

Linking with community development

*An outsider working in
remote Aboriginal communities
of central Australia*

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EXECUTIVE SUMMARY

The study investigates my experience as an outsider working in remote Aboriginal communities of central Australia. A descriptive and interpretative evaluation of my role as a physiotherapist with Alice Springs Remote Health Service (ASRHS), within three (3) different models for practice is provided. The evaluation is set within the conceptual framework of 'linking with community development' and grounded in the experience. The study is set between early 1989 to mid 1995 inclusively.

A qualitative research methodology was chosen to conduct the study. Elements of the grounded theory approach with a social constructionist perspective were used to guide the analysis. Three case studies form the data and are documented as autobiographical narratives. They are presented in chronological order, to provide a longitudinal perspective.

The narratives are;

- i) ASRHS Physiotherapy Service
- ii) A Good Life for Old and Disabled People: A community project
- iii) People with Disabilities: A Regional Needs Assessment

Consistent with the grounded theory approach, patterns in this data were allowed to emerge to generate four categories:

- a) Insider involvement
- b) Outsider practises
- c) Information and communication processes
- d) Strategies for maximising opportunities and minimising constraints

These four categories were then integrated into an emergent core category:

- e) Linking with community development

These categories form the basis for analysis and interpretation of the case studies and comparison with the literature.

While broad attention was given to the literature for initial conception of the topic, specific review occurred after commitment to the categories. This occurred to guard against preconceived categories emerging from the literature and to allow categories to emerge from the experience. This ensures the analysis remains grounded in the experience.

Implications for outsider practice were generated from each category and integrated within a conceptual framework of 'linking with community development'. These implications may have useful application in the development and delivery of Allied Health Professional (AHP) services and to others working as an outsider in remote Aboriginal communities. The study can also provide the first step of an ongoing action research approach to AHP services to remote Aboriginal communities of central Australia.

Statement of Authorship

I declare that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge it does not contain any materials previously published or written by another person except where due reference is made in the text.



Ruth N. Barker

Declaration by Supervisor

I believe that this thesis is properly presented, conforms to the specifications for the thesis and is of sufficient standard to be, *prima facie*, worthy of examination.

Keith McConnochie

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Glossary of Abbreviations

A&DSIG	Aged and Disability Special Interest Group
AHP	Allied Health Professionals - a term used referring to the professions which include Physiotherapy, Occupational Therapy, Speech Pathology, Nutritionists, Psychologists, Social Workers, Audiologists, Podiatrists etc
AHW	Aboriginal Health Worker
ASRHS	Alice Springs Remote Health Service
ASHS	Alice Springs Health Service
ATA	Aboriginal Teaching Assistant
ATSIC	Aboriginal and Torres Strait Islander Commission
CAFRC	Central Australian Family Resource Centre
CARPA	Central Australian Rural Practitioners Association
CBR	Cross Border Region
CDEP	Community Development and Employment Program
DMO	District Medical Officer
HACC	Home and Community Care
NAHS	National Aboriginal Health Strategy
NH&MRC	National Health and Medical Research Council
OT	Occupational Therapist
RAN	Remote Area Nurse
RFDS	Royal Flying Doctor Service
RHSET	Rural Health Support Education and Training
THS	Territory Health Services
VVRAHPG	Very Very Remote Allied Health Professional Group

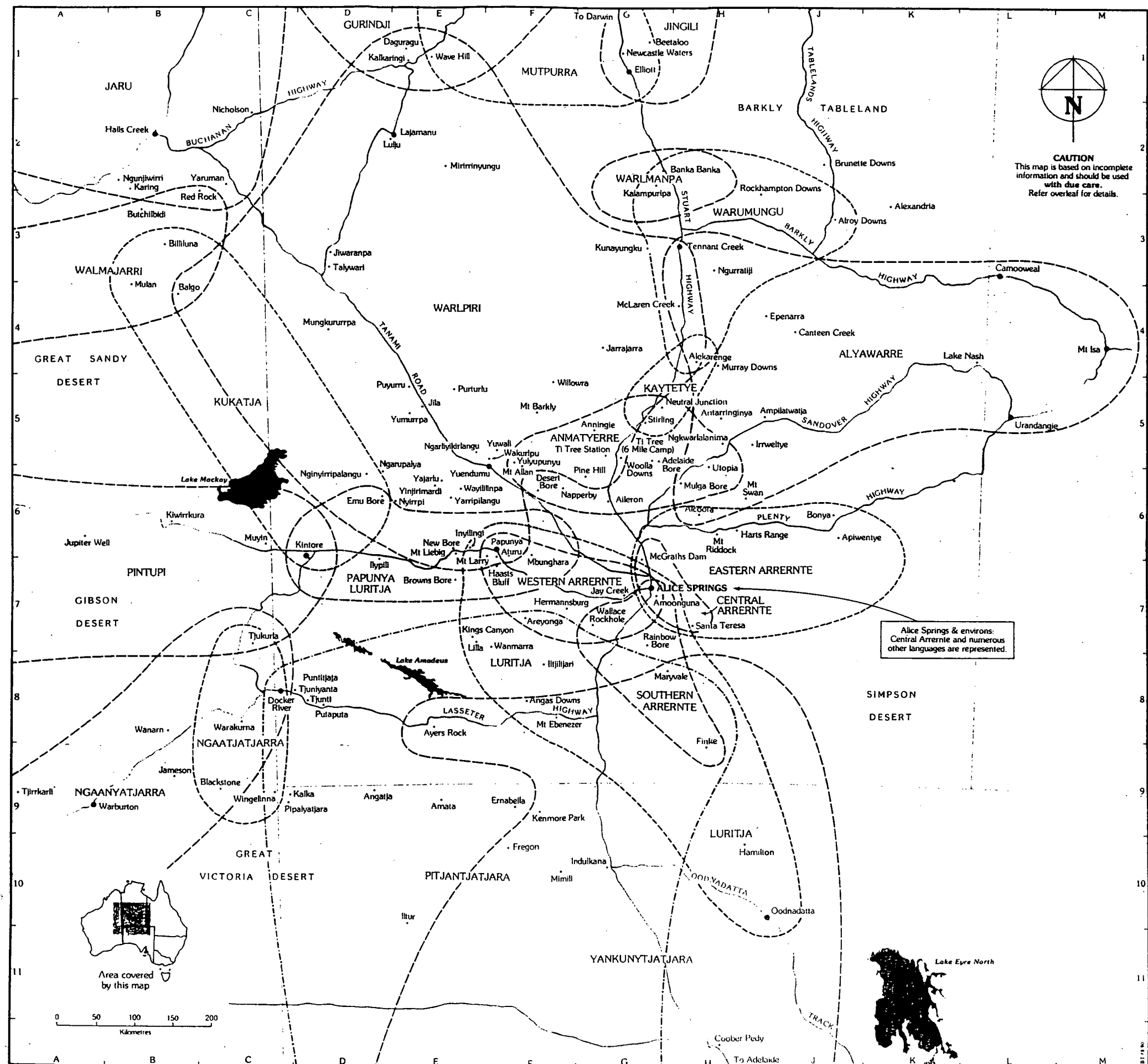
Warlpiri Words Terms and Names

Yapa	The word for person or people. It is used by the Warlpiri people to refer to themselves
Kardiya	Word commonly used by the Warlpiri people to refer to a non Aboriginal person
Warlpiri	The language spoken by a group of people whose traditional land lies north west of Alice Springs in central Australia. It is also the word used to describe people who speak that language
Ngangkari	Traditional practitioner (healer)
Wirlyajarrayi	The Walpiri name for Willowra
Lawa	The Walpiri word meaning no
Kinship network	The means by which all Yapa relationships are determined and defined within an intricate interconnected system
Skin name or skin term	A name one shares with other relatives who are similarly classified within the subsection system (which has eight name categories) of the kinship network.

Pitjantjatjara Words Terms and Names

Anangu	The word for person and people. It is used by the Pitjantjatjara people to refer to themselves
Tjukurpa	the religious interpretations of the profound bonding of people to one another; to their country; and to the species of animals and plants inhabiting it. It is continually renewed by its expression, song, dance, verbal narratives of creation stories, and symbolic depiction; and re-enacted continually in ceremonial journeys

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CHAPTER 1

INTRODUCTION

1.1 Purpose

The purpose of this study is to investigate my experience as an outsider working in remote Aboriginal communities of central Australia. A descriptive and interpretative evaluation of my role as a physiotherapist with ASRHS, within three different models for practice, is provided. The evaluation is placed within a conceptual framework of 'linking with community development', which emerged from the experience. This ensures the evaluation is grounded in the experience.

As a physiotherapist working with the ASRHS, my position was one of the first Allied Health Professional (AHP) positions dedicated to service delivery for people from the remote Aboriginal communities of central Australia. At the time no specific models for practice had been established. As no evaluation has been done to date, this study aims to provide an evaluation which documents what has been done, what outcomes have occurred, and what lessons could be learnt. This could promote critical debate, provide insights and perhaps guide future practice.

Three case studies are presented in chronological order to provide a longitudinal perspective. An autobiographical narrative style has been chosen for presentation of this data to ensure that practical information is available to new and continuing AHPs in the field. It also aims to give the reader the opportunity to draw from the experience what is relevant to them and to draw their own conclusions. Subsequent analysis and interpretation provides one reflection of the work, from my experienced vantage point. Comparison to the extant literature, is intended to provide the reader with a challenge to my interpretation, their own interpretation and to add greater density to both. The study aims to make a contribution to the small body of literature available to AHPs in the field, as well as for other outsiders working in service delivery to remote Aboriginal communities.

From my perspective as an outsider, the purpose of the study is to step back and critically analyse the experience, in a creative approach. Rather than considering the merits of working in alternative structures or models, it aims to give expression to the experience within the opportunities and constraints of each context. From this, implications for outsider practice can be identified across a range of structures, models and contexts for practice.

The study is also motivated by a strong attachment to the Aboriginal people I have worked with, a deep appreciation of the experience shared and a desire to share such a positive experience with others, believing it has something to offer.

1.2 Context

1.2.1 Remote Aboriginal Communities of Central Australia

Central Australia is defined as the geographical area of the Northern Territory (NT) and Western Australia (WA) and South Australia (SA) extending to Elliott in the north, the NT border in the east and the Pitjantjatjara Yankunytjatjara and the Ngaanyatjarra Lands of Western Australia and South Australia, to the south and west.

Central Australia is characteristically red and rugged with a diversity of landscapes and vegetation including majestic mountain ranges, vast open grasslands, ghost gums, mulga, sand hills, spinifex, dry river beds scattered with river gums, and blue skies. It has a semi arid to arid climate. Long hot summers and warm winter days with cold nights, are typical for this area. The region is surrounded by deserts with the Tanami Desert to the North, the Gibson Desert to the West, the Great Victoria Desert to the South and the Simpson Desert to the East. The population in remote areas is approximately 19,000 of which approximately 12,500 or 65% are Aboriginal people (ABS 1991, NPY Women's Council 1994:112). The major languages spoken in the region include Pitjantjatjara, Yankunytjatjara, Ngaanyatjarra, Ngaatjatjarra, Pintupi, Luritja, Eastern, Western and Southern Arrernte, Warlpiri, Anmatyere, Kaytetye, Alyawarre, Warumungu, Jingili and Mutpurra (IAD 1990). In remote areas of central Australia greater than 93% aged 5 years or more speak an Aboriginal language at

home. In central Australia 41% of Aboriginal people claim to speak English not well or not at all (ABS 1991).

Alice Springs is the major regional service centre for central Australia with 3,708 Aboriginal people recorded as living there. Tennant Creek is a smaller service centre for the Barkly District with 928 people recorded as living there (ABS 1991).

History

Prior to white settlement, the Aboriginal people of Central Australia traversed their respective 'country' in small clans or extended family groups. Daily life largely consisted of hunting and gathering, with movement dependent on the availability of adequate food and water supplies, and obligations determined by the sacred law. Family groups, linked by the kinship system would come together at certain times to engage in ceremonies, often involving travel over large distances (Downing 1988, Nathan & Leichleitner 1983b). This lifestyle centred around, was embodied within, and prescribed according to the Tjukurpa. Tjukurpa is defined as:

the religious interpretations of the profound bonding of people to one another; to their country; and to the species of animals and plants inhabiting it. It is continually renewed by its expression in song, dance, verbal narratives of creation stories, and symbolic depiction; and re-enacted continually in ceremonial journeys. (H.A.L.T. 1991:2)

Records and the recollections of Aboriginal people suggest that people in Central Australia prior to white settlement, were in good health and free from disease. The land provided a nutritious diet, their lifestyle involved frequent exercise and with people living in small groups the spread of infection was minimal (Nathan & Leichleitner 1983b, Garrow 1994:13, Franklin & White 1991:3).

White settlement and the process of colonisation in Central Australia began in the 1870's following the 1862 crossing of Australia from north to south by John McDouall Stuart, completion of the overland telegraph station in 1872, establishment of the first central Australian pastoral station, establishment of Hermannsburg mission in 1877 and from 1896 the beginning of many gold seeking expeditions (Read 1991:ix-xii, Downing 1988 xi-xiii).

Central Australia attracted many adventurers, explorers, gold seekers, cattle men and the occasional missionary. The effects of many of those intrusions on the

Aboriginal people were devastating and caused some people to leave their tribal areas' (Downing 1988:1).

With white settlement, a series of government policies were imposed. With initial colonisation, and drought conditions, competition for scarce resources resulted in violence towards Aborigines. This led to a policy of protection and segregation and the establishment of reserves, an oppressive structure of control over the lives of Aboriginal people. Haasts Bluff established in 1930s was the first of many reserves established in central Australia. In the 1950s the policy of assimilation was introduced. Aboriginal people became wards of the state, 'half caste' children were removed from their Aboriginal families and Aboriginal culture negated in the push for Aboriginal people to become 'just like us'.

The events which surrounded these policies, led to many Aboriginal people of central Australia moving from their traditional lands towards areas of settlement including missions, reserves and camps on cattle stations or other areas of white settlement. With majority power, imposed decision making and the extensive loss of land, Aboriginal dependence resulted (Eckermann et al 1992b: 34-55, Crawford 1989:7-14).

In 1967, following a national referendum, the Federal Government gained the power over the states to legislate on Aboriginal issues. Aboriginal people gained citizenship and a policy of integration recognised the positive potential in allowing cultural differences and the different needs and aspirations as part of these differences. In 1972 a policy of self determination was introduced which acknowledged the right of Aboriginal people to determine their own destiny, with government help in providing human and financial resources and support. Since 1975 a policy of self management has taken this further, with Aboriginal people now being accountable for their own decision making and financial management and the recognition of the importance of Aboriginal involvement in the management of their affairs (Eckermann et al 1992b: 34-55, Crawford 1989:7-14).

Since the mid to late 1970's there has been a return to traditional lands with the development and government support for the homelands movement, outstation or country camp movement (Downs 1988, Nathan & Leichleitner 1983b). In addition the passing of the Land Rights Act of 1976 has meant that many Aboriginal people have been able to remain or return to their land. Today, within the central Australian region, greater than 75% of land is held by Aboriginal people. The Ngaanyatjarra Lands of WA are held under a 99 year lease agreement

with the WA Government, The Pitjantjatjara Lands of SA are inalienable freehold title under the South Australian Pitjantjatjara Land Rights Act. In the NT communities are subject to different land tenure regimes including freehold and special purpose lease excision (NPY WC 1994:40-50) and include approximately 47% of land in the Central Land Council Region (CLC pers. comm Nov 1995).

Despite recent more positive changes in policy, past policies have determined the powerlessness of Aboriginal people, and much of the interaction between outsiders and Aboriginal people today (Crawford 1989:7-14, Eckermann et al 1992b: 34-55).

The legacy of past policies lives on in present day Aboriginal communities, in people's experiences, attitudes, values and ways of perceiving (Crawford 1989:7).

Today

In central Australia today the Aboriginal people living in remote communities maintain varying degrees of traditionally oriented lifestyle. This lifestyle is generally supplemented by transport, store food, western health and education services and social security payments. There are well over 150 communities, the largest being approximately 1000 people, over 30 communities with 100 or more people and the remaining are smaller outstations or homelands. Larger communities have services including schools, clinics, a general store, perhaps a church, council office and women's centre or resource centres. Homelands or outstations are generally small, belonging to a family group who will often have traditional ties to the land. In smaller outstations there may be only a house or small cluster of houses and a bore. In larger ones, small one or two teacher schools exist. Outstations tend to be dependent on the larger communities for health and education services, store food and materials and for attendance at meetings. Some families live more or less permanently on their outstations while others return on weekends and school holidays.

The health of Aboriginal people today in Central Australia is extremely poor (Saggers and Gray 1991, Reid and Trompf 1991, ABS 1991). Mortality still remains four (4) times higher than for other Australians. Although there has been a reduction in infectious diseases resulting in death, there has been and will continue to be an increase in the lifestyle diseases of Aboriginal people. Only 35% of people in remote areas participate in the workforce. However in remote areas 87% of adults over 15 years have an annual income of \$12,000.00 or less

(ABS 1991). For Aboriginal males in the NT, life expectancy at birth is 53 years and for females is 64.8 years compared with the total Australian population of 73 years for males and 79 years for females (Thomson in Reid & Trompf 1991 : 43-44).

It would therefore appear that Aboriginal people of Central Australia are among the poorest and sickest people in Australia. Siggers and Gray (1991:17) suggest that there is a general agreement among researchers that the cause of the poor health status include 'a history of oppression, exclusion from economic opportunity, poverty, poor nutrition, substandard housing, poor hygiene and traditional beliefs and behaviours'.

The impact of past policies on the present conditions of Aboriginal people today, is seen not just as a state of poverty and ill health but as a state of powerlessness. Crawford (1989:4) explains: 'Poverty, ... is not seen simply as an absolute, material state of deprivation'... but rather is 'seen as a state of felt powerlessness...a lack of power over resources, a lack of power in decision making, a lack of power in relationships and a lack of power over information'.

The provision of health services to Aboriginal people of central Australia consists of a combination of traditional practitioners, Aboriginal community controlled organisations funded by the federal government and or state and territory governments and the Territory Health Services (THS) run by the Northern Territory Government (NTG).

In the provision of these health services, there are a large number of non Aboriginal people who are living and working or visiting Aboriginal communities. While Aborigines still remain in the majority, with their languages retaining priority over English, there is an extremely high turnover rate of non Aboriginal staff. This occurs not only in the delivery of health services, but also in education, stores, essential services, community administrators and resource centres. This contributes to the rapidly changing circumstances for the people of remote Aboriginal communities.

1.2.2 *Alice Springs Remote Health Service*

ASRHS is part of THS, the NTG health service. It aims to provide a primary health care service to remote Aboriginal communities of the region. This is an area of approximately

490,000 km² within the NT borders with a population of approximately 11,000 people of which 60% are Aboriginal people. This area largely consists of the traditional lands of four major language groups, namely the Warlpiri, Arrernte, Pitjantjatjara and Luritja. In the region ASRHS is responsible for 24 health clinics and centres, and a large number of outstation mobile runs.

By the end of the study period ASRHS employed over 160 staff including Aboriginal Health Workers (AHWs), Remote Area Nurses (RANs), District Medical Officers (DMOs), Environmental Health Officers, Welfare Officers and a Resource Team consisting of Nutritionist, Physiotherapist, Occupational Therapist, Mental Health Practitioner, Women's Health Practitioner, Pharmacist, Aboriginal Health Worker Educators and Remote Staff Educators, supported by administration staff located in the regional office in Alice Springs.

AHWs and RANs are resident in communities and are employed following a community selection process, as permanent staff of the health clinics and centres. DMOs provide regular visiting clinics on a one to two weekly basis as well as a 24 hour consultative service by telephone and radio and emergency retrieval service via the Royal Flying Doctors Service (RFDS). ASRHS also provides the medical consultative service and emergency retrieval to those communities within the region who have a community controlled health service.

The physiotherapy position and the nutritionist position were the first AHP positions to be dedicated to service delivery to remote Aboriginal communities. Gradually AHP numbers increased to make up a proportion of the Resource Team which developed. Members of the Resource Team consist of positions which are town based, providing a visiting service to communities on a routine basis and in response to specific requests. The team also provide services to communities within the region which have a community controlled health service.

A multi disciplinary management team is responsible for planning and provision of the health service. In developing the ASRHS operational plan, direction is taken from the operational plans of the individual community health teams, the National Aboriginal Health Strategy (NAHS), the Recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) and Health for All, the NT Aboriginal Health Policy and the THS Corporate Plan.

Since 1989 major changes have occurred within the structure of ASRHS. Following a review in 1990 a major move towards integrated health services saw a shift from the predominantly medical service of DMOs, RANs and AHWs to become a health service, with the development of the resource group and a multi disciplinary approach. It is within the context of the implementation of these changes that case studies one (1) and two (2) are set. In 1995 further restructuring began and continued into 1996. This has been the second major change in five years, and while positive in a number of ways, results in a lack of continuity in philosophy and practise and subjects people in Aboriginal communities to continually changing circumstances.

In this environment the non Aboriginal person is an outsider. With the professional, personal, cultural and geographical isolation and physically difficult conditions, living and working in this cross cultural environment can be highly stressful. It is important to add that this same environment can be to the outsider, highly stimulating, challenging and rewarding.

1.3 Definitions

The key words and concepts in this study generate a variety of meanings and assumptions. These have been explored and defined within the context of this study on the basis that:

Words have no fixed objective meanings in their own right - they derive their meanings from their use by people (Crawford 1989:15).

1.3.1 *Outsider*

An 'outsider' is someone who is a non member (Kauffman 1994:179) or non kin (Bain 1992:230) who has not been born into or socialised into a group. Rather than considering it synonymous with white people or non Aboriginal people, outsider refers to someone from elsewhere (Sutton in Rowse 1991:56). An outsider on first entering a remote Aboriginal community would be someone outside the predominant culture and world view, with no knowledge of the major spoken languages and the differing day to day practices and priorities. Agendas of the community and decision making procedures would not be open to them.

In considering the implications of the role and status of the outsider, Kauffman (1994:179) suggests that an outsider is (a) bereft of the direct, intuitive sensitivity that alone makes empathetic understanding possible; (b) incapable of comprehending alien groups, statuses, cultures and societies; and (c) 'excluded in principle from gaining access to knowledge and understanding of the group'. In contrast, Simmel suggests outsiders may 'hold an advantaged position', as, not being caught up in commitments of the group, they can more readily acquire relative objectivity (ibid:179).

It is important to recognise that as interaction occurs between an outsider and the context, the status and role of the outsider will change. The definition of outsider within each different context will therefore, have a dimension of it's own.

1.3.2 *Linking*

Within the context of this study linking refers to an association or connection that creates a channel along which influence can flow. Linking is dependent on personal connections between individuals, who are part of a group or community and part of the processes within which the group operates. As such, linking may occur with individuals, groups and processes.

Linking may extend from people knowing of each other, to a casual association, consistent dialoguing between people or working with an organisation. Linking may be direct, or indirect as part of a chain. For example, if an outsider develops a strong working relationship with an AHW who is also a council member, a link with the council may result. Linking may have positive or negative connotations. Where there is trust, friendship and shared agendas one might expect positive connotations. Where there is hostility one may expect negative connotations. Positive or negative influence on one portion of the chain may lead to positive or negative outcomes at other points along the chain. For example, if the AHW has a positive profile within the council, this could promote a positive profile for the outsider in the eyes of the council. Alternatively, if the AHW had a poor profile with the council, this may influence the extent to which the council are prepared to support the role of the outsider. Linking may be initiated, maintained or resisted by any of the individuals involved. As linking occurs within a dynamic context, it becomes a dynamic relationship.

1.3.3 *Community*

Within central Australia, 'community' is used to refer to a residential location which is 'a mere aggregation of various groups of Aborigines brought together under pressure from white settlement' (Bain 1992:221). Such a community is defined politically, through administrative boundaries but often has little meaning to its members. In contrast, heritage and social relationship boundaries have created communities that are not recognised administratively, but mean much to the members (Taylor 1992:221). Community for Anangu, has been described as interlocking sets of complex social relationships, which extend over vast tracts of country (HALT 1990:viii). Rowse (1991:51-96) notes the duality between 'indigenous and introduced political structures' and suggests there is an 'indeterminate relationship' between them.

It is important to recognise that we all belong to not one, but many communities at the one time and many levels within the one community (Labonte 1990:66-69, Crawford 1989:22). Only the individual has the right to define which communities he or she may belong to (Stacey 1988:318). Each community is a subsection of society, not an autonomous social unit but directly related to larger social structures (Reitzes & Reitzes 1982: 267). In one geographical community there may be many communities, creating difficulties for one council to represent any one community (Eckermann 1992:192). A community is also not necessarily an harmonious unit. It may be the scene of competing and conflicting power structures and sectional interests, and of exclusion rather than inclusion or togetherness (Taylor 1992:2). It may limit possible actions while presenting opportunities for action (Cox et al 1979: 198).

The definition by Eckermann et al (1992:2 & 108) is consistent with the use in this study.

"Community" in this material does not necessarily refer to designated communities as is common in some state government definitions. Rather we are using the concept to include family groups which occupy specific territory or utilise particular services. The use of 'community' in this sense does not imply unity or commonality of interest...

Some of these [family groups] are aligned. Others, though related are long standing antagonists. The collectivity of the family groupings in any one geographic location may be labelled as 'the Aboriginal community' by the

researcher, but it may have only limited reality to its Aboriginal constituents. Rather Aboriginal people may be viewing their collectives in terms of family alliances which are fluid and may go far beyond any one locality but which may not include all members residing in it, while 'community' has become a convenient label to facilitate negotiations with the majority.

1.3.4 *Community Development*

The history of community development in Australia has always been a history of contested activity (Kenny 1996: 104).

Community development as a concept has changed over time and at any one time has meant different things to different people. The terms of reference in which it has operated and its practical form have varied (Kenny 1996: 104). It has been defined as 'a kind of revolutionary undertaking aimed at redesigning the pattern of community life' (Goodenough 1963:286). In contrast it has been defined as a 'process of political cooption, using social action to achieve national goals' (Jackson in Jakubowicz 1974:9). A more consistent definition is that it is a process whereby people become 'more competent to live with and gain some control over local aspects of a frustrating and changing world' (Biddle and Biddle (1965:78).

Within the context of this study, community development is defined as an approach which works towards personal growth and social change (Connexions 1990:5). It is a facilitating process (Sommerland 1973:7) which 'encourages, educates, influences or helps people to become actively involved in meeting some of their own needs' (Kamien 1978:235). It is about ensuring that the people have the knowledge, skills, opportunity and resources to do this on their own terms (Crawford 1989:1-3). By collaborating with people in the community and institutions which affect them, needs can be assessed and goals addressed through problem solving with local talent, resources and management (Lassiter 1992:29 -39, Taylor 1992: 1-7). This approach has application at all levels or stages of a continuum, which include developmental casework, mutual support, issue identification and campaigns, participation and control of services, and social movements' (Jackson et al 1989:66-68)

Community development is not equated with improvement, given that 'what constitutes improvement is a value judgement' (Brookfield 1983:123) and that no change or development is cost neutral (Folds 1993:35). What is important is that community development concerns

the 'creation of healthy (equitable) power relations among community groups and institutions' (Labonte' 1993: 23) whereby individuals and communities have both the right and freedom to decide the direction and process for their development (Onyx 1996: 100, Hollinsworth 1996:118).

Processes involved in community development may include projects or programs, the system of social organisation such as families or organisations, as well as the schedules, routines and the ways people prefer to make decisions, to initiate action, and to organise themselves. (Eckermann et al 1992:125). Schools, community councils, health services, women's centre, the kinship network protocols and the community routines and schedules are all examples of community development processes. These processes are formal or informal, deeply entrenched, more recent or temporary processes. They include traditional or ritualised processes, processes which may be internally or externally generated or which occur as a local response to societal forces.

Each individual who is a member of a community is part of community development. Different community development processes occur simultaneously in one community, with different power relationships and alliances or conflicts between those processes. Community development is a dynamic process as alluded to by Moe (Cox et al 1979:198) in his suggestion that a community may be 'unplanned, implicit or emergent', not "centrally directed" ... articulating with other processes, 'conflicting, competing and exchanging resources in unplanned ways'.

1.3.6 *Linking with community development*

In order to avoid adding unnecessary density to the text, it is implied that 'linking with community development' refers to myself as an outsider as the subject of the linking.

Within this study, the underlying assumption is that 'linking with community development' is a dynamic process rather than an action or event. As individuals within a community are part of community development, in linking with an individual, one is linking with those processes of which the individual is a part. It is important to note that linking in itself does not suggest that a contribution is made to community development. Crawford (1989:1) illustrates this

point in saying that ‘outside service workers have a role to play, but ideally only as the community decides to be appropriate’. Labonte’ (1990 p66) also illustrates the point in saying that professionals and their organisations are challenged to ‘assess which community problems they feel are worthy of assisting, which community solutions they feel capable of assisting and with which community groups they feel comfortable working’.

Within the context of this study ‘linking with community development’ refers to a channel along which influence can flow as part of a dynamic relationship between myself as an outsider and the individuals, groups and processes involved in personal growth and social change within a given community.

1.4 Background that led to identification of topic

Working as an outsider in remote Aboriginal communities of central Australia, I struggled to define my role within three successive models for practice. As a result the topic for this study emerged from a personal voyage of cognitive change.

In Case Study 1, I had entered the field with little knowledge or experience as an outsider working within the context of remote Aboriginal communities. In struggling to establish my role, I became aware of the many circumstances and variables involved in developing appropriate practices and in establishing a relevant service. I saw changes often imposed on communities, with only short term outcomes. Changes in funding arrangements, in policy, in federal, state/territory or local government or with restructuring of government departments led to changes in structure, models of service delivery and support systems. These changes could alter the expectations placed on Aboriginal communities and on the individual outsider, despite the fact that the change was not a response to the success or failure of the previous structure at the community level. While these changes could facilitate improvement, they could also be disruptive to the community. These constantly changing conditions caused me to look for a long term view for my practices.

In Case Study 2, I lived and worked in a community. I began to increasingly reflect on my role as an outsider, as I became more aware of the impact outsiders could have on Aboriginal communities. On entering Aboriginal communities for relatively short periods, outsiders often

brought their own ideas. On leaving these ideas could be dropped for those of the next outsider, with little recognition of existing ideas or ways. The lack of continuity as a result could be disruptive. Within this flow of non Aboriginal people into Aboriginal communities, there appeared to be a seemingly random chance of the community selecting an individual who would contribute in a positive or negative way. A community could have a positive experience and appear to move ahead. A significant outsider position could change and the process could be reversed.

In Case Study 3, I worked on a project that had strong interest and support, but significant obstacles to project implementation. Many of these obstacles highlighted the complexity of the context in which I was working. Organisational structures with inflexible administrative arrangements, language, cultural and political differences between myself and the Aboriginal and non Aboriginal people I was working with, as well as professional peer pressure all contributed to the complexity of this context. The politics surrounding government services or government initiated projects further complicated an already difficult context. These obstacles I encountered and the changing circumstances as a result, made it difficult to determine appropriate practices.

There were recurring questions which arose for me. How can I work within this context? Given the frequency of changes how can I ensure that my interaction with Aboriginal people has intrinsic value in itself so that benefits are realised for Aboriginal people? How can I save the next outsider from starting at the same starting point, despite the fact that the context for practice keeps changing? How can I ensure I do not promote or facilitate change which has undue cost to the community? What role does the outsider take? Is it as an advocate, adviser, or an observer, who makes no commitment or allegiance to an idea or process? As an outsider, within the context of central Australia, how can I ensure that something of positive value is added and no deficit created?

The need to explore these recurring questions and the illusive nature of a fundamental goal for practice within the complex context of remote Aboriginal communities of central Australia, strongly determined the topic and my approach to the study.

1.5 Location of Researcher in the Study

As the researcher I am located centrally within this study. This study speaks for me, a white Anglo Australian female, educated and trained as a physiotherapist and teacher. My background and world view have predetermined certain aspects of the study. My assumptions and perspective have led to certain kinds of questions, my values have shaped the research process and provided the conceptual roots on which my knowledge and interpretation of the experience have developed.

The style of presentation has also been determined by what I believe is a constructive manner to express the information. My perspectives have influenced the presentation of the case study narratives and data interpretation. Positive and negative experiences of the work have created biases and assumptions.

Given my location in this study, a subjective analysis will be provided which I believe reflects a trained, experienced and advised subjectivity.

Denzin has written of the need to make the problematic, lived experience of ordinary people directly available to policy makers, welfare workers, and other service professionals, so that programs and services can be made more relevant to people's lives. He suggests that an interpretive perspective identifies different definitions of the situation, the assumptions held by various interested parties, and appropriate points of intervention (Stringer 1996:80-81)

While the narrative style of presentation of the case studies specifically declares my location within each case study and allows the reader to detect some biases, my location and specific elements of bias that I have recognised have been declared below.

1.5.1 Location in Case Study 1

Prior to the commencement of Case Study 1, I had 3 years experience working with Aboriginal children and their families, in the field of education, in New South Wales and had travelled to a community in the Top End as part of that experience. While I had read extensively of Aboriginal history in general and contributed to curriculum development in Aboriginal Studies, I had no formal training in this field. While travelling around Australia, I

worked as a locum physiotherapist in Alice Springs Hospital. The physiotherapy position with ASRHS was available. My thirst for knowledge of the people and their culture and the personal and professional opportunity it offered to me led me to apply for the position. I had no specific knowledge of Aboriginal people in central Australia, the field of Aboriginal Health or models of health service delivery. I held a broad personal belief that all people have a right to have access to services and a right to control over their lives, as I did.

During the period of Case Study 1, I read extensively of Aboriginal people of central Australia and undertook post graduate studies in Aboriginal Studies. This was motivated by a desire to extend my learning and to have the learning structured, so as to challenge thought processes and expand conceptual roots on which knowledge could grow. I was also strongly influenced by the philosophy of Primary Health Care, promoted by ASRHS and the Central Australian Rural Practitioners Association (CARPA). Of greatest importance to me was the practical experience gained, the relationships I established with Aboriginal people and the knowledge and understanding I developed from listening to and learning from them.

1.5.2 Location in Case Study 2

At commencement of Case 2, I had 4 years experience working in remote Aboriginal communities (Case Study 1) and a relationship and personal attachment to Willowra community. I had been given a skin name (Nakamarra) which was almost exclusively used by community members, which gave me a place in their social structure. The community had requested that I live in the community and work with a project. My role and the project process were defined by the community. I accepted the position as it offered me both a personal and professional experience which I was eager to have. I also believed very strongly in the people of Willowra community and their commitment to the project. During the project I actively avoided the influence of professional peers whose influence I believed would challenge my focus on the agendas of the community. What was of particular importance in this project was the growth of my understanding of community development and my interest and conviction in its importance.

1.5.3 *Location in Case Study 3*

At the commencement of Case Study 3, I had five years experience working in remote Aboriginal communities (Case Study 1 and 2). My emerging belief in a community development approach for practice, dictated my project management process, while a commitment to improving access to disability services motivated me to seek outcomes. Relationships were established with Aboriginal people in some regions but not at all with others. I was seen to be aligned with one group, which assisted with that group and those associated, but created barriers with other groups. Within the political context of central Australia, working as an outsider for a government organisation, I believed my role had a stigma attached which created limitations for me.

1.6 The Importance and Relevance of the Study

It is important to realise that the ideas you hold have consequences for the actions you take. Reflecting on your ideas is as important a part of the work process as anything physically done as a service worker (Crawford 1989:28).

The initial development of an AHP position dedicated to working in remote Aboriginal communities came about as a result of structural change. As a relatively recent innovation it is important that evaluation occurs now, before it is assumed that given structures are appropriate and become locked into the system making future changes difficult. It is important to look at the advantages gained by the changes, but also to consider any costs to the people of central Australia brought about by the changes.

The experience in itself has been quite unique and may have value to those who follow in the position or in project work within ASRHS. Given the 'new ground' covered by this work it is important that this is provided and that some interpretation of the value of AHPs working in remote Aboriginal communities is explored. Given the ongoing scarcity of AHP resources the importance of ensuring that those resources which exist are adequate and used appropriately is a priority.

A programme that can bring about an improvement for people must be communicated to others so that more people can benefit. A programme that fails

to bring about an improvement must be carefully reconsidered, as the assumptions and theory behind the programme may be incorrect (Hawe et al 1990:13).

The study is set within a political climate which advocates Aboriginal community control of services. Within this climate, a culture of conflict between Aboriginal organisations and government organisations has developed. In referring to 'dilemmas which are neither clarified nor resolved by assigning "blame" to governments ... and implying that they should be behaving other than they are', Rowse (1992:54) argues that:

There is a danger of complacency in these reflections, a risk of implying that nothing can be done to improve the ways that government agencies assist 'community development' among the Aboriginal people dependent on the public sector.

As no physiotherapy and few AHP positions exist in Aboriginal organisations, people from remote Aboriginal communities of central Australia are dependent on the public sector for these services. This study must, by necessity, challenge such a 'complacency'. This may foster debate and criticism, but may potentially provide a framework for reflection if not action.

The study represents a sound attempt to make a constructive contribution to the literature. The intended audience includes AHPs other health professionals and health administrators. Within THS over 90% of the employees are non Aboriginal and the 'further preparation and informed cooperation' (Harris 1990: xiii) of non Aboriginal health professionals also remains crucial. For others new in this field who may wish to gain some understanding but 'who do not realise the magnitude of the task of aiding an Aboriginal community...' may find it useful (Kamien 1978:6).

1.7 Ethical considerations

As Australia moves into the 1990's, service workers from governmental and government-funded agencies have become the prime outside influences shaping the nature of remote Aboriginal communities. In this position you, as service worker, have replaced the missionaries and pastoralists of the past. How you play your role, will leave its own legacy (Crawford 1989: 63).

As an outsider, it is not merely my right, but my responsibility to change my practices in order to improve the services provided to Aboriginal people. To reflect on my practices in a meaningful way, it is important to evaluate. Sharing the evaluation with other AHPs in this field, may provide benefits to Aboriginal people.

The importance of this evaluation is reflected in the following statement:

Evaluation provides incentive for shifts in thinking and radical new approaches. A lot of what happens will be unexpected. Stigma should not be attached to programmes that fail, only to those programmes that fail to learn from these experiences or to those programmes which fail to evaluate (Hawe 1993:14).

The belief that to evaluate my own practices was worthwhile came from Frankl (1962:12) in his statement that 'What alone remains is the last of human freedoms - the ability to choose ones attitude in a given set of circumstances'. This statement led me to believe I also had the freedom to choose my response in a given set of circumstances. That response in essence forms my practices, which are my responsibility.

Ethical approval was granted for the research components of each case study. Permission has been granted by Willowra Community Council for publication of Case Study 2.

CHAPTER 2

METHODOLOGY

2.1 Introduction

A qualitative research methodology has been used to provide a descriptive and interpretative evaluation. The specific qualitative methodology employed to guide the analysis, includes elements of a grounded theory approach with a social constructionist perspective.

Three case studies, presented as autobiographical narratives, form the data. Four (4) categories were allowed to emerge from the data and integrated into a core category. These categories form the basis for analysis and interpretation of the data and comparison with the extant literature.

The study aims to formulate interpretations of data grounded in reality but not to build theory. Interpretations made will be related to others within the discipline and related fields and may have implications for practice. The evaluation is grounded in this motivation.

2.2 Qualitative Research Methodology

Qualitative research methodology has been described as ‘a non mathematical analytic procedure that results in findings derived from data gathered by a variety of means’ (Strauss & Corbin 1990:18). It stresses meanings in context rather than numerically measured data (Anderson and Poole 1994:26). It is a ‘search for patterns in data and for ideas that help explain the existence of those patterns’ (Bernard 1988:319). Qualitative research is about understanding, not about proving something.

Strauss and Corbin (1990: 20) describe the major components of Qualitative Research as:

- i) Data from a variety of sources
- ii) Analytic and interpretive procedures and
- iii) Written and verbal reports of the findings

Themes or processes of the qualitative research methodology outlined by Wadsworth (1991:80) match the requirements of this study. These include: naturalistic inquiry involving the study of real world situations as they unfold naturally; inductive analysis moving from practise to theory rather than the other way around; openness to whatever emerges with a lack of predetermined constraints on outcomes; unique case orientation; personal contact and insight; attention to process; empathetic neutrality; context sensitivity; and design flexibility.

The specific qualitative methodology used in this study includes elements of the grounded theory approach with a social constructionist perspective. The grounded theory approach provides a research strategy for studying a phenomenon grounded in experience. It provides a systematic set of procedures to develop an inductively derived theory about a phenomenon. It also allows a researcher to stop at any level of the analysis and report their findings (Strauss and Corbin 1990, Charmaz 1989, Chenitz and Swanson 1986).

The grounded theorist begins with a general research question or an area for study. By exploring the data, patterns or recurrent themes which relate to this area are discovered and allowed to emerge. These emergent patterns are temporarily placed in conceptual categories. By following interests and leads more data is gathered. These categories are then tested against this incoming data and altered to cater for it. Central to this is the selection of a core category, with all categories relating to it and to each other. This process arrives at relevance as it allows these patterns to emerge. The categories form the basis for analysis, interpretation, and comparison with the literature. Reading of the literature often occurs after having developed categories for analysis, to decrease the likelihood the researcher will be locked into preconceived categories rather than develop new ones as they emerge from the data (op cit).

A grounded theorists may start with a 'hunch', but not a preconceived hypotheses. A social constructionist perspective acknowledges that this leads to certain kinds of questions being

asked. The researcher therefore colours the approach and actively shapes the research process (Charmaz 1989:1164-1166).

A social constructionist perspective assumes an active, not neutral observer whose decisions shape both process and product throughout the research (Charmaz ibid:1165).

The grounded nature of this approach is therefore three-fold:

- 1) the research process begins with the experience and the data generated from it
- 2) the analysis is built directly on patterns and processes which emerge from this data
- 3) comparison is made between the research findings and the extant literature and theory

This methodology has been chosen to explore a 'hunch' developed as a result of the experience, and to evaluate the experience according to that hunch. It provides a retrospective, descriptive and interpretive evaluation, which allows me to report fully on what has been done, to explore the intricate details of the experience, gain an understanding of the processes, gain fresh slants and highlight the implications of the findings. The nature of the research question and the given context have therefore determined the method.

2.3 Data Collection

Data consists of three case studies, presented in the narrative style. These cases are:

Case Study 1: ASRHS Physiotherapy Service - A visiting service

Case Study 2: A Good Life for Old and Disabled People - A community based project

Case Study 3: People with Disabilities - A regional needs assessment

The study period is from 1989 to mid 1995 inclusively and involves my role as a Physiotherapist employed by ASRHS.

2.3.1

Sources of Data

Data used in creating the narratives was generated by me, individually or with others, at the time of each case study. It has not been collected from Aboriginal people or other outsiders, and in no way presumes to know or reflect the experience of Aboriginal people or other outsiders. While this data has been couched within my retrospective view of the events, it draws upon comprehensive contemporary documentation.

In Case Study 1, data for chronological development of the narrative came from:

- ASRHS Physiotherapy Trip Reports from February 1989 to May 1993. These reports included a list of consultations, 'other activities', as well as 'ideas for the future', which provided some of my interpretation of events.
- Photographic records (prints, slides and negatives) developed during that period.

Detailed descriptions of specific activities or issues, were drawn from:

- Internal memos, reports, strategic plans, minutes and letters held on internal files
- 'The Healthy Kids Program' resource book, research report and journal article
- 'Stimulus Pictures for Aboriginal Children growing up in remote Areas of Australia'
- Aboriginal Health Worker Training teaching materials
- Survey of Rural Physiotherapy Service 1992
- Workshop and Conference presentations from the 1992 and 1993 VVRAHPG, and the 1992 workshop on Aged and Disabled people in remote Aboriginal communities.

In Case Study 2 data was drawn from:

- The comprehensive photographic record compiled for the project, as a strategy for communication and an official record for literate and non literate people., including:
 - A profile of Willowra community and the lifestyle of the people
 - The story of the project process and progress, from the first meeting to negotiate the grant and continued for the duration of the project
 - Visits to other services for old and disabled people
- The project file titled, 'A Good Life' RHSET Grant 75, which contains:
 - All written correspondence for negotiation of the grant and reports to the funding body
 - Administrative details and negotiations within and outside of the community in relation to administration of the project and printing and distribution of resources
 - All written correspondence as part of the process of gathering information and ideas

- The book and poster produced as a resource for sharing these ideas
- Reports produced on conclusion of the project

The data for Case Study 3 was drawn from:

- The file titled 'A project to look at the need for services for people with disabilities from remote Aboriginal communities of central Australia 1994-95'. This file consists of:
 - All written correspondence, including letters, faxes and internal memos
 - Documentation of meetings held, trip reports and workshop preparation
 - Information gathered and disseminated on disability services in the region
 - Workshop proceedings, reference group meetings and project planning days
 - The Barkly Project Report and the Final Project Report
 - Documentation of negotiation of funds, administration, budget and expenditure details.
- The photographic record of the Barkly Workshop and the preparation for it

2.3.2 *Style of Presentation*

The need to understand the total situation within the case studies caused me to adopt the autobiographical narrative style and preserve the language of each setting. The Aboriginal participants use of what is often 'non standard' English is represented in the various contexts it took place. Use of the autobiographical position allowed reflection of the usage and relevance of this language for me, as well as my location within each case study. Specific effort was not made to write in this manner, rather I focused on presenting a narrative, with few external constraints placed on language usage, in order to best represent the experience. I also attempted to maintain the integrity of the information and the flow of the text, by including 'non standard' English lexical items and concepts when to standardise or exclude them would alter meaning.

In texts the resources of language are always organised in systematic ways deriving from the structures and processes of the social occasions in which the text originated (Kress 1985:33).

Kress also points out the importance of the social settings in which language is experienced, whether as reader or hearer, or as speaker or writer. The specific roles assigned to us in those texts also make up the total language experience.

The following examples demonstrate what has been described. In Case Study 2 the use of the term 'old ladies' is maintained, as an exclusive term, which relates to a specific group of senior women with recognised status. The term 'old women' lacks this exclusive status. The use of the term 'old' rather than elderly also reflects common usage within the context. The term 'disabled people' is used in Case Study 2, while in Case Study 3 the term 'people with disabilities' was used, reflecting a change in common usage between the time periods of Case Studies 1 and 2. In Case Study 1 the terms 'kids' and children are used, with kids 'reflecting' the common usage and 'children' used synonymously, reflecting a more formal usage on my behalf. In Case Study 2 the term 'toyota', a generic term used by the Aboriginal people concerned, for any 4WD vehicle, reflects my integration of this term into my language usage. The use of these terms have been maintained to preserve the meaning they hold within the context of central Australia.

In Case 2 the terms Kardiya (non Aboriginal) and Yapa (people of and related to the Walpiri language groups) are used reflecting local usage and relevance. In Case 2 and 3, the terms Aboriginal people and non Aboriginal people are used. The term Aboriginal people represents the indigenous people from central Australia as a group, reflecting a geographical classification where no one cultural classification exists. The term 'non Aboriginal' is used to identify those people who are not Aboriginal people. Objection to this may be on the basis that people are described by who they are not, rather than who they are. However to classify people who are not Aboriginal, is not relevant in the context of this study. Within a single case study either 'Aboriginal' or 'non Aboriginal' or 'Yapa' or 'Kardiya' are used to be consistent and to avoid confusion.

Narratives have been documented in chronological order to provide the reader with a range of experiences and a longitudinal perspective on what is my interpretation of my reality. Therefore the 'research report is also a social construction of the social constructions found and explicated in the data. (Charmaz 1989:1165)

2.4

Strategies for Analysis

As a result of the experience I had developed a general research question and a hunch. Following broad attention to the literature as part of the initial conception of the thesis topic, the 'outsider' and 'community development' formed the area for study. The raw material for the narratives and the early drafts of the narratives were then explored. Themes, patterns or concepts relating to this area were allowed to emerge, and were randomly and continually discovered and listed down. I was mindful of core themes or patterns emerging. Those which predominated were tentatively placed into conceptual categories and a core category identified as the central phenomenon. On returning to the data to check the 'fit' of the categories, patterns both consistent and inconsistent with the categories were pursued. The original categories were modified and one additional category created to more effectively represent or 'fit' the emergent patterns in the data. I then returned to the data to extend the categories and to fill out the case studies. On writing and rewriting the case studies, further discoveries were made and further clarification made of the emergent categories and their integration into the core category. The four categories which emerged were:

i) Insiders' involvement

This is defined as the involvement of the specific group of Aboriginal people under study. Involvement is defined broadly, for example, participation, consultation, negotiation, coordination or management. Who specifically constitutes insiders within each case study is as follows:

In Case Study 1, 'insiders' denotes the Aboriginal people living in the geographical area serviced by ASRHS.

In Case Study 2 'insiders' denotes the Aboriginal people from Willowra community, who collectively refer to themselves as Yapa.

In Case Study 3, 'insiders' denotes the Aboriginal people living in the geographical region of central Australia.

ii) 'Outsider practices'

This is defined as my practices as the 'outsider'.

iii) 'Information and communication processes'

This is defined as processes which include seeking, generating, imparting, conveying or exchanging of ideas and knowledge in a two way process of transmitting and receiving (Bourke 1991: 39).

iv) 'Strategies for maximising opportunities and minimising constraints'

This is defined as strategies which were designed or served to maximise opportunities or to minimise constraints impacting on the project or service.

The core category which provides the conceptual framework for the analysis is:

v) 'Linking with community development'

This is defined as linking between myself and the individuals, groups and processes involved in community development in each project or service.

Each case study was then analysed according to the four (4) categories and the core category. This analysis involved specifying the properties of each category, noting the conditions underwhich it arose, relating how it changed, describing its consequences and ultimately specifying its relationship to the other categories (Charmaz 1989:1168). Comparison occurred across each of the case studies, drawing attention to patterns which emerged. Following the process of writing and rewriting the main analytical message was established.

The process for reporting of the analysis then involved reducing and ordering the data. This represented both selection and interpretation. The basic similarities and differences between the three case studies were identified. The most relevant properties of each category in relation to the main analytical message were selected, compared across the three case studies and their consequences identified. Factors which contributed to the similarities and differences between the case studies were identified.

Specific review of the literature occurred after commitment to the categories and to the main analytical message, in order to guard against preconceived categories or ideas emerging from the literature. A review of the literature was then undertaken according to the four (4)

categories and the core category. As a result concepts were not borrowed from the literature, rather the categories that emerged from the experience influenced the selection and ordering of relevant literature. The study is ultimately framed within the literature. Those factors which the outsider is able to influence are then drawn out, interpreted and translated into 'implications for practice' in order to provide a framework for action.

2.5 Strengths and Limitations

The methodology chosen provides a process for achieving the aims of the study. It provides documentation of what has been done as well as changes and developments over time. It provides an evaluation of the work completed drawing out implications which could have application in the field. It explores questions and hunches which arise from the experience.

The narrative style for presentation of the data engages the reader and provides practical ideas for practice. Being dialogic in nature, the narratives do not require a fixed position, but rather enable me to represent particular shifts in my understanding and an emerging conceptual framework for practice (Dalley in Prain 1997:78-79). The inherent risk lies in giving precedence to form over content so that the reader 'has no basis on which to judge 'whether they are reading about an experience very different from their own or whether they are reading the product of a mind very different from their own' (Wolf 1992: 60). However by engaging the reader in a highly personal and highly subjective experience, it may place them in the context and give them a sense of being there, and something that some may relate to. This assigns not only some freedom but also some responsibility to the reader to make their own interpretations of the information presented.

The autobiographical narrative can provide 'a persuasive detailed account of the "situated particularity of the individual" and an understanding of the effects' on an outsider working in remote Aboriginal communities, that is grounded in lived experience (Prain 1997:78). As a reflexive text it can also reveal many of my biases and my state of mind at the time of particular events. From this, arises evidence of the process for the development of practical ideas for responding to the challenges encountered.

An autobiographical narrative may suggest an 'excessive authorial presence' which might make the study seem 'a bit self indulgent' (Wolf 1992:51). There is also a large difference between 'lived experience in all its complex diversity and what can be represented of the experience in words' (op cit). This creates some threat to the believability of the work. There is also the difficulty in relating and assessing one's own work with a temptation to justify perceived failings, understate or overstate successes or to reveal selected information. Another difficulty lies in standing back from the experience. While the earlier experiences may be assimilated into my thinking, my perception of the events in the most recent experience continued to change over the course of writing. However by evaluating my own work, I am able to highlight the intimate and subtle constraints, difficulties and opportunities, potentially moving closer to reality rather than the ideal. The challenge is to provide an accurate reflection of the experience to promote understanding that has meaning and relevance within the context.

As a result of my 'intimate familiarity' (Lofland in Charmaz op cit :1164) with the data and my broad exposure to formal and informal education processes during the study period, specific beliefs and prejudices held by me will have developed as a result. The earlier work and documentation will have differed quite markedly from the later material, having gained in both confidence and skill, leading to further insights and new ideas. These factors will have influenced the design and consequent interpretation of each proceeding case study. It will also have influenced selection of the data and certain lines of analysis.

The very nature of observation entails selective perception and one codes and interprets events within a particular framework and value system (Sommerland 1973).

The grounded theory approach is process oriented and provides the opportunity to report on these changes over time but also on the experience according to what has emerged as relevant. A social constructionist perspective assumes the subjective nature of the researcher and that assumptions and biases will always exist. Potential distortion is minimised by declaring assumptions, and being open to negative evidence. Conflict is an expected component of community development processes and as such it is intended that it is declared or alluded to rather than defended. In the interpretation, cases which do not fit the assumptions made or categories developed, are used to challenge the interpretation.

Within the grounded theory approach there is the risk of prematurely committing the evaluation to a set of analytical categories. The specific selection and review of the literature after commitment to the categories, will decrease the likelihood that I would limit what is being looked for in the case studies and only see what has been alluded to in the literature. Initial thesis development also involved minimal input from others in the field of Aboriginal Health so as not to 'accept the folk analyses of articulate or prestigious informants' (Bernard 1988:319). While this could involve marshalling those who support my interpretation and silencing those who do not, it also allowed themes to emerge from the experience, not from dominant thought, allowing the data to remain firmly grounded.

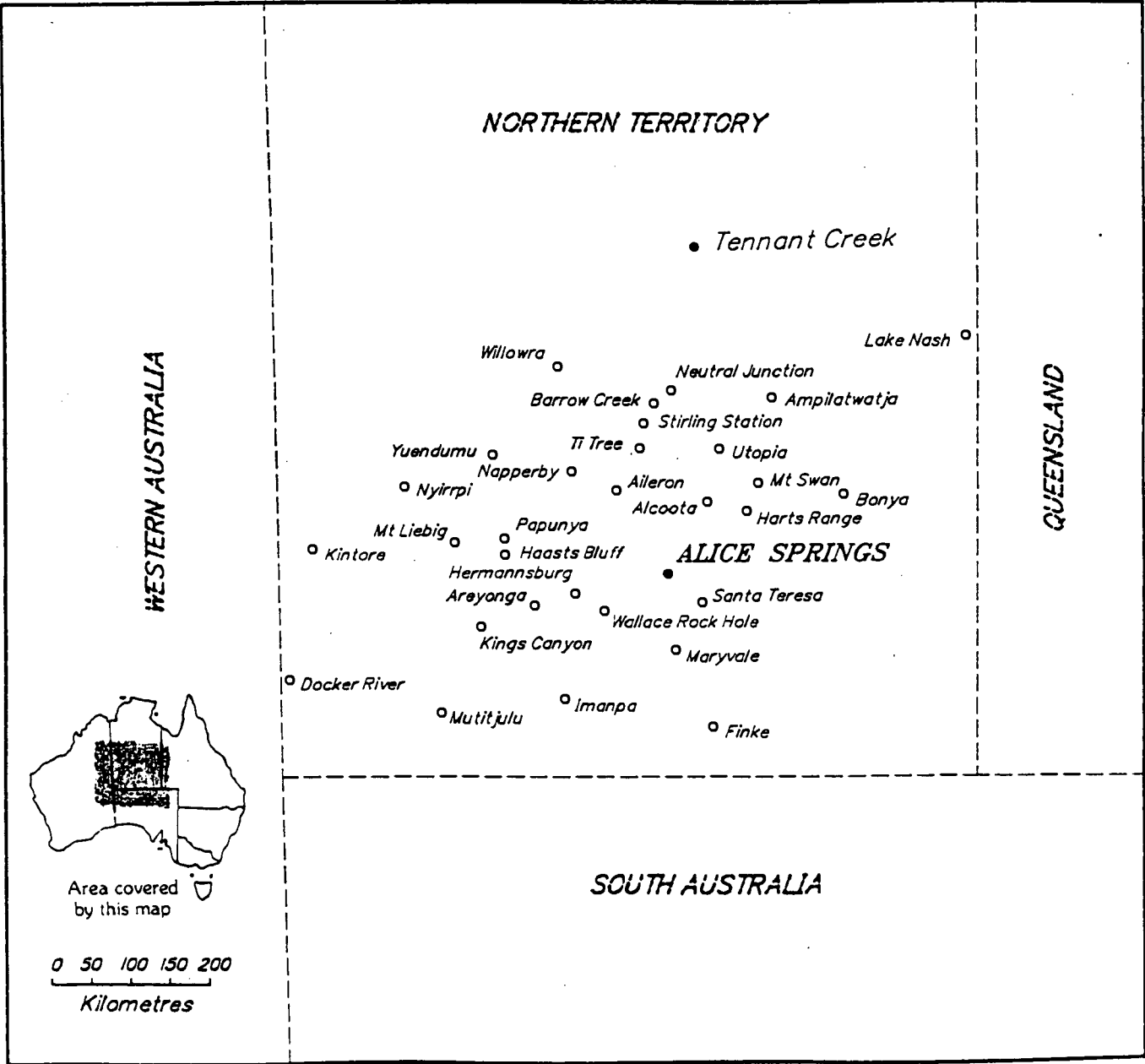
In choosing this type of qualitative methodology my aims and the expectations of this study may broadly achieve the following:

When a scientist propounds a theory ... he can take sole responsibility for what he says and claim only that he has offered one man's hopeful construction of the realities of nature for he assumes from the outset that ultimate truth is not so readily at hand - but to be judged in terms of whether his proposition seems to lead toward and give way to fresh propositions: propositions which, in turn, may be more true than anything else has been thus far. (Kelly 1969:66-67 in Bannister & Fransella 1986:1)

CHAPTER 3

CASE STUDIES

3.1.1 Map of the Region for Case Study 1



Some of the main centres visited routinely are labelled according to official usage during the study period.

3.1.2

Case Study 1:

ASRHS Physiotherapy Service

A three month physiotherapy locum at Alice Springs Hospital (ASH) gave me my first introduction to central Australia. Having worked with Aboriginal school children in New South Wales, I had some awareness of Aboriginal issues and contact history but no knowledge of the Aboriginal people of central Australia. I remember an old woman who spoke no English, sat in the corner of the ward and cried every day. She was from out bush, had never been in hospital before and went to a nursing home. I knew it wasn't right. I remember my first sight of pitchiri (chewing tobacco) only I'd thought the woman had lip cancer. On the kids' ward I learnt to avoid eye contact with the young mothers by sitting beside the mother and looking at her baby while I talked. It was the only way I could stop myself from doing what was normal for me. I wanted to know these people, their culture and countryside and so I read keenly, frequenting the hospital library and local bookshops.

At this time a sole physiotherapy position had been created to go out bush to follow up the 150 or so bush kids on the 'chronic chest list', as an alternative to mothers and babies previously brought back into town. I didn't know how or if I could do the job, but being keen, I took it on for three months and stayed for four years. Travel was by four wheel drive (4WD) or light aircraft with RFDS and involved providing a service to some communities who were serviced by the government health service, ASRHS and to others that had their own community controlled service. Initially the position was based in Alice Springs Urban Service and was to alternate monthly between the town and the bush. This structure was to be the source of much frustration.

Orientation involved a three day bush trip by road to three different communities. Having grown up in the country, I was familiar with the dirt roads and the intrigue of new country. With the AHWs, I saw mothers with their babies who had chest problems, and an old man and his wife to whom I would become close and from whom I would learn. A visit to an old woman in the camp on dusk when all ages and generations gathered together, was my introduction to the meaning of family. It was the hot time with people returning to the camp at midday, with no movement again until well into the afternoon. With the AHWs leaving work

as their pay had not arrived on the mail plane again, being humbugged for money, being averted from a scurry of drunks, and a three hour blackout in the evening, I remained fascinated. Talking to the RANs at night, I heard about payback and problems for the clinic staff and from one nurse who had worked out bush in central Australia for nearly twenty years, I heard of some of the community's history. Later when I travelled with this woman I would nut out some of my dilemmas with her. She looked at things differently from me, but she had been there, and had strong relationships with many Aboriginal people. She'd had her times of being upset with the system, with the 'plight' of Aboriginal people and the frustrations in cross cultural work. The next trip I flew out to a community. I remember the plane trip back on a hot day in a single engine 4 seater for three hours over flat red land. The romance of flying with RFDS was tainted as I learnt of what could be one of the physical discomforts of the job.

I began visiting communities to follow up the kids on the chronic chest list. This was difficult. Babies were often reluctant to be taken from their mothers, toddlers difficult to get to deep breathe and cough and school aged children were at school or difficult to find, and rarely with their mothers. I recommended and demonstrated 'chest physio', the standard treatment, finding if the child cried, it was not culturally acceptable, and not complied with. It was really no surprise to find on later reassessment with my stethoscope, that children were much the same. I had to think how I could approach this task.

I went to a community where the kids loved chest physio. If this was possible in one community then I considered it possible in other communities. From then I worked on promoting a pleasant experience for the child as part of everyday practices. A friend who was familiar with the camp setting, drew pictures with the mothers doing chest physio, sitting or lying on the ground as they would in the camp. These were distributed to clinics, mothers, grandmothers and family.

There was the difficulty in taking babies from their mothers to assess or to demonstrate treatment techniques. One day I was shopping and saw a black doll. I wondered if it would be acceptable for demonstration or insulting. Thinking I would give it a try, I bought it and took it out to a community clinic and left it in the tea room. Two senior AHWs found it, swept it up, established their relationship with it and insisted on buying some clothes for it. Their response suggested to me, it was acceptable. This doll, Nungarrayi, my daughter according to

the kinship network, was to be a greater success than I had envisaged. She served all purposes, attracting children, mothers, grandmothers, and when I demonstrated on her, kids would do the same. She also became a tool for my learning of the kinship network. Generally Nungarrayi broke down barriers, and was something I, and others following in the job, used in all areas of my work.

Later I spotted the small windmills on a stick at Alice Springs Show and tried them with kids doing deep breaths. These became an instant success and a major tool for chest assessment. Young, middle aged and old people couldn't help but blow them, when placed in their hand. I would get the deep breaths in what was a playful pleasant experience and could attract the shy child so I could assess and demonstrate treatment.

A mother of a young baby who had had pneumonia three times asked me 'How can I stop my baby from getting sick?' I somehow felt stumped. I knew the answer wasn't to do chest physio. It had a profound effect on me. My approach from then on was different. I gave her every thing I knew about chest physio, nutrition, medication, hygiene and anything that may help prevent a recurrence. I also encouraged the use of her own 'Aboriginal ways' with the grandmothers to help her.

I would see people wherever they wanted to be seen. One day the AHW took me to a family who were out in the bush cooking emu. I worked with the younger kids while all of the family looked on and encouraged their participation. It showed us all how health care could be part of every day activities. I would also work with health teams who wanted to make their own posters, videos and other educational material on chest physio. Despite all of this I learnt that a change in socioeconomic conditions was the factor that would reduce the incidence of respiratory problems. What was I doing all of this for? Yet I knew this change wasn't going to happen overnight. I had to work out what I could do to have an impact within the present conditions, and job limitations.

I started seeing school aged kids at school. This involved singling them out and removing them from the classroom, to be passive recipients of treatment given by me. This was disruptive, culturally inappropriate and resource intensive. I needed to look for a different strategy. I started assessing as I would treat and in a way that could be done by the kids. For example, I would get the kids to 'blow their nose', hearing how full the nose was, while

working to clear it. With five deep breaths, I could hear, see and feel their chest expansion, while helping to mobilise secretions. With 'two strong coughs' I could hear and clear secretions. It was all a demonstration of what mothers and kids could do to assess and treat the problem and gave me information I wanted.

In one community in response to teachers' questions, I suggested the kids cough before and after exercise. Presenting me with a big group of kids I was asked to demonstrate. Thinking on my feet, I started.... 'Blow your nose, keep blowing, now 5 deep breaths and 2 strong coughs, then do 10 star jumps, then 5 deep breaths, 2 coughs again and 10 runs on the spot, then 5 deep breaths, 2 coughs and another exercise and last of all blow your nose and have a big cough'. That was my demonstration.

I realised that this was a strategy where the kids were active participants, it was easy for staff and kids, it took only five (5) - ten (10) minutes, and required no equipment or extra cost and was fun. When I did this with kids out in the community, often at their request, other kids would join in, big kids would help little kids, parents would push kids forward to join in, and cheer the kids on. When I saw kids using the program within their play I was content that it was a culturally acceptable program.

In another community a non Aboriginal and Aboriginal teacher team expressed concern about the kids chests. I showed them the same 'program'. The teachers and kids did this every school day. After eight months, I noted a marked improvement in the kids' coughs and an audiologist who coincidentally had been screening the kids' ears, noted an improvement in ear health. This prompted formal evaluation of this program. Following approval from community councils and the NT Department of Education, a community based trial was conducted in eight schools. We designed it to be non intrusive, culturally and ethically sensitive and to utilise local skills and resources in a cost neutral project. The kids were supported in participating in both testing and trialing of this program by AHWs, Aboriginal Teaching Assistants (ATAs), teachers and the nurse audiometrist and myself. The results suggested that the program could be an effective approach to the problem and showed it was well accepted. One day a child said after blowing his nose 'see my nose is empty'. I realised that to 'empty' the nose was the goal and so 'check if it's empty' became part of the program. I'd sent a draft research paper to an ENT specialist in Aboriginal Health, who advised that the valsalva manoeuvre be added. So to 'pop your ears' after noses were empty, became part of

the program. This program and research had become an important part of my role as a bush physiotherapist, with a hard but steady taskmaster from Menzies School of Health Research who walked me through the process and assisted with the analysis and reporting. When preparing visual displays with AHWs and ATAs to disseminate the results to kids and communities involved, I realised that promoting ear health, not a usual task for physiotherapists, had become an appropriate part of my role.

What became the 'Healthy Kids Program' developed. Unlike previous strategies, this program used a population strategy that was directed towards all children. It was promoting a change in behaviour in all of the children and so could gain acceptance as a social norm. I realised that this strategy could have an impact but I would need to promote it and let it go by encouraging people to make it their own. By demonstrating and distributing pictures of the program in schools, clinics, the Education Department, Ear Health Workers, other bush physiotherapists, AHW Training, ASRHS inservices, workshops and conferences I could not only directly promote the program but could demonstrate a technique for others to develop and promote it. I worked with AHW's and with Aboriginal teachers in translating the program into language, and making charts for individual schools with photos of their kids doing it. One AHW, through his community literacy centre, made it into a book and being a musician, wrote a song with me. This process was important as this AHW expressed. 'We worked together, Kardiya and Yapa, side by side'.

In one community, I worked with an AHW taking photos of the kids to make up a chart of the program. The following week this AHW was in hospital and each day would come to my office nearby. Little by little with help from me, this man, with limited literacy, typed up the words on the computer (first time), cut and pasted, and gradually over a week made up the chart to go in the clinic on his return home. It was bright and beautiful and kids would come to the clinic for the express purpose of doing the program. We had both been opportunistic in seeking and providing support where it was needed.

Years later these and other ideas were gathered to create a booklet which included what the program is, why we do it, how we do it and some variations and extension materials being used around Australia. It was made to be copied and used by others and adapted to meet their local needs. As a program that has become standard in central Australia and with the resource

material available to assist the many people promoting it, it has a life and momentum of its own.

When faced with a standard treatments that aren't working or aren't appropriate it would have been easy to blame the person involved, 'she didn't do it', 'he didn't wear it', or to give up, 'it doesn't work', 'there is nothing I can do'. The approach which I learnt, was to look for strategies that were culturally acceptable, relevant to the persons life and so easy to comply with, and then if it wasn't successful look to why it didn't work. This often involved going back to the basis of what I had learnt in my training and then trying to apply it differently, to provide a strategy or options that could be relevant within the family or remote Aboriginal community context. I would also try to give people all the information I had and see what they did with it. This was no simple task I found, requiring a high level of lateral and innovative thinking, and a sense of fun.

A lady with a painful arm as result of a mal united fracture had had surgery, tried bandages, elastic arm bands and back slabs, but pain persisted. Noticing that she would bind it up as tightly as she could in a scarf, I tried a custom made pressure garment with supports in it, usually used for burns. Success at last.

A man had a plaster and had been sent home, to return to the ASH in 24 hours for a plaster heel. He lived 300 km away, so returning wasn't an option. I had no plaster heel. I looked at door knobs, pieces of tyre and eventually in the bush I found a football boot with sprigs. I pulled the sole off and plastered it on. The man, despite his post football age, called to the young fellas that he would be on the field soon !

Discovering and developing effective strategies was a priority, but I realised that without an effective model of service delivery the value of the service would remain limited. The structure of the position, alternating between town and bush, meant I was attending two lots of meetings, getting to know two teams of people and having responsibility to two organisations with different principles and needs. The demands were excessive, and eroded my time. I couldn't focus on either service and the position was administratively splintered with confusion about who pays what, with no specific budget committed to the position. Being located in Urban Services, if busy or money was short, the bush missed out, there was no radio to communicate to most communities, no 4WD vehicles, I was surrounded by Urban

talk and supervised by Urban Services. This demonstrated to me the need for health services to be created around the people the service is for, not around a professional team. This structure caused complications in service delivery and needed to change. I learnt that writing memos was an important skill in communicating facts, requiring a sound argument and process for change presented in a context relevant and consistent with management agendas. Patience, I learnt, was also an important skill. With the memos, meetings and conflict, after a year the position was full time and located in ASRHS. After two and a half years, it became supervised, administered and accountable to ASRHS.

As a part of the service of ASRHS, which aimed to provide a primary health care service, providing clinical consultations, rehabilitation, health promotion, community education and more were all to be components of the job, and needed to be considered. My reports in the first few months reflect multiple variables being considered as well as some rather differing logic applied to different cases. One report states a person 'living on an outstation can not be seen every time' and in contrast another report states that 'need to visit [a community] once a month'. I did visit once a month for 3 months, and developed some relationships and a sense of community, but worked in a clinical, rather than educational way. I was soon to realise that this wasn't realistic and that the person on the outstation was just as deserving, which is after all, the basis on which a remote area service is established. One clinic ran similarly to an urban doctors clinic with people called into a separate room for individual consultations. I have reported it as 'running well so continue with and keep running smoothly'. Clinically, it was running well, but I had not identified that it left no room for seeing children and adults in their own environment.

As a new service, not defined or moulded, there was the freedom and autonomy not to be bound to work in a certain way. This also meant making my own way and in every community this could mean a different thing. On arriving at a clinic the RAN could closely attend, supporting or sometimes dictating how I worked. Alternatively they could pay little attention, depending on other commitments or the personality or philosophy of the RAN. This could mean I was left to work it out by myself. When you don't know or understand what's happening, it can be really tiring, when you're waiting, pretending you're relaxed, but in fact, despairing. If left and feeling at a loss, I would read notes in the clinic or go to the shop, a public place, where I was exposed to the community and open to be approached. I would also visit the school and other community organisations I found or knew of, to let them know of

the service and what I thought it could offer. Relying heavily on the AHW and community people for direction and advice was initially difficult but to my ultimate advantage. I would work with AHWs most of the time and report back to the RANs and if relevant, to the DMO. Some of my work was in the clinic with individual consultations, and some out in the community, in the camp or with other organisations. Working out in the community, relationships were more quickly formed. The people were in a world they knew well and I was in a world I didn't know, that exposed me to their routines and lifestyle. In the early days, I needed to 'treat' a certain number of people, to show and to feel I was doing my job but I also wanted to be exposed to the culture and lifestyle. My way of reconciling this was to see the numbers of people, then spend time working in the community around this. Resistance to my mode of working did come from some non Aboriginal workers with an expectation that the role be more clinical. As my confidence and credibility developed, the balance changed. I increasingly sought approval from community members, but I never totally lost the need to meet with approval from myself and professional peers. In my early days on arriving in a community I would report to the RAN or DMO, but later it was to the AHW and community people. In some communities this way of working was keenly supported, while in others it was wise to pay due attention to the non Aboriginal staff regardless of the relationship you may have with the people.

In one community I had quite a sense of being taken under the wing by AHWs who were senior women. Within time I was given a skin name, Nakamarra. By learning what the name meant, and my place in the kinship system, the cultural world of land and law started to take on real meaning to me. It provided a framework for knowledge that would be shared with me and for the further development of relationships, an extremely important component of my work. People told me that relationships were really important and I chose to believe them. It was not until I developed relationships for myself that I could really feel the importance of relationships and know how important this was to my work. Some of the old people would talk about their lives and their history. Initially it was hard, not having the language, but it started to give me a picture, as I saw and heard expression and emotion, and watched the interaction. This was like learning to read and hear the language. Accepting when people asked to go hunting, taught me about lifestyle and every day activities. Travelling to outstations with AHWs, one heard more about family, about country and about hunting, all the plants, the seasons and the family connections between communities. I would come home

and read and read. I'd visit the librarian for books about specific communities, eventually learning to ask the people as well when a certain level of familiarity had developed.

Being expected to provide a service to all communities meant there was a lot to learn and a lot of people to get to know, but it did have some other advantages too. People are mobile within and between communities and often when I wanted to see someone, I could discover they had gone hunting, visiting or were just not there, but could find them when visiting the next community. I also discovered some useful 'ways', or therapy strategies, being used in one community and was able to communicate them to the next community.

Working in the context of the family, helped me to get some idea about being culturally appropriate or acceptable. You don't want to immobilise yourself and risk denying someone a service by believing that a strategy has to be always culturally appropriate. It doesn't have to be appropriate, just not in contradiction to social practices. Something that is comfortably incorporated into day to day activities, like a toyota, is a healthy adaptation and certainly acceptable. Offering acceptable options in your work gives some recognition of the capacity of Aboriginal people and Aboriginal culture to adapt and change. If what you are offering is relevant and acceptable then leave it to the people to see where it fits.

Remembering that people already had their own system of medicine and beliefs about health and healing was important in understanding the choices people could make, particularly in relation to leaving hospital. There were people who needed to go home to see the Ngangkari (traditional practitioner) and others who needed to take their new born baby home to be smoked (traditional ritual for the newborn). One man wanting to leave hospital, despite not being medically ready, told me 'I need to go back to my country or otherwise I will get sick. I must look after my country and my family'. And later, he told me 'I am ready to go back to hospital now'. At the same time, people shouldn't have to communicate their whole culture to me so that I can make a decision - it is not my decision to make. What is more important is that I communicate what my system of health care can offer so that they can incorporate that in their decision making.

I learnt of the world of men's and women's 'business' or ceremonial life and of the existence of protocol attached to this. I learnt to be a woman with the women and a white professional with the men. It was important to respect the differences. Sometimes it was suggested that the

council be the link or starting point into the community, however as a female and as a health person it would often feel quite inappropriate. I also learnt of 'sorry business', the right thing to do or the 'proper way' when someone died. I learnt this all too soon and all too often and found it hard to come to terms with the number of deaths of all ages, in the Aboriginal community.

To be accountable to communities, to find out what people on communities wanted and to find ways of delivering this service was an ever present goal for me. I focused on developing an accessible service, providing an appropriate, relevant, basically useful service where options were presented and people's right to choose for themselves, respected. Bush trips were three out of four weeks. This meant two (2) visits to each community a year. This schedule was tight, with no room to be responsive to requests. I sent a questionnaire to clinics, with the result that the schedule was changed to one routine visit to each community each year with additional visits when requested according to need and other demands. The purpose of the routine visit was to maintain knowledge of, access to and dialogue or presence in each community and would be from one (1) to five (5) days. It would involve responding to referrals, reviewing children and adults with a disability and those previously seen and then being available to the clinic, school, women's centre and community as appropriate for advice or education etc. Subsequent requested visits may involve going home with people after they had suffered a stroke, to spend time with them and the family to make sure they had equipment and advice to help them to manage and support the persons recovery. This flexible plan also allowed me to be a resource on community development projects when requested. In developing a workable schedule, I realised the service must be built around and flexible in relation to 'business' or ceremonial life, 'sorry business', hot weather, wet weather, availability of cars, anyone else going, but most importantly the needs and requirements of the communities and the other visitors or happenings in the community.

My time in town was taken up with preparation and follow up from bush trips, requests by phone and personal contact, meetings and education sessions for ASRHS in physiotherapy specific skills, for example, an orthopaedic or asthma workshop. Initially I would follow up bush people in the hospital and attend clinics such as amputee clinics, orthopaedic clinics and paediatric clinics. I couldn't sustain this as my time was so limited and to get out bush, was my priority. I found if I stayed in town too long I would lose my 'bush head'. I wasn't hearing

what was going on out bush, and I was forgetting the way and pace things happened. I could lose a bush focus or sense of bush priorities without even realising.

One of the responsibilities was to provide a service to the Child Health Unit (CHU), a place for mothers and babies, between the hospital and bush communities. In my early days, I spent time working with the mothers and staff on chest physio education, doing child assessments and providing home programs. If I was in town doing this work in CHU, I wasn't getting out bush to see kids in their family and home environment with the grandmothers I needed to be working with. However CHU included kids from the Cross Border Region (CBR) of SA and WA who had no other access to such a service at home and so could not be followed up out bush. I found this hard to accept, but then even the service I was providing to them had to go. This was a really hard decision, that never sat comfortably with me. Later a town physiotherapist would do some of the assessments and I found I would stay away from CHU unless specifically asked to attend, so that I didn't relinquish my decision and so that I didn't feel too guilty.

Packing up in town and rushing, rushing, rushing until I was on the road, and then switching into bush mode was an important but a difficult shift to make. Trying to relinquish the work ethic so firmly instilled in me, that was needed to get through all the work in town wasn't easy. I found the hardest shift was when working hard and fast in town, bush people would come to see me in my office. To me it was a priority to be available, there and then. One minute I wouldn't have time to scratch myself and the next I would appear to have all the time in the world to talk with them. Putting a veneer on was too stressful in the long term, so you really needed to make the shift. You just had to down tools and relax and give the time to the interaction.

Finding an office was an interesting task. Not having a professional or program head, I had to find it for myself, taking time and a few moves. I did find a central office beside the AHW room where I could be easily located and accessed by Aboriginal people and ASRHS staff to come visiting.

Within the first three months I became involved in AHW training. Even as an experienced school teacher, I found it daunting. The first lesson, I spoke while few of the AHWs looked at me, and of those that did their facial expression showed me nothing. No-one asked a question

and the interactive work was flat. I came away feeling I hadn't connected. The material I had prepared wasn't bad, so it had to be more than just that. I wasn't able to read the body language or any non verbal language of the AHWs. I either gained no feedback or read it according to my culture, which lead me to believe they were disinterested. I worked at my preparation and presentation style and things did improve for me and hopefully for the AHWs. I developed strategies involving practical or manual tasks to avoid the need for verbal interaction for a start, and as I got to know some of the AHWs, things improved. I'm sure that what has made the real difference has been my increasing familiarity with the body language ensuring more reliable feedback and increasing knowledge of the context to make the information more relevant. If possible and when requested, providing onsite health worker training, focusing on practical tasks and skills eg making plaster backslabs and reinforcing plasters, helped in establishing relationships, working together on a task rather than just talking, with a concrete outcome for all concerned.

There was an increasing awareness and demand for the service. The nature of requests and referrals had changed from chests to people with disabilities. As people became more aware of the role of the physiotherapist, I no longer had to seek these people out. A gradual but solid change occurred in the source of referrals. Initially referrals came from DMO's, the hospital and RANs. In time referrals came from AHWs and Aboriginal community members as well as specific requests for a visit to assist in community development type work. It had always been my practice to work with an AHW when seeing someone for the first time and wherever possible or appropriate after that. With the turnover of non Aboriginal staff, the knowledge of the service was remaining within the community.

There was a lot to learn when working with families with a child who is developmentally delayed or has a disability. By visiting their family in the camp, I got to see the child in his / her natural physical and social environment, and would be surrounded by the family. I became aware of the different child rearing practises that I had to consider in anything I recommended. It wasn't necessary to know the right person to speak with, as in the camp, the appropriate person could hear and speak for themselves. They may not participate, but could observe and act upon what occurred. I could support the existing set of family rules or obligations without having to know and understand them all. Communicating a home program for a little girl, to her family who could not speak, read or understand English well, took some thought. I called a friend who had lived in an Aboriginal community for a long time. He drew

some quick pictures, in the context of a typical camp setting. The whole family responded to the pictures with everyone trying them out and encouraging the child with them. Over time we worked on building up a booklet of pictures and as I gained responses from families and I learnt more, we modified some earlier pictures and later pictures became more relevant. I would also promote home programs by making up photo albums when possible and appropriate. I made it a priority to get the home program out quickly to communicate the information to family, community and clinic. Formal assessment reports providing information to other health professionals were of secondary importance to this.

I was asked for ideas for a young man who had become ataxic resulting from chronic petrol sniffing. I suggested ideas using weight or resistance, like putting heavy boots on his feet, getting him to push someone around by the shoulders or perhaps tie a sock full of sand around his waist. What the family did with this information was really interesting. His mother and father would walk him through the sand in the creek every day. The deep sand provided the resistance he required. By giving the family information they had worked out how to make it relevant. This is the type of idea I would communicate to another family or community with the same problem.

Barriers to providing the service people required were varied. Often the service did not exist, or was not appropriate or relevant. Accessing services in Alice Springs could involve a number of difficulties. Transport or accommodation was often not available. One old lady really wanted an artificial leg and requested it on several occasions. She wouldn't leave her community as she knew her family would kill all of her dogs. Another old man would not go to rehabilitation for fear that his young wife would run around while he was away. Some felt too lonely and isolated or hassled by the grog, while others were prevented from going by their family because they would 'get on the grog'.

Attitudes towards Aboriginal people with disabilities could be a major barrier to people receiving the service they required. One way of thinking at the time was 'he can't possibly live out bush'. At one time a senior man had a stroke, and was unable to sit up or move around by himself. After three weeks in hospital, he wanted to go home. His family supported his wishes. The day after he returned home, I went out to work with him and his family on activities to practise sitting up and moving about and to provide what information and equipment they needed to manage. The following day and in the following week, on the

insistence of two non Aboriginal residents that he would be 'left to die' he was returned to hospital twice, only to return the same day according to his wishes. This man worked hard with his family and had a remarkable recovery. On my last visit, he wasn't at home as he had driven family to a community 250 km away.

I could understand where the attitude of the non Aboriginal residents was coming from, having seen some terrible situations where old people were in a very poor state. I found it grim and depressing and could feel sad and angry. But I learnt to be really careful with generalising. I had to visit a very old very thin lady who was looked after by her daughters. The AHW and I went to see her in a long corrugated iron humpy, the single women's camp. She was inside, by herself, lying on the red, red dirt. After speaking to her in language, the AHW told me that she was hungry. I had this vision of my own mother, lying by herself in the dirt, and starving. I felt sad and depressed by the whole scene. When I was back in the clinic the daughters came in and the AHW told them we had been to see their mother. They were pleased and said they'd just been at the shop to get her some food as she was hungry. I was to learn a lesson. This old lady preferred the dirt to the cement, she preferred to sleep inside in the cool of a humpy during the day and outside at night. She had been hungry but only at the time and that the whole situation was being well looked after.

At other times families could have little understanding of someone's medical condition and were scared to have the person come home in case he died. There was one man on domiciliary oxygen whose family were reluctant for him to come home at all. On bush trips, I took him from town to visit his home community for just a few days. The family and health staff got to see that he was alright and got to learn about his machine and requirements without the fear of having him dumped on them without knowing what to do. This ended up being the beginning of a graded return home for this man. For others this routine could provide the same, or at least a visit.

A woman with cerebral palsy who was 'shamed' about her hand that was deformed, talked to me about it, requesting that it be straightened. I investigated options for her and she was keen to have surgery. We came up against the 'medical' opinion that it didn't really matter to Aboriginal people what things looked like and so cosmetic surgery of this nature wasn't really necessary. After two (2) years of efforts I listened in despair as a medical specialist asked closed questions based on this stereotype. He received just the response he expected, as she

answered in the way she thought she was meant to. I've seen this happen a lot between Aboriginal and non Aboriginal people and I think it was more likely to happen with the formality of the consultation between a younger female Aboriginal woman to an important non Aboriginal man. Another year later following her continuing requests she was put on an eighteen month waiting list for surgery. She had waited long enough I felt and requested her surgery date be brought forward. It was, and three years after her initial request, she had surgery with an outcome that pleased her.

Some people with disabilities who had always coped without equipment did not want it when it was available. People could also change their mind after years, for their own reason. One man had lost his leg growing up in the desert living a nomadic life. He moved with a pole using a very swift vaulting action. He had been given an artificial leg and not used it and rejected any further intrusion in relation to it. In his eighties, as his mobility decreased he requested a leg and met resistance to the suggestion from the amputee service, on the basis that he would not use it.

It can be hard to work with some of these attitudes, some of which you may find within yourself, other Aboriginal and non Aboriginal health staff, families and the person with the disability. To follow what you believed, it was not always possible to avoid conflict, so learning to handle conflict is part of the job. If you don't, there is the risk that you become part of the problem, burn out or become minimally effective.

Meeting the needs or getting the services, getting beyond the barriers required different strategies. I saw a young school boy who had had an operation and needed exercises. It was difficult working with the family as there were lots of problems. Even though a family may appear to be quite dysfunctional, trying to work against or without the family shows disrespect, and doesn't allow a family to accommodate its own dysfunction. This family were supportive of the school. By providing pictures of exercises for the Part Time Instructor (PTI) which had been worked out with the boy himself, he was provided with a service that worked for him and his family.

I would try to get to know what services and organisations were in the community and their function. By being well informed in this way, you can then be opportunistic in relation to needs which have been identified. An old disabled man was getting a new house, of which his

wife informed me. Together, we went to the Resource Centre Coordinator and talked to him about wheelchair access to the house and an appropriate bathroom. Not only was this done as it was built, but it could also have improved the awareness of the coordinator of the need to consider these modifications when further houses in the community were built.

Finding suitable equipment for people out bush developed over time. When I started, most people had only equipment that had been 'written off' in town. It's hardly surprising it was quickly non functional or wasn't used. It was known that bush wheelchairs were to be built, but there was never really an outcome so doing the best with what we could get, was the solution. This included buying commercially made equipment with various modifications. For example, wheelchairs with BMX tyres at the front and made of mesh would go through the sand and would be cool in the summer. Additional modifications could be made if required. For example, a bush trolley made from a shopping trolley with front wheels changed to cope with the terrain. Some times simple equipment could be built by the local senior citizens, like the bright coloured trolleys with fat wheels made for kids who needed assistance in learning to walk. Looking at alternatives such as fold up walking frames for people was important to ensure that they could maintain the mobile life. In working out what equipment would help it was good to look at what people were already using. People use bush sticks, that are strong, serve other purposes (for example, keeping cheeky [nasty, vicious] dogs away) and encourage upright standing more than the commercially made walking stick. All I'd do was put a rubber stopper on the end of it. It may be important to be mindful, but not frightened of the cost, if you really want to discover some alternative options.

When I started there were a small number of houses in most places. Now there would be up to 10 times more houses in some communities. I noticed that no one was building ramps into houses or bathrooms that would be accessible for people with disabilities or old people. I was seeing big steps, showers over baths and narrow doorways etc. In public buildings like the council office, shop, school and even the clinic, national standards for access for people with disabilities wasn't mentioned or complied with. An opportunity arose to address this with a meeting at ASRHS to look at design requirements for new clinics, that could be recommended to communities. In this forum I pushed for the clinic and its bathroom to be accessible for all people, young, old, abled and disabled. Attempting to get the same in a bush school only on a one off basis was an arduous task, however ultimately successful. There has been a change, with people now talking about this as an issue and national standards gaining a place.

I organised for one little boy who had cerebral palsy, to go with his mother to the Spastic Centre in Sydney for a week of intensive therapy and education for the mother. This was bureaucratically difficult but with no equivalent service in the NT and family support in Sydney, it was supported. I tried to organise for a young school child to go with her mother to intensive therapy in Adelaide. This was to be approved but the mother coming from a very remote community was not familiar with Adelaide or any of the capital cities, and was not willing to go or could not have been expected to go without another person for support. There was no money for support available. I found it hard to reconcile that I could get the service for one child and not for another. I decided that you can't deprive one child simply because you can't provide for the next. Both missing out isn't better and I believed it was important to set the precedent and highlight a need, creating discussion which could lead to change. Only recently, there have been definite developments in creating flexible funding to provide for such a situation.

People do know what is best for them, and can make their own decisions. A man, following a head injury, was unable to walk but was extremely offended by the suggestion of using a wheelchair, preferring to drive a car and use a walking frame. I doubted if he could manage a frame even with assistance, but this is what he wanted and this is what he got. He found it a shame job to be in a chair so he was strongly motivated to learn to walk on a frame. It took a long time but he learnt and now he is able to walk independently, with no aid at all.

Trip reports were designed to document information, to communicate what was done and what follow up was required, to record the process, individual and community contact and activities. Added to this, writing in notes, completing child assessment reports, and sending home programs out to clinics and family could seem repetitive. However, with different audiences and a high turnover rate of staff, this was essential with little risk of communicating too much.

I always had a plan to develop a register of the people with disabilities, so that people would not be lost from the system and perhaps to lobby for more resources. I had one sticking point that always immobilised the process. I believed a register should provide information for people with disabilities and their communities, to improve their quality and control over their own lives and not the system's control over their lives. I've never found a way to do this but I

believe there will be a way. To date there is no register. I'm not sure if it is a good thing to have no register rather than a register that fails to meet these ideals.

With the lack of services and options for people with disabilities and old people out in communities, there were difficulties with frail aged people. Sometimes the family or sometimes health staff would be pushing for them to go into respite or full time care, when they did not want to. People are not eligible if they don't want to go. As part of my role I had to ensure that they did not go if they didn't want to. Advocating for the old person, I had times of wondering what right I had to suggest to the family what could or couldn't happen. Who was advocating for the carer who was nearly breaking, trying to look after a very high needs person in a humpy with no support? Some of the RANs would be involved in some most distressing situations and I found it very difficult to not doubt my role, myself, and my commitment to the old person's rights.

There was a THS town assessment team who as part of their role carried out assessments and made recommendations. They were not connected to remote area services, resulting in some duplication and little use of or support for existing services. We tried to get the service to work with us to support what health staff and other community people were doing. We did this by designing a referral and assessment procedure so relevant community organisations and people were consulted and recommendations with options made. In time we lobbied to get this role as part of ASRHS, which we successfully did.

In establishing health service standards there was an important role. This included developing a design for asthma management plans, establishing the most suitable nebulisers and peak flows for all clinics, involvement in new clinic design which included national standards for access. A less than successful attempt was also made to establish a protocol for the treatment of burns. There were difficulties keeping dressings dry and clean, dry weather led to scar breakdown and summer heat made it impossible to wear pressure garments. Monitoring and follow up could be difficult with infrequent visits on my part and mobility of the family between communities. Standard protocol couldn't apply and so with help from specialists in city burns units I took each case on its own and with the health team and family would work out the best options.

As awareness of services increased, people with disabilities and their families started to express their needs. Services needed to be responsive to this, by being accessible and

interactive, so that communication of needs and appropriate service delivery could occur. Locating the service so that it is accessible and accountable is essential. Located in ASRHS, the point of convergence for bush staff and a regular visiting place for bush people in town, interaction was enhanced. As the demand for services and for equipment increased, and following numerous memos, meetings, patience and persistence, we were successful in gaining an Occupational Therapy (OT) position and budget, and an equipment shed and budget. Delays in ordering, payment and receiving of equipment had resulted in four out of six people dying before their wheelchairs had arrived. Having a shed and equipment pool meant people could see and try equipment and distribution could be made with ease and minimum time, improving the responsiveness and accountability of the service. With budgets allocated to the position and a budget for equipment, a request or complaint out bush could go directly to the person responsible and accountable for the outcome. Too many people between a client and the point of decision making is a real barrier to a responsive service.

Another strategy I used was to call for interest in the development of an Aged and Disability Special Interest Group. The response was strong and a multi disciplinary group within ASRHS developed. All members were voluntary and included 2 AHWs, the Nutritionist, 1 RAN, 2 DMOs and myself the physiotherapist. Our meetings were by teleconference at lunch time, to ensure bush staff had equal opportunity for input and so community members could listen and join in if so desired. Our agenda was to share ideas, respond to what was happening, and work towards and support the increase and improvement of and access to services, at a community level and organisational level. We would discuss issues which arose, learning from each other as we went. This helped us all to look at people as part of a family, and to take a multi disciplinary approach to supporting the person's needs. We would check if they had firewood, blankets, a way of being compliant to medication, if they could walk around the community and take part in community life. There was a very strong role for the two (2) AHWs, who had the expert knowledge of community issues. Among our achievements were two very successful workshops on 'Aged and Disabled People from remote Aboriginal communities', designed to involve both staff and community members. While I coordinated it, members of the group took on responsibilities relevant to them. Attendance, participation and enthusiasm was high, with many Aboriginal people as presenters. We documented the proceedings of the workshops and now three years later we have had to reprint a third time, as a result of continued demand. The group and the workshop resulted in the increased

awareness and profile of aged and disabled people from remote Aboriginal communities, with many benefits since.

As the job developed it became too big. The work load was excessive and many of the needs never met. It was demanding, both personally and professionally. It was not just a job. It was a way of life. What I had to do was prioritise and this was something I maintained the right to do for myself. This was guided by requests and responses from the people, by what was already happening and by doing what I was skilled at and where I had a lot to contribute because of experience. One area in which I had to prioritise was with the many meetings. If I expected to have minimal influence I didn't go. It was a bush job so it was a priority to go out bush. Working out the best use of your limited time with each consultation could be difficult. If you provided assessment and treatment, was there time for educating the person in what they would need to do? If someone was in pain would I relieve the pain or show them how to relieve the pain, so they could repeat this if there was a next time? I had a portable ultrasound which I started to use out bush, until one man believed it was the answer to his problems, which if I only visited once a year, was not much of an answer. I had to be real about this and work with the time I had and make the most of it.

There was pressure in the job at many levels. Conflict that came with change at an organisational level was stressful. The energy it took to improve the structure of services and to get services working together was enormous. The feeling that you have to mould your personality to suit each different community clinic, as you go around being a visitor, can become a bit much. Talking to RANs at night was a source of great information for me, and often a debrief for them. As time went on the balance could shift to all debrief and little information. It was important to not take it on, in order to survive. I learnt to let go as I drove away from a community, realising that I had done all I could given my limitations. I could also find some of the deceptively smaller issues wearing. For a while I found shopping for a bush trip on the weekend an intrusion, and I hated it. I finally realised that to shop on Monday morning was perhaps better than resigning! It's the need for self awareness and knowing your limit before you reach it, that is important in this type of job. The need for holidays of sufficient length to get right away and to have time to let go is critical. When I had only a memory of having had a personal life or would find myself 'spending so much time complaining about a job that I would just kill to have' (Valmai McDonald PC 1995), then I knew it was time for a holiday or change of course. Flexibility and time in lieu were important

for survival and effectiveness. The job was not and could not be an 8.00 to 4.21 job. When the job demanded I gave it the extra hours and when the pressure was off and my needs pressing, I took time in lieu, in order to do myself and the job justice.

A new management structure was developed with representatives of each discipline on a team. Previously, decisions in ASRHS had been made by the DMOs and Medical, Nursing and AHW executive. Now, all of the professions within ASRHS had something to contribute and I believed this structure gave respect for and utilised the unique contribution each could make. However, being part of the management team created extra responsibilities. Attending meetings was only the beginning, as, given the history of the integration of my position, I was to work on the integration of other AHPs into ASRHS. After a lot of hard work, I realised I had responsibility but no real authority or time so put a proposal forward for action by others. As a sole position, if it wasn't directly relevant, I needed to contribute but not take on responsibility that could compromise the service I was providing. Also in taking a team and organisational approach whose responsibility was it when the environment or culture of a clinic was overtly racist? Who was I to be the 'moral sheriff? Objecting and confronting racism attracted enormous defences. But by not confronting it we were allowing racism. All of these dilemmas, while very important depleted the resources of the sole position. Yet it was all part of exploring for the most suitable role with such limited resources. The work load was a problem but going around and around the bush for ever and ever not improving or changing the situation was not justifiable either.

The position needed to be a resource to other staff and to the people of remote Aboriginal communities. By getting out bush, working with people, demonstrating what I did and establishing relationships, I became more familiar and approachable and could be utilised for all the skills I had, professional or otherwise. I made it a priority to present training sessions in town or out bush when requested and to develop promotional and educational material for others to use. My office location and a policy to make time for people from the bush, regardless of how busy I was ensured I was available. Giving patients lifts home improved my accessibility, learning a lot on the way, letting people know what I did. With acknowledgment that I was entering someone else's country, it helped to establish relationships. Being a resource meant assisting people to gain access to the service they needed, out bush, or in Alice Springs or Adelaide etc. This may involve informing people of the options, so they could decide what they needed, for example, respite, rehabilitation, additional or different equipment, or could involve working to ensure a service was relevant. A man from out bush

and I, put together his story showing his home, family and some of his lifestyle so that staff in the Spinal Unit in Adelaide could make his rehab relevant to his life. As my knowledge and ability to communicate increased, I was busier, but more productive. One day, sitting in my office, totally occupied with responding to requests on the phone and from people coming in the door, I knew I had undoubtedly become a resource.

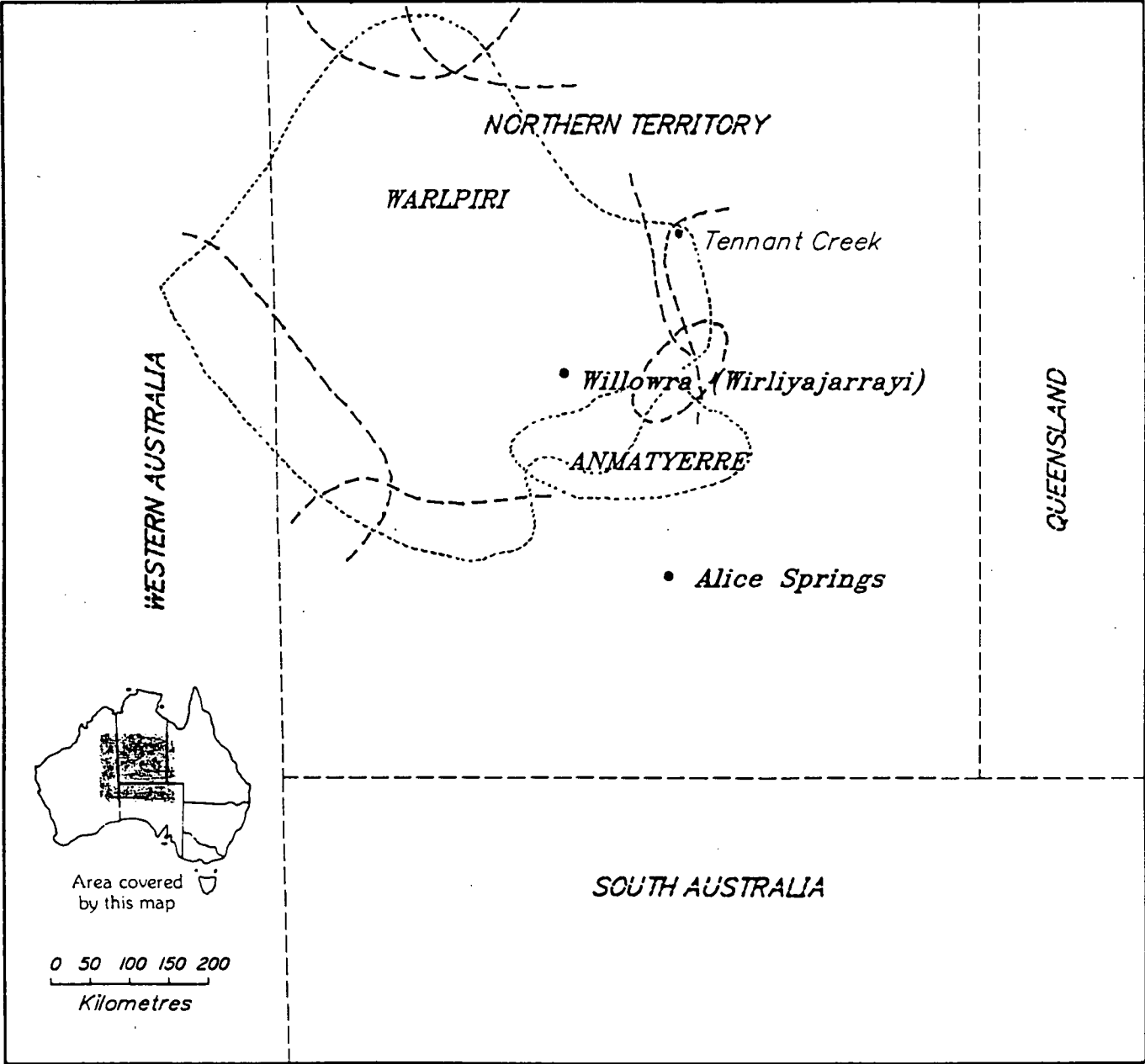
The position was professionally accountable to the General Manager of ASRHS. Minimal direction was given and the job description outlined clinical responsibilities only. With a growing number of AHPs (for example, OT, Pharmacist, Mental Health Practitioner) joining ASRHS in sole positions, we recognised the need for support. A reluctance to lose our autonomy by being placed under an administrator not of our professions, led to the development of the Resource Group. While responsible for our own positions we aimed to support members, and as sole positions, work on appropriate service delivery, and an accountable and responsive service to communities.

People living in remote areas deserve quality of service as those living in the city. Being professionally isolated, and needing to be an expert at everything, I learnt to use my professional knowledge, my practical ingenuity, and to put aside pride and shame and ask. I would ring or fax whoever I needed to ask, including specialist physiotherapists, OTs and doctors in major city hospitals, or locally, depending on my need. I read articles and literature and attended lectures and conferences to learn about the specific nature of Aboriginal Health in Central Australia. If I was sitting around waiting for AHWs or RANs or at a loss, I would read my clients notes thoroughly, helping me to understand disease processes and to know the people I was seeing. As an AHP going into a service where most staff are medical - doctors, nurses and AHWs, I could feel professionally isolated with people not realising I had different needs that I was struggling with. Who would want to talk to me about finding alternatives to doing stretches on a child that aren't painful and so can be complied with, to ensure muscle length and range of movement? I needed some professional support structures as an AHP in the field of Aboriginal Health. In the early days of the position there was only a remote area physiotherapist in Darwin who I made contact with. Over the years this led to the development of the Very Very Remote Allied Health Professional Group (VVRAHPG) which has been a key support network. This is now a small group of AHPs who provide services to remote Aboriginal communities. In 1992, an initial impromptu workshop, with 6 participants from the NT was a great success with a commitment to two teleconferences and one

conference a year. The conference is held in a different remote location each year, despite the financial and logistical difficulties this presents, to ensure that we have equal opportunity to attend and to focus on the issues of our own region, rather than holding it in a major centre and further marginalising the group we were trying to be and to support. We made a commitment to inviting the local community to attend and to participate, with our guest speakers drawn from members of the Aboriginal communities of the region hosting the conference. Proceedings are published in full, so those who are unable to attend and those in the future will be able to share in the information gathered. We've honoured these commitments and have a group of up to 20 AHPs. As our only forum, it is important to keep the agenda located around our professional issues arising from this working environment.

After four years I was tired. I wanted to move on. Another physiotherapist was keen to take on the position and had taken every opportunity to learn of the job. I had also been asked by the women of Willowra Women's Centre to assist them with a project on Old and Disabled people and I accepted the position. It was important that the changeover of staff in this position occurred with minimal slippage. A month overlap was provided by ASRHS to orientate the next incoming physiotherapist. Once released from the position with the support of ASRHS, I was able to respond to a request by the Cross Border Unit of the Department of Human Services and Health and Nganampa Health Service (the community controlled service for the Pitjantjatjara Lands of South Australia), to visit their region. There were no visiting services for people with disabilities, so I carried out some assessments, attended a meeting with health staff from all communities and in the light of my experience, completed a discussion paper in relation to the need for services for people with disabilities in the Cross Border Region. This paper was used to support the establishment of a Disability Support Worker for the region, a change that I had urgently wanted to see. This was a productive end to my time as the physiotherapist with ASRHS, a personal and professional experience which had been guided by my gut feel, professional peers, ASRHS, community response, a genuine interest in Aboriginal people and a sense of fair play. After four years I moved on, feeling I had something to show for my efforts.

3.2.1 Map of the Region for Case Study 2



—— Areas outlined indicate the distribution of the Walpiri and Anmatyerre Language Groups.

A Good Life for Old and Disabled People in Remote Aboriginal Communities

Willowra or Wirliyajarrayi as it is known in Warlpiri, is a remote Aboriginal community north west of Alice Springs. It has a population of 300 to 400 Yapa (Aboriginal people) and between 12 to 16 Kardiya (non Aboriginal people). This community, comprised of houses, humpies, a clinic, shop, garage, council, school and women's centre, old station homestead buildings and stock yards, sits on the bank of the Lander River. Willowra had been a cattle station, and in the 70's was returned to Yapa, in the first purchase of land made by the Federal Government for Aboriginal people. Warlpiri or Anmatyerre are spoken by all age groups. The traditional kinship system determines appropriate behaviours, ceremonies are practised, hunting a regular activity for all ages, with people either living on or with access to their traditional land. The lifestyle is supplemented by social security payments and CDEP wages.

Visiting Willowra as the ASRHS Physiotherapist, the RAN, AHWs and I would check all of the babies on the chronic chest list, see the adults and visit the old people. As a cross cultural team we would assess a senior woman for her asthma using a peak flow and according to the number of goannas she could catch in one day. In the afternoon I would sit outside with the women and babies doing chest physio until school was out, when the kids with and without bad chests, would arrive, expecting to do nose blowing, deep breathing, coughing and running races with some 'family' around to cheer them on. This became the routine for my visits. The Yapa and Kardiya teachers and I would work together developing school activities to improve the kids' ears and lungs. As the well respected and long standing community adviser and his family needed my services as a physiotherapist, I also had the opportunity to establish a relationship with them. I was given a skin name, Nakamarra, by which I am most commonly referred. With continual schooling I worked hard to learn of its meaning and my place in the kinship network. All of these links were to help me develop a relationship with the people and to later become part of life at Willowra.

In my second year of visiting, April Nangala Martin an AHW returned to Willowra. April and I worked well together, and with April as one of the AHWs and I as the physio on the ASRHS A&DSIG, our working relationship developed. When this group held a workshop on 'Aged and Disabled people in remote Aboriginal communities', April and six women from Willowra Women's Centre came to tell their story. This is the story presented by April for Willowra.

In Easter 1991 we first of all had a meeting - the whole community, men and women to talk about the Women's Centre. The community picked four ladies: Gracie Napangardi, Lillian Nakamarra, Dora Napaljarri and Jeannie Nampijinpa. These ladies started working by themselves with help from Sister Hannah and Audrey the CDEP Coordinator and myself, April AHW for Willowra. First of all we got our building but we had no power. The ladies cooked the food on the fire outside, later they got power and then they cooked inside. They've got microwave, oven, stove and fridge. They cook every day (Monday to Friday) one meal, they cook the meal for old men and old women. They also take meals on wheels. We take it to the house where they live, on trucks or by foot. Children under 5 years are fed too. Skinny kids are listed on the Road to Health chart and they are given extras. Then we check their weights a couple of days later. Now we got no skinny kids in Willowra. The women's centre ladies decided after 7 months to ask for a Kardiya Coordinator, so one year later we got one. The Kardiya we've got is Vivienne Nungarrayi. She used to be a teacher at Willowra so we got her back. Since we got her back we are sewing as well as cooking. We did a big painting about Women's Centre Dreaming. It is in Willowra. Soon we will be moving to the new Women's Centre (1992 ASRD).

Following a submission compiled by two OTs and myself, ASRHS received a Rural Health Support Education and Training (RHSET) Grant for an OT for a year, to develop a resource package for health staff and community workers to assist old and disabled people in their activities of daily living. Unfortunately the two OTs with relevant experience could no longer do the job and ASRHS could neither provide the AHW position or the transport required. One of the options RHSET gave, was to change the project to suit the budget allocated and so at the workshop, 'Aged and Disabled People in remote Communities' participants were informed of the grant and expressions of interest sought. Willowra Community expressed an interest.

April Nangala and Lillian Nakamarra had arranged for Kathie the Regional OT and I, to visit Willowra to help them in setting up the new women's centre for the old people to use. Working with April and an older woman who was disabled, and a choice of different rails and bathroom equipment, the bathroom was fitted out. The old ladies, the most senior women in the community, were brought to see the result. They looked and talked and with the bathroom

echo, their approval was loud and clear. We took photos of this scene as a record for the women's centre.

This set the scene for the meeting Kathie and I had been asked to attend. With the old ladies, the women's centre ladies and April we were asked to discuss the grant and the possibility of Willowra Women's Centre taking it on. Sitting outside on the ground we talked about the grant with April interpreting. We provided photos of equipment from elsewhere out bush, some pictures used to help Yapa kids with a disability and a photo album of a disabled man's story. The old ladies who were the focus of the meeting, talked and looked, asked more questions and talked again. I didn't understand just how important their part was. We talked about the grant, how it was for both old and disabled people and about sharing with others what we had developed and learnt. With most discussion in Warlpiri and some in English, I could see and hear the emotion and know what was going on. The old ladies wanted to see Willowra do this project for both old and disabled people and appeared to feel both worthy and privileged to share with others, what they were doing. The old ladies said yes, they wanted Willowra to do this project.

The women asked would I help. I said not now, but later I could. To confirm the arrangement I asked if they were happy for me to be a regular visitor to their community. The answer was no. I had to live at Willowra to learn about Yapa way and to work with the women all the time. I wasn't able to do this for six months but the women wanted to wait. I was to be the Project Coordinator. It was agreed that Kathie was to be a resource person and would come and 'sit down in Willowra' to provide us with OT skills, at different times during the project.

The old ladies then chose the Yapa workers. Lillian Nakamarra, who had already been working for the old people and was keen to develop more services, was chosen as the community worker to be my cultural assistant. Lillian has a disabled son living in town. I didn't know that at the time. April was chosen to work on the Kardiya side with me, to learn about running a project. April wanted to do the project and be an AHW, so it was agreed she would work in the clinic in the mornings and the project in the afternoons. Janet Nakamarra was chosen to be the artist and linguist for the development of the resources. The meeting was strong, with a clear agenda set by the senior women, and endorsed by the senior men and council. We recorded it with photos.

We modified the budget to suit the way the women wanted to do the project with RHSET requesting a letter from Willowra Women's Centre to confirm this. I rang April and let her know. April faxed a letter into me and this is what it said 'Dear Ruth, we like what you and the OT have been doing and we would like you to continue doing that in our community'. This was an interesting way of expressing what they wanted and gave some indication of their expectations of us. A formal letter then went to RHSET and to Willowra Council confirming the arrangements.

I really believed in the women and people of Willowra and that if they wanted to do this project, they would provide direction for me. This underlying belief was to get me through the hard times. Some of my peers questioned the value in Willowra taking the project on, as they managed well in looking after old and disabled people. To me, by looking at where things are working, and sharing what they are doing, gains could be made by other communities.

Six months later, when I took up residence in Willowra, the project started. A collaborative approach consistently occurred with support from the health clinic, the store, the council, CDEP, the school, the Women's Centre Coordinator and workers and the people of Willowra community. Project employment was designed so that extra resources provided by the grant could have benefits distributed widely, with specific jobs and services developed by the workers, to be maintained after the project. I was the only person paid full time from the grant. April worked half time in the clinic and half time with the project as part of her role as an AHW and was paid by ASRHS, with higher duties paid by the grant in recognition of the extra responsibilities undertaken. Lillian and later Maggie, Ray and Timothy, the community workers, were employed by CDEP for 20 hours a week. Excess hours worked (top up) were paid from the grant. Kathie as a resource to the project was paid by ASRHS. Janet maintained her job in the shop and was paid for art, interpreting and transcribing work from the grant. For Maggie, another artist who joined us later, expenses were paid by the grant for travel, food, film and art materials and a negotiated sum for the pictures produced. Accommodation was provided for Kathie, Maggie (artist) and for myself in the ASRHS visitors accommodation. An office was provided in the women's centre. The louvred windows were not dust proof, so the grant paid for the cost of replacing the windows and purchase of office furniture and a computer, with a view to this becoming the women's centre office at the completion of the project. We were given use of the Tanami network on ASRHS time, and the use of council and clinic telephones and fax machines. Access to literature production equipment ie

photocopiers, laminators etc was provided by the school. Transport for community work was provided by the women's centre toyota and a proportion of the fuel costs paid from the grant. The health vehicle was also used. Transport to and from Alice Springs was provided by me in my own personal car, for which I was reimbursed, and in wet weather 4WD transport was provided by ASRHS. Transport of equipment was provided by the store truck. Costs for a trip to Sydney for all participants, designated project workers or not, were paid entirely from the grant. This included transport, accommodation and food. No travel allowance was paid at all throughout the project. This decision was made by the project workers from the community, to ensure we had adequate funds available and equal conditions for all women's centre workers. These arrangements which formed the operational foundations for the project were indicative of the support provided by both Kardiya and Yapa, throughout the community.

Who would control the project funds was never really an issue. Willowra Council were given the option of taking on the grant, but having administrative priorities elsewhere, supported that the grant funds were administered by ASRHS. I also believe this decision came from trust in April, Kathie and me as ASRHS employees and in their DMO who was the General Manager of ASRHS. For the council to be in control of funds, I would have had to make an issue where there wasn't one. I would have dumped administration of funds where it wasn't wanted. This would have been a far cry from community control, for the sake of being seen to be doing things the correct way. That wasn't my role. My role was to work in partnership with April, as the Yapa Coordinator, with support from a nominated ASRHS administrative officer. As this officer showed no commitment, ASRHS management, choosing not to address this, directed me to be fully responsible for administration. This was a new area we hadn't anticipated. The day to day running of the project itself, involved a large amount of skill development and responsibility. For April and the community, it was the priority, not the financial administration of the project. So, with a lot of assistance from Finance in THS, I administered the grant, while April read and circulated reports and financial statements as part of what became her role as overseer of the process. Towards the end of the project, I was to learn how fortunate all of these administrative arrangements would be.

The project was conducted within the Yapa cultural context of the community. At the beginning of the project, Lillian, as the cultural assistant led me around the community and introduced me to all of the old ladies and old men. This was done primarily in recognition of and respect for the status of the old people in the community. This was repeated on the first

project visit Kathie made to the community. When decisions were to be made within the project (eg. selection of women for trip to Sydney), opinion and approval was formally sought from the senior women and then the senior men. Usually, it was my job to go to the senior men having no cultural avoidance relationships. I'd go meekly, as a white women talking to a group of senior Aboriginal men. These men were to become some of the strongest supporters of the project and my role in it.

In the first week of the project, in response to a community member, I explained that the project was about finding ways to look after old and disabled people at home in their community so that they didn't have to go to a nursing home. I received an immediate and strong response from the project workers. 'Lawa [No]!!!! We don't send people to nursing homes'. There was a subtle difference in our agendas, that I had not, until then, realised. Willowra's story was about looking after their old people in the community, and doing that well. It was about quality of life. The title for the project then became 'A Good Life for Old and Disabled People' reflecting the women's and community's focus.

A formal meeting was held in the second week, with the women at the women's centre. This started with clarifying how the women wanted to do the project. Lillian, April, Janet and I (the project workers at that time) prepared the meeting together. After April introduced the meeting, I spoke in English and April repeated the message in Warlpiri. Discussion was in Warlpiri, of which I understood little at that stage. Watching the discussion I saw the importance of the 'old ladies'. I knew they were important, but I started to feel just how important they were that day.

From the meeting and following endorsement from the senior men, it was decided that the project would look for ways that old and disabled people could have a good life at home in their communities in remote central Australia. The project workers were to talk with the old people, work on the ideas and visit other communities and services to get their ideas. These ideas would be presented in a booklet for people living in and providing a service to remote Aboriginal communities. We were to produce a booklet for Aboriginal people, and initially one for non Aboriginal people too, until we realised non Aboriginal people could benefit most with a perspective of and for Aboriginal people.

We started by establishing the washing program as this is where Lillian wanted to start. Lillian, with her six month old child who was our constant companion, and I started collecting and washing in the mornings. This helped me to learn to fit in with the routine of the women's centre, and moving around the camp gave me the chance to interact and become familiar with the old people while at the same time doing something for them. Late in the afternoon the women would often ask me to be the driver to take them to get firewood for the old people. I became one of the workers and was utilised for the skills I had. The pattern of our work developed where Lillian and I would be involved in delivering services as part of the women's centre. April would join us in the afternoon and that would be our planning, organising, recording and consolidating time. I would try to not do anything on my own, at least not consistently.

Permission had been given for me to write up the project for my study. I very quickly realised that my own study would give me a separate and additional agenda and so decided not to. I wanted to lose sight of the projects purpose as I saw it, so that I could become incorporated in the culture of the project created and driven by the women. Already it was hard to block out my own expectations and the pressure of my professional peers to work in a certain way. If I wanted to take direction from the women, I felt as though I had to shut out these outside influences so that I could actually hear the women. I needed to create a space within my consciousness to allow me to integrate the Yapa agenda. This was no easy task.

Talking with the old and disabled people was the communities priority for the project. Together, the project workers worked out a check list of needs and I wrote it down. Lillian and I started talking with some of the old ladies and Lillian then seemed to sit back from the discussion. I was referring to the checklist and as Lillian is not literate this had cut her out. We talked about this and realising that many of the people looking after the old and disabled people would not be literate, we asked Janet to draw pictures for our check list. Her knowledge of her community made it easier for her to depict the items on the checklist. When we started using pictures, placing them in front of the old people, they talked spontaneously, as they travelled around the checklist. This was an unexpected outcome. Asking questions hadn't been appropriate, and only gave us the information we wanted. The pictures were allowing the old people to take charge of the information given, ensuring that it was of relevance to them.

To look at services for old and disabled people, we went on a trip to Sydney and to some other communities. In preparation, we took photos and put together a community and a project album to share our story. Six women were chosen by the community to go to Sydney. The trip included visits to Redfern Aboriginal Medical Centre, to the Independent Living Centre to see equipment and to Prince Henry Hospital to see the Rehabilitation unit where I had previously worked. We recorded it all in photos. When we returned we made up a Sydney album to show the people of Willowra and other communities. April organised for us to talk with other women's centres who were linked up with the Tanami network, about what we were doing and about what they were doing. There were about three languages all going at once which left me very much a fascinated spectator. We went to another community east of Willowra to look at their clinic, designed for access and use by old or disabled people. While there we visited an outstation where an old man and old woman, both in a wheel chair, were being looked after by their family. Their daughter-in-law showed us the difficulties they were experiencing. We showed our photo albums to the AHWs and others, and took photos of the visit to add to the albums. It was our standard practise to record the project process in photos, to share what we were doing with the people of Willowra and the many people caring for old and disabled people in central Australia. These albums also helped April to tell the story of the project to those interested Kardiya in senior positions in THS and RHSET, allowing me to stay out of that role.

Maggie Napangardi, on her request, joined us as an additional community worker following approval by the senior men and senior women. At much the same time, Lillian and April and some of the women decided that we needed a man to work on the men's side. Ray Japaljarri was nominated and approval was given. Lillian, Maggie and Ray took up the role of completing the checklist with each old and disabled person in the community. The main problems they found were not enough firewood, rubbish, carrying shopping home, cleaning houses and high steps into the houses where the wind had dug away the dirt. We talked to the council about the rubbish and to the women's centre workers about the house cleaning. Ray got the tractor with a scoop and started putting river sand in front of the houses to level the entrances, and the women's centre Toyota was made available to give people lifts home after shopping on pension day. The suggestions had been made. What developed after that, took time.

Services had been developed within a cultural context and the project was to continue this way. We expressed it as 'Families look after old and disabled people. We are working to help families look after their old and disabled people'. This was Yapa way and our job was to help it remain strong. I started to realise what contributing to community development meant. I could see that unless services were built around cultural practices and/or norms they would neither develop or be maintained. The routine of a service had to fit in with what was already happening and needed to accommodate the workers' lifestyle, not compromise it. This was demonstrated well when a worker was away for business or whatever and other workers would fall in behind, particularly with the cooking, which was the first, the most important and the consistently maintained service. The more I learnt and understood community life the more I could recognise and accept the way things were. On pay day many people played cards or watched. I didn't like it, fought it in my mind and felt quite tormented about it. I realised that this was community life, and learning to fit in with the community routine was important. I learnt to hold meetings mid morning while people were assembled awaiting pays and to use the time after pays to have space for myself, and to get my paperwork up to date.

The importance of family and of old people, grandmothers and grandfathers was confirmed for me with a visit from my own mother, who was welcomed with enthusiasm and importance. As a grandmother she was treated with the utmost respect and actively included in hunting, invited to watch dancing and painting. Her skin name was used consistently despite my introductions, 'Kardiya way'. I was expected to look after and spend time with her as a priority in my work not outside of it. The community workers recorded her visit in photos and their report to RHSET.

Education of the two Kardiya workers, myself and Kathie, in Yapa way, was actively encouraged throughout the project. The women clearly saw it as their responsibility to provide opportunities for us to learn and to include us in their activities. We both had skin names, and knowledge of our place within the kinship network was fostered and encouraged. I was given every assistance with language as I struggled to improve. For me, activities included country visits, hunting for the day and for a whole weekend, watching dancing and painting and being included in a large ceremony with many communities from around Willowra. Explanations of paintings was a great source of information for me as I would often type up people's stories for their paintings. Involvement in the day to day life of the community was also nurtured and encouraged. One mid morning Napanangka, one of my mothers, came to me and said they

needed to take me hunting goanna. I was working so I couldn't really do that, or could I? I went with the women, my mothers and grandmothers, on a most productive and educational trip. Eventually learning to be open to these lessons, on a working day, I would put my instilled work ethic on hold. It taught me about day to day living instead of seeing these activities as leisure time. Going with the 'old ladies' and seeing their roles in activities, I could learn what having a good life was all about. In an effort to learn about community life and be open to it, I used to always walk around the community. I got to know people of all ages and of course I would eventually walk home or to the shop with people.

When things happened that I didn't understand, I could find it hard to relax with not knowing. It wasn't normal for me. It may not have been my business, and sometimes Yapa weren't aware I didn't understand or needed to understand. I would say to Lillian or April that I didn't understand something and if they gave me an explanation, good, and if not, I presumed I didn't need to know or shouldn't know. There were times when the project workers weren't at work. I could wonder what I had done or failed to do, but most often it had nothing to do with me. When I stopped worrying a bit I realised that while one project worker took time out there was always one of the others there. It was hard too, when people didn't seem interested. We could have a 'high time' (Willis 1988) and in between I'd feel this inertia, and feel alone in Yapa culture, like an outsider on the inside, knowing that reading it wrongly could set me on the wrong path. I had been employed to give guidance and I couldn't work out if people were waiting for guidance, rejecting the guidance, or was it just the hot weather or not the right time. I wasn't sure what was expected of me even though I had been given definite guidelines. While wearing this uncertainty, I sought support from Vivienne the Women's Centre Coordinator, Kathie and the two visiting DMOs. Even with these willing listeners I felt such loneliness and isolation and a sense of ignorance and confusion. In the late afternoon it was often my practice to go for a walk by myself down a picturesque track leading out of the community. The more anxious I felt the further I would walk. This was the best therapy to help me to just let things happen and to accept that not knowing was alright.

The project was always strongly influenced by what was or was not happening in the community with community meetings, family disputes, community disputes and strong community support all affecting it. The approach I stuck to was to respond to suggestions made by the women and community despite not always knowing why, and to be guided by responses to what I did or suggested. Sometimes I just had to have a go. I had my gut feelings

and my own limits, that meant I could make my own decisions and my own choices too. I knew it was important to have the capacity to get through the slow times even if it didn't make sense to me, and to resist the temptation to push.

Kathie joined us for a couple of weeks and injected a new energy into the project. This was the time we concentrated on disabilities. We talked to the disabled people and ordered equipment to try. This created interest and participation particularly testing the wheelchairs over the terrain and their accessibility to community buildings.

We had started to gather information for our booklet. We drew up questionnaires to ask others for ideas they had for the items on our check list. Lillian and Maggie faxed them out to other women's centres, April sent them to other clinics and Kathie and I sent them to the few other bush Physiotherapists and OTs. We had decided for every page of words of our book, there was to be a corresponding page of pictures catering for both literate and non literate readers. At this point Janet, our artist, left Willowra, amid events disturbing to the whole community, in which I unwittingly became involved. For all of us, getting on with the project meant sorting out what 'cultural business' had to be sorted out. I was able to follow Yapa protocol but only to a point, when I believed I had to stay out of it. Yet I found that to preserve my own cultural integrity in my own eyes and the eyes of the community, I needed to 'sort it out' my way as well. There were also the practical issues to address. We had recorded only a few old people's stories and Janet was transcribing them so we decided not to continue with this as it was more than we could handle. Needing to find another artist, we talked about it, made a few suggestions and decided to leave it while all of us took leave to attend ceremonial business or to return to family for Christmas. Although I found it stressful not knowing if we'd have an artist with only two (2) months to go, I had learnt that you don't know what will happen next and, at times, I did have faith it would be okay.

When I returned from holidays I visited all the relevant organisations in Alice Springs, to seek information for our book on the money and services communities can get for old and disabled people. Then I returned to Willowra to find that kids had broken into my house. I felt really culturally isolated and with a rather heavy heart I looked to the women for support. It was interesting because it worked to re open dialogue and it was then that we started to talk about an artist. If we didn't find someone, the end result would be different. We had to work with the resources we had and not pine for what could have been. I had fears about whether I was

doing my career any good by sticking to what I saw as a community development model. What if there was nothing to 'show' for our efforts? I knew the community were really happy with the project and that if nothing more was to be produced from it, people of Willowra would consider it to have been successful. This was very important to me, but I still worried about what my professional peers would think. I had to be careful with these feelings because they are the sort that put you at risk of pushing, instead of just letting it happen.

We found an artist in Alice Springs. She was Maggie Napaljarri, Janet's sister-in-law. She was a Kardiya woman who was married to one of Janet's brothers originally from Willowra. The idea of employing Maggie Napaljarri was floated, taken up, discussed enthusiastically and approved by the women, and then the men. Maggie was invited to the community. Although known and familiar to the people, she didn't know about our project. The Yapa project workers introduced her to the project, telling her the story. Hearing their story was an evaluation for me and affirmation for the roles we had all taken. This feedback gave me extra encouragement. They were proud, I had no doubt. Maggie's method for drawing was to work from photographs. As we'd taken photos to record the project's progress, the Yapa workers could be directive in the extra photos to be taken. Maggie's method proved to be invaluable. As Kardiya, she wasn't intimately familiar with people's posture and behaviour according to age and different social settings, yet drawing from photos she could capture this, giving the pictures she drew, much authenticity.

We collated the questionnaire responses to create the words for the book. I facilitated the process, while April wrote, and Maggie Napangardi (Yapa project worker) and Lillian contributed the ideas from the responses as well as the ideas already being used in Willowra. April and I both typed, I sorted and edited and we all completed the final edit of the text, with Lillian, as the most senior, endorsing the final words. The next step was for Maggie (artist) to draw the corresponding pictures. One by one they were drafted and approved until a set of 35 pictures were completed. This process made it clear to me again the confidence the women had in their own community, the project and the roles they played.

We decided to do a Yapa dot painting to tell the story of our project and Willowra community. Lillian, April and Maggie Napangardi worked it out on paper, using me for input or reassurance. They then took it to the single women's quarters for discussion, before painting the main features on to canvas. This canvas was again taken to the 'old ladies' in the

single women's quarters, and with a large number of women of all ages gathered, the story was related. Active discussion with a few additions made, led to a strong note of approval. April explained the story to a senior male relative who took the painting to the men and related it as he had been told. An active discussion again ensued with overwhelming approval for the story the painting told. I was an observer to both meetings, conducted in Warlpiri. I was amazed to see how the language of dot paintings was so readable to the people and stimulated an enormous amount of interaction. From this, it was clear to me that this was the Willowra story. The background was completed by many people, and the painting taken back through the same process to be viewed. In writing the story down we started in Warlpiri, but as we didn't have Janet, and April could only write fluently in English, I wrote it down in English as it was related to me, then checked it back with the project workers before it was translated into Warlpiri. This seemed backwards but I think it was important to the Yapa workers that the story was written with the skills we had between us. The production of the painting was a powerful process producing a strong story and an aesthetically pleasing painting ideal to make a poster. Soon after this, I was to leave Willowra, as my time was up. This painting gave me professional and personal feedback as an evaluation of the project.

With the poster and 100 page book, written in both pictures and words, we had far exceeded the initial expectations in both quality and quantity of information. Costs for printing were well beyond the budget allocation. As the value of the resources developed was recognised, support was demonstrated through the commitment of funds from other sources within ASRHS and THS. This gave additional professional recognition for the project workers, the Women's Centre and for the community.

As my time was up, I moved back to Alice Springs and became a regular visitor to Willowra for both follow up with the project work, and social visits. Shortly after I left, the project workers took time off and seemed to lose enthusiasm. I didn't expect this to happen. Willowra Community and Willowra Women's Centre had established some services for old and disabled people long before the project started and had chosen to take this project on as a way of adding financial and professional resources to this development. What was confusing was that a supposedly good measure of the success of a community development project is that it continues after the outsider leaves. Yet even with so many factors as they should have been, here was a project that began before I arrived and now finished after I left. That fact didn't feel great to me. Then I thought about how I felt after the intensive eight months, and

remembered the need and the relief I felt to have a break. When I visited, the old women spoke to me, and called a meeting together to talk about the problem.

Just as things started to move again, a new Kardiya arrived to work at Willowra. A major disagreement involving Kardiya staff, resulted in the Women's Centre Coordinator leaving the community. She'd been the coordinator because the women had asked her. She had always given her utmost support to whatever the women had wanted to do, particularly the project. Days of wailing expressed the loss to the women. The centre was closed, broken into and looted, the bus and Toyota taken over by different family factions. A series of coordinators were then employed by the Kardiya administration, rather than selected by the women. Few women returned to their women's centre, while Kardiya men drove their Toyota and the bus was given to the men to use until it broke down. The women called a meeting with ATSIC, to try to get their women's centre back.

In the midst of this the books and posters arrived from the printers. They were magnificent. Taking time off from another project I was working on, Kathie and I travelled to Willowra and with the project workers, showed the book around the community to the old women and old men and to all the councillors. It was made clear that any distribution process was not to involve the new Kardiya administration. Had the council taken on the grant instead of leaving it with ASRHS, this would have been unavoidable.

Working together, we sent books and posters to all those people who had helped us, with the Yapa workers spending much time compiling personal letters to go with these. We then sent a letter and a book and poster to all women's centres, clinics, councils, and Aboriginal organisations in central Australia, to Aboriginal health services in Australia and Aged and Disability service providers for central Australia. The feedback has been positive and ongoing in person, by telephone, and in letters. These letters are all collected by April, for the benefit of the women's centre and the community. Feedback from the community is best represented by the statement the senior men made. 'That one's really good. You told our story proper way'.

Following a large demand for the books and posters in the first six months we applied for additional funds to reprint. This was granted on the condition that the books and posters were sold on a cost recovery basis. As it was not appropriate for ASRHS to sell what was a

Willowra production and Willowra Council had neither the time, skills or infrastructure to take this on, the Yapa project workers wrote to seven Aboriginal organisations inviting them to take on the sale and distribution. The Central Australian Family Resource Centre (CAFRC) whose role involves supporting organisations in bush communities, accepted the invitation. An arrangement was negotiated between ASRHS, CAFRC and Willowra. The books and posters were to be reprinted and given to CAFRC with additional funds to cover the cost of the administration of the distribution. CAFRC with Willowra Community planned to design an order form which includes a simple evaluation, to be sent to all those people on our distribution list and to those requesting copies. Willowra clinic, women's centre and council were to hold order forms so that when requests are made they would be able to respond. It was hoped that this arrangement would help to establish a relationship between the Willowra Women's Centre and the CAFRC.

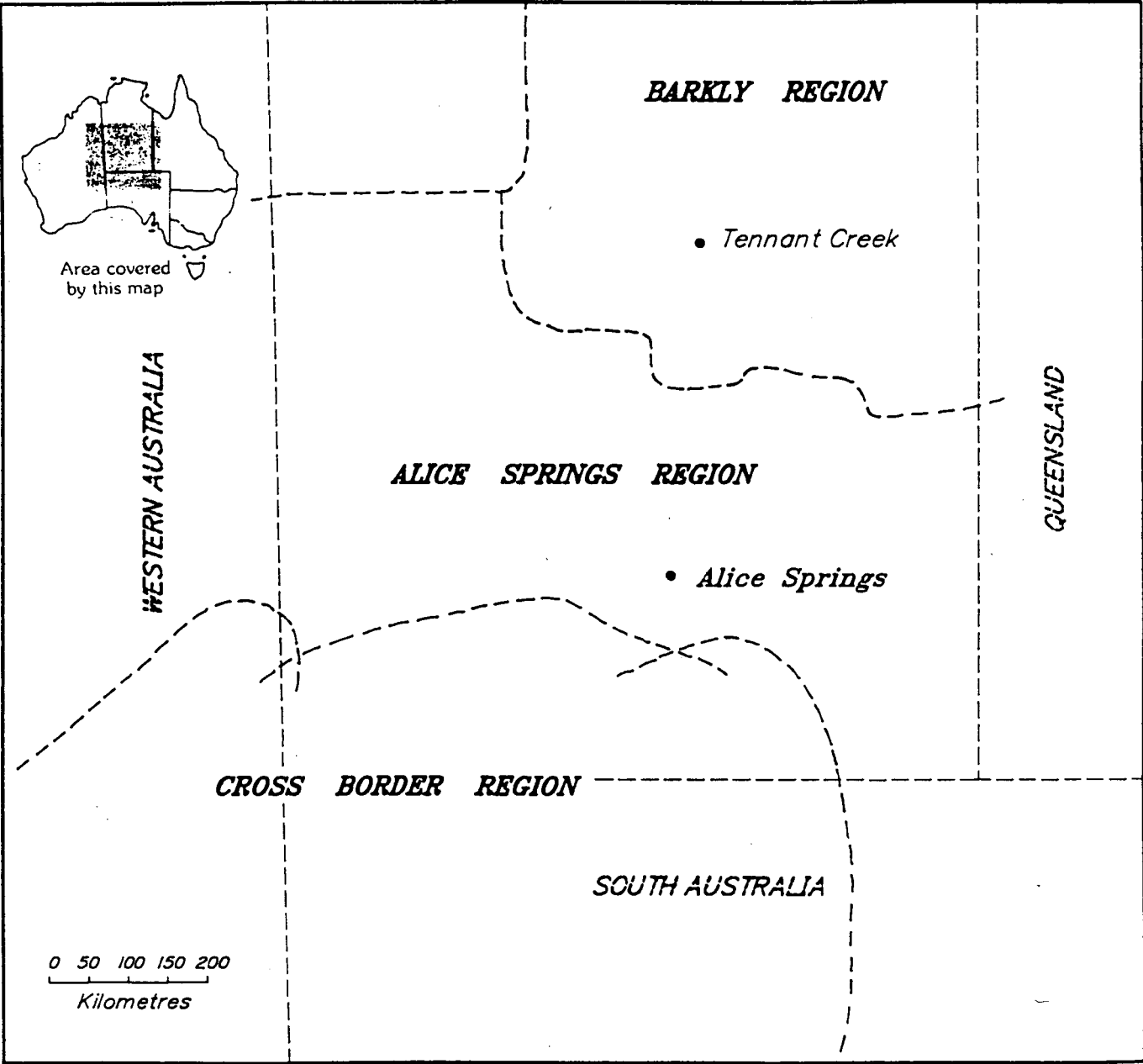
A new Kardiya employed by the council had been at Willowra for three weeks. Despite negotiations being completed, she believed it was not appropriate, and arrangements were frozen. I had tried to work so I didn't control or take ownership only to have another Kardiya take control. Somehow I always wondered how much control the women had? Did they have as much control as I or other Kardiya allowed them? If I had believed that the women had control, would I have worried about taking it? I realised that just because I wasn't in control, it didn't mean the women would be, especially if challenged. But I also realised that if I acted now, I would take the ownership I had worked hard to avoid. The community had had problems with Kardiya staff for months, which had been disturbing. I didn't need to create any more. I talked with the project workers and they said to leave it and they would sort it out Yapa way. So I waited. Some five months later some senior women approached me stressing the importance of the book being reprinted with the instruction to 'leave her aside'. In responding to this request we worked to endorse the established decision making process. We wrote and circulated letters to be signed by all project workers and council executive requesting the CAFRC to proceed with the arrangements. I learnt from this. I had worked on a project that was well supported. I realised that in central Australia, a politically challenging environment, it is not only about developing appropriate working practices, but about learning to respond to what you may believe are inappropriate practices, so that you do not become part of the problem yourself. Yapa had been dealing with Kardiya for a long time and had something to teach me, on this matter.

Subsequently, a Willowra man, Charlie Japangardi, had a stroke. I was still with ASRHS but long gone from the Remote Area Physio position which at the time was in the process of changing over. I knew Charlie and I knew his family and so together we talked about what could happen. I was happy to visit, and Charlie and his family were keen for me to work with him. I found myself in a position I had always worked towards, where I would be familiar with a person's environment and social context and be able to be a resource to them. To not work with Charlie defied logic and the ASRHS physiotherapist and management supported an obvious role for me. It offered Charlie a service he wouldn't otherwise have and for me it offered an opportunity to visit people I had a strong attachment to. Initially Charlie was in the new Rehabilitation Unit at the hospital. As a new centre, there were staff who had little knowledge of life in remote Aboriginal communities, so we decided to take some photos on Charlie's first weekend visit to take back to them. This developed into Charlie telling his story in photos and me writing it down for him. Together Charlie, his family and I, printed his story for other Yapa who may need rehabilitation and for Kardiya who will work with them.

Together the people of Willowra community and I, had worked on a project and developed a way of working that had successfully used the skills and knowledge available from two cultures, to combine to create resources for contemporary life in a remote Aboriginal community. This was achieved through two way learning and respect for what each worker had to offer. This is perhaps best expressed in the story the painting tells:

'Yapa teach Kardiya about Yapa way. Then Kardiya can help Yapa to use Kardiya ways to keep Yapa way strong'.

3.3.1 Map of the Region for Case Study 3



People with Disabilities - Regional Needs Assessment

This is the story of a project initiated and conducted by ASRHS. It came about in response to an identified need for services for people with disabilities from remote Aboriginal communities of central Australia. My role was that of the project officer. It was a tough experience but an interesting story, given that there was both strong support for this project and significant challenges to it.

While I was still employed in the Willowra project (Case 2), I was approached by ASRHS to work as the project officer, for a Disabilities Needs Assessment. The overall idea of the project was to look at the need for services for people with disabilities from remote Aboriginal communities. This was to be done by firstly consulting with government and Aboriginal health organisations to gain their support and direction for the project. The expected final outcome was to make recommendations to the relevant service providers and funding organisations.

That the need was there, I was in no doubt. In all of central Australia there was a dearth of services for people with disabilities. The limited services which existed were provided and controlled by government services from the NT, SA and WA. The nature and number of people with disabilities appeared to be increasing as a result of trauma, substance abuse and lifestyle diseases. With a greater push by people with disabilities and their families, to remain in their country, community people and bush health teams were requesting assistance and support in the care of people with disabilities. Government policy was also being directed towards de-institutionalisation and integration of people with disabilities, requiring an increase in community based services to support this policy. There was inadequate funding or suitable funding criteria to establish appropriate services within remote Aboriginal communities.

Some allied health services were available in remote communities of the ASRHS region, but the demand far exceeded the capacity of the positions. Of the services outside of communities, few people were accessing them, not knowing about them, or because they were not

appropriate services for people from remote Aboriginal communities. In the Cross Border Region (CBR), there were unique problems in the provision of services, with the geographical borders and administrative involvement of the NT, SA, WA and Commonwealth Governments.

The idea of a project such as this, had been talked about for years, within and outside of ASRHS. Now the profile of this need had reached a point where funding had been allocated. Having worked for some years where little by little, some services for people with disabilities had developed, I believed that this project offered an opportunity to establish services in a coordinated and comprehensive fashion. I had worked out bush long enough to believe that people knew what they wanted. The problem was getting that information to funding organisations and service providers. I believed the task at hand was to facilitate a process whereby people from remote Aboriginal communities could communicate what they wanted and give direction in a process of planned and comprehensive service development. I could see that this project created the possibility for positive change at the ground level.

However, I didn't really know if I wanted to do the job. I enjoyed being a 'grass roots' worker. While I was complemented to be considered to have the skills, I didn't really want to work at an inter-organisational level. Also, it was a government initiated project. While I knew in myself it was precipitated by Aboriginal people and the non Aboriginal people working with them, this exact project or my selection as a project officer had not been formally requested. My experience in Willowra had cemented my belief in using my skills to be a resource to activities initiated and controlled by Aboriginal people, as a priority. Working in this way that was seen to be the 'correct' way, also avoided some of the criticism one was likely to get from other non Aboriginal people, when working on a government initiated project. However, I was aware that people with disabilities and their carers and families were often the least empowered people of all. I didn't believe that because they didn't collectively, initiate their own process of change, you could ignore their expressions of need. I believed it was a responsibility of the government service, to address this issue.

I accepted the position to be a project officer for 3 months with the determination that I would facilitate a process under the direction of people from remote Aboriginal communities, particularly those people with disabilities, their families, carers and those who delivered services to them. I believed that it had to be not only possible, but also essential to find a way

within a government organisation. ASRHS was in a strong position, being based in the regional centre for central Australia. For people with disabilities, ASRHS provided funding for establishment of community based services. It was staffed by the remote area physiotherapist and OT making up the Aged and Disability Team. With a reliable equipment supply and budget, the positions provided a visiting service with educational support and support for community based projects. This service was provided to government and Aboriginal controlled health services and communities in the remote regions around Alice Springs. I was to work as part of this experienced team who, with management, were strongly supportive of the project and my method of operating.

The starting point for the project was to confirm that people wanted this project, and to find out how they wanted it carried out. It was also important to establish whether the other service providers and funding organisations would support it. The project region was to be the ASRHS region. Interest and support from key health organisations, and a specific request from the Barkly, resulted in the project being extended to remote Aboriginal communities of central Australia. This included the Barkly, Alice Springs and Cross Border Regions.

I started by consulting with the major government and Aboriginal health organisations in the region. From these discussions a draft project proposal was developed and successful applications made to the relevant ethics committees in the NT and SA. As it became clear that three (3) months was insufficient time to conduct this project, a project budget for an additional six (6) months was allocated by THS to ASRHS.

My next step was to gain support and information from the funding bodies and service providers for these regions. I made visits to Kalgoorlie and Perth, Port Augusta and Adelaide, and Darwin and Tennant Creek community organisations and service providers. Support was voiced by all but one of the organisations consulted. With this one organisation, ongoing negotiation occurred in order to respond to these concerns. Information on availability of Disability Services was gathered, documented and distributed to community organisations. The SA and WA state government services responded well to discussion re their commitment of funds to the project. At this point the project stood to become a collaborative venture.

This project had no promise of funds at the end of it so it was only realistic to promote improving the services we already had, while working for more services and funding. This

reinforced the need for the project and each activity within itself to be of value. As a physiotherapist with experience in remote areas and knowledge of disability services, I knew I could respond to some of the immediate needs that people presented to me. By talking with people with disabilities within their own physical and social environment, I could provide them with an opportunity to speak for themselves where they felt comfortable to do so. I could support what people and their communities were already doing, by linking them with funding or services they may require. This approach could be a beginning for building relationships in regions I was new to, could demonstrate what the project was about and generate interest in more long term solutions.

As part of the consultation process and with these ideas of my own developing, specific project procedures began to emerge. These were formalised to guide the process and my practices as the project officer. There was to be ongoing consultation and participation by people with disabilities, community members and stakeholders. The project aims and project process were to be flexible and subject to change to respond to the directions given. Reference groups consisting of people with disabilities and their families, community members and service providers were to be nominated by each region to guide the project. Support was to be given for current community projects and not co-opted or duplicated. If any information was provided by these projects, it was to be acknowledged. I was to be available, when requested, as a resource to support community initiatives, whether related to the project directly or not. Information was to be communicated in an accessible and culturally acceptable form, for example, project descriptions in written form and visual form. Aboriginal Research Workers (ARWs) were to be selected and employed according to the wishes of each community. They were to be employed under legally acceptable conditions, with rates of payment in line with community awards. I was to be responsible for coordination and training of the ARWs who would collect the data. This data was to be handled confidentially and approval gained for release of results. Community councils were to be reimbursed where costs were incurred, for example, for fuel. To ensure informed consent from community organisations, written consent was to be sought only after consultation had occurred and a process agreed upon. A contract, to give consent and ensure ethical guidelines were followed, was to be developed between myself and community councils.

With these procedures established, my time was then committed to ensuring that I could adhere to them. Within a public service organisation this proved difficult and time consuming.

Conditions for employment and reimbursement were rigid and formed barriers in responding to the needs of organisations and individuals. For example, where a person with a disability or an old person, on a pension, was chosen to contribute to the project, becoming a THS employee involved delays and would interfere with the pension payments, despite the fact that the work may only extend to a number of hours. Exploring flexible alternatives became a major component of the project and involved lengthy discussions with personnel, finance, budgets and senior executive.

Locating and negotiating for further funding to meet the commitments made also became a major task. As a result, the skills I developed in budgets and administration also became a significant outcome of the project for me. Financial contributions were made in different forms at different times during the project. Funds for my salary were contributed by different THS programs. Travel interstate was contributed by one organisation and funds to conduct the workshop were contributed by another organisation. Negotiations were initiated with WA and SA state services to provide funds for ARWs and operational costs expended in their areas of the CBR.

However, in the CBR, despite support from service providers and health organisations, the project continued to be opposed by one community organisation with some authority for the region. Discussions occurred for some time, but were always limited to non Aboriginal employees of the organisation. Eventually, I sent a formal invitation to the organisation to be involved in the project. This was declined, on the basis that it was both appropriate and preferable for the organisation to address the issues and not appropriate for ASRHS. The region was therefore not to be included in the project. In an effort to respond positively to the decision made, stakeholders in SA & WA were informed and requested to communicate with the community organisation re services and any future service development.

In ASRHS region the project was introduced to a meeting of the senior AHWs. There was much discussion and interest with a the focus on alternatives and conditions for employment of ARW and reimbursement to communities for resources used. There was a positive response to what had been developed. The discussion led to my working with the Assistant AHW Manager to design a job description to be assessed for an appropriate award. We also commenced negotiations with the Institute for Aboriginal Development (IAD) for a ARW training course.

As my office was located within the AHW area of ASRHS, discussion continued on an informal basis. On one occasion a senior AHW who had previously worked with me on the A&DSIG (referred to in Case Study 1) talked of the success of the workshop we had run. In remembering the high level of involvement of Aboriginal people both in participating and presenting, she suggested we have a workshop like that, as part of the project.

Further progress in the ASRHS region was postponed as a result of internal difficulties within ASRHS which created a weak link between ASRHS and non government organisations. Repeated efforts to resolve the difficulties were unsuccessful. A proactive decision was made, by the Aged and Disability Team, to redirect resources to supporting organisations in the region in the development of their own services. Resources were also redirected to the Barkly when a subsequent request to extend the project time in that region was made.

Strong support for the project had been expressed by Barkly organisations following the initial meetings held with the range of government and Aboriginal organisations. While the Barkly had contributed to the development of the overall project procedures, their support was also based on specific conditions. The Barkly portion of the project had to include town and bush organisations, given that they saw themselves as a district. They also insisted that it be conducted separately from the Alice Springs region. Many people in the Barkly held the strong belief that decisions are too often made by Alice Springs for the Barkly, inappropriately and with no authority to do so. Consistent with this view, it was requested that ARWs were to come from and be selected by the individual communities and not from outside of them. This was to ensure that the employment, training and experience provided would occur in and remain in each community. The ARW would have the right to speak for and be accountable to their own community.

I notified organisations that the project would proceed according to the project procedures and according to the specific requests made. On this basis, I moved to Tennant Creek, took up residence, and accepted a base in an office with the AHWs whose traditional country was in the Barkly. I had additional support from a few non Aboriginal people who had been long term residents of the Barkly. The scepticism linked to 'blow ins', especially those from Alice Springs, was present but minimal. Support and training for me by the AHWs, about the Barkly District, was constant.

The next step of the project was to become acquainted with the Barkly people and communities out bush. Being located in the AHW room in town was an important part of this. The AHWs and Aboriginal Health Promotion Officer organised to take me out to most of the bush communities. On the way they would tell me about each community and on arriving they would introduce me to the appropriate people. When the AHWs from out bush and other community members came to town they would often come to the AHW office to visit or pick up medical supplies. This helped me to meet and consolidate relationships with people. AHWs in town and out bush increasingly became a resource for me. My location also meant that I too could be a resource to them. (for example, in the use of their new computer).

Sometimes I would start by meeting people with disabilities and those people caring for them. In the camps I heard people's stories and heard of their needs. Where I could address these needs I did (for example, by providing equipment). To me the interaction at this personal level was really important, for establishing some trust and common ground. The book and poster that had been developed as a result of the work I had been part of in Willowra (Case Study 2) had only recently been published and distributed. As strong ties exist between Willowra and the Barkly, it was common to meet people who were related to the people from Willowra and from other parts of the ASRHS region. This helped people to identify me and the area of work I was in and helped me to establish relationships in the Barkly.

Often talking with people informally at home with family, would lead to discussion of what was happening in the community as well as those things people believed should be happening but weren't. This could lead on to my making contact with a service, for example, old people's meals on wheels service. Acknowledging what they were doing and offering any service I could give, was the first step. In another community who were working on a housing project, I was able to give them information in relation to access for people with disabilities.

In one community I was introduced to the council manager and president first. I was formally told what was happening in the community for people with disabilities, and put in contact with the person they felt could speak for that area. In another community I was invited to attend a council meeting first. In another community I saw people with disabilities and their carers, clinic staff, their council and their HACC service. Although there were differences between them, they all wanted to see something done about accommodation for the old

people. I was able to talk about what other communities were doing, as well as seek out information on alternative forms of funding to achieve what different organisations and communities wanted.

People started thinking about who would be their ARW. In one community, the person chosen appeared obvious to everyone and was consistently nominated by all factions of the community. In another place it was to be a man with a disability who was familiar to a number of communities. In yet another community one person was nominated, but soon after the council changed and the nomination fell away.

Following the direction of the AHWs and along a different pathway each time, I had discussions with people with disabilities, their families, councils, HACC services, women's centres, clinics and disability services in bush communities and town organisations. I introduced the project and sought their views on how they wished to proceed with the project. I made some suggestions, one of which was to have a workshop, relating the views expressed by the AHW in the ASRHS region. People believed it was time that a workshop was held in Tennant Creek, and that it was the best way to share information and to discuss the needs of the district. It was also seen as a forum in which people with disabilities and old people, their families and carers could participate.

I met with members of the Aboriginal town organisations to present the views I had gathered from bush communities. They then set the workshop agenda. Their emphasis was placed on attendance by the old people and disabled people and on presentations by local Barkly people. Information on availability of services and funding was also to be given. Organisational details were then decided. An Aboriginal co-worker was employed to gain training and to assist me with the coordination of the workshop. My time was then committed to assisting and training community workers and community organisations in the preparation of displays and presentations. Funding was contributed by a community organisation to support the travel and accommodation needs of people from out bush.

The time I spent with people with disabilities, the old people, their carers and the people providing services was very important. Each step in the process of nominating of speakers, inviting them to participate, and assisting them in their preparation, gave recognition for the value of the story they had to tell. Supporting people through the steps of preparation of poster

displays and presentations, not only taught people skills but helped them to gain some confidence in themselves and the value of the work they were doing.

Participants, including the organisers and I, were very happy with the success of the workshop. Old people and people with disabilities, families, carers, community and regional service providers of Aboriginal communities of the Barkly attended, made presentations and participated. The highlight was the many Aboriginal people with disabilities and the old people who stood up and told their story, often in their own language or languages. Discussion ensued in many languages at once within the audience. The workers in Aboriginal organisations made presentations about the services they were providing in their communities. They were acknowledged for what their service was contributing. They also provided incentive and information for others who wished to provide a similar service. Their posters, handouts and presentations, provided both experience and documentation of their services not only for the workshop, but for their own organisations. For the old people it had been a day out, which focused on their needs and their stories, told to an interested and captive audience. It was also an opportunity for people with disabilities to seek support and to discuss their issues and needs. Some negotiated a service they required. For example, one man from out bush who came to tell his story, gained a wheelchair that had been brought for display. For a group with little power, it was a chance to have a say and be heard. For others it was a chance to be recognised for what they were doing and the contribution they were making.

At the end of the workshop, participants developed some recommendations for the Barkly Region. They were keen to ensure that their recommendations were implemented, yet concerned that this may not happen. They wanted to keep the process going until implementation of their recommendations had occurred. To do this, they selected a reference group comprised of representatives from each town and bush organisation. The need for extra funding to continue for a longer period of time was discussed. The first strategy was to seek additional funds from THS. Another option I proposed was that as I had just been notified that I had won a scholarship, I could continue as the project officer on the scholarship on the basis that it was used for my studies. The remaining funds allocated by the project for my salary, could be released and allocated to employment of the ARWs in each community, to ensure that their employment could continue for a more extended period of time.

Immediately following the workshop, it was a priority for me, with the assistance of the Aboriginal co worker to compile the proceedings. We used text and a large number of photos, so that it could be easily read by Aboriginal people all over the Barkly, of all ages and literacy levels. On completion, we distributed the proceedings to all of the participants, Aboriginal organisations in the Barkly and to the service providers and funding bodies.

Following a break, I returned to the Barkly and received confirmation to proceed according to what had been proposed. Extra funding was allocated by THS and I commenced working under a scholarship. The next step was to have a reference group planning day, to develop an action plan to implement the recommendations and to define my role and a contract with community organisations. It was a rather detailed and complex process which gave the reference group knowledge and experience and a sample contract for future projects. Unfortunately, it also drew the focus away from the reference groups more immediate and burning issues. I wasn't sure whether I was facilitating, controlling or pushing and I wasn't sure whether the reference group wanted me to facilitate, control or push. I had hoped that they would take a stronger role so that I could withdraw to be more of a resource. However it seemed that the process increasingly relied on my skills.

At the end of the day, the recommendations were clarified and prioritised, with support for each individual community's activities as the first priority. These recommendations were distributed to funding bodies and service providers, in the hope that they would influence their future decisions. We also asked for their assistance with implementing the recommendations. The next step was to develop a proposal for a one off grant. One of the larger community organisations were to take on administration of the funds to be allocated to each individual community for the employment of ARWs and their operational expenses. This was the way that had been agreed, that ARWs could be employed on their own terms, without the restrictions of the public service. Letters were then sent out to all community councils in the Barkly, formally inviting them to be involved and requesting their consent according to the contract drawn up.

It was at this point, the process was interrupted. In the early stages, the project had been extended from three (3) months to nine (9) months. As a result a new application was requested from the ethics committee in the NT. A letter from the opposing organisation in the CBR had then been sent to the committee stating the nature of their opposition. When the

application was processed four months after it had been submitted, approval was declined on the basis of this opposition, that there was 'no evidence of written support' and that 'it had all been done before'. This was the response, even though the project was not going ahead in the region where the opposition had come from. Approval had been given originally for the same project and the workshop proceedings had demonstrated the high level of support and participation by people of the Barkly.

I felt the ethical process had become politicised. It hadn't protected the stakeholders or the process. This was frustrating and caused major disruption to the project process. Barkly people were confused in relation to my link with a committee from Alice Springs and alarmed that yet again Alice Springs had asserted control over Barkly matters. This led to some loss of confidence in the project, and ownership of the project by the Barkly. As the Barkly project was 'not the business of Alice Springs', confidentiality was expected of me. This had been contradicted by the comment that insufficient information had been made available. The Barkly request that ARWs were to come from each local community, was contradicted by an ethics committee request for a single ARW to be employed. To comply with these demands would have been in contradiction to the project procedures.

I found the situation difficult. With this opposition to the project, I questioned should I continue. However, I could not ignore the strong support given, particularly from the people with disabilities and their families. In continuing, I realised my response to this opposition could impact on the Aboriginal people I was working for. It was my responsibility to see that there was not a negative impact. In a project that attracted a lot of attention there was also my professional credibility and the effect on me personally to consider.

Talking with Aboriginal people and especially people with disabilities was my priority, and was also included in the project procedures. Yet in some of the larger and more powerful Aboriginal organisations I found myself talking to the non Aboriginal employees who acted in a gate keeping role. There was also a divide between what I was hearing and the direction I was being given at the grass roots and the bureaucratic level of both government and Aboriginal organisations. Who was I to listen to? There was also the pressure of time and money. On one hand I felt it caused me to push the process, yet at other times I felt I didn't move fast enough with so much administrative work involved in meeting project procedures. There was the National Health & Medical Research Council (NH&MRC) guidelines, the

ethics committee, ASRHS and the more powerful Aboriginal organisations, who often had differing expectations for a correct process and applied differing pressures. The least powerful of all were the people with disabilities, their families and carers and community based service providers. I believed that these were the people who I should be talking to, focused on and listening to. Yet in adhering to the project procedures I moved away from what people with disabilities expressed as their need.

As obstacles occurred, the experience became wearing. Criticism was expressed largely by non Aboriginal people at a bureaucratic level and so in responding to this, I spent time and energy communicating at this level. This meant I was more exposed to and more influenced by this level. Again this drew the focus of the project away from people with disabilities. At Willowra I was aware of the influence of what I felt was peer pressure and I actively avoided it, to ensure that what the Aboriginal people said remained my focus. Somehow I hadn't been able to do the same in this case.

In order to move on, I spoke with the ethics committee chairperson to get the information that Barkly people were requesting and to clarify what would be required to be assured of approval. I then took this information to a project information day, conducted so that at the very least Barkly people could be informed of their rights and role in research for the future. At the most it could clarify the confusion and allow the project to proceed as planned. I knew that the loss in confidence could have already eroded the process, but information on the conduct of research and surrounding issues could help Barkly people in the future, to establish their own conditions for approval.

Another application was submitted to the ethics committee and approval given three months later. With the initial confusion and this delay, support by some town organisations had been withdrawn. By this time, I had worked at many levels but still believed the focus must be on working with people with disabilities and those caring for them. As such, I believed strongly in the reference group as their representatives. Despite their commitment to implementation of the recommendations, this group were some of the busiest people and were spread out over the Barkly. Their inability to mobilise as a group and their lack of real power or authority meant they had little hope of swaying the outcome. Had I focused even more on consulting with senior council employees and members of the larger and more powerful Aboriginal organisations, the project may have withstood the challenges posed. However making a

project stronger by including powerful players could mean the less powerful voices may continue to go on unheard.

Strong support from the bush community councils to proceed had been maintained. This was the group for whom the project had initially been designed. Perhaps they had little to lose, having no services, being keen to have training for their own ARW and dependent on THS for health services anyway. Having initiated the involvement of this group of people in the project and always encouraged their participation, I felt a sense of responsibility towards realising outcomes. The project had linked and supported what they were already doing within their communities, and for some, gains had already been made. People were poised to move on with the project eager for the particular outcomes that each community wanted for themselves.

However, I was concerned that these communities might be exposed to problems that could occur as a result of what had become a contested project. I was not confident that what I believed were deliberate obstructions, would not continue, and result in a deficit for the Barkly and for myself. This conflict did not belong to the Barkly. It was at this point, with conflicting sentiments and against some resistance, I withdrew. By making a proactive decision not to continue, I believed it was possible and a priority to preserve what had been done, to draw out the positive outcomes, and to focus on and give energy to these. I was determined that by withdrawing I could ensure outcomes of positive value and avoid any deficits.

The old people, people with disabilities and the workshop participants, the reference group and I, had all been part of a successful project. In producing a report for Barkly communities, I decided to include the process, material developed and information gathered. The reference group or individual communities could then at some time later, work towards implementing their recommendations, in a manner that was suitable to the community or whole district. The report was distributed to all community councils, clinics, reference group members and service providers involved. Application was made to roll over funds remaining so that they would be available to the Barkly for this purpose. This would allow for someone to pick up where we left off, at the community level or district level, to move on with the same process or use the information to develop a new project proposal.

At the end of a difficult project such as this I felt the goal in writing the final report of the entire project, was to highlight both the process and the outcomes achieved. I wanted to see that the report could precipitate a positive perspective, so that development of services for people with disabilities in the central Australian region could move on.

Some of the process outcomes were quite concrete where others could be subtle or unseen. The initial process of consultation led to a large amount of valuable information on Disability Services being shared and gathered, particularly on service types, availability and access. This was documented for government and Aboriginal organisations in the region. This whole process could help to establish links and contacts and important groundwork and impetus for future development.

The Barkly workshop in itself, was an outcome of the project. It also precipitated other outcomes from the recommendations that were made. A specific submission was initiated and developed for the Disability Brokerage Fund (DBF). This was to provide flexible funding for access to services by people with disabilities from remote Aboriginal communities. About six months after the project was finished, two more allied health positions were allocated to the Barkly, under a special project. This was consistent with the recommendations, but had not been as a direct result. Had the recommendations influenced either the thinking or the decision?

The workshop proceedings produced have been used as orientation for new staff to the Barkly, and for people working in disability services for Aboriginal people. As there is little literature of this nature, requests for copies came from other parts of the NT, and interstate. Following their distribution, information and guidance about the participatory process for planning, conducting and documenting of a workshop for people with disabilities was requested to assist a community organisation in their own planning process.

The resource role I played led to assistance being given particularly to gain services for people with disabilities and to gain funding for the development of services in the community (for example access to specialist services). The resource role allowed me to directly contribute to and advocate for people of central Australia in the ongoing development of services and policy within the THS. There was also no doubt that professional skill development was a major outcome of the project for me.

Alternatives developed for employment of Aboriginal people and their organisations involved in research were in contrast to the rigid public service conditions. These alternatives could have application for THS when conducting any research with Aboriginal communities. Following discussion with regional executive of THS, it was recommended in the final report that these alternatives be documented in a Research Project Manual. Disappointingly, this or an alternative strategy has not been developed by THS, limiting the extent to which this was an outcome of the project.

This project confronted me with difficult, and often conflicting issues. While some of these issues I had anticipated, I had not recognised the extent of the differences in the context in which I was working. I realised that the risks to the project had been inherent in the size and diversity of the region and the politics surrounding government initiatives. The region covered a large area geographically, administratively, culturally and politically. There were a large number of different government and Aboriginal organisations involved, with different structures, from two states and a territory. Within this combination there is bound to be existing differences and conflicts. The diverse cultural and language groups within the Aboriginal population and the diverse cultural and political groups within the non Aboriginal stakeholders meant that communication and negotiation could be intensely political. Working towards a correct process within this context, all too often drew my attention and the attention of the project away from the focus on the issues for people with disabilities. Yet it was important that the project procedures, dictating the correct process, were not abandoned.

I had been determined that I would facilitate a process whereby people with disabilities and their families and carers could have maximum input and control over the direction of the project. Responding appropriately to the cultural, political and administrative barriers to achieving this, proved a challenge and a major responsibility of my role. Working within this project I developed an increasing awareness of the complexity of the context of health service delivery to remote Aboriginal communities of central Australia.

CHAPTER 4

ANALYSIS AND INTERPRETATION

The process for reporting of the analysis has involved reducing and ordering the data according to the categories that emerged. Firstly, the basic similarities and differences between the context for the three case studies are identified. Secondly, the case studies are compared according to each category and the core category, drawing out the relationships between them. Thirdly, factors contributing to the patterns that emerged as relevant to 'linking with community development' are identified and explored.

This process is reflected in the style of presentation. The analysis of the case studies, represents an analysis of my personal experience using a personalised style of presentation. The interpretation draws factors from the experience and explores them further. As a result, a more generalised style of presentation is used.

4.1 Comparison of the context for the case studies

In each of the case studies I was working as an outsider in remote Aboriginal communities of central Australia. I was employed by ASRHS, as a physiotherapist and each service or project was administered by ASRHS.

In each case study I worked in a different location, took on a different role and worked within a different model. The experience, the relationships and networks I developed in one service or project, provided the groundwork and context for each subsequent one. As a result I was located differently, physically, socially and politically, in each.

Each service and project differed in the make up of the groups of Aboriginal people for whom it was catering. In Case Study 1, the Aboriginal people were a diverse group of people from a variety of language and cultural groups, from one government administrative health region. In

Case Study 2, they were a closely knit group of people from two culturally linked language groups, from one location. In Case Study 3, the Aboriginal people came from a variety of language and cultural groups from the town and bush, government and non government organisations and administrative regions. There were different agendas, alliances and conflicts within and between groups represented.

The purpose, the initiation and the funding arrangement for each case differed. Case Study 1 was a visiting service initiated by ASRHS, with ongoing reliable funding. Case Study 2 was a community based action research project initiated by the community. It had administrative flexibility as a one off or one line grant with additional funds available. Case Study 3 was a regional needs assessment precipitated by Aboriginal people. It was initiated by THS, with minimum allocation of funds, no promise of further funds and relatively rigid administrative arrangements.

Each case study existed within the broader context of central Australia and within a different time frame within the seven year period. As a result the external factors that impacted on each case presented different opportunities, different challenges and different stakeholders in each service or project. These factors included the resource and grant allocations consistent with different political policies and agendas. They included the different agendas, people and personalities within ASRHS, community councils or Aboriginal health organisations within a broader political context that moved and changed over the seven year period.

The context for each service and project and my position within each case was significantly different. However, in all three case studies, I was placed in a position of power. My power was by virtue of my position as an outsider, as a professional, working for a government organisation that controlled the resources allocated. My power was also as a representative of the dominant culture.

It is important to clarify that the analysis does not explore or defend this position of power or the power relationships it may precipitate. It does not deny the power of Aboriginal people or the power relationships between Aboriginal people, as insiders within the context. What emerged as relevant from the analysis was the need to explore my practices, within the context of these power relationships.

4.2 Comparison between categories

4.2.1 *Insider involvement*

The involvement of Aboriginal people across all of the case studies was diverse. People were involved in different capacities, for example, as passive recipients, as active participants or as initiators of ideas or strategies. People were involved within different roles for example, as patients, AHWs, family, project workers, cultural assistants, people with disabilities and service providers. Their involvement occurred at different levels, for example, the individual, family, community and inter organisational level, and in different environments such as the bush, the camp, in the women's centre, the office, and in workshops.

The involvement of Aboriginal people differed in the nature and extent of involvement and their influence over the process. In Case Study 1, Aboriginal people gradually became involved at the individual and family level and then increasingly at a community and organisational level. As their involvement developed and increased, their influence over the process of further service delivery and development grew. In Case Study 2, the project initially involved the women's centre workers, the old and disabled people and the senior men and women but eventually grew to involve the whole community. Having initiated the project, identified my role and the process to be used, the Aboriginal people consistently maintained their influence over the process. In Case Study 3, the Aboriginal people had influenced the initiation of the project, the project procedures developed and the progress of the project. Obstacles to the process resulted in inconsistent involvement from region to region and across the duration of the project. While some powerful Aboriginal groups and organisations maintained influence over the process, this compromised the influence of others.

Across all the case studies the involvement of Aboriginal people informed and influenced the process for the service or project. This enhanced the relevance of the service and projects to a range of individuals, groups and processes within the community. It led to interaction and dialogue between Aboriginal people and myself and their access to my knowledge and skills, to meet their needs and agendas. It also led to some inconsistencies in direction given, and the compromising of involvement of some groups of Aboriginal people by others.

4.2.2 *Outsider practices*

My practices also extended across a diverse range in keeping with the diversity in the needs and agendas of the Aboriginal people involved. They differed in that they grew and developed from case to case. Those practices developed in one case became integral to my practices in each subsequent case and were built upon in response to each new set of conditions.

At the beginning of Case Study 1, I took a very clinical approach, but recognising the limited value in this, my practices gradually changed. From there, in each case I developed a range of approaches, for example, an educational and public health approach. I worked in a number of roles, for example, clinical, educational, research and community development roles, across the different levels and environments. Positioning the central point for the service and working in an environment where I was exposed and available to Aboriginal people became a priority throughout. In Case Study 2, I increasingly collaborated with Aboriginal people and worked within the existing processes within the community. Seeking a balance between being directed by the community and taking a directive role within the project, working to avoid pushing the process and avoiding competing influences became important components of my practice. In Case Study 3, I was determined to maximise the influence and control of Aboriginal people over the process, precipitating the use of both collaborative and participatory processes. This led to challenges that had not been anticipated. This required me to be proactive in responding to these challenges to ensure they did not impact negatively on the Aboriginal people.

Each case differed in the extent of my dialogue with Aboriginal people and their influence over my practices. In Case Study 1, there was a gradual development. In Case Study 2, it was constant and significant throughout. In Case Study 3, this occurred inconsistently between groups and was challenged by competing influences.

Across all the case studies my practices resulted in my exposure to Aboriginal people and their context. This enabled Aboriginal people to inform and influence my practices to be more relevant to their needs and agendas. This also enabled my skills and knowledge to be known and to be available to a range of Aboriginal people and processes. Competing influences and obstacles to the process, highlighted my responsibility to preserve outcomes and avoid any deficits as a result of my practices.

4.2.3 *Information and communication processes*

Given the diversity in the involvement of Aboriginal people and of my practices, information and communication processes that developed were also diverse. In each case, processes occurred among Aboriginal people, between the Aboriginal people, ASRHS, other service providers, funding bodies and myself. Information and communication processes differed between cases as my skills, experience, relationships and networks from one case provided a starting point for the processes developed in each subsequent case. The involvement and influence of the Aboriginal people also differed, consistent with the previous categories.

In Case Study 1, I began by observing, listening, talking to people and demonstrating treatment strategies. The extent to which I communicated with Aboriginal people was strongly motivated by my interest and thirst for knowledge. Realising the value of this for building relationships, informing my practices and providing information to people, I then set out to interact and dialogue with Aboriginal people at any opportunity in any way I could. As a result, the processes used, expanded. In each case they included a range of both written and visual communication, in different languages, using different technology such as teleconferences, faxes and videoconferencing, across the many levels and environments.

In Case Study 2, there was an additional focus on the use of existing processes within the community and on the use of processes that did not require my skills to continue. In Case Study 3, the focus was on personal interaction to facilitate meaningful involvement and the use of a collaborative project process and a participatory workshop. This open process led to competing influences and power relationships becoming challenges to the project. In order to preserve what had been achieved, recommendations and outcomes were documented and distributed, to influence future decisions of funding bodies and service providers. It could also allow the process to continue under circumstances suitable to the region.

Across all the case studies, information and communication processes resulted in the development of a wide variety of channels for interaction and dialoguing among Aboriginal people and between Aboriginal people and myself. This allowed for collaboration to produce resources, which when documented provided resources for a wider audience of Aboriginal and non Aboriginal people. This also allowed the inclusion of competing influences and differing power relationships to become obstacles to the project. Processes facilitated,

precipitated and influenced decisions and changes by ASRHS and other service providers and funding bodies, consistent with the needs and agendas of Aboriginal people.

4.2.4 *Strategies for maximising opportunities and minimising constraints*

Corresponding with the other categories, strategies developed in diversity. These strategies were based on simple principles such as taking a one off opportunity and perhaps using it to set a precedent. They were based on responding when and where a need was verbalised or repeating a successful strategy from one place in another. They included doing what people were already doing and building on it, supporting what was already happening, working where one could contribute most and making each activity of value in itself. Strategies based on these simple principles developed across a range of levels, for example, the individual level with the use of the black doll and the intra organisational level in contributing to clinic design. They developed in different areas, for example, in service delivery by using a population strategy, in research by using local resources and in administration by developing alternatives for employment of ARWs.

Strategies differed between case studies, growing in diversity and complexity as I became more experienced and encountered the opportunities and challenges within each new set of conditions. In each case, strategies had focused on increasing the involvement and influence of Aboriginal people and on informing my practices to provide a service or project that was relevant. Then in Case Study 2 and to a greater extent in Case Study 3, additional strategies were developed. These were focused on maximising the influence and control of resources by the Aboriginal people, on preserving outcomes and avoiding losses or deficits. Strategies were used to make the most and lose the least from the context, particularly when responding to changes that occurred and challenges encountered.

Consistent with the other categories, strategies differed in the involvement and influence of Aboriginal people. In Case Study 1, I developed strategies by myself, influenced by the Aboriginal people with whom I was interacting. In Case Study 2, strategies were developed in collaboration with the Aboriginal people, or by the Aboriginal people themselves. In Case Study 3, strategies were again developed in collaboration with Aboriginal people.

However difficulties encountered, resulted in my taking a more directive approach to the development and use of strategies, with inconsistent collaboration with Aboriginal people.

Strategies for maximising opportunities and minimising constraints enhanced the involvement and influence of Aboriginal people, the relevance of my practices and the establishment of channels for communication between Aboriginal people and myself. This gradually developed as an approach, for responding to the context and changing conditions, to preserve positive outcomes, while minimising or avoiding deficits for the process of community development.

4.2.5 *Linking with community development*

Consistent with all of the categories, there was diversity in the nature of linking between individuals, groups, community development processes and myself. Each case also differed in the involvement and influence of Aboriginal people.

Linking developed differently within each case. In Case Study 1, linking occurred with individuals and increasingly with those groups and processes within the community that supported them. For example, linking occurred with a person with a disability and then with the resource centre building their house. At first I initiated linking but increasingly Aboriginal people initiated it. As linking became established within one framework or process, emphasis was shifted to another, for example, from the clinic to the school. This facilitated more comprehensive linking within a community and within the model of service delivery, (for example, working with AHWs) perpetuating a process for further linking. Linking often built upon the links of others (AHWs taking me to the camp) or created links for others (Aboriginal people to ASRHS management). Linking in one community could create linking in another (through the appointment of a skin name).

In Case Study 2, linking had occurred prior to the project and had precipitated my position within a community development project. The project itself exposed me to many individuals, their families and other community development processes. The expectation that I would be a resource to the community, ensured that linking increasingly occurred in a more comprehensive way across the community. In Case Study 3, I began by linking with the processes within which people operated, such as the organisations that provide services or

represented the Aboriginal people. From there, linking that developed between AHWs and myself, led to linking with the individual people with disabilities and the groups and services that supported them. However links with some groups compromised the links with others. This resulted in my decision to withdraw from the process, to avoid any deficits as a result of linking.

Linking with community development was not a specific goal of each service and project, but emerged as a framework for practice as a result of the experience. In Case Study 1, I had become aware of the importance of each of the categories. In Case Study 2, I increasingly developed an understanding of community development and learnt to link with community development processes as a strategy to provide more direction for my practices. I also realised that, by linking with community development, Aboriginal people could choose to use my skills and knowledge. This motivated me to consciously set out to link with community development processes in Case Study 3. This approach allowed me to be a resource, and gains to be made, to many individuals and processes as part of the process. As challenges occurred I became aware of the negative effect that could occur as a result of the linking of which I was a part. This precipitated my awareness of my responsibility to ensure that my practices did not impact negatively, but could be available to contribute positively, to community development.

In each of the cases, 'linking with community development' resulted in a diversity of channels along which influence could flow between the individuals, groups and processes within Aboriginal communities and myself. This enabled my practices to be grounded not only in my professional expertise, but also in the needs and agendas of the community. My practices could then be available to contribute positively to their community development, with any losses avoided or minimised.

4.3 Factors influencing 'Linking with Community Development'

A common element or pattern across the case studies was the diversity that existed. A number of factors contributed to this diversity. The purpose of each service or project was broad and the make up of each group of Aboriginal people was diverse. The range of Aboriginal people

represented had a range of needs and agendas. An interest in this diversity precipitated my flexibility to respond to requests, to develop relevant practices, and to be available as a resource across this diverse range. The flexibility of ASRHS allowed for this diversity by supporting my flexibility in service delivery and in the use and reallocation of organisational resources. Other stakeholders, such as those employed as service providers, within funding bodies or others working in ASRHS, also contributed. Their referrals and requests and their support for involvement of Aboriginal people across the diverse range enhanced this diversity.

A common difference that emerged across the case studies, was the extent of the influence of Aboriginal people. A number of factors also contributed to the nature of this influence. The closer the central point for the service, to the Aboriginal people and the greater the frequency of opportunities for them to interact, the greater their influence. Where the make up of the group was consistent with existing cultural groupings and existing alliances, Aboriginal people had more influence as a group. Where they were brought together into groups that were unnatural groupings or where there were existing conflicts, their influence declined. The more flexible the administrative arrangements, the greater the influence of Aboriginal people over decisions made.

The Aboriginal people themselves were actively involved, contributing to their influence. This included the extent to which Aboriginal people accessed the project or service and communicated their needs and agendas. It included their flexibility and willingness to apply their skills and resourcefulness to participate. The extent to which the Aboriginal people incorporated their language, cultural protocols and priorities and their routines and schedules into each case, contributed. The nature of Aboriginal people's involvement, for example, as passive recipients, or participants in a collaborative process, was also a determining factor. In addition, the competing influences of more powerful Aboriginal people or organisations could compromise the influence of other groups and organisations.

The extent to which Aboriginal people informed and influenced my practices was a major factor contributing to the influence of Aboriginal people. Their interest in me, my culture and the service or project, as well as their willingness to educate, collaborate and provide direction and include me in their processes contributed. The relationships, networks and trust between Aboriginal people and me, determined in part, the extent to which Aboriginal people used my skills and my knowledge to increase their own influence over the process.

My practices were open to the influence of Aboriginal people. A strong personal interest and personal agenda to get to know and to work with the Aboriginal people and their culture, meant that I wanted to be influenced by them. My need for education, direction and support within each role, reinforced this. The position of the office and the work environment I chose where I could be exposed to the people and be available as a resource allowed this to occur. My flexibility to respond to the needs presented, requests made and directions further enhanced their influence.

Knowledge of networks and resources within ASRHS, service providers and funding bodies and my credibility within these organisations increased my ability to enhance the influence of the Aboriginal people. It enabled me to negotiate for funding and modify administrative arrangements to maximise the control of Aboriginal people. It enabled me to facilitate communication of needs or agendas. The extent to which I made my knowledge known and available to Aboriginal people, contributed to the extent to which Aboriginal people could have influence over the decisions that affected them.

Practices that were relevant to the needs and agendas of Aboriginal people within an environment where Aboriginal people could feel comfortable and empowered to contribute, enhanced their influence. This was dependent on my personal, professional and cultural flexibility to work in the community environment and social context, routines and schedules, according to community agendas and priorities. It was also dependent on the extent of my knowledge of these existing processes by which the community operated.

The nature of my communication with Aboriginal people and the nature of the processes used within the service or project contributed to the influence of Aboriginal people. The use of communication processes that were open and inclusive, that catered for the needs of Aboriginal people enhanced it. My participation in existing processes and the use of processes that could continue without my skills (such as the use of photographs to record the project) also contributed. The exchange of skills and information and collaboration in the development of resources among Aboriginal people and with me, influenced the nature of the resources produced. Alternately, communication that did not involve Aboriginal people, that was not accessible by the majority of Aboriginal people or which relied on my skills limited the influence of Aboriginal people.

The extent of collaboration with Aboriginal people in finding solutions to their problems and the problems of the service or project contributed to their influence. This included collaboration about how the service or project could respond to changes, to challenges and to other influences or pressures. Alternatively, seeking solutions to challenges to the process without collaborating, led to a decline in the influence of Aboriginal people.

The flexibility of ASRHS to respond to needs presented, requests made or directions given could enhance or constrain the influence of Aboriginal people. The flexibility to modify the model of service delivery, to use or redistribute organisational resources such as technology or funding or the flexibility to move the central point for the service all enhanced their influence. In contrast, the inflexibility in employment conditions within ASRHS as a government organisation created a major obstacle to meeting requests made and limited the extent of the influence of Aboriginal people over linking.

Other stakeholders could enhance the influence of Aboriginal people by supporting their requests and agendas, by initiating linking through their referrals or requests and their support for the involvement of the Aboriginal people. This support often took on the form of collaborating with, providing guidance, and contributing funds to a process aimed at meeting the agendas of the Aboriginal people involved. Other stakeholders could also create obstacles to linking when their influence, expectations or criticism diverted the focus or impacted negatively on the Aboriginal people or the process.

CHAPTER 5

COMPARISON WITH THE LITERATURE

Consistent with the grounded theory approach, a review of the literature is undertaken and compared with the study findings, according to the categories which emerged as relevant.

5.1 Insiders' involvement

The concept of 'insiders' involvement' appears frequently throughout the literature. It is defined in a variety of ways, including community participation, citizen participation, involvement, negotiation and consultation. This reflects some of the diversity that is found in the study. Interestingly, the literature not only provides a more detailed analysis of this diversity, but specifically concerning the influence of Aboriginal people. Reference is made to the Friere method, requiring 'total participation of the people themselves based upon dialoguing between equals' (Minkler & Cox 1980:312), and on genuine participation throughout the decision making process (Kirkpatrick 1990:283). Comparison in relation to the type of involvement that occurs and the relative power of insiders is made by Harris (1992:562) with reference to Arnstein's eight (8) levels of citizen participation. He sees therapy and manipulation as non participation, informing, consultation and placating as degrees of tokenism, while he sees partnership, delegated power and citizen control as degrees of citizen power.

Difficulties which insider involvement presented for outsider practice within the study, have been clearly reflected in the literature. 'It can not be assumed that intra-group communication is unproblematic or underpinned by commonalities of purpose, interests or culture'(Hollinsworth 1996:122). The effect of the conflict or tension as a result of such differences can have 'pervasive effects on service delivery'(Gerritson 1982:16). Alinsky (1971: 104) points out an additional problem not identified in the study. He notes that 'people

often don't know what they want' creating inner doubt in an organiser as to 'whether they are competent to make decisions democratically'.

Discussion of insider involvement in relation to its inherent value for personal growth and community change is found in the literature. It is seen as important on the basis that 'people learn best and grow quickest by doing things for themselves' (Downing 1984:1) and that the only real solutions societies achieve are those they develop for themselves' (Wallerstein & Bernstein 1988:380-384). Involvement is seen to be empowering, in influencing people's belief that they can change their personal and social spheres and by personal growth as a result of participating in community change (Harris 1990). Risks are identified, where involvement does not occur, which include apathy and passivity on the part of insiders (Crawford 1989:2). This approach is consistent with the definition and understanding used within the study. However the analysis does draw out the importance of collaborative and participatory processes, but in terms of the importance to outsider practices, rather than to its inherent value to insiders.

5.2 Outsider practices

Discussion of outsider practices within the literature is consistent with the findings within the study. A number of similar strategies and approaches that were identified as factors influencing 'linking with community development' are promoted within the literature. Downing (1984:2-9) highlights the importance of actively setting out to build relationships and to learn from and about the community. He emphasises the importance of learning about family structures and relationships. He also recognises the importance of communicating your role and the kind of resource you can offer.

A flexible approach, using the most appropriate techniques at hand (Sommerland 1973) and working with 'what is available, not with what you think would be ideal'(Franks & Curr 1996:117) are two such approaches. Working with the 'existing pace in the community and the pace at which a community will involve itself in a community venture'(Ross 1955: 187) and working with community members on their own territory, (Jackson et al 1989:69) can lead to a better understanding of the natural networks within the community, but also amounts to handing back some professional power. Bain (1992:229) promotes respect for traditional

relationships and their 'significance in social practice by working in such a way that Aborigines can retain these things at a functional level for as long as they want to do so. Sommerland (1973: 8-9) compares a puristic model where 'a change agent must be non directive in his approach and adopt as his principal strategy that of helping citizens determine their own set of goals and their own priorities' with the alternative model which 'assumes a more directive role for the community worker and believes it is legitimate for him to propose goals'.

While the diversity in outsider practice is identified in the analysis, the literature provides more detailed discussion and description of the diversity, particularly in relation to outsider skills and the levels of outsider practice. Jackson et al (1989:68) describe the 'community development continuum' along which an outsider may enter at any point and may shift back and forth over time. This continuum is seen to extend from developmental casework, mutual support, issue identification and campaigns, participation, control of services to social movements. This continuum is well reflected across the case studies.

The different skills required of the outsider are highlighted and recognition given that 'no one worker can possess all of these'. These skills include technical skill, belief in mission, cultural empathy, a sense of politics, organisational ability as well as skills of research, information and information technology, analysis, interpersonal skills; motivational skills and education and training (Ward et al 1983, Taylor 1992).

Within the literature, power in relation to the outsider's practice is discussed. Within the study, the power relationships are acknowledged. The study recognises rather than explores the position of power. However the outsiders' influence within the context of the power relationships that exist, emerged repeatedly as relevant to linking with community development. Interestingly some of the strategies promoted within the literature, are consistent with those that emerged from the narratives and the analysis, in relation to the influence of the outsider. Stacey (1988:321) suggests that the outsider must be prepared to give as much of their ability and as much of their power as people will take. Rappaport (1981:15) promotes an empowerment ideology for practice which includes looking to many diverse local settings where people are already handling their own problems in living, in order to learn more about how they do it. It then involves taking what was learnt and making it more public so as to help foster social policies and programs. Labonte'(1990:66) sees that

there is an empowerment continuum along which the outsider can work, from personal empowerment, small group development, community organisation, coalition advocacy to political action.

Difficulties and conflict, confronting outsider practices were acknowledged as a component of the context for the outsiders' practices. This is well reflected in the literature. This may present as 'requests for assistance from different groups [of insiders] whose interests are diametrically opposed'(Brookfield 1983:101) or it may present as conflict with or between other outsiders.

The study analysis and the literature highlight the importance of the outsiders' response to these challenges, particularly in relation to the impact on Aboriginal people. The difficulty of dealing with this conflict is reflected by Downing (1984) with his suggestion that it may 'test your skills in human relations and your patience and christian grace'. Ward et al (1983) believe the outsider has a responsibility to resolve conflict with clients, while Franks and Curr (1996:118) see the importance of resolving conflict between outsiders. They believe that harmony between outsiders is an integral ingredient for overall intercultural partnership'. Franks and Curr also believe that it is 'how you respond to conflict and resolve it is important not that it has happened'.

5.3 Information and communication processes

Within the literature discussion of information and communication processes is extensive. and consistent with the study analysis. The importance of communication with the many stakeholders in the environment is identified. 'There is communication with Aboriginal people who make up the bulk of the population; secondly there is communication with other whites in the community; and thirdly there is communication with outsiders in the form of visiting officials, support personnel and other Europeans' (North Australia Network News 1982: 5).

The need for an environment and social climate that permits, facilitates and is open for communication is seen as important (Watt 1986, Ross 1955). A message will also be 'more widely distributed, and received with more understanding, if it is relayed through channels

that are familiar to those for whom the message is intended' (Ross 1955:180). Communication for interpersonal as well as collective strategies is highlighted, in order to build stronger collectives amongst the relatively powerless so that effective political actions can be undertaken (Labonte' 1990: 65).

The importance of relationships, as identified in the study is consistently supported by the literature. Downing believes that 'good relationships are an important factor in communication' and that one needs to proactively 'seek opportunities to communicate with people, with individuals, families, councils' and make the effort to 'communicate with the whole community' as well as work on relationships with other staff and with government officers. The importance of relationships for good communication is frequently reiterated in the literature (Downing 1984, Ross 1955, Franks and Curr 1996). Egan (Franks and Curr 1996:7) sees the need to understand and to consult with your client group, and believes it is 'eminently sensible to start with kinship, relationships and language...'

The literature not only highlights the importance of the existing processes within Aboriginal communities it confirms the influence of Aboriginal people over them. Bain (1992: 231) looks at the different communication processes used by Aboriginal people and highlights the point that 'what to choose and when to make critical changes from kin relationships and from interaction to business relationships and from interaction to transaction are difficult decisions, decisions that only Aborigines can take'.

Communication is seen as important in a process of change. Wallerstein and Bernstein (1988:381-382) refer to Friere's 3 stages of firstly, listening to understand the felt issues or themes of the community, secondly, participatory dialogue about investigated issues using a problem posing methodology and thirdly, action on the positive changes that people envision during their dialogue. This provides some reflection on the participatory and collaborative processes used in the study as part of an action research approach to the two projects.

5.4 Strategies for maximising opportunities and minimising constraints

Strategies for maximising opportunities and minimising constraints appear in the literature infrequently. However principles of problem solving and approaches to change do appear, while opportunities and constraints to outsider practice or the process, are identified.

Stanley (1989: 229) saw 'maximising opportunities and minimising constraints as not only 'an overall goal of any social program' but something which gave individuals 'greater choice and control over [welfare] resources'. McArdle (1989: 49-52) refers to both providing opportunities for participation and removing physical, cultural, structural and other obstacles to participation in decision making and service delivery...". Eckermann et al (1992: 124) highlight the structural obstacles which are likely to inhibit our efforts, for example, professional structures.

Kamien (1978: 234 -237) emphasises the importance in his practices of developing problem solving skills and 'enabling social change to occur with as much benefit and as little harm and discomfort as possible'. Friere (1970:65) in his 'problem posing education' sees it as accepting neither a 'well behaved' present or a predetermined future, but rather roots itself in the dynamic present. Jackson et al (1989:70) believe that 'the worker must have a repertoire of strategies for change' and 'a knowledge of the system being tackled'.

5.5 Linking with community development

Literature relating to a community development approach to practice is extensive with each of the categories seen to be relevant to this approach. Nevertheless, there is no evidence of specific discussion of these categories or of a community development approach in terms of the conceptual framework of 'linking with community development'.

There are some writers who do however, allude to such a notion. Paterson (Brookfield 1983: 127) claims that adult educators 'must work within existing society and must accept its social (and educational) priorities'. Franks & Curr (1996:112) promote that one could accept

‘community structures and decide to work within them, not battle to change what have been entrenched habits of generations’. Connexions (1990:5) recommends starting ‘where people are at, recognising their reality and their context and acknowledging the institutions, cultures and relationships which are part of their lives’. Crawford (1989: 52) emphasises the importance of working ‘with the community structure, working with the community as a whole and its legitimate authority figures’. Nathan & Leichleitner (1983:21) related the success of their project on ‘using the set of rules employed by the Aboriginal community, including their informal communication patterns, channels of authority and status and standards of credibility’. Beresford (1996:138) perhaps recognises the dynamic nature of ‘linking with community development’ in stating that ‘a more effective community practice is one that recognises and works with the temporary and shifting nature of the community’.

This would suggest that ‘linking with community development’ offers an additional or alternative conceptual framework for outsider practice, as part of a community development approach to practice.

CHAPTER 6

IMPLICATIONS FOR OUTSIDER PRACTICE

The purpose of this chapter is to translate the study findings into a practical form, to ensure they have relevance and application in the field. They are specifically written for the outsider, but may also be used in the planning of services to remote Aboriginal communities.

6.1 Introduction

To provide a framework for action it is necessary to firstly consider the ways in which outsider practices can affect 'linking with community development', and to secondly, translate those factors into implications for outsider practice. This involves drawing out practical ideas from the experience and supporting them with those from the literature. It is important to point out that these ideas should be used cautiously, given that they are drawn only from my experience as an outsider. This experience will have been strongly influenced by my personality, by my profession and by the organisation for whom I worked, within a specific time frame within the context of central Australia.

In identifying these 'implications for practice' it is acknowledged that the outsider, as a professional, holds a position of specific authority and responsibility to contribute their professional skills. The outsider has both power and responsibility within this context. It is therefore, important to seek guidelines for outsider practice that ensure the responsible exercise of that power, to contribute positively, and not impact negatively, on community development.

These implications are based on the assumption that 'linking with community development' could provide such a framework for practice in remote Aboriginal communities of central Australia. As individuals and organisations consider how they will determine their roles, this framework and these categories may be useful.

6.2 Insiders' involvement

It is important to work towards the maximum involvement and influence of Aboriginal people over the service. This may mean making it easier for Aboriginal people to be involved, to access you, to interact with and influence you. One way to do this is to go to the Aboriginal people, to their environment and work within their social context. People are then in an environment where they can feel empowered to contribute. When working with an individual, work with the groups and processes that support them. This will provide an opening for working within the natural groupings which exist within a community and within those processes by which the group operates. This can be further enhanced by working within the schedules and routines of the individual and according to the agendas and priorities of the specific group or community. In addition, try to locate yourself and the central point for the service so that the Aboriginal people can interact and dialogue with you, and access you as a resource.

Be flexible enough to grasp any opportunity for Aboriginal people to be involved, in any context or environment at any time. The more you interact with Aboriginal people, the more relevant you make the service and the more aware Aboriginal people will become of the service. The more the service has to offer, the more worthwhile it will be for Aboriginal people to become involved. Where there are obstacles to the involvement of Aboriginal people, try to work out strategies that will overcome the obstacles and allow them to be involved.

It is important to work to enhance the involvement of all Aboriginal people for whom the service is to be provided. This will help to ensure that the diversity in individuals, groups and processes is represented and will influence your practices to be relevant to them all. However, it is also important to retain your focus on the Aboriginal people for whom the service or project is provided, by working to their agendas and priorities and avoiding competing influences.

6.3 Outsider practices

It is important to expose yourself to Aboriginal people, their environment and social context and their routines and schedules, so they may inform and influence your practices. Do this by positioning yourself so that you are surrounded by the Aboriginal people, so they may frequently and easily interact and dialogue with you and ultimately influence your practices. It is important to accept opportunities to be educated by Aboriginal people in their culture, lifestyle, needs and agendas. Seek out and accept direction given by them for your practices and for the service you may be providing. Develop flexible practices to respond to needs and requests when and where they are made. This will more broadly inform your practices, increase your skills and Aboriginal people's awareness of what you have to offer. Take opportunities to be influenced by and available to the Aboriginal people. This could involve changing the central point for the service, lobbying for more resources or seeking support where your skills and experiences are minimal. Position yourself to be influenced by the group for whom the project or service is designed, to ensure your focus is maintained and that direction you receive is more likely to be consistent.

It is important to acknowledge your position within the context. The knowledge you have and will develop will give you greater power in the context. It is important to use that power to enhance Aboriginal people's control over their lives by making it available to Aboriginal people by collaborating with them in meeting needs and agendas. It is also important to acknowledge your responsibility to contribute your professional skills and knowledge. Pass on as much information and skills as possible in an appropriate and acceptable form, allowing people to use them as they see fit. In responding to the needs and requests of the Aboriginal people, do not underestimate or disguise any of the skills you have. You can also make your skills available to Aboriginal people in a directive way by offering advice and direction and by demonstrating when appropriate. This may assist people to make their own decisions.

Recognise that you are working within a context that will have constraints and obstacles. The nature of your response to these obstacles, may impact on Aboriginal people. It is important to ensure that your response, under both favourable and unfavourable conditions, leads to positive outcomes or at the very least the avoidance or minimising of losses or deficits. While maintaining this focus on community development, collaborate with people and exercise your responsibility to make an informed judgement on what you will support and contribute to.

6.4 Information and communication processes

It is important to use information and communication processes that are open and inclusive and allow a flow of information and influence between the Aboriginal people yourself and other stakeholders involved. Cater for the communication needs of the specific group of Aboriginal people on whom you are focused. Try to use their existing processes, or processes that are not reliant on your skills or input to continue. Always involve the Aboriginal people in decision making and focus any decision making around those for whom the service or project is provided. Try to ensure that the environment you are working in is one where the Aboriginal people are comfortable and where they will feel empowered to contribute.

Relationships are of paramount importance. In building relationships you are building the trust and skills required to collaborate and work together. The best utilisation and passing on of your skills will be dependent on this. To build relationships means taking an interest in Aboriginal people, their culture and lifestyle, as well as responding to the interest shown by Aboriginal people to your culture and lifestyle. Actively build these relationships with Aboriginal people by taking time to get to know people, to be amongst people so that they are comfortable with you and able to share information with you. Work to minimise the constraints of time, budgets and other commitments or priorities in order to maximise the building and consolidating of relationships.

Use the technology and resources you have, to bring you into more direct contact and to increase the frequency for communication among Aboriginal people, between Aboriginal people and yourself and service providers and funding bodies. Use the skills you have, share those skills and combine them with those of the Aboriginal people. Use a variety of processes to ensure there are a variety of channels for communication open and available.

Use your contacts, your influence and power to assist Aboriginal people to communicate their needs and agendas to the organisation you work for or to the appropriate service providers and funding organisations. Use processes that combine the skills of both cultures to ensure relevance to Aboriginal people and to the non Aboriginal people who are providing services. Document these processes to share them with a wider audience and to influence future decisions and developments.

6.5 Strategies for maximising opportunities and minimising constraints

It is important to work with what you have got and make the most of it, in any context, or under any model of service delivery. Try to grasp opportunities and minimise the constraints or obstacles that exist for the involvement and influence of Aboriginal people and the relevance of your practices. Apply the same strategies to the establishment of open and inclusive channels for communication between the Aboriginal people involved, yourself and other relevant service providers and funding bodies.

To develop this it is important that you get to know your context for practice. Try to learn about the environment, processes, resources and networks of the Aboriginal people, the funding bodies, service providers, and the organisation for which you work. In addition, develop relationships and networks and establish your credibility within this context. This will provide you with many different options and many different people with whom you can develop or negotiate strategies. Collaborate with Aboriginal people in negotiation of these strategies to ensure they meet their needs and agendas. Do this to ensure you use your power to increase the influence and control of Aboriginal people over the decisions that affect them.

It is important to work with people in finding their own solutions. Collaborate with the Aboriginal people you are working with in the development of strategies. They will provide direction as well as additional strategies and knowledge, skills, networks and resources and additional influence within the context. Take direction from the Aboriginal people particularly where pressure may be exerted by others or you do not understand the obstacles encountered.

Use this approach, in collaboration with Aboriginal people, when responding to the complex, constantly changing and challenging context in which you are working. Rather than viewing the context, change or challenge as right or wrong or good or bad, look for the opportunities for positive outcomes to be achieved while minimising any losses that may be incurred.

6.6 Linking with community development

In summary, when working within the conceptual framework of 'linking with community development', it is recommended that you, as the outsider :

Maximise the involvement and influence of the Aboriginal people for whom the service or project is provided. The needs and agendas of the range of individuals, groups and processes can shape your practices and the service or project.

Maximise your exposure and availability to the Aboriginal people, their environment and social context. This can influence your practices to be relevant to the needs and agendas of the individuals, groups and processes within their community.

Use a variety of communication channels which are open and inclusive in order to enhance ongoing interaction and dialogue between the Aboriginal people involved, yourself and other service providers and funding bodies. Choose an environment where Aboriginal people feel comfortable and empowered to contribute.

Use strategies to maximise opportunities and minimise constraints to enhance the involvement, influence and control of Aboriginal people over the process and the resources allocated. Use this approach, in collaboration with Aboriginal people, to respond to the context, the changing conditions and challenges encountered, to achieve or preserve positive outcomes and avoid or minimise losses or deficits, for community development.

Within a framework of linking with community development for the purpose of:

Linking with the individuals, groups and processes within a community in order to ground your practices in their needs and agendas. This will allow your skills and knowledge to be available, to contribute positively to community development.

CHAPTER 7

CONCLUSION

This study highlights the complex and dynamic nature of working as an outsider in remote Aboriginal communities of central Australia. It provides one interpretation of the experience according to one conceptual framework that emerged as relevant from the experience. It has drawn attention to patterns that emerged, but no attempt has been made to develop a theory.

Consistent with the aims of the study, the value of the study lies not only in the information it contains but in the style of presentation. The narratives provide some orientation for an AHP entering the field, or working in an alternative model. They also provide the opportunity for further interpretations of the data, according to categories relevant to the individual reader or categories drawn from the literature. The categories and the conceptual framework that emerged promote a method and framework for reflection for other outsiders working in the field and some practical ideas and approaches for their practice. For others it provides a starting point for their own framework that has meaning, relevance and guidance for their practice. Others may choose to apply this framework to their practice and then evaluate.

One of the major uses of grounded theory has been in preliminary and descriptive studies and has been considered a precursor for further investigation (Chanitz & Swanson 1986:7)

In any evaluation of AHP services to remote Aboriginal communities, it is important to record why services developed, how they developed and why subsequent changes were made. The descriptive and interpretive nature of this study provides that record. The study also provides scope for further investigation of AHP services as they develop in the future. As the study is emergent, it can form the first step or phase of an ongoing action research inquiry into the delivery of AHP services to remote Aboriginal communities of central Australia.

In the development of additional AHP services in remote Aboriginal communities, the importance of 'linking with community development' as a conceptual framework for practice,

lies in the guidelines and responsibilities for outsider practice. It provides a process and structure for working towards grounding the application of the AHPs professional skills in the needs and agendas of the individuals, groups and processes within a community. This framework and these categories can be used to guide the process for development of additional AHP services. Appropriate service structure and resource allocation can allow Aboriginal people maximum influence and control over the direction and process for their community development.

This study was motivated by the experience of working as an outsider in remote Aboriginal communities of central Australia. It gives expression to my experience and the gradual emergence of 'linking with community development' as a conceptual framework for my practice.

With so many unknowns and our belief in what is truly a known fact changing, the learner is left with the challenge of keeping his or her mind open to change and new learning while holding onto a flexible, not rigid, paradigm that allows that practitioner to comfortably evaluate and treat clients within a dynamic, ever changing environment'. Umphred (1995: ix)

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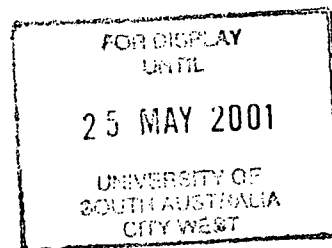
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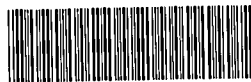
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