation's DrugInfo service., Responding to the needs of children and families experiencing drug and alcohol problems*(10(1)), 7,8.
- Sundbery, J., Coade, S., Proctor, K., & Moloney, B. (2010). *Indiegnous Family Therapists' Community Performance Workshop*. Paper presented at the 31st Australian Family Therapy Conference, Melbourne.
- Sundbery, J., & Dwyer, J. (2012). *Aboriginal AOD worker perspectives on how family therapy is making a difference in the treatment of substance misuse in Indigenous communities* Paper presented at the Beyond 2012: Leading the way to action, NIDAC Conference, Fremantle.
- Sundbery, J., Freeman, G., Kelly, J., & McIlwaine, F. (2011). *How does family therapy fit with Aboriginal families where there are problems with substance misuse?* Paper presented at the Making a Difference: Family inclusion, innovation and integration, Beacon Conference, Melbourne.
- Sundbery, J., McIlwaine, F., & Kelly, J. (2010). *Family Healing: Understanding the training and support needs of Indigenous AOD workers*. Paper presented at the Listening Learning, Leading, NIDAC Conference, Adelaide.
- Sundbery, J., Proctor, K., & Latham, R. (2011). Empowering Indigenous family workers by degree. *Australian Philanthropy, Indigenous Philanthropy*(80), 23-24.
- Swantz, M., L. (2008). Participatory Action Research as Practice. In P. Reason & H. Bradbury (Eds.), *The Sage Handbook of Action Research: Participative Inquiry and Practice* (Second ed., pp. 31-49). Los Angeles: Sage Publications.
- Swisher, K., & Deyhle, D. (1987). Styles of learning and learning of styles: Educational conflicts for American Indian/Alaskan Native youth. *Journal of Multilingual and Multicultural Development*, 8(4), 345-360.
- Teasdale, K. E., Conigrave, K. M., Kiel, K. A., Freeburn, B., Long, G., & Becker, K. (2008). Improving services for prevention and treatment of substance misuse for Aboriginal communities in a Sydney Area Health Service. *Drug and Alcohol Review*, 27(2), 152-159.
- Templeton, L., Velleman, R., & Copello, A. (2005). Family interventions in the treatment of alcohol and drug problems. *Drug and Alcohol Review*, 24(4), 369-385.
- Thiele, S. (2005). Sociologists and 'Indigenous Issues'. *Nexus*, 17(1), 13.
- Tomlins-Jahnke, H., & Taiapa, J. (1999). Māori research. In C. Davidson & M. Tolich (Eds.), *Social Science research in New Zealand. Many paths to understanding*. Auckland: Longman.
- Tonkinson, M. (1982). The mabarn and the hospital: The selection of treatment in a remote Aboriginal community. In J. Reid (Ed.), *Body, land and spirit: health and healing in Aboriginal society*. St Lucia: Univeristy of Queensland
- Toombs, M., & Gorman, D. (2010). Why Do Indigenous Students Succeed at University? *Aboriginal and Islander Health Worker Journal*, 34(1), 14-16.

- Trouw, N. (1997). Scaffolding Children's Learning in a Multi-ethnic Classroom. In S. Harris & M. Malin (Eds.), *Indigenous Education: Historical, moral and practical tales*. Darwin: Northern Territory University Press.
- Tsey, K., Whiteside, M., Deemal, A., & Gibson, T. (2003). Social determinants of health, the 'control factor' and the Family Wellbeing Empowerment Program. *Australasian Psychiatry*, 11(s1), S34-S39.
- Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (2005). Trauma exposure, posttraumatic stress disorder and problem drinking in sexual assault survivors. *Journal of studies on alcohol*, 66(5), 610.
- VACCA. (2008). *Aboriginal Cultural Competence Framework*. Melbourne: Victorian Government Department of Human Services.
- VACKH. (2009). *Victorian Aboriginal Health Plan 2009*. Melbourne: Victorian Advisory Council on Koori Health.
- van der Kolk, B. (1987). *Psychological trauma*. Washington, D.C: American Psychiatric Press.
- van der Kolk, B. (2007a). Developmental Impact of Childhood Trauma. In L. Kirmayer, L. Lemelson & M. Barad (Eds.), *Understanding Trauma: Integrating biological, clinical and cultural perspectives*. New York: Cambridge University Press.
- van der Kolk, B. (2007b). The Developmental Impact of Childhood Trauma. In L. Kirmayer, L. Lemelson & M. Barad (Eds.), *Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives*. Cambridge: Cambridge University Press.
- van der Kolk, B., & McFarlane, A. (1996). The black hole of trauma. In B. Van der Kolk, A. McFarlane & L. Weisth (Eds.), *Traumatic Stress: the effects of overwhelming experience on mind, body and society*. New York: Guilford Press.
- Van Der Sterren, A. E., Anderson, I. P., & Thorpe, L. G. (2006). 'Individual' harms, Community 'harms': reconciling Indigenous values with drug harm minimisation policy. *Drug and Alcohol Review*, 25(3), 219-225.
- Velleman, R. D. B., Templeton, L. J., & Copello, A. G. (2005). The role of the family in preventing and intervening with substance use and misuse: a comprehensive review of family interventions, with a focus on young people. *Drug and Alcohol Review*, 24(2), 93-93.
- Vicary, D., & Andrews, H. (2000). Developing a Culturally Appropriate Psychotherapeutic Approach with Indigenous Australians. *Australian Psychologist*, 35(3), 181-185.
- VicHealth. (2000). *We Don't Like Research...But in Koori Hands it Could Make a Difference*. Melbourne.
- Villanueva, M., Tonigan, J. S., & Miller, W. (2007). Response of Native American Clients to Three Treatment Methods for Alcohol Dependence. *Journal of Ethnicity in Substance Abuse*, 6(2), 41-48.
- Vos, T., Barker, B., Stanley, L., & Lopez, A. (2007). *The burden of disease and injury in Aboriginal and Torres Strait Islander people 2003*. Brisbane School of Population Health, The University of Queensland
- Vygotskiĭ, L. S., Veer, R. v. d., & Valsiner, J. (1994). *The Vygotsky reader*. Cambridge, Mass., USA: Blackwell.
- Waldegrave, C., & J.T.T. (2003). *Just therapy a journey: a collection of papers from the Just Therapy Team, New Zealand*. Adelaide, S. Aust: Dulwich Centre Publications.
- Walker, R., & Sonn, C. (2010). Working as a Culturally Competent Mental Health Practitioner. In *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* Canberra: Department of Health and Ageing.
- Walter, M., & Saggars, S. (2007). Poverty and social class. In B. Carson, T. Dunbar, R. Chenhall & R. Bailie (Eds.), *Social Determinants of Health* Sydney: Allen and Unwin.
- Waples-Crowe, P., & Pyett, P. (2005). *The Making of a Great Relationship: A review of a healthy partnership between mainstream and Indigenous organisations*. Melbourne: Victorian Aboriginal Community Controlled Health Organisation.
- Weaderburn, D., Snowball, L., & Hunter, E. (2006). *The economic and social factors underpinning Indigenous contact with justice system: results form the 2002 NATSISS survey*. Sydney.

- Westerman, T. (2004). Engagement of Indigenous Clients in Mental Health Services: What role do cultural differences play? *Australian e-journal for the Advancement of Mental Health (AeJAMH)*, 3(3), 1-7.
- White, L. (2005). Batchelor Institute's 'both-ways' journey: 1968-1985. *Ngoonjook*, (27), 6-17.
- White, M. (1997). Challenging the Culture of Consumption: Rites of passage and communities of acknowledgement *Dulwich Centre Newsletter*, 1997(2&3), 38-42.
- White, M. (2003). Narrative Practice and Community Assignments. *International Journal of Narrative Therapy & Community Work*, 2003(2), 17-55.
- White, M. (2007). *Maps of narrative practice*. New York: W.W. Norton & Co.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- Whiteside, M., Tsey, K., McCalmana, J., Cadet-James, Y., & Wilson, A. (2006). Empowerment as a framework for Indigenous workforce development and organisational change *Australian Social Work*, 59(4), 422-434.
- WHO. (2010a). *ATLAS on Substance Use (2010): Resources for the prevention and treatment of substance use disorders*. Geneva: World Health Organisation.
- WHO. (2010b). *Global strategy to reduce the harmful use of alcohol*. Geneva: World Health Organisation.
- Wiechelt, S. A. (2007). Trauma and Substance Misuse: Critical Considerations in Understanding the Maelstrom. *Substance Use & Misuse*, 42(2-3), 527-527.
- Wilkes, E., Gray, D., Saggars, S., Casey, W., & Stearne, A. (2010). Substance Misuse and Mental Health among Aboriginal Australians. In N. Purdie, P. Dudgeon & R. Walker (Eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Canberra: Department of Health and Ageing.
- Wilkinson, R. G. (1999). Putting the picture together: prosperity, redistribution, health, and welfare. *Social determinants of health*, 256-274.
- Wilkinson, R. G., & Marmot, M. G. (2003). *Social determinants of health: the solid facts*: World Health Organization.
- Williams, R. (1999). Cultural safety — what does it mean for our work practice? *Australian and New Zealand journal of public health*, 23(2), 213-214.
- Wilson, M., Stearne, A., Gray, D., & Saggars, S. (2010). The harmful use of alcohol amongst Indigenous Australians. *Australian Indigenous HealthInfonet*, 4.
- Wilson, R. (1997). *Bringing them home: report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children and their Families* Canberra: HREOC.
- Woods, W., Wanatjura, E., Colin, T., Mick, J., & Lynch, A. (2000). Atunypa Wiru Malparara Malparara: The strength of working together. In W. Weeks & M. Quinn (Eds.), *Issues Facing Australian Families: Human services respond*. Frenchs Forest, NSW: Longman Australia.
- Wunungmurra, W. (1989). "Dhawurrpunaramirri": Finding the common ground for a new aboriginal curriculum. *Ngoonjook*, (2), 12-16.
- Yunupingu, M., Australia. Dept. of Employment, E., & Training. (1994). *National review of education for Aboriginal and Torres Strait Islander people: a discussion paper*. Canberra. (Report).
- Zubrick, S., Dudgeon, P., Gee, G., Glaskin, B., Kelly, K., Paradies, Y., . . . Walker, R. (2010). Social determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing. In N. Purdie, P. Dudgeon & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. Canberra: Australian Institute of Health and Welfare.
- Zubrick, S., Lawrence, D., Silburn, S., Blair, E., Milroy, H., Wilkes, E., . . . Ishiguchi, P. (2004). *The Western Australian Aboriginal Child Health Survey: The health of Aboriginal children and young people*. Perth.

‘The Gap’



Artist: Robyne Latham

This egg tempera painting titled ‘The Gap’ (H 2070mm x W 930mm) is dedicated to the 52 Aboriginal and Torres Strait Islander graduates of the post Graduate Certificate in Family Therapy, Bouverie Centre, La Trobe University. The work also pays homage to the professional body of Indigenous family therapists, The Aboriginal and Torres Strait Islander Family Therapy Network, founded in August 2011. The first five training locations Shepparton, Geelong/Ballarat, Gippsland, Mildura and metro Melbourne, are identified by the five circular motifs and the lines radiating from these centres. The layered patternation that connects the five locations identifies the statewide linking, networking and communication between the Aboriginal and Torres Strait Islander family therapists. It also refers to communication of the family therapists with their services, their client base and their Communities.

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