

Stories of Resilience:

Indigenous Alcohol and Other Drug Workers'
Wellbeing, Stress and Burnout



Ann Roche
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NCETA

Australia's National Research Centre
on AOD Workforce Development

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NCETA

The National Centre for Education and Training on Addiction is an internationally recognised research centre that works as a catalyst for change in the alcohol and other drugs (AOD) field.

Our mission is to advance the capacity of organisations and workers to respond to alcohol- and drug-related problems. Our core business is the promotion of workforce development (WFD) principles, research and evaluation of effective practices; investigating the prevalence and effect of alcohol and other drug use in society; and the development and evaluation of prevention and intervention programs, policy and resources for workplaces and organisations.

NCETA is based at Flinders University and is a collaboration between the University, the Australian Government Department of Health and Ageing and the SA Department of Health.

Dedication

In acknowledgement of the motivation and unrecognised contribution of Indigenous workers we would like to dedicate this report:

'To Kin and Country'

Kin - denotes kinship

Country - expresses the importance of country to all Indigenous people, as in 'my country' (not Australia as a whole).

Artwork

The artwork for the report, The Talking Stones, was specially designed for the project by Irene Allan.



Irene Allan is a descendant of the Tanganekald Clan from Kingston South East, South Australia. She has been painting and programming Stones to hold healing energy for over two decades. When held with faith and belief, the Stone empowers the mind to focus and attract positive thoughts.

The Talking Stone

Talking Stones are special stones used to facilitate sharing and communication in groups (talking circles). The person running a talking circle starts by holding the Talking Stone and acknowledging the ancestors and traditional owners of the land. They then pass the Talking Stone to the person on the left.



The Talking Stone is used to allow people to speak freely and to share what is on their mind. You only speak when you hold the Talking Stone. Anything that is personal must stay in the circle. The more you use the Talking Stone, the more energy it will hold. The Talking Stone will become very strong. It will be very powerful, trusting and sacred.

Preface

This project was funded by the Australian Government Department of Health and Ageing and was also endorsed by the Cooperative Research Centre for Aboriginal Health (CRAH) as an in-kind project.

The project involved several components including public submissions, a national online survey, site visits to undertake face-to-face interviews and focus groups, and a literature review addressing key issues. Major findings from the interviews and focus groups are presented here. Findings from the other components of the project are presented in separate reports:

- Duraisingam, V., Roche, A.M., Trifonoff, A., and Tovell, A. (2011). *Indigenous AOD Workers' Wellbeing, Stress, and Burnout: Findings from an online survey*. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide SA.
- Gleadle, F., Freeman, T., Duraisingam, V., Roche, A., Battams, S., Marshall, B., Tovell, A., Trifonoff, A., and Weetra, D. (2011). *Indigenous Alcohol and Drug Workforce Challenges: A literature review of issues related to Indigenous AOD workers' wellbeing, stress and burnout*. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide SA.

This project is part of a wider program of work by NCETA examining wellbeing, stress, and burnout among workers involved in the alcohol and other drug field. For details of related projects visit the NCETA website: www.nceta.flinders.edu.au.

Other publications in this wider program of work include the following:

- Skinner, N., & Roche, A. (2005). *Stress and burnout: A prevention handbook for the alcohol and other drugs workforce*.
- Duraisingam, V., Pidd, K., Roche, A.M., & O'Conner, J. (2006). *Satisfaction, stress and retention among alcohol and other drug workers in Australia*.
- Duraisingam, V., Roche, A.M., Pidd, K., Zoontjens, A., & Pollard, Y. (2007). *Wellbeing, stress, and burnout: A national survey of managers in alcohol and other drug treatment services*.

Copies of these resources are available from NCETA.

Acknowledgements

This report is part of a larger project on Indigenous Worker Wellbeing undertaken by the National Centre for Education and Training on Addiction and funded by the Australian Government Department of Health and Ageing.

This report was made possible by contributions from many people. Firstly and most importantly, we thank the participants for taking part in the focus group discussions and interviews without which this research would not have been possible. We gave participants the option to be acknowledged in this report. Here is the list of participants who wished to be acknowledged:

Rowena Albert	Jennifer Hayes	Tony Swain	Ms Sharon Drage
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Josephine Appoo	Leonie Jefferson	Caroline Swinton	Mr Mick Gooda - Cooperative Research Centre for Aboriginal Health
John Arber	Jillian Kantawarra	Mark Thompson	Mr Don Hayward - Drug and Alcohol Services South Australia
Nathan Aucote	Peter Kay	Nicholas Thompson	Ms Jacqui Malins - Australian Government Department of Health and Ageing
Mercy Baird	Jamie Key	Deni Tonkin	Ms Coralie Ober - Queensland Alcohol and Drug Research and Education Centre
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Grant Drage	Connie Nungarrayi-Walit	Byron Wright	
Grace Draham			
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Peter Harris	Rodney Robbins	Dr Colin Dillon - Queensland University of Technology	
Kristie Harrison	Fiona Ryan		
Phillip Hassall	Travis Shorey		
Lucia Hassett	Sylvia Solomon		
Geoffrey Hawkins	Annalee Stern		

How To Use This Document

This document contains a large amount of material on the views of Indigenous alcohol and other drug workers in regard to worker wellbeing. To help readers make practical use of this resource we have mapped out below some suggestions about how different groups of readers might be able to make best use of the material contained in this report.

For Frontline Workers

This report outlines a range of issues of relevance to the health and wellbeing of Indigenous alcohol and other drug frontline workers. It identifies issues that are likely to cause or contribute to levels of stress that may affect their wellbeing.

For frontline workers it is suggested that they might like to: spend some time with their work mates and colleagues to discuss issues in the report that apply to them personally; and form an informal support group. Having done that, look at the strategies contained in the report that are designed to help resolve some of these issues. See if some of these strategies might work for you. Discuss these with your work mates to identify how you might be able to bring some of these changes into effect.

For Managers

This report outlines issues that cause stress and “distress” for Indigenous alcohol and other drug workers, and that may have a substantial impact on their wellbeing. Such factors are also likely to impact on worker efficiency and retention. Many of the issues identified are amenable to change. Some will require resourcing. One suggestion is to work through the report and identify, in conjunction with your staff, key areas where improvements or changes could be made. Then, in collaboration with your Indigenous frontline workers, prioritise these areas for change and identify the strategies that you think might work best for you in your particular circumstances.

For Funders / Policy Makers

Many of the issues that affect worker wellbeing also have a substantial impact on the overall efficacy of the alcohol and other drug service delivery sector. It is in the interests of funders and policy makers to attend to those areas that impact on the delivery of quality care and best use of scarce resources. Several strategies are outlined in this report that if implemented, will not only improve worker wellbeing but also assist in the delivery of quality care to one of the population groups in Australia with the greatest level of need.

Stories of Resilience Team



Professor Ann Roche

Ann Roche is Professor and Director of the National Centre for Education and Training on Addiction at Flinders University. Ann instigated this project and was responsible for the project design, execution, and the writing of the final report.



Amanda Tovell

Amanda is a non-Indigenous woman who was born in rural Victoria and has spent most of her life living in South Australia, including Ceduna, Port Augusta and Adelaide. Amanda contributed to this project through undertaking interviews, data analysis, and report writing.



Donna Weetra

Donna commenced work with NCETA in June 2008 as the Aboriginal Project Officer for the Indigenous Worker Wellbeing, Stress and Burnout Project. Donna has experience conducting Aboriginal Health research and has expertise in a range of aspects of Aboriginal health research. She assisted in data collection, analysis, and report writing.



Nancy Bates

Nancy Bates joined NCETA in November 2009, to support the Indigenous Worker Wellbeing, Stress and Burnout Project as a Project Officer. Nancy has experiential knowledge through her professional roles with the Aboriginal communities of SA in the areas of Child Protection, Aged Care, and more recently with SA Link. Nancy ran workshops and assisted in data analysis and report writing.



Allan Trifonoff

Allan Trifonoff is the Deputy Director (Programs) at NCETA. He has extensive working across the health and law enforcement sectors in alcohol and other drug field. Allan commenced at NCETA in January 2008. He joined the Indigenous Worker Wellbeing, Stress and Burnout project team in March 2008 and was involved in data collection, analysis, and report writing.



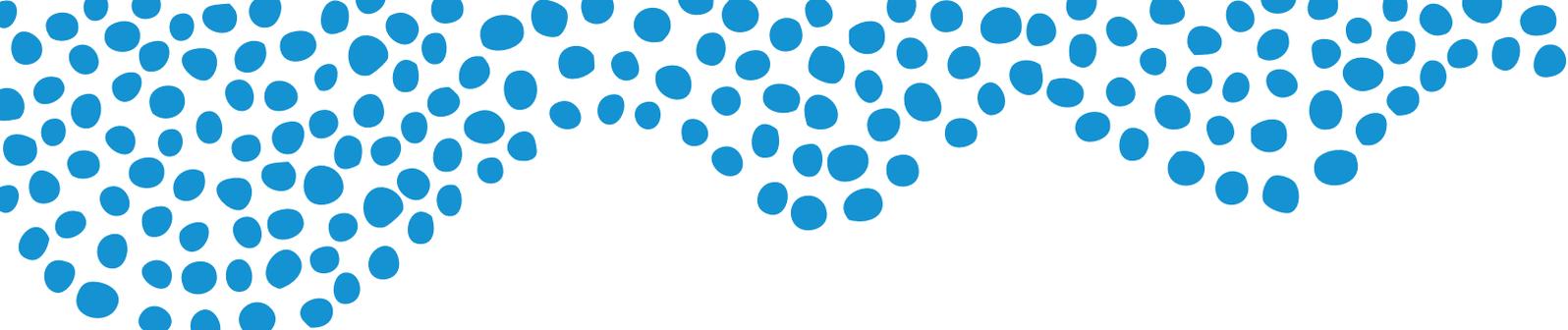
Toby Freeman

Dr Toby Freeman was a Research Officer on this project. He contributed to the development of ethics applications, interview protocols, and data analysis.



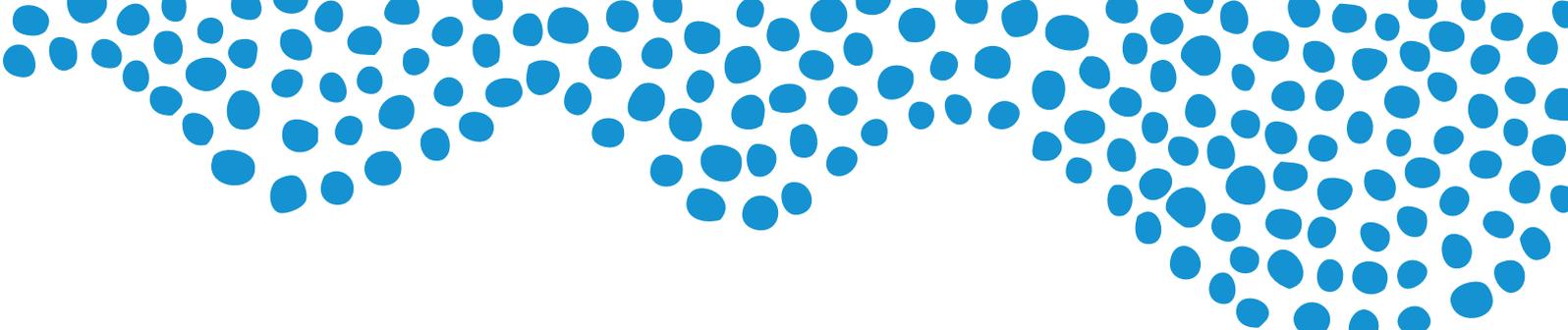
Tania Steenson

Tania Steenson joined NCETA in March 2007 as a Project Officer. Tania provided administrative support for the project team for the last 12 months of the project.



A Note on the Terminology Used in This Document

Aboriginal and Torres Strait Islander peoples have diverse languages, cultures, and communities, and live in urban, rural, and remote settings. Many of these groups seek to maintain their particular cultural identity and preferred names as distinct from others. For the purposes of this report, and in recognition of this diversity, we have opted to use the term “Indigenous” Australians as a way of acknowledging all Australian Aboriginal and Torres Strait Islander groups, except where other terms were used by project participants in which case the authenticity of their words has been retained. We are, however, aware that this terminology has limitations.



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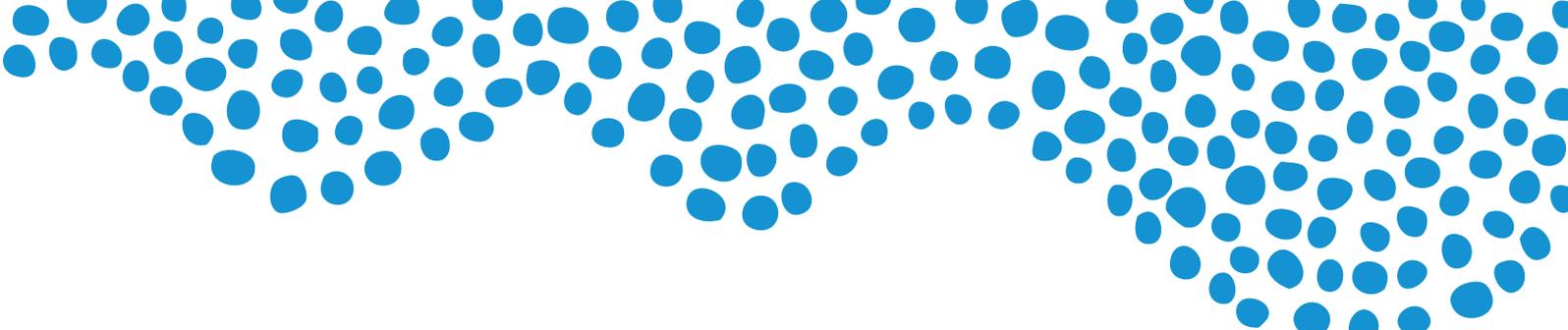
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Executive Summary

This project is part of a larger workforce development (WFD) program of work undertaken by the National Centre for Education and Training on Addiction (NCETA) that has examined a range of key WFD issues impacting the alcohol and other drugs workforce in Australia. The project focused on Indigenous alcohol and other drug worker wellbeing and extends NCETA's previous examination of stress and burnout among alcohol and drug workers in general. It also complements parallel projects undertaken by the Cooperative Research Centre in Aboriginal Health (CRAH) in relation to social and emotional wellbeing (Kelly et al., 2009).

This project was funded by the Australian Government Department of Health and Ageing and was also endorsed by CRAH as an in-kind project.

Background

Alcohol and other drug work does not stand in isolation. Well documented associations exist between alcohol and other drug use and domestic violence, child abuse, juvenile crime, assaults and other criminal activities, as well as health issues such as injuries, diabetes, heart disease, cancers, stroke, and mental health. Alcohol and other drug use can also contribute to economic impoverishment, where household incomes are spent on alcohol or other substances, and not food or household bills. It may also negatively impact on an individual's employment status and may increase risk of incarceration.

Added to these complexities is the uniqueness of the Indigenous alcohol and other drug worker's client base. Relatedness, obligatory rites associated with culture and lore, and the social connections within families and communities makes alcohol and other drug issues especially challenging for Indigenous workers.

The role of Indigenous healthcare and alcohol and other drug workers has been described as difficult,

demanding and poorly paid, and often considered unrewarding (Gray, Haines, & Watts, 2004). While there is general acknowledgement of the challenges encountered by this crucial workforce, there has been relatively little examination of the work-related stressors they experience and the impact that this has on their overall health and wellbeing.

This project was undertaken to address this gap in our knowledge, to provide Indigenous alcohol and other drug workers with a voice and to identify strategies that might be used as levers for change and improvement.

The Program of Work

This report is part of a series of three reports stemming from the project examining Indigenous alcohol and other drug worker wellbeing.

The principal aims of this project were to identify and understand Indigenous alcohol and other drug workers' experiences and perspectives on wellbeing, stress and burnout. The longer term aim was to develop the capacity of alcohol and other drug workers and service providers to improve Indigenous workers' wellbeing.

The full project entailed several discrete components:

1. a literature review
2. an online survey¹ and call for submissions²

1 An online survey conducted in 2008 of Indigenous and non-Indigenous alcohol and other drug workers examined levels of stress and wellbeing and their contributory factors. Two hundred and ninety four (294) alcohol and other drug workers (184 (62%) Indigenous and 108 (37%) non-Indigenous) completed the survey. Results are presented in a separate report (Duraisingam, Roche, Trifonoff, & Tovell, 2010).

2 Submissions were invited (April-June 2008) from relevant stakeholders (e.g. managers and frontline workers) in alcohol and other drug treatment agencies, government and non-government health services, community-controlled organisations and representatives from Indigenous communities and peak bodies.

Executive Summary

3. interviews and focus groups with alcohol and other drug workers.

Three separate reports have been prepared, corresponding with the separate components of the project. This report presents the findings from the third part of the project, that is, the interviews and focus groups conducted with Indigenous and non-Indigenous workers.

This Project

The project had a national focus and involved face-to-face interviews and focus groups with 156 participants from diverse geographical locations including capital cities, regional, rural and remote locations. Participants came from all states and territories (except the ACT and Tasmania). Of the 156 participants, 96 were Indigenous and 29 were non-Indigenous (the Indigenous status of the remainder was unknown). Thirty-five individual interviews were held (with 26 Indigenous and 9 non-Indigenous participants), and 17 focus groups (involving 121 participants).

The focus of this research was on Indigenous alcohol and other drug workers' stories in relation to worker wellbeing, stress and burnout. It examined the factors and strategies that supported resilience and fostered the ability to deal with difficult and challenging circumstances. Key aims were to develop an understanding of work-related factors that acted as stressors, and conversely factors that enhanced wellbeing and social inclusion, by learning from the experiences of Indigenous alcohol and other drug workers.

The approach taken was based on strategies to enable Indigenous workers' ideas, stories, and experiences to be freely shared.

Wellbeing

There are various definitions of wellbeing. A number of these have been developed by Indigenous groups to reflect a comprehensive view of health and wellbeing from an Indigenous perspective. Wellbeing does not just refer to the presence or absence of an illness or disease but rather covers the wellness or positive state of an individual (Pink & Allbon, 2008).

The National Aboriginal Health Strategy (NAHS) defined health as:

“Not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.”

(Office for Aboriginal and Torres Strait Islander Health, 1989)

The definition applied in this project incorporated elements at the individual level (i.e., physical, emotional, psychological and spiritual) and at the broader level comprising the social, material, and natural environments.

Work-related Stress

Stress is experienced when individuals feel unable to cope with the demands placed upon them (Farmer, Clancy, Oyefeso, & Rassool, 2002). Work stress refers to psychological, physical and behavioural responses to work-related demands over a discrete or short-term period (Dollard, Winefield, & Winefield, 2003). Burnout is qualitatively distinct to stress (but may include signs and symptoms of stress). Burnout is a long-term process characterised by “chronic malfunctioning” and negative and cynical attitudes towards clients and work in general (Maslach, Schaufeli, & Leiter, 2001).

Prolonged exposure to stressful working conditions and job demands can result in worker burnout over time. Workers in the health and human services field, and those involved in emotional labour, including Indigenous alcohol and other drug workers, often experience high levels of work-related demands and stressors, and are particularly vulnerable to stress and burnout (Dollard et al., 2003; Dollard, Winefield, & Winefield, 2001; Dollard, Winefield, Winefield, & de Jonge, 2000). Alcohol and other drug workers are also vulnerable to vicarious trauma that stems from the nature of the work they undertake. This manifests in higher levels of Post Traumatic Stress Disorder (PTSD) and a phenomenon described as compassion fatigue (Fahy, 2007).

In addition, Indigenous people experience increased threats to their social and emotional wellbeing (SEWB) (Kelly, Dudgeon, Gee, & Glaskin, 2009) from factors, that are only now beginning to be understood, such as:

- unresolved grief and loss
- trauma and abuse
- domestic violence
- substance misuse
- physical health problems

- identity issues
- child removals
- incarceration
- family breakdown
- cultural dislocation
- racism, discrimination and social disadvantage.

This project represents a small contribution to the extension of knowledge in relation to Indigenous alcohol and other drug workers' wellbeing, stress and burnout.

Key Findings

Participants in this project identified many potential sources of stress that threatened their wellbeing. However, it is important at the outset to highlight two outstanding characteristics of Indigenous alcohol and other drug workers:

1. their principal motivation was to improve the health and wellbeing of their community with whom they felt unified in heart and spirit
2. they felt great reward and satisfaction from the work they did, in spite of the stress, pressure and demands placed on them and the conditions under which they were often forced to work.

"First thing, always for me, is to help my people."
[FG12; M; Ind; R/R]

Rewarding aspects of Indigenous alcohol and other drug work included:

- Being connected to community and building relationships
- Reciprocity – both the receipt and giving of knowledge
- Advocating on behalf of communities and peers
- Mentoring and training Indigenous (and non-Indigenous) colleagues
- Creating new services and opportunities for communities and peers
- Ensuring non-Indigenous organisations and peers work in culturally accountable ways with Indigenous people
- Partaking in decision-making and problem-resolution processes
- Engaging in ethical employment within the Indigenous community.

"People come in broken, they walk out fixed."
[Int12; M; Ind; Met]

Workers also expressed satisfaction in seeing health service delivery models adapt to become more responsive to Indigenous ways of working and to Indigenous clients' needs. There was also a strong sense of pride and achievement in being part of solutions to improve Indigenous health and increase access to services.

The close family and community bonds that typify Indigenous Australians were a great source of strength and resilience, as was sharing their culture with younger members of their community and teaching cultural ways. Maintaining family bonds and telling and hearing their stories were key elements in workers' spiritual wellbeing. Laughter and humour was also regarded as an essential strategy to remain positive and resilient.

Sources of Stress

Participants also exhibited a growing level of awareness about work-related stress. Many talked about pro-active strategies to prevent stress or deal with it in its early stages of development. The role of the workplace in helping to prevent, reduce or manage stress and stressors was also acknowledged.

Stress originated from various sources including:

- living and working in the community
- being available 24/7
- effects of loss and grief, and sorry business, and
- dealing with culturally insensitive, and sometimes racist, staff, management, and external organisations.

Overall, 10 major sources of work-related stress were identified that were particularly relevant to Indigenous alcohol and other drug workers (see Table 1.). These ranged from excessive work loads and extensive 24/7 demands and expectations with little "down time", through to issues related to lack of recognition, inadequate reward (including exceptionally low salaries) and pervasive stigma and racism. Compounding these stressors were workers' complex personal circumstances (where alcohol and drugs may be involved), often profound levels of loss and grief and a lack of culturally safe working environments.

Juxtaposed with the 10 key sources of stress were 10 pivotal workforce development (WFD) strategies (see Table 2.). These WFD strategies were identified as critical mechanisms that could be employed to relieve or ameliorate the stresses experienced by Indigenous alcohol and other drug workers.

Executive Summary

Many of the WFD strategies identified can be implemented with relative ease and little expense. Some, for example, require straightforward changes to policies and procedures. Others, however, are more complex and will require an infusion of funds and other forms of resourcing to make change possible. A range of entrenched issues was identified that will take considerably longer to address and will require complex and multi-level interventions. Some of the latter issues also relate to ingrained views that are either racist, discriminatory or inadvertently act to diminish the wellbeing of Indigenous workers.

In spite of a wide range of stressors and complex demands placed on them, many Indigenous alcohol and other drug workers were also found to be remarkably resilient in the face of extreme pressure. Many had developed a variety of stress management strategies that enabled them to deal with the pressures of their work roles. Some of these are indicated in Table 3 and are grouped according to five domains: traditional, recreational, social, domestic/personal, and work-related.

An important range of strategies was identified that organisations and agencies could put in place to help reduce and relieve the level of stress experienced by their workers. It is of crucial importance to appreciate that much work-related stress originates with the structures and systems within which workers operate. It is therefore vital that change occurs at these levels. Participants' suggestions for changes are listed in Table 4.

Organisational Strategies

Workers also identified initiatives that could be adopted at the organisational level to decrease stress. Some initiatives focused on team building and ensuring that workers felt respected and supported within the workplace. Other proposals were broader and involved proactive workplace strategies to address inequalities experienced by Indigenous workers.

Reflecting the distinctive nature of the stressors and constraints confronting Indigenous workers, interviewees identified that workplaces needed to:

- adopt more flexible working conditions
- regularly consult with staff about their workloads and working conditions
- augment workers' skills by providing opportunities for learning and ongoing professional development
- coordinate with other services to streamline administrative and clinical processes, as well as to provide greater networking opportunities
- provide employees with incentives to help them manage and reduce their stress levels, and redress systemic inequalities.

Overall, this project has captured both the joy and distress involved in being an Indigenous alcohol and other drug worker. High levels of unrelenting pressure and workload are issues that warrant immediate attention and are readily resolved through increased funding to expand this workforce.

Indigenous workers have privileged access to and acceptance by communities beset by alcohol and other drug and associated health and social problems. This unique workforce is an exceptional resource that is ideally placed to make a major contribution to the resolution of many Indigenous healthcare issues and to "Closing the Gap". Yet, they remain under-funded, under-resourced and their significant contribution is under-recognised.

The standout issues and related strategies to address are:

1. the imperative to reduce the work load, most readily achieved by the appointment of more staff
2. the need for better and more rewards and recognition especially of the unique work that Indigenous alcohol and other drug workers undertake that cannot be replicated by other members of the workforce
3. provision of support to overcome various forms of isolation experienced by workers
4. tackling stigma and racism and increasing the level of perceived "deservingness" of Indigenous alcohol and other drug workers and their clients
5. acceptance and accommodation of Indigenous ways of working.

A key feature of the Indigenous alcohol and other drug workforce is their unique ability to influence the health status of the most compromised groups in Australia today. There is great scope to more appropriately recognise the invaluable contribution made by these dedicated and hard working professionals.

Table 1. Ten Principal Contributors to Work-related Stress Among Indigenous Alcohol and Other Drug Workers

Factors	Descriptor
1. Workloads	Workloads were invariably high and not commensurate with the resources available to meet the needs.
2. Expectations	Workers consistently demonstrated high levels of personal commitment to their work role and their community. In addition, there is a complex set of community obligations that workers need to fulfil.
3. Boundaries	Many workers saw being available 24/7 as part of a cultural obligation; others were increasingly learning to place appropriate limits and boundaries in culturally secure ways to prevent burnout.
4. Recognition, Respect and Support	Workers reported that recognition or respect was often not afforded to them. They also were often solo or isolated workers with insufficient support.
5. Working Conditions	Difficult and stressful working conditions were common, especially among workers in rural and remote settings.
6. Racism and Stigma	High levels of stigma were associated not only with alcohol and other drug work but also the Aboriginality of the clients and the workers. Racism was commonly experienced from co-workers and mainstream community and constituted a major source of stress.
7. Complex Personal Circumstances	Many workers were single parents or responsible for dependent children, elderly and other family members. Many had experienced significant bereavements, domestic violence, and previous problems with alcohol or drugs. Family members were also often alcohol and other drug clients.
8. Loss and Grief and Sorry Business	Heavy community losses through premature deaths including suicides. Traditional bereavement leave was rarely adequate. The importance of Sorry Business, and loss overall, was also often not understood.
9. Culturally Safe Ways to Work	Although noted to be improving, there was a significant lack of understanding about Indigenous ways of working. This created regular conflict and clashes with mainstream colleagues and services and undermined the health and wellbeing of both clients and workers.
10. Funding, Job Security and Salaries	Short term funding and short term appointments with low salaries contributed to high stress levels and high turnover rates.

Table 2. Ten Principal Workforce Development Strategies to Facilitate Indigenous Alcohol and Other Drug Worker Wellbeing and Reduce Work-Related Stress

Factor	Descriptor	Response Strategies
1. Capacity Building	Building capacity of workers, organisations and communities to provide culturally appropriate (Indigenous) and culturally safe (mainstream) alcohol and other drug services is a crucial social determinant of health.	Address organisational funding issues to provide continuity of funding, provide sufficient funds to allow appointment of adequate numbers of staff, implement appropriate workforce planning, and management and leadership training programs.
2. Salary	Recognition of work demands and the unique role played by this workforce to improving the overall health status of Indigenous people through more equitable salaries across all sectors.	A move to parity of salaries for all levels of staff across all sectors including government, community controlled and non-government health services.
3. Recruitment, Retention and Turnover	Complex and difficult work and employment conditions, especially in remote areas, create a constant strain on alcohol and other drug workers and acts to discourage new recruits from entering the field and fuels high turnover.	Promote a positive image of the alcohol and other drug field. Recruit Indigenous high school students into tertiary education pre-employment workshops, support for literacy and numeracy, pre-vocational and introductory courses, job rotations, and flexible traineeship and apprenticeship on-the-job programs that involve managers in additional responsibilities.
4. Career Paths	Lack of career pathways and opportunities for professional advancement for Indigenous people in alcohol and other drug work was commonplace and compounded recruitment and retention challenges.	Create new staffing categories that workers can aspire to that provide incentives and promotional and further skill development opportunities.
5. Role Clarity	Very broad and overly inclusive roles and lack of role clarity were common.	Better definition of workers' roles within their organisations are required. Provide resources to support workers through clinical supervision, mentoring and debriefing could be achieved at relatively low cost.
6. Qualifications and Training Issues	Alcohol and other drug workers often did not have sufficient alcohol and other drug knowledge or adequate access to training. Training at higher levels was also sought.	Extend the focus beyond the Indigenous workers at the level of Certificate III and Certificate IV and provide management training.
7. Mentoring	Mentoring was recognised as a valuable professional development tool.	Implement mentoring as a standard support strategy.
8. Clinical Supervision	Clinical supervision was recognised as an effective strategy to prevent or manage stress but was not widely implemented.	Implement clinical supervision as a standard strategy to prevent or manage stress. Develop Indigenous-specific clinical supervision guidelines for the alcohol and other drug sector.

Table 2. (continued)

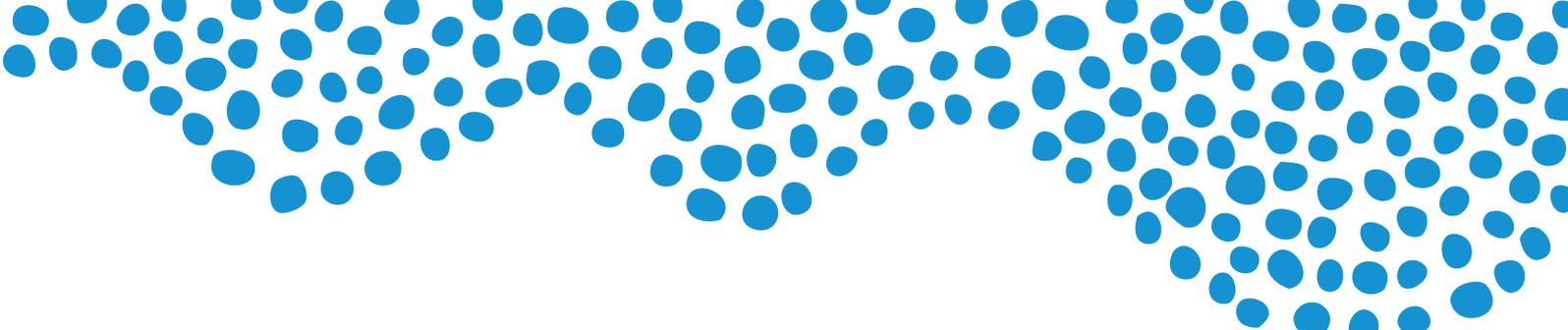
Factor	Descriptor	Response Strategies
9. Debriefing	Debriefing was recognised as an effective mechanism to reduce stress; however, debriefing opportunities and preferences were highly varied and were often found to be non-existent.	Identify and promote various forms and sources of debriefing suitable for Indigenous workers and their working contexts.
10. Team and Co-Worker Support	The need for diverse forms of support for workers was a priority.	Provide worker support at various levels and in various forms including mentoring, clinical supervision, formal and informal debriefing opportunities as well as recognition of good work.

Table 3. Individual Stress Management Techniques Identified by Participants

Traditional	<ul style="list-style-type: none"> • Take time out to participate in a traditional activity • Go home to community • Practice your spiritual understanding of the world
Recreational	<ul style="list-style-type: none"> • Take time out to participate in an enjoyable activity • Listen to music • Meditation, yoga, breathing exercises • Go for a walk with a friend/dog • Have a regular massage
Social	<ul style="list-style-type: none"> • Share knowledge; learn new things • Have a close personal support network • Spend time with family • Visit friends • Eat well, go out for dinner • Laugh
Domestic/Personal	<ul style="list-style-type: none"> • Take a nap • Turn off phone, lights, TV; spend time alone • Do not answer the door • Enjoy a movie or favourite TV show • Go for a long drive • Gardening • Have regular medical checks • Practice healthy living (i.e., do not smoke, drink, use illicit drugs)
Work-related	<ul style="list-style-type: none"> • Have a coffee and debrief informally with work mates • Have a routine • Take one day at a time • Consider things from another perspective • Accept your limitations • Look forward to the end of the working day; do not take work home

Table 4. Strategies Suggested by Participants for Organisations to Implement

1.	Provide training that focuses on stress management techniques
2.	Offer pampering sessions to staff (e.g., neck massages)
3.	Allow staff to take cultural leave, including taking time off for sorry business and funeral leave to enable them to be able to grieve properly
4.	Provide Rostered Days Off (RDO) for case managers if they have worked on the weekend or done overtime
5.	Provide staff with flexible working arrangements
6.	Support access to professional development
7.	Ensure provision of clinical supervision, ideally with external providers
8.	Provide appropriate debriefing
9.	Encourage and foster collegial support
10.	Facilitate professional and social networks
11.	Acknowledge the work and achievements of staff
12.	Provide staff with an extra week's paid leave at Christmas as an added bonus
13.	Provide staff with a number of training opportunities e.g., First Aid, conflict resolution
14.	Pay for workshops and all training costs
15.	Create informal networks with other nearby health workers for debriefing and support - formalised with Memoranda of Understanding (MOU), have organisational policy, make a commitment to support time and other resources required for worker to participate in these networks
16.	Schedule training opportunities in regional areas to have a weekend before or after



Chapter 1: Introduction

“There is strong evidence that the expanding expectation and increasing responsibility on the small number of Indigenous community workers is leading to burnout and gaps in much needed services. Specified job requirements do not consider the small number of Indigenous workers attempting to meet the extent of the demands of a disadvantaged community...”

(Parliament of Victoria, 2006, p. 1008)

The role of the Indigenous healthcare worker, including alcohol and other drug workers, has been described as difficult, demanding and poorly paid, and often considered unrewarding (Gray et al., 2004). While there is general acknowledgement of the challenges encountered by this crucial workforce, there has been relatively little examination of the work-related stressors they experience and the impact that this has on their overall health and wellbeing. This project was undertaken to address this gap in our knowledge, to provide Indigenous alcohol and other drug workers with a voice and to identify strategies that might be used as levers for change and improvement.

Background

It was only as recently as 1962 that Indigenous Australians were recognised as citizens with their right to vote subsequently recognised in 1967. Some maintain that to this day, Indigenous Australians remain citizens with limited rights (Chesterman & Galligan, 1997) and severely compromised status in many respects. This is reflected in insufficient involvement setting policy, service design and program implementation. It is also evident in the disproportionately small number of Indigenous workers in key health areas.

“The recent history of ... Aboriginal and Torres Strait Islander communities, is one of loss of land (often accompanied by violence), forced removal, and detention of differing clans in missions and reserves, with consequent loss of culture, autonomy, identity and life skills. Many patients come from such traumatised family backgrounds. Dealing constantly with traumatised patients and the resulting problems of unemployment, poor education, substance misuse and violence can become a threat to the wellbeing of staff.”

(Panaretto & Wenitong, 2006, p. 528)

Some hold that change can only be brought about through creating a greater sense of control over one's life and through self determination (Keel, 2004), and not through increased levels of external controls. Much initiative for change is still driven by those who hold resources and power, further reinforcing cycles of marginalisation. Involvement in decision making is a crucial part of the empowerment process. This project aimed to allow the voices of Indigenous workers to be heard and their experiences to be better understood.

The Indigenous Workforce

Indigenous workers who respond to alcohol and other drug issues are the focus of this project. This workforce includes Aboriginal Health Workers, Aboriginal Mental Health Workers, and Aboriginal liaison officers, as well as Indigenous doctors, nurses, community health workers, social workers, drug and alcohol clinicians, and mobile patrol staff.

The size of this workforce is difficult to estimate. The number of (Indigenous and non-Indigenous) workers in specialist alcohol and other drug agencies in 2003 was estimated at 10,190 (Roche, 2008). However, this does not account for general or allied health organisations such as hospitals or community health centres. The workforce that responds to alcohol and other drug issues is consequently much larger.

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In 2009 (Australian Institute of Health and Welfare, 2009) it was estimated that the number of Indigenous people employed in health and community services had increased from 9,307 to 15,005 (see Table 5). This is a substantial increase but represents only a shift from 1.4% to 1.8% of all workers in these occupations. While encouraging, it is still a significant shortfall in terms of the 3% of the population that Indigenous people represent.

There is clearly a large shortfall in the number of Indigenous healthcare workers resulting in an excessively heavy load on available workers. This places tremendous pressure on Indigenous workers employed in key health roles.

The disproportionately heavy workload of Indigenous healthcare workers is also problematic for Indigenous

doctors and other health workers who choose to work in Aboriginal Community Controlled Health Services to support their community (Panaretto & Wenitong, 2006). The total number of Indigenous doctors has been steadily increasing and currently there are around 140 doctors and 137 Indigenous medical students (AIDA, 2009).

The majority of Indigenous workers in the health sector are employed as Aboriginal Health Workers or nurses. The role of Aboriginal Health Workers is not consistent across jurisdictions and organisations. They may undertake clinical, transport, liaison, or advocacy functions, and have differing levels of clinical training (Australian Government Department of Health and Ageing, 2008; Genat, Bushby, McGuire et al., 2006).

Table 5. Indigenous People Employed in Health and Community Service Occupations in 2001 and 2006 (modified from Australian Institute of Health and Welfare, 2009)

Occupation	2001			2006		
	Indigenous	All persons	% Indigenous	Indigenous	All persons	% Indigenous
Aboriginal and Torres Strait Islander health workers	853	916	93.4	967	1012	96.2
Other health workers/managers	1,166	90,267	1.3	2,222	131,142	1.7
Other community services	1,136	18,595	6.2	3,030	33,016	9.2
Community Services Total	5,484	217,018	2.5	9,467	294,234	3.2
Health Total	3,823	446,722	0.9	5,538	548,384	1.0
Complete Total	9,307	663,740	1.4	15,005	842,615	1.8

Rural & Remote Indigenous Alcohol and Other Drug Workers

A large proportion of Indigenous alcohol and other drug workers are located in rural and remote areas. Indigenous workers in rural and remote communities experience unique working conditions that impact on their wellbeing. Workers in these areas characteristically encounter geographical, environmental and cultural differences that create unique challenges. Given that living in rural and remote areas of Australia presents special challenges, workers in these areas were of particular interest to this project.

Working remotely means that alcohol and other drug, medical, and policing supports are often significantly distant from the community, creating a burden for Indigenous workers who are endeavouring to provide services. Living and working in remote communities intensifies being “on-call 24/7”, and professional / personal boundaries become blurred. Access to training and support for workers is difficult and arranging transport for both clients and workers is an arduous task.

Workers in rural and remote communities require additional resources to cope with the isolation, travel and long distance communication. Droughts, floods, cyclones, and dust storms are some of the environmental hazards for those who “work out bush”. In these areas, English is more often a second language, and cultural practices require specified knowledge of laws and customs pertaining to individual communities.

Nonetheless, living in rural and remote areas has also been found to be associated with higher levels of wellbeing for Indigenous people (Kelly et al., 2009).

Wellbeing

There are various definitions of wellbeing, and a number of these have been developed by Indigenous groups in an attempt to capture a comprehensive view of health and wellbeing from an Indigenous perspective. It is generally agreed that the concept of wellbeing does not just refer to the presence or absence of an illness or disease but rather extends to cover the wellness or positive state of an individual (Pink & Allbon, 2008).

For example, Trewin (2001) defined wellbeing as “... a state of health and sufficiency in all aspects of life” (p. 6). This definition incorporated elements at the individual level (i.e., physical, emotional, psychological and spiritual) and at the broader level comprising

the social, material, and natural environments that surround each person. The National Aboriginal Health Strategy (NAHS) defined health as:

“Not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.”

(Office for Aboriginal and Torres Strait Islander Health, 1989)

The South Australian Aboriginal Health Partnership (2005) described a high level of social and emotional wellbeing as:

“... living in a community where everyone feels good about the way they live and the way they feel. Key factors in achieving this include connectedness to family and community, control over one’s environment and exercising power of choice.”

(South Australian Aboriginal Health Partnership, 2005, p. 6).

Thus, from an Indigenous perspective, wellbeing encompasses not just the individual but also the health and wellbeing of the family and wider community. This concept of wellbeing stands in contrast to Western medical notions of health equalling freedom from disease (Brady, 2001).

An important area of life that contributes to a person’s wellbeing is their work, namely, how satisfying and rewarding work is at an economic and non-economic level (Trewin, 2001). More specifically, occupational or workplace wellbeing can be seen as a positive, subjective evaluation of the different aspects of one’s job, including affective, motivational, behavioural, cognitive and psychosomatic dimensions (Van Horn, Taris, Schaufeli, & Schreurs, 2004).

Stress and Burnout

Stress and burnout indicate a set of affective, behavioural and cognitive symptoms that reflect both short- and long-term physical and emotional strain in the workplace (Price & Spence, 1994). Thus, if an Indigenous alcohol and other drug worker is experiencing high levels of stress, it means that their wellbeing has been negatively affected.

High levels of non-specific psychological distress have been reported by Indigenous Australians. The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2004–05 indicates that while the majority of

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Indigenous adult respondents reported only low levels of psychological distress, more than a quarter reported serious psychological distress and were twice as likely to do so compared to other Australians.

A recent report (Kelly et al., 2009) on the social and emotional wellbeing (SEWB) of Indigenous Australians examined the determinants Indigenous people have identified as impacting on their SEWB. These included:

- unresolved grief and loss
- trauma and abuse
- domestic violence
- substance misuse
- physical health problems
- identity issues
- child removals
- incarceration
- family breakdown
- cultural dislocation
- racism
- discrimination and social disadvantage.

A complex array of environmental, social, economic, cultural, and historical factors contribute to the SEWB of Indigenous people. A similar set of factors also impact on the wellbeing of Indigenous workers.

Negative outcomes from serious psychological distress include suicide and intentional self harm; anger and aggression; problem gambling; and smoking. Systemic discrimination is also now seen as a determinant of serious psychological distress among Indigenous people and a barrier to those seeking access to support services to cope with distress.

In addition to the risk factors listed above, a number of important strengths or protective factors have been identified, such as social cohesion, a sense of positive wellbeing and resilience, and connection to land, culture, spirituality and ancestry. At present, this is an under-researched area. Kelly et al. (2009) maintain that further research is needed to gain a better understanding of the nature and impact of protective factors related to SEWB.

The current project represents a small contribution to the extension of knowledge and understanding in this area with a particular focus on factors that act as stressors on Indigenous alcohol and other drug workers.

Stress is experienced when individuals feel unable to cope with the demands placed upon them (Farmer

et al., 2002). More specifically, work stress refers to psychological, physical and behavioural responses to work-related demands over a discrete or short-term period (Dollard et al., 2003).

The state of burnout is qualitatively distinct to stress. Burnout may include some of the signs and symptoms of stress, but it also has its own features over and above stress reactions. Burnout is a long-term process characterised by “chronic malfunctioning” and negative and cynical attitudes towards clients and work in general (Maslach et al., 2001).

Three core dimensions of burnout have been identified:

- emotional exhaustion (feeling overextended and drained of emotional and physical resources)
- depersonalisation (negative, detached or cynical view of one’s work)
- reduced personal accomplishment (low sense of achievement, feelings of incompetence, low self efficacy)

(Maslach et al., 2001).

Prolonged exposure to stressful working conditions and job demands can result in worker burnout over time. The symptoms of stress and burnout may differ but similar factors contribute to both outcomes. It is increasingly acknowledged that workers in the health and human services field often experience high levels of work-related demands and stressors, and are therefore particularly vulnerable to stress and burnout (Dollard et al., 2003; Dollard et al., 2001; Dollard et al., 2000).

Similarly, alcohol and other drug workers face many significant challenges related to:

- the client population (complex circumstances, stigmatisation of drug use, reluctance to engage in treatment)
- community attitudes towards drug users (and the people who work with them)
- the need to continually develop and refresh knowledge and skills to manage changing treatments and complex client presentations (e.g., poly drug use)
- working conditions (e.g., remuneration, availability of professional development, job security, access to clinical supervision, client workloads)

(Knudsen, Johnson, & Roman, 2003; Pierce & Long, 2002; Pitts, 2001; Roche, 2002; Roche & Pidd, 2010; Skinner, Feather, Freeman, & Roche, 2007).

Research findings indicate that stress is a significant issue for the alcohol and other drug workforce. For example, an NCETA national survey found that almost one in five frontline alcohol and other drug workers experienced high stress levels, which contributed to lower job satisfaction and an increased likelihood of leaving their job (Duraisingam, Pidd, Roche, & O'Connor, 2006). Recent research has also found high levels of Post Traumatic Stress Disorder (PTSD) among alcohol and other drug workers stemming from vicarious trauma (Fahy, 2007). Alcohol and other drug workers, like other workers involved in emotional labour, also experience compassion fatigue. Anecdotal

evidence suggests that stress for alcohol and other drug Indigenous workers is likely to be substantially greater than that experienced by their non-Indigenous counterparts.

In the first study examining the rate of burnout among alcohol and other drug managers in Australia, Duraisingam et al. (2007) found that nearly a third of managers experienced an elevated level of stress, and 8% experienced a very high level of burnout. The extent of burnout among Indigenous alcohol and other drug workers in Australia is still unknown but anecdotal indicators suggest that it is high.

Substance Use/Abuse as a Risk Factor

The following excerpt from the CRC for Aboriginal Health report on Social and Emotional Wellbeing (Kelly et al., 2009) highlights the elevated risks associated with alcohol and other drug use that Indigenous Australians experience and they have important implications for the role of the Indigenous workers in this sector.

- Indigenous Australians appeared to be exposed to a range of risks to social and emotional wellbeing and the development of serious psychological distress not experienced by other Australians.
- Indigenous people were taken into custody for public drunkenness at 43 times the rate of other Australians in 2002, median length of time spent in custody being six hours (AIHW, 2008).
- Mental and behavioural disorders due to psychoactive substance use were the most common mental health conditions for which Indigenous people were hospitalised (AIHW, 2008). Indigenous males and females were hospitalised for diagnoses related to alcohol use at five and three times respectively the rate of other Australians.
- Indigenous Australians were hospitalised for acute alcohol intoxication at eight times the rate of other Australians, for withdrawal states at 10 times the rate and for alcoholic liver disease and accidental poisoning by alcohol at five times the rate of other Australians (AIHW, 2008).
- Indigenous Australians died from mental and behavioural disorders due to alcohol use at 10 times the rate of non-Indigenous Australians, from alcoholic liver disease at eight times the rate and from poisoning by alcohol at nine times the rate of others.
- Indigenous Australians were hospitalised for mental and behavioural disorders from use of volatile substances at around 32 times the rate of others (AIHW, 2008).

Indigenous people who use/abuse alcohol and illicit drugs are exposed to a range of risk factors to health and SEWB experienced at a higher rate compared to other Australians, including: police custody, alcoholic poisoning, addiction, withdrawal states, liver disease, hospitalisation and preventable mortality.

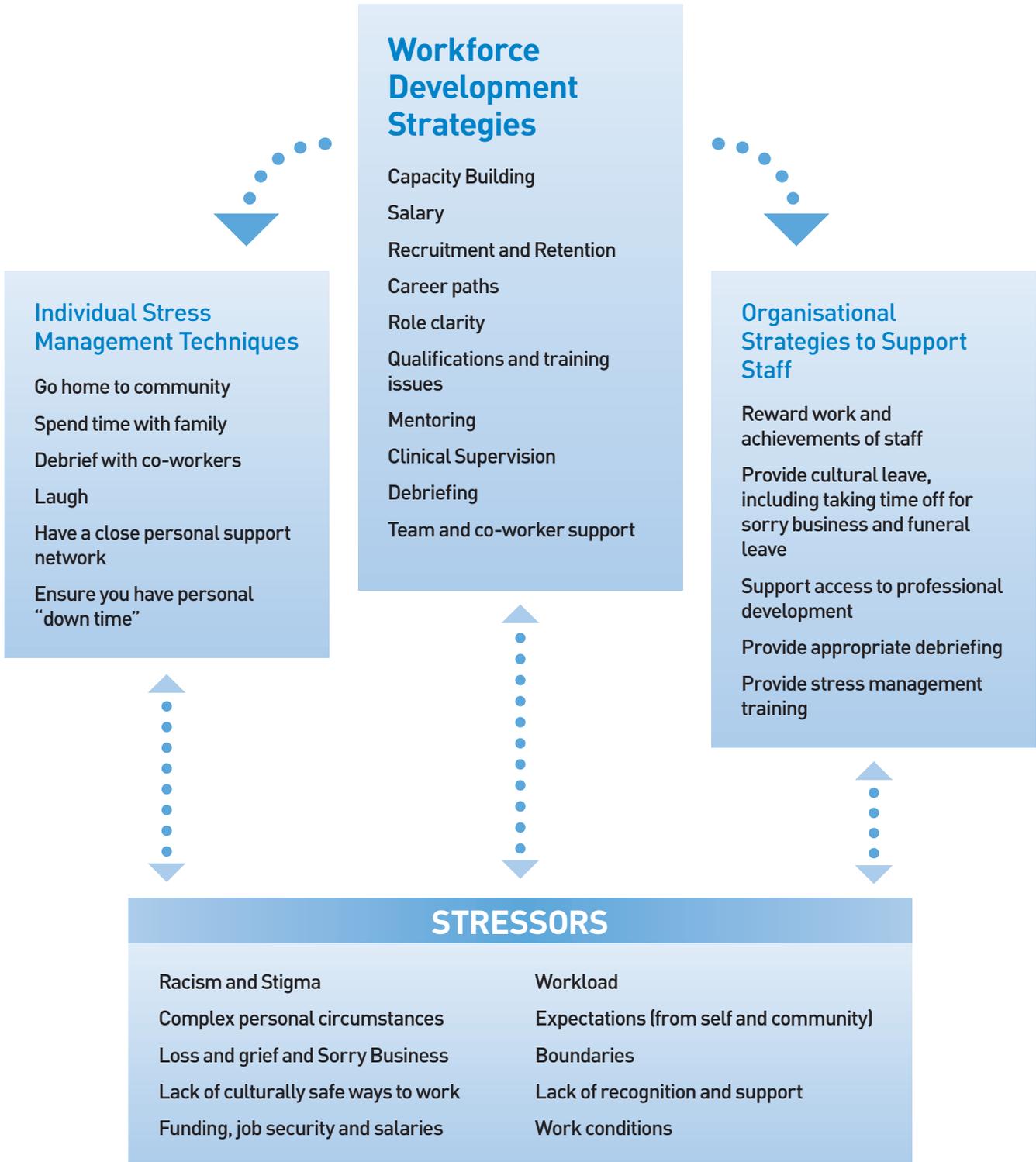
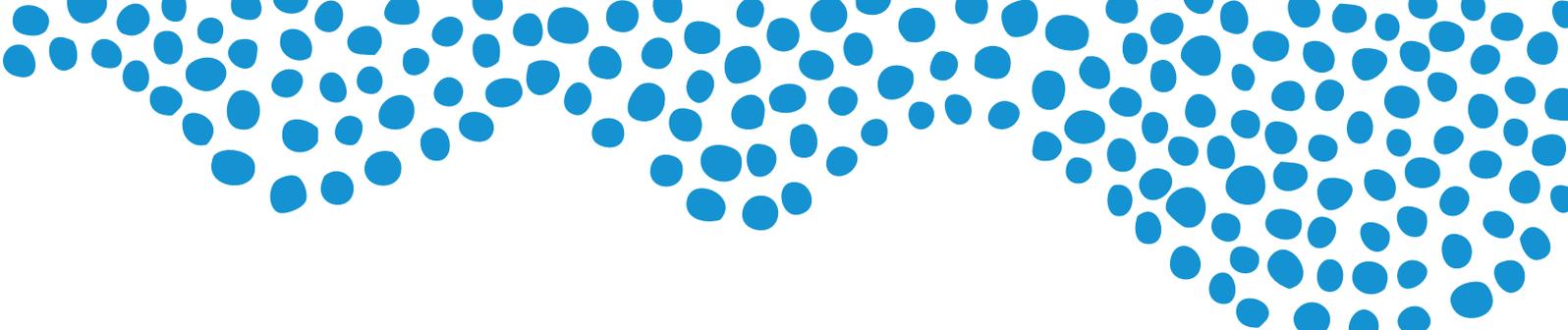


Figure 1. A Representation of Strategies and Stressors for the Indigenous Alcohol and Other Drug Workforce



Chapter 2: Methodology

Project Aims

The principal aims of this project were to understand and identify Indigenous alcohol and other drug workers' experiences and perspectives of worker wellbeing, stress and burnout. The longer term aim was to develop the capacity of alcohol and other drug workers and service providers to improve Indigenous workers' wellbeing.

In undertaking this project we operated within the context of the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health (AHMAC, 2004) and the National Health and Medical Research Committee's Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research (NHMRC, 2003).

The approach taken was based on strategies to enable Indigenous workers' ideas, views and experiences to be freely expressed. A constructivist³ approach was taken to wellbeing that accommodates differences. But in doing so, we were also mindful of traditional perspectives of wellbeing in general, and worker wellbeing in particular.

A key focus of this research was on Indigenous alcohol and other drug workers' narratives of worker wellbeing, stress and burnout. It allowed us to examine strategies that support resilience and foster the ability to deal with difficult and challenging circumstances. A primary aim was to develop an understanding of factors that enhance worker wellbeing and stress by listening to the experiences of Indigenous alcohol and other drug workers.

The approaches used enabled participants to reflect on their experiences using narrative formats. In undertaking qualitative research with Indigenous people about their views and perceptions of work-

related stressors, the aim was to see the world from the view of the person and to understand the meaning of experiences from their viewpoint. We have attempted to capture both the unique experiences of individuals together with identifying similarities among "typical" narratives (but avoiding "master narratives") (Hampden Turner, 1981). The importance of understanding the world view of participants has been highlighted by Bourdieu (1977) who also describes how the landscape of ideas and concepts form a crucial part of one's "habitas", i.e., the space one inhabits.

Methods [Stories and Voices]

Stories were used to build up the knowledge base about Indigenous alcohol and other drug workers' experiences so that the patterns and themes that emerged could be used to inform solutions and future pathways. The approach we took was to allow the voices to speak for themselves and to not attempt to reduce participants' stories to quantitative averages or "norms".

Information was shared in the stories told to us about what worked, and what did not, in terms of both processes and strategies. Our approach attempted to be as relaxed, informal and conversational as possible, to allow maximum scope for participants to explore issues of greatest salience to them.

Feedback indicated that participants found the experience to be positive and one in which they did not feel subjected to scrutiny, but rather felt invited to explore the aspects of their work role and environment that impacted on their wellbeing and that contributed to stress.

"...opportunity to hear from others."

[FG10; M/F; Ind; Met/R/R]

³ Constructivism is a social and collaborative process of actively interpreting and constructing knowledge through culture and language.

Multiple Methods Approach

A multiple methods approach was used that included:

1. *Conversations* with Indigenous and non-Indigenous leaders, senior alcohol and other drug and frontline workers that addressed wellbeing from a holistic and systemic perspective.
2. *Observations* within the groups and other settings of processes of interaction, exchange, support and dialogue.
3. *Listening* to participants discuss among themselves the issues raised.
4. *Reflections* among the research team on the observations and stories.
5. *Discussion, synthesis and interpretation* of ideas and meaning and implications of the narratives and underlying themes.

We used ethnographic narrative, systemic conversation and story telling to examine experiences of Indigenous alcohol and other drug workers and its impact on wellbeing, and to identify common patterns and ways to learn from success.

Process

Stories were captured through face-to-face interviews and focus groups that were undertaken in various metropolitan, rural and remote locations throughout Australia. Telephone interviews were conducted where face-to-face interviews were not possible.

The project was promoted in relevant journals and magazines (both online and hard copy versions), and at conferences and seminars. It was endorsed as an in-kind project by the Cooperative Research Centre for Aboriginal Health (CRCAH) and was posted on the CRCAH website under the heading of Social and Emotional Wellbeing. An overview of the project was also posted on the Indigenous Social and Emotional Wellbeing Programs Project and Lessons pages of the Australian Indigenous HealthInfoNet website.

Ethics

Ethics approval was obtained from the Flinders University and Southern Adelaide Health Service Social and Behavioural Research Ethics Committee. Ethics approval was also obtained from the Aboriginal Health and Medical Research Council (NSW); Aboriginal Health Research Committee (SA); and the Western Australian Aboriginal Health Information and Ethics Committee. Letters of support were also obtained from organisations that participated in the interviews and focus groups.

Procedures

Pilot

A protocol was developed by the research group in consultation with key informants and the Project Reference Group (PRG) that included a set of initial questions. The interview and face-to-face protocols were piloted, developed iteratively and modified following feedback.

Addressing different ways of seeing and experiencing was discussed by the research group throughout the project, both during the interview and “conversation” phase as well as during the analysis and interpretation phase of the project. Active empathic listening was especially important; as was “hearing” the distress and pain expressed in many of the conversations. Triangulation of the stories, conversations and other forms of input (including the survey and submissions) was a key part of the final components of the full project.

Semi-structured interview and focus group questions were used to help focus the discussions, and participants were encouraged to expand on their answers and to relate anything else important or relevant to them. A copy of the interview and focus group protocol is provided at Appendix 4.

Sampling

A stratified purposeful sampling technique was used to identify participants for interviews. Focus group and interview participants were purposefully recruited through various avenues including existing networks such as alcohol and other drug non-government organisations and government-funded services, and through the extended networks of NCETA researchers, their colleagues and associates, as well as through advice provided by the PRG.

Interviews were undertaken with males and females, representing a variety of ages, residing in various geographical locations and with different backgrounds and levels of experience.

The project had a national focus and participants were sampled from diverse geographical locations – capital cities, regional and rural – including:

- Capital cities (e.g., Sydney, Melbourne, Adelaide, Darwin, Perth)
- Regional areas (e.g. Cairns, Qld; Marla, SA; Port Augusta, SA)
- Rural and remote locations (e.g., Alice Springs, NT).

Interview schedules followed a semi-structured format whereby depth and detail in the qualitative data focused on norms, behaviour, contexts, beliefs, perceptions and meanings associated with alcohol and other drug work and work-related issues that may have been a source of stress. The schedules were informed by the emerging themes identified through the project literature review.

Using the schedule, researchers adopted an analytical interviewing approach to aid the process of understanding, whilst maintaining a conversational style of interaction that supported participants in sharing their stories and experiences. This involved continual prompting for further detail and new issues. The researchers purposefully adopted a neutral position when undertaking interviews. This allowed the researchers to be open to participants' responses and avoid assuming inherent meanings or understandings in participants' responses.

Where permission was granted, interviews and focus group sessions were audio recorded on a digital voice recorder. Anonymity was assured for all interviews.

Recruitment

Interviews were organised by making initial contact with a potential participant who met the criteria. At the beginning of each session, the researchers briefly described the project aims and the participant's role in the project, and sought verbal consent.

Data Collection

Focus Groups

Each focus group was led by a facilitator who provided a brief description of the project, the objectives of the focus group and the "rules of engagement" (e.g., respect for people's opinions, confidentiality of comments made in the group). The facilitator's role was to prompt discussion among participants using open-ended questions and to reflect the key points back to the group. Focus group discussions were highly participatory and interactive.

A note-taker assisted the facilitator to conduct the focus group by collecting participants' consent forms and demographic data, providing materials when needed, assembling and monitoring several recording devices, and taking notes on the setting, context, insights and issues raised, as well as the emotional tone of participants. At the end of the discussion, the group was provided with a brief summary of the ideas

and issues that were raised to ensure that the notes accurately reflected the group's views. This process of cross-checking served to clarify and validate the information and positioned the participants as the expert in relation to their experience.

Group discussions involved between five and 10 participants, ran for approximately 90 minutes and were conducted in a range of appropriate locations including meeting rooms at services, community centres and in the meeting rooms of other services.

Individual Interviews

Individual interviews were undertaken with Indigenous and non-Indigenous key informants from a range of backgrounds and settings. The interviews enabled a more in-depth exploration of issues from an individual perspective. Individual interviews enable sensitive information to be elicited that may not be accessible through group discussion (Liamputtong, 2007).

Data Analysis and Management

Analysis of the data obtained from interviews and focus groups involved identifying key themes and patterns and areas of convergence and divergence (Banathy, 2000).

Data Analysis

Data were subjected to thematic analysis and a grounded theory approach. Theoretical ideas identified through the accompanying literature review and researchers' existing knowledge and discipline-specific expertise were the lenses through which emerging data were interpreted and analysed (Glasser & Strauss, 1967; Strauss & Corbin, 1997). The onus was on the researchers to interpret, conceptualise and examine relationships and to generate the theoretical positions that are discussed in the following sections of this report.

Two key methods were combined to achieve in-depth analysis:

1. Content analysis of the emerging research data was used to generate analytic categories
2. Constant comparison of these categories with new findings was undertaken to identify emerging themes.

This method enabled analysis that went beyond description to meaningful interpretation and theoretically-oriented explanations of findings, resulting in the emergence of new understandings and analytic frameworks.

Chapter 2: Methodology

Our central goal was to understand the experience of Indigenous alcohol and other drug workers from their perspectives. In this approach, the participants become co-researchers. They shaped and informed the knowledge base that was established and they influenced the subsequent “knowledge generation”.

Data Storage

Data emanating from the research and used in the analysis included:

- audio recordings of interviews and focus group discussions
- focus group facilitator’s and interviewer’s comment sheets.

Audio Files

Interviews and focus groups were recorded on a digital voice recorder and uploaded to a secure location on the NCETA computer network with access limited to authorised researchers. Electronic copies of field notes and researcher comment sheets were stored in the same secure location. A recording protocol was designed and implemented by all researchers to ensure audible sound quality and appropriate sound file storage.

Focus group discussions were recorded using two digital recording devices to ensure all voices in the room were audible. The use of software to analyse audio files negated the need to transcribe interviews. This also improved the quality of data analysis as researchers analysing the data were able to detect nuances in voices during analysis that are more difficult to access in a voiceless transcript.

NVivo Software

NVivo qualitative data analysis software was used to aid data management and analysis. It was selected for its capacity to manage the large volumes of data that were generated. The research team undertook training in the uses of NVivo that was tailored to the specific requirements of the project with diverse and complex data.

Process for Data Analysis

From Categorisation to Themes

Data analysis began by “open coding” the data sources (audio recordings of interviews and focus group discussions, observation notes, researcher focus group and interview comment sheets), that is,

grouping together conceptually similar data into categories. A mixed approach of topic coding (open coding) and analytic coding (using a pre-defined coding scheme) was undertaken. The meaning of each code was noted in the researcher’s memos along with thoughts about how the code linked to the evolving theoretical understandings. Using NVivo data management software, audio files (focus groups and interviews) were coded directly from the file.

Researchers listened to each recorded interview or focus group and selected sections of the recording that were relevant to this project. The selected recordings were then copied and coded by researchers into themes by creating “nodes” in the NVivo program (Richards, 2005).

Reporting and Interpreting Qualitative Research

In comparison to quantitative research, the qualitative approach used in this study aimed to illuminate Indigenous people’s own perspectives and subjective meanings through a variety of methods. The opinions and experiences of the participants have been transcribed in the findings.

In order to contextualise comments, a transcription key is included (see Table 6) that identifies data source, participants’ gender, Indigenous status, and geographic region. The key de-identifies participants while providing contextual detail. For example, the citation [FG; M/F; Ind/non-Ind; Met/R/R] refers to a focus group comprised of male and female Indigenous and non-Indigenous participants from metropolitan and regional areas.

Participants

A total of 156 participants were involved in the study. Of these, 96 were Indigenous, 29 were non-Indigenous and for 31 this information was not provided. Of all participants, 78 were male and 78 were female.

Thirty-five individual interviews were held with Indigenous (n=26) and non-Indigenous (n=9) participants across Australia. Seventeen focus groups were also conducted involving 121 participants. The total number of interview and focus group participants was 156. Table 7 presents a summary of all Indigenous and non-Indigenous participants by gender and the state or territory in which they primarily worked.

Interview and focus group participants worked across all organisational types; community-controlled, government and non-government.

Representation was sought from all mainland states and territories and a broad range of geographical working regions including metropolitan, regional and remote. A summary of this data is presented in Table 8.

At least one focus group was held in each mainland jurisdiction [except Tasmania and the ACT where participants could not be recruited within the time frame available].

Table 6. Quotation Attribution Key

	Descriptor	Key Used
Data Source	Focus group	FG
	Interview	Int
	Submission	Sub
	Survey	Sur
Gender	Male	M
	Female	F
	Focus groups with male and female participants	M/F
Indigenous status	Indigenous	Ind
	Non-Indigenous	non-Ind
	Focus groups with Indigenous and non-Indigenous participants	Ind/non-Ind
Geographic region	Metropolitan	Met
	Regional and/or Remote	R/R
	Participant(s) who worked in all geographical regions	Met/R/R

Table 7. Indigenous Status by State and Gender

Gender & Indigenous status	State/Territory							Total
	ACT	NSW	NT	QLD	SA	VIC	WA	
Indigenous male	0	8	9	3	27	0	4	51
Indigenous female	0	3	15	4	19	0	4	45
Non-Indigenous male	0	0	4	3	5	0	2	14
Non-Indigenous female	1	0	0	4	9	0	1	15
Female*	0	0	0	8	0	9	1	18
Male*	0	0	0	3	0	10	0	13
Total	1	11	28	25	60	19	12	156

*Indigenous status was unknown for these participants.

Table 8. Total Number of Participants by Organisation Type, Geographic Region and State/Territory

Organisation type	Geographic region	State/Territory							Total
		ACT	NSW	NT	QLD	SA	VIC	WA	
Alcohol and Other Drug Network*	Met								-
	R/R								-
	Met/R/R		10			21	19		50
Community Controlled	Met					7			7
	R/R			6	1			5	12
	Met/R/R					20			20
Government	Met					5			5
	R/R		1	22	11	1			35
	Met/R/R				1	1			2
Non-government Organisation	Met								-
	R/R				11	1			12
	Met/R/R					1			1
Peak Body#	Met					1			1
	R/R								-
	Met/R/R				1			1	2
University	Met					2			2
	R/R								-
	Met/R/R	1						6	7
Total		1	11	28	25	60	19	12	156

* Where focus groups were arranged as part of a particular state's Indigenous Alcohol and Other Drug Network, data was not collected on participants' individual workplaces and 'Alcohol and Other Drug Network' was used as a proxy for organisational type.

Similarly, interviews were sought from members of the National Indigenous Drug and Alcohol Committee (NIDAC) and key academics in Indigenous health, therefore "Peak Body" and "University" are also organisational type proxies.

Limitations

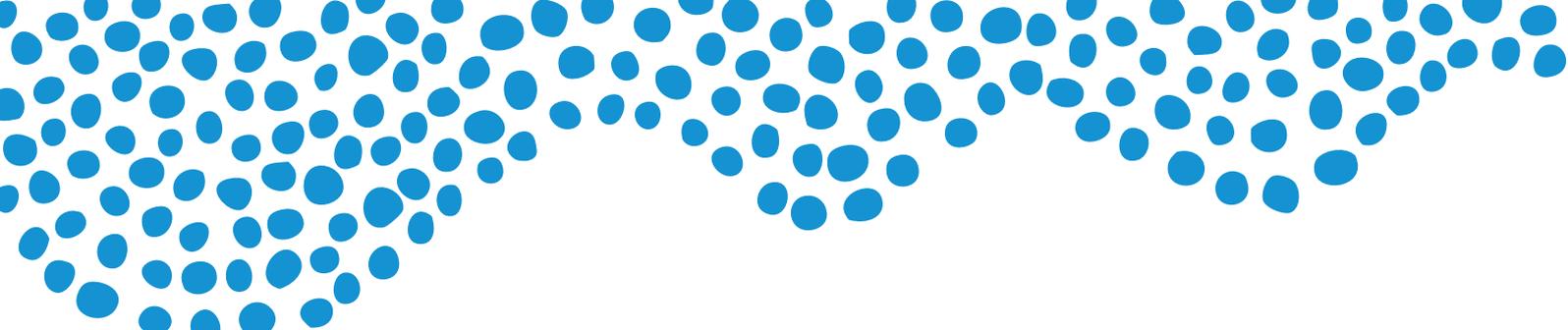
The approach to the research process was to try to maximise the comfort of participants and to encourage them to speak freely and frankly. Moreover, it was important that participants felt empowered by the process. Every effort was directed towards this end. However, it is acknowledged that there were often substantial limitations in terms of time. The project resources did not allow for repeat visits with the same group or individuals. This would have been beneficial in terms of further developing rapport and understanding.

As interviews were taped and then downloaded electronically for analysis interviews were not transcribed. Hence, there was no scope to return transcripts to participants for comment and feedback. This therefore curtailed the extent to which iterative feedback could be used as a method of data analysis.

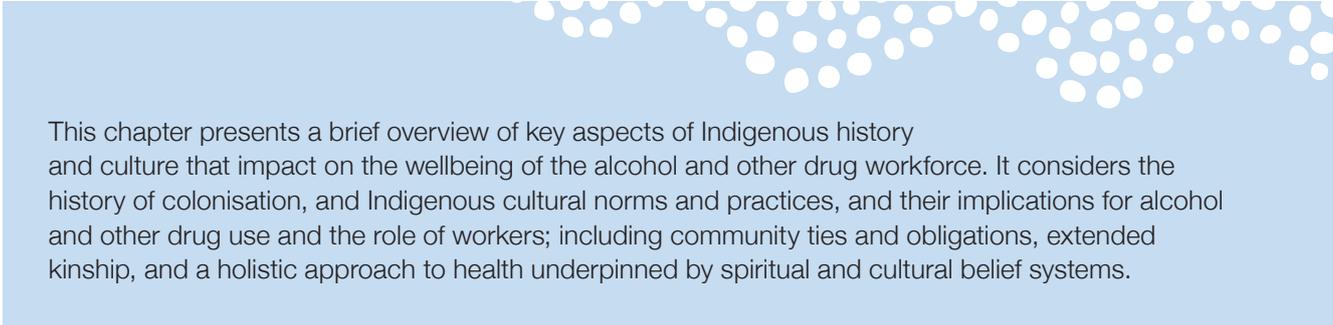
Under ideal circumstances, greater time and resources would have been available to allow repeat visits and sessions with the same groups of individuals. This would have also assisted the gradual development of trusting relationships over time and facilitated a truly respectful dialogue. This is an important recommendation for future work of this type.

It is also noted that some of the research team were Indigenous but most were non-Indigenous. This again, is likely to have impacted on the process.

The next chapter provides a brief overview of the major historical and cultural factors of relevance to an examination of Indigenous alcohol and other drug workers' stress and wellbeing. This is then followed by a chapter that enumerates the major stress factors identified.



Chapter 3: Historical and Cultural Context of Indigenous Alcohol and Other Drug Work



This chapter presents a brief overview of key aspects of Indigenous history and culture that impact on the wellbeing of the alcohol and other drug workforce. It considers the history of colonisation, and Indigenous cultural norms and practices, and their implications for alcohol and other drug use and the role of workers; including community ties and obligations, extended kinship, and a holistic approach to health underpinned by spiritual and cultural belief systems.

"We know that there are layers upon layers of issues that the individual or their families are currently dealing with and the impacts of that stem from colonisation, stolen generations and premature death within our community."

[Int1; F; Ind; Met]

Any attempt to comprehensively understand the experiences of Indigenous workers in the alcohol and other drug field must be undertaken from a historical and cultural perspective. The following provides a brief overview of some key aspects of living and working as an Indigenous worker, and examines how this impacts on wellbeing. In doing so, it is important to note that Indigenous culture is varied and diverse. Thus, the information presented in this report attempts to reflect a broad range of thoughts, feelings, and experiences of Indigenous workers in this sector.

An understanding of the history and ongoing impact of colonisation on Indigenous Australians, including its contribution to alcohol and other drug use, is essential. The policies and practices of past governments are also central to conceptualising issues faced by Indigenous workers. Further to this, the Indigenous perception of history holds that the past and present exist simultaneously (Williams, Thorpe, & Chapman,

2003). Therefore, history for Indigenous people is a social determinant of health (Anderson, Baum, & Bentley, 2004). Failure to acknowledge Indigenous issues within a historical context continues to be frustrating and hurtful and will distort any attempt to understand factors impacting on the wellbeing of the Indigenous workforce.

"...[we need to] take into account the link between people's alcohol and other drug use and other sources of ill health to trans-generational trauma [and] the ongoing contemporary consequences of colonisation and the social determinants of health."

[Int26; M; Ind; Met]

The contemporary effects of colonisation with regard to the Indigenous alcohol and other drug workforce are so complex and multi-layered it is not possible for them to be fully described here with any exactness. However, the trauma, grief and suffering experienced within Indigenous communities continue unabated, with problematic alcohol and other drug use emerging as a result.

The following social inequities are also implicated as causal, contributory and consequential factors in problematic alcohol and other drug use:

- dispossession of land, culture, and language
- forced removal of children under “Assimilation Policies”⁴
- stolen wages
- racism
- lower life expectancy and higher mortality and comorbidity
- inequity in housing, education, and economy.

Further to this, Brady (2008) has examined the origin of alcohol use amongst Indigenous populations, and maintains that contemporary alcohol issues are also related to how Indigenous Australians learned about grog. This has important but often under-recognised implications for both Indigenous and non-Indigenous alcohol and other drug workers who confront many of the misconceptions about Indigenous people and alcohol.

Marmot (2010) has highlighted the ways in which the social determinants of health, and more importantly “poor health”, are linked to “inequalities in society”:

“Inequalities in health arise because of inequalities in society—in the conditions in which people are born, grow, live, work, and age. These inequalities are a matter of life and death.”

(The Marmot Review, 2010, p. 16)

Indigenous alcohol and other drug workers’ wellbeing is intrinsically linked to the gross social inequities encountered by their families, communities, and all Indigenous nations in Australia today. Marmot’s “Review on Health Inequalities” (The Marmot Review, 2010) highlights the needs of Indigenous communities and Indigenous alcohol and other drug workers.

Marmot (The Marmot Review, 2010) recommends that reducing health inequalities will require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all.

4 A number of State and Territory Acts were used to remove Indigenous children from their homes and place them under the care and guardianship of the State. The forced separation of Indigenous children from their families and communities was formally acknowledged in the “Bringing Them Home Report” and the Prime Minister The Hon. Kevin Rudd’s Apology to the Stolen Generations in 2008.

5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

Objectives 2 to 6 of Marmot’s key policy areas are particularly relevant to Indigenous alcohol and other drug workers, and a substantial proportion of this report is related to these factors. To better understand the experiences of Indigenous alcohol and other drug workers and to place this project in a broader historical and cultural context, we briefly describe below relevant aspects of Indigenous culture.

Indigenous Ways of Working

“There are major cultural differences between Aboriginal and non-Aboriginal people in the workplace.”

[Int1; F; Ind; Met]

In essence, Indigenous ways of working uphold the values, beliefs and social structures of land, family and kinship. Indigenous ways of working vary significantly from mainstream Australia in many respects. An understanding of these issues is essential to fully comprehend the range and nature of stressors experienced by Indigenous alcohol and other drug workers and the way in which such stressors impact on worker wellbeing.

Understanding, acceptance and respect for Indigenous ways of working has grown slowly. It is clear, however, that this is still more likely to be the exception rather than the rule for many alcohol and other drug workers. Many workers reported receiving little acknowledgment or support from non-Indigenous colleagues or managers in regard to the importance of Indigenous ways of working. A common experience was that mainstream norms were expected to be adopted and Indigenous ways of working would be given a tokenistic and ineffective “nod” at best, or ignored at worst.

“They have, as every organisation has, their little cultural part of their strategic plan, stuff like that, and I think that’s where it lies. It seems token, you know ... ‘we’ve got it in our strategic plan, we’ve met our EO [Equal Opportunities] part of it, we’ve ticked the EO box’.”

[Int15; M; Ind; Met]

Recognition of Indigenous ways of working is not common. For example, the vast majority of diagnostic tools used to identify health needs of Indigenous people largely disregard the Indigenous

Chapter 3: Historical and Cultural Context

world view.⁵ This has had a significant impact on the ability of workers to utilise Indigenous ways of working. Culturally based solutions are required to address culturally derived problems: failure to do so is disempowering and compromises the cultural integrity of the Indigenous workforce.

“Sometimes an Indigenous client will present to a Western counselling and say this client has got psychosis but in actual fact that client maybe has been ‘Sung’... all sorts of other reasons. Depression in the Western world means feeling depressed. In Indigenous society the client might be missing home, country, spirit, family.”

[FG16; M/F; Ind; Met/R/R]

Kinship

For most Australians, “kinship” comprises immediate family, and a limited number of other family members who are closely related. However, kinship for Indigenous people is very different and incorporates a wider range of kin through blood, marriage, and skin relationships. Complex and extended kinship systems are a fundamental element of remote Indigenous communities, and they operate in modified forms within rural and urban Indigenous communities.

Within Indigenous communities a sophisticated system of family exists which means that attribution of sibling status extends to cousins, regardless of birth generation, and aunts and uncles take on parental, or often grandparental, status in many circumstances. Furthermore, there need not be a biological relationship for a family bond to exist; for example:

- Indigenous people can be related through marriage (affinal kin), or having been “grown up” by a family/community
- Elders are often referred to as Aunty, Uncle or as grandparents even though no blood relationship exists
- Indigenous people share moiety, where community is divided into two groups on the basis of unilineal descent, creating two separate moieties. Belonging to the same moiety establishes a family relationship
- further subsections of some Indigenous language groups are given “skin names” and sharing the same “skin name” thereby establishes a family relationship.

5 Exceptions include the recent development of the ‘Indigenous Risk Impact Screen (IRIS)’, an Indigenous tool designed to assess alcohol and other drug and mental health risk: see Schlesinger, Ober, McCarthy, Watson, & Seinen (2007).

Kinship creates social and behavioural structures which define obligatory roles, and strengthens community through upholding respect and reciprocity and teaching understanding of human connectedness to each other, to spirit, and to country. However, many Indigenous alcohol and other drug workers experience a lack of understanding from employees and employers in regard to kinship systems.

“Just imagine being in a small community and there’s a death, and everyone is related to each other in some way, through blood or skin. Then someone asks what relation they [the deceased] are to them [the worker]! They ask, ‘well is that your brother, or your sister, or what’. Don’t understand kinship and skin relationships.”

[FG13; F; Ind; R/R]

Commitment to Community

There exists within the Indigenous alcohol and other drug workforce a strong commitment to community, driven by a strength and spirit connected to the heart of what it means to be an Indigenous person. Professional boundaries and separation of work and home life is frequently lost in upholding cultural integrity and reciprocity within community.

“I don’t think there is much of a separation between the words ‘family’ and community and that Aboriginal community sees the whole community as their family. So making that separation is just not as easy as you would do.”

[FG16; M/F; Ind; Met/R/R]

Indigenous alcohol and other drug workers are part of the community in which they live and work, and therefore professional boundaries bear little significance to the reality of their working lives. Whether Indigenous alcohol and other drug workers are located in urban, rural, or remote areas, they consistently have a strong commitment to community, a desire to effect change, and the need to engage in culturally ethical employment for Indigenous people.

Experiential knowledge, coupled with a strong motivation to address social inequities, was a major factor for many Indigenous people entering into alcohol and other drug work within their communities.

“It’s also about being a role model for our community. We’ve been there, done the alcohol, and we’re middle-aged!”

[FG10; M/F; Ind; Met/R/R]

Holistic Approaches to Health

Holistic care is a fundamental feature of Indigenous ways of working. It involves an approach that incorporates seeing and understanding individuals within the context of their family and community, rather than addressing these elements in isolation.

“... the whole person—community, mind, body, soul, spirit.”

[FG8; F; Ind/non-Ind; R/R]

An important implication of a holistic approach to care is that it often involves greater time commitment and more intensive use of resources. Participants indicated that their alcohol and other drug clients want holistic care, within the context of their family and with cognisance of broader environmental factors.

“... want recovery to happen within their family. One service places a lot of emphasis on the individual, which doesn't work very well with Aboriginal people because not only are they the client's issues, but the current environment's as well.”

[Int1; F; Ind; Met]

The need for more holistic and integrated approaches to healthcare was identified as a priority issue by participants in this project.

Women's Business, Men's Business

According to long-established Indigenous lore, sharing responsibility between men and women reveres the strength, knowledge and essence of what it means to be a man or a woman. Assignment of “roles and life ways” are determined by gender. These roles govern relationships with nature and society, and extend to responsibilities to country and ceremony (Grieves, 2009).

For Indigenous workers, the complexity of maintaining culture within the workplace, and honouring the sanctity of “Women's Business, Men's Business”, is of crucial importance. However, cultural needs and expectations of work roles often do not marry well in relation to gender issues.

“Some people that you can't deal with because women won't open up to a bloke. Like you got Women's Business and Men's Business. It's pretty important to have a female worker as well.”

[FG2; M/F; Ind; Met/R/R]

Some organisations require workers to carry out duties which conflict with their cultural values and beliefs.

“When I was working as an aged care worker we couldn't work with Aboriginal men because they wouldn't let women go near them unless they were the wife. It's a cultural aspect of not wanting a female touching him.”

[FG6; M/F; Ind; Met/R/R]

Indigenous Concepts of Time

A major differentiating characteristic of mainstream and Indigenous ways of working is the concept of time. A contemplative and considered approach to tackling tasks and interventions is likely to be encountered among Indigenous workers.

“... it's working it out slowly, slowly. No point in rushing into things. That's when all the trouble starts happening ... one thing at a time.”

[Int32; M; Ind; R/R]

Incorporating Indigenous ways of working into workplace practice requires allocating time to decision-making processes and the intricate, complex system of consultation that embodies Indigenous cultural practice. Community consultation involves seeking and listening to the views and knowledge of Indigenous people in order to develop, implement and evaluate the way alcohol and other drug services should be provided to the community.

“Some people may say we're lazy but we're not. We're thinkers, we're talkers. You see a group of Elders sitting, nutting something around and around till suddenly they find the right answer, that's how we work as people.”

[Int5; F; Ind; Met]

Respect for Elders

A further central feature of Indigenous culture is the importance of showing respect for Elders. Elders are the foundation of community, imparting knowledge, wisdom and guidance through story. This is achieved through a system of reciprocity whereby workers and Elders are bound to uphold each other. The position of Elders within Indigenous society is extremely important, as it is recognised that with age comes status and wisdom.

Chapter 3: Historical and Cultural Context

"I've had Elders ringing and they want you to come out at 10pm, you can't say no, once you say no you lose all respect from the community and that's hard to get back. You just go deal with it."

[FG2; M/F; Ind; Met/R/R]

Grief and Loss

"A lot of the Aboriginal staff have their own loss and grief issues and we don't look after them very well."

[Int1; F; Ind; Met]

The depths of grief and loss experienced by Indigenous alcohol and other drug workers is likely to be profound and well beyond experiences encountered by mainstream society. The death of young people and children, including suicides, in Indigenous communities is a major contributor to overwhelming grief and loss issues for Indigenous workers and their communities.

"Most stressful thing is the grief and trauma that clients experience."

[Int28; M; Ind; R/R]

The pervasive nature of loss and grief is not always well understood by non-Indigenous people. As a result, many workers may experience a lack of support in this area. This creates further stress for Indigenous alcohol and other drug workers.

"People talk about compassion fatigue, well maybe there is grief fatigue."

[Int26; M; Ind; Met]

Sorry Business

Following the death of Indigenous people there is a period of mourning called Sorry Business. It can have an immense impact on Indigenous workers who experience a high number of deaths within their client, family and community groups. Without adequate support to participate in Sorry Business and culturally appropriate ways of mourning, feelings of sorrow and bereavement accumulate; as they have done over several generations. This is known as intergenerational grief and loss, and has been observed in, and by the Indigenous alcohol and other drug workforce.

The frequency of deaths within the Indigenous community intensifies and prolongs grief and loss experienced by workers, and exacerbates alcohol and other drug issues for their clients.

"So much grief and loss, always in Sorry Business mode ...hard to do your job."

[FG12; M; Ind; R/R; NT]

High mortality rates in Indigenous communities result in the need for Indigenous workers to attend a greater number of funerals (Sully, 1997). As a consequence, Indigenous workers require a greater number of bereavement leave days than is feasible under most workplace policies.

"When Aboriginal people want to go to funeral, the system that our people work in doesn't allow them to attend. You can honestly say that the system is racist because they're not prepared to change it."

[Int1; F; Ind; Met]

For Indigenous alcohol and other drug workers, not to take time to attend a funeral and pay one's respects reflects very badly on them. Attendance is a compulsory cultural requirement, rather than a personal choice or preference.

"It's also about beliefs ... you have to go, to pay your respects. Obligation is different between white and black people—family get funny. That's the difference, it's not compulsory for white people to go. It's up to the individual. But that's not Aboriginal way."

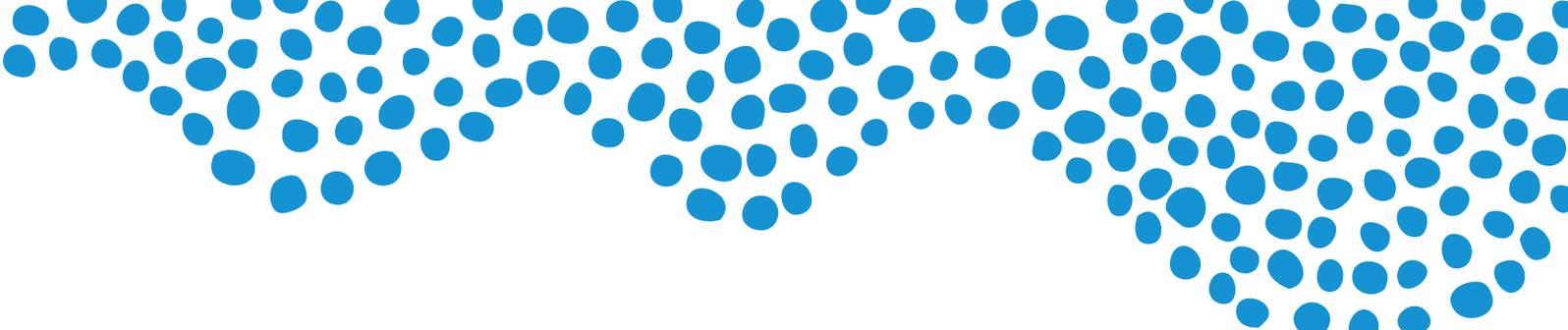
[FG13; F; Ind; R/R]

The "tug of war" between work requirements, and cultural expectations and obligations takes a heavy toll on the Indigenous workforce.

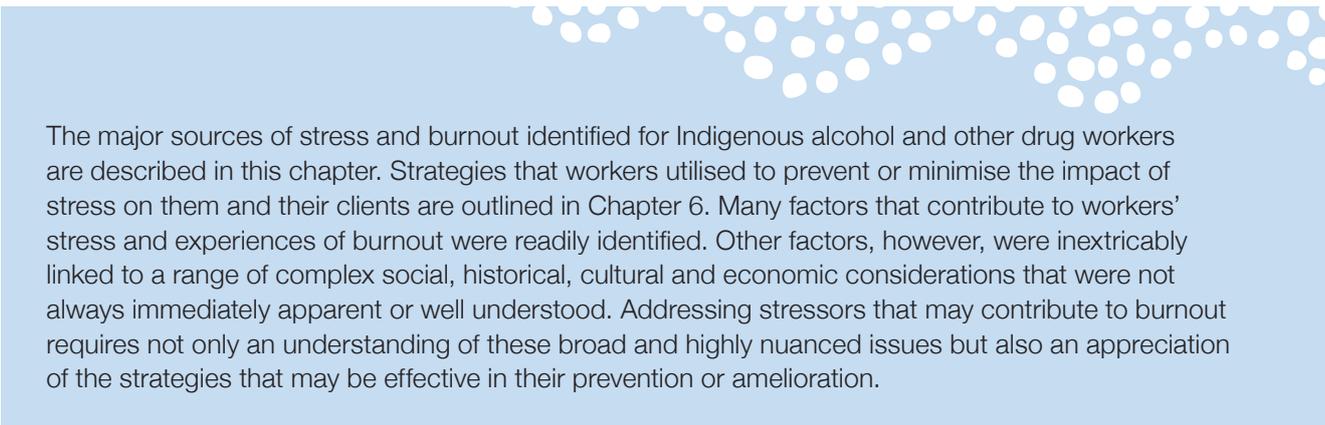
Summary

Indigenous alcohol and other drug work must be understood from a historical and cultural context in order to fully comprehend the source of threats to Indigenous workers' wellbeing and to be able to identify culturally appropriate strategies to move forward. Indigenous ways of working ideally incorporate practices that reflect Indigenous knowledge, uphold cultural integrity, and allow for the application of principles of reciprocity. When these principles are undermined it impacts on the health and wellbeing of the Indigenous community and Indigenous workers and contributes to work-related experiences of stress.

It is with this contextual background in mind that the issues of worker wellbeing, stress and burnout are examined in the following chapters.



Chapter 4: Sources of Stress



The major sources of stress and burnout identified for Indigenous alcohol and other drug workers are described in this chapter. Strategies that workers utilised to prevent or minimise the impact of stress on them and their clients are outlined in Chapter 6. Many factors that contribute to workers' stress and experiences of burnout were readily identified. Other factors, however, were inextricably linked to a range of complex social, historical, cultural and economic considerations that were not always immediately apparent or well understood. Addressing stressors that may contribute to burnout requires not only an understanding of these broad and highly nuanced issues but also an appreciation of the strategies that may be effective in their prevention or amelioration.

"...what causes burnout? Frustration, overloaded, and the community's expectations."

[FG4; M/F; Ind; Met/R/R]

One worker succinctly stated that, in essence, there were three key factors that acted as major contributors to Indigenous worker stress and ultimately burnout. These factors were high levels of frustration, workload and expectations.

While frustration, workload and community expectations clearly accounted for much of the stress reported by Indigenous workers, other factors were also evident. We identified at least 10 major sources of stress for Indigenous alcohol and other drug workers (see Table 9.). These 10 factors involve a set of complex elements, and there is strong evidentiary support for each. This chapter will explore the following 10 factors:

1. Workload
2. Expectations (from self and community)
3. Boundaries
4. Lack of recognition and support

5. Work conditions
6. Racism and stigma
7. Complex personal circumstances
8. Loss and grief and Sorry Business
9. Lack of culturally safe ways to work
10. Funding, job security and salaries.

These 10 factors are not presented hierarchically; rather, these categories represent a convenient way to organise the diverse array of stress factors described by participants. It is also important to note that these categories are not mutually exclusive and there is some degree of overlap.

The next chapter addresses workforce development strategies that have specific applicability to the work-related stressors identified by Indigenous workers. The last chapters of the report outline mechanisms that have been developed to help overcome or minimise work-related stress and to maintain workers' overall health and wellbeing. Finally, workers' views about the positive and rewarding aspects of their roles are also detailed.

Table 9. Ten Principal Contributors to Work-related Stress Among Indigenous Alcohol and Other Drug Workers

Factors		Descriptor
1.	Workloads	Workloads were invariably high and not commensurate with the resources available to meet the needs.
2.	Expectations	Workers consistently demonstrated high levels of personal commitment to their work role and their community. In addition, there is a complex set of community obligations that workers need to fulfil.
3.	Boundaries	Many workers saw being available 24/7 as part of a cultural obligation; others were increasingly learning to place appropriate limits and boundaries in culturally secure ways to prevent burnout.
4.	Recognition, Respect and Support	Workers reported that recognition or respect was often not afforded to them. They also were often solo or isolated workers with insufficient support.
5.	Working Conditions	Difficult and stressful working conditions were common, especially among workers in rural and remote settings.
6.	Racism and Stigma	High levels of stigma were associated not only with alcohol and other drug work but also the Aboriginality of the clients and the workers. Racism was commonly experienced from co-workers and the mainstream community and constituted a major source of stress.
7.	Complex Personal Circumstances	Many workers were single parents or responsible for dependent children, elderly and other family members. Many had experienced significant bereavements, domestic violence, and previous problems with alcohol or drugs. Family members were also often alcohol and other drug clients.
8.	Loss and Grief and Sorry Business	Heavy community losses through premature deaths including suicides. Traditional bereavement leave was rarely adequate. The importance of Sorry Business, and loss overall, was also often not understood.
9.	Culturally Safe Ways to Work	Although noted to be improving, there was a significant lack of understanding about Indigenous ways of working. This created regular conflict and clashes with mainstream colleagues and services and undermined the health and wellbeing of both clients and workers.
10.	Funding, Job Security and Salaries	Short term funding, short term appointments with low salaries contributed to high stress levels and high turnover rates.

Workload

One of the most common sources of stress described by Indigenous alcohol and other drug workers was the relentless and often overwhelming nature of their work and the associated heavy workloads. The sheer volume of work and the multiple demands placed on these workers was consistently identified as a major source of stress, and one of the main factors that ultimately contributed to the burnout experienced by some workers.

"... work is hard enough. It's really difficult doing the jobs I gotta do. I can deal with that to an extent, ... you just keep going and going and going."

[Int01; F; Ind; Met]

"And so you wonder why fellas burnout ... you don't stop work!"

[FG4; M/F; Ind; Met/R/R]

Participants described heavy workloads in terms of their expected roles and responsibilities to care for and support Indigenous clients. They also outlined the multiple additional roles that they undertook. It was the combination of these multiple responsibilities that contributed to the common experience of work overload.

"... there are a lot of skills that Indigenous workers have. Lots of workers have multiple roles, often natural leaders, and get to the point where they are doing so much other stuff. Sometimes informally, they get torn between community expectations and health expectations."

[FG9; M/F; Ind/non-Ind; R/R]

Indigenous alcohol and other drug workers were often employed as part of very small teams and were often the sole Indigenous worker. The impact of being a solo worker was substantial, not only in terms of workload but also in terms of professional and cultural isolation and lack of support.

"One drug and alcohol worker in the community, a big Aboriginal community, and only one worker. So the expectations are very high."

[FG2; M/F; Ind; Met/R/R]

Not unexpectedly, many Indigenous workers in such circumstances reported that their workload was especially high.

"... we are snowed under with work."

[FG2; M/F; Ind; Met/R/R]

"I am often flat out trying to do what is required."

[Int14; M; Ind; R/R]

In some instances, the array and extent of tasks for which a single worker was responsible was exceptionally large. Moreover, their roles entailed dealing with highly sensitive and emotionally charged alcohol and other drug, mental health, and sexual and family violence issues that further contributed to a sense of being overwhelmed by the job, at least some of the time.

For any workers involved in what is known as emotional labour the role is understood to be taxing and it often takes a heavy toll on the individual, and sometimes those around them (Fahy, 2007; Skinner et al., 2007; Williams, 2003).

"The position looks into drugs and alcohol, mental health, the infrastructures of family violence and breakdowns. It looks at all those avenues that affect families, but there is only one such position for a huge population with a lot of these problems."

[Int14; M; Ind; R/R]

Participants recounted their experience of observing other workers succumbing to work pressures. The associated transformations that often occurred were also described in vivid terms.

"People throw themselves into the job— don't realise the toll it's taking on them. You see changes in them— they turn from being nice into a prick."

[FG4; M/F; Ind; Met/R/R]

Other issues identified as a source of stress included the challenge of offering support to clients with complex needs. This included the demands involved in finding suitable services to meet clients' personal and cultural needs. Workers reported their ongoing struggle to find suitable and supportive services to accommodate their clients' complex needs. They were confronted daily, and often overwhelmed by issues such as overcrowding, homelessness, and deaths of community members, together with the grief associated with the loss of community members.

"... a lack of services available for clients, no detox centre, increasing rate of homelessness, overcrowding in houses, significant number of deaths in the community and therefore high levels of grief in the community. This can become overwhelming for workers, especially when trying to undertake that supporting role for family members of alcohol and other drug clients."

[FG9; M/F; Ind/non-Ind; R/R]

Chapter 4: Sources of Stress

For some Indigenous alcohol and other drug workers it was not the type of work or nature of the clientele that was most challenging, rather it was factors related to the location in which they worked. Particular stressors were identified in relation to jobs in remote settings and these are discussed in more detail in “Section 4.5”.

Stress was experienced by both Indigenous and non-Indigenous workers when they felt unable to provide adequate care and support for their clients. This was particularly evident when workers were reluctant to refer their clients to services that they believed were not culturally safe.

“...That stress comes back on to me, because I feel I need to manage my client on my own, because I’m not prepared to set them up to fail somewhere else. So that is a real stress.” - non-Indigenous worker

[FG15; M/F; Ind/non-Ind; Met/R/R]

“The mob that are most vulnerable get the least help.”

[Int34; M; Ind; R/R]

The physical and emotional load carried by Indigenous alcohol and other drug workers is far in excess of that encountered by their mainstream counterparts.

Although the nature of the work was a key source of stress, other stressors stemmed from multi-tasking, in conjunction with the extensive travel requirements involved in some positions.

“...most stressful when I need to multi-task, being stretched across a range of portfolios. The travel is taxing. You never get back the time you put in.”

[Int21; F; Ind; Met]

While the workload and related demands were typically described as extremely heavy, to the point of excessive and intolerable, it was repeatedly pointed out during conversations with project participants that increasing the number of workers would automatically reduce the workload of the current workforce. There was, in many instances an immediate and obvious resolution to one of the principal sources of stress for these workers.

“It’s something! We can have more Aboriginal workers in that area, or maybe not specifically working in that area but having knowledge around drug and alcohol issues and the ability to work with Aboriginal drug and alcohol workers that fit into that mould. I think that would lighten the workload more and reduce the stress levels a bit and make it a much more enjoyable type of work; rather than having to be stressed out about what this person is doing.”

[Int13; M; Ind; Met]

Encouragingly, reductions in stress levels were often reported to be associated with increases in staff numbers and more equitable workload distributions within a given service, further underscoring the importance of the provision of sufficient and adequate staff numbers in the first instance.

“When I first started here I used to go home and sit at home for a while and do hardly nothing—just to unwind. It was so stressful. It’s got easier now. I can go home and relax and enjoy myself. Stress has been reduced because there are more team members now and the workload is more evenly distributed.”

[Int27; M; Ind; R/R]

Another important challenge that arose for Indigenous workers was the difficulty encountered in working with mainstream services (not other Indigenous services, although at times friction with such services was also noted). For many workers, this was the most difficult and stressful component of their work. Strategies for remediation of this source of stress are multi-factorial and are dealt with in later sections of this report. To a very large extent, the origins of most stress experienced by Indigenous alcohol and other drug workers stemmed from non-Indigenous society at a structural, systemic and individual level.

“...the most stress is from working with other agencies who make it hard to do the work.”

[Int14; M; Ind; R/R]

Here Catch

Heavy workloads and associated problems were also exacerbated by practices reported to be engaged in by non-Indigenous colleagues. A common experience described by many participants was finding that all Indigenous patients/clients in a given service, hospital or agency were referred to the Aboriginal Health Worker, regardless of that person’s health problems or circumstances.

“I just find ... you’re one Aboriginal worker, you’ve got every Aboriginal patient that comes through that door is your responsibility, and sometimes ... just the other day ... somebody came to my door and ‘oh, can you help, because she wants to see a doctor’ and I thought but you know as much as I know. They’ve all got to come through Emergency if they haven’t got an appointment, but everybody comes to me because the patient is Aboriginal.”

[FG10; M/F; Ind; Met/R/R]

The “here catch” phenomenon of indiscriminant referral of all clients was frequently depicted by Indigenous workers. Not only did it create an added burden on top of an existing heavy workload, it also left many workers feeling that their colleagues basically ‘dumped’ Indigenous patients on them. While at one level this may be interpreted as an indication of an attempt to ensure that Indigenous clients were seen by another Indigenous person to maximise receipt of culturally appropriate care, it nevertheless also conveyed a strong sense of avoidance on the part of mainstream workers. In some instances, it was a clear case of not wanting to deal with Indigenous clients/patients at all. The propensity to deflect all Indigenous clients, and other avoidance practices, is explored further in the section on stigma and racism.

“...yeah, there’s no-one else in the whole building ... [who can help these clients].”

[FG10; M/F; Ind; Met/R/R]

Similarly, some urban Aboriginal Health Workers described how in mainstream services Indigenous clients were categorised according to their Aboriginality and not their presenting problems. The consequence of this pattern of referral was that Aboriginal Health Workers were required to deal with an extremely wide range of health conditions and other issues, further stretching and stressing their limited time and available resources.

“... everyone gets clumped into same category... An Aboriginal person comes in [to the service] so they get the Aboriginal Health Worker and they can do everything... have to be clinical workers, social workers, psychiatrists.”

[Int15; M; Ind; Met]

In a similar vein, the common experience of inappropriate referrals from other agencies and services that were not alcohol and other drug-related also added to the workload and stress level of workers.

“... frustrating having to deal with clients who have been inappropriately referred by other services. For example, a referring agency may refer a client with alcohol and other drug issues but during the assessment it may become obvious that there is a greater need for the client to address their parenting and child-caring issues.”

[Int31; F; Ind; R/R]

One participant made reference to the mantra that Indigenous health is “everybody’s business”, and issued a plea that this be acted on and not just left to the overworked, under resourced and not well supported Indigenous alcohol and other drug workers.

“[If]... Aboriginal health is everybody’s business, well ... then, make it everybody’s business and do the right thing by us.”

[FG10; M/F; Ind; Met/R/R]

It was evident, however, in this examination of support for and engagement with Indigenous workers and clients that we are still a long way off seeing Indigenous health as everybody’s business. Until that is achieved in a functional sense, Indigenous workers will continue to carry an untenable workload.

Managers/CEOs and Burnout

The experience of stress and burnout was not restricted to young or relatively inexperienced frontline workers. High levels of stress associated with low levels of support were also reported by very experienced workers and those who held senior managerial roles up to CEO level. Some workers were clearly at the end of their tether and at breaking point.

“...hours are far more than what get paid for— on call 24/7. Meant to have a RDO once a month to cover that, but don’t normally have it. Maybe am over possessive of position, but other CEOs who I’ve spoken to appear to have similar experiences. I’m currently looking for another position.”

[Int05; F; Ind; Met]

“I know that I can’t go on like this, my Board is not listening to me, and unless some of [my] ideas for support are implemented, I will have to move on.”

[Int05; F; Ind; Met]

The flexibility to be able to take accumulated leave to manage and relieve work-related stress was often also found to be difficult for a variety of reasons. Frequently lack of backup acted as an impediment to opportunities for leave. While this was noted among frontline workers, it was also evident in relation to managers as their seniority and the more specialised nature of their role made it more difficult for them to find appropriate backup. For some workers, however, taking leave provided only temporary relief from the stressors of their job, as when they returned they often encountered an accumulated backlog of work that further compounded their already high workload.

“I went away and another worker became the acting director which just means in title because that worker still has to maintain their job with the added position of Acting Director and the worker has to deal with all the director issues while the Director is away. And then that worker can’t really do a lot of the things that are for the Director

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personally. And, so when you get back from being away you're basically trying to catch up."

[Int06; M; Ind; Met]

Finding backup for recreation leave and/or to attend training was a common challenge for frontline workers. This was even more difficult when it came to those who held managerial roles, as appropriate backup was rarely available in such circumstances. This added to the burden carried by those in managerial positions and made the option of taking leave even more difficult.

"...it's all very well to have all of these strategies. But if you don't have access or the time, because that's what it comes down to, suppose if you actually took the time to go to a counsellor or massage or whatever at the end of the day your stress at work would be a lot less. But when you're working in a relatively small organisation, if you're not there then who takes your position [as Director]."

[Int06; M; Ind; Met]

Among the more senior and experienced staff there was also stress associated with supporting junior and

less experienced staff and other team members. This included having to pick up extra workloads that junior staff were not able to manage effectively.

"I feel like I'm constantly at the 'beck and call' of others, especially with my own staff who require support and I'm often 'picking up the slack' for workers who are underperforming."

[Int21; F; Ind; Met]

Summary

Indigenous alcohol and other drug workers reported work-related stress in relation to many aspects of their work role. Many if not most of these sources of stress centred around their excessive and unreasonable workloads. These work-related factors included low staff numbers, heavy workloads, complex client needs, inadequate services to support the needs of clients, being the 'catch-all' worker to deal with Indigenous clients, or the sole worker, and lack of backfill for leave. These stressors were identified by frontline workers, managers and CEOs alike.

Personal Stories of Burnout

Some workers discussed their personal experiences of burnout. One worker, for example, related how he had experienced burnout twice and described the enormously negative impact that it had had on him.

"Burnout, believe me, is shocking. I laid on the floor, and I was sleeping with my eyes open. I couldn't think, and I didn't want to go to work, you know. I didn't want to walk out that door. And your life becomes unmanageable. You've got to get away from your work environment completely— take 12 months off, and come back refreshed ready for your next burnout."

[FG4; M/F; Ind; Met/R/R]

Another worker related his experience of working in a stressful and demanding environment, which included clients dying, and that ultimately resulted in burnout. The process of burnout in many instances is insidious, as illustrated by this worker who described how it "crept up on him".

"In the sobering up unit it took a long time to show stress-related effects on me. I got really close to the clients and they started dying and it took a long time for that to actually affect me physically and mentally. I basically got burnt out and after 6 years I didn't even wait for my 7-year long-service leave. That's how burnt out I was."

You know it creeps up on you and you think, I am going good, and then, all of a sudden, you just burnout. That's why I left that job, went and did a year of study and got a job here. This place doesn't stress me. I think it's more the workers and the clients that stress me. We've had a big turnover here that has been pretty stressful when you just get used to one lot of changes, the changes in the workplace has been more stressful than the clients."

[Int02; F; Ind; Met]

Expectations and Obligations

In addition to the excessively heavy workloads carried by Indigenous alcohol and other drug workers they were also subject to a wide range of internal and external expectations and obligations. The pressures and high expectations placed on workers were one of the consistent features of discussions with Indigenous workers.

"...expectations are very, very high."

[FG10; M/F; Ind; Met/R/R]

The high expectations on workers came from a range of different sources and were continually reiterated throughout this project. Some expectations were external and included community obligations, as well as the expectations and requirements of the services within which they worked. Other expectations were internal and derived from the strong personal commitment that most Indigenous workers felt towards helping their community and fellow countrymen. These heavy and extensive expectations resulted in workers being called upon for all manner of activities, some of which extended well beyond their job description, training and skill sets.

"...you've got to be superwoman."

[FG10; M/F; Ind; Met/R/R]

"[Male worker] you're expected to be the jack of all trades."

[FG10; M/F; Ind; Met/R/R]

Workers experienced significant expectations from their own communities, and/or the communities in which they worked (these were not always the same). Some respondents described how pressure from clients, family and the wider community created many "masters" for workers. The sense of being pulled in many directions simultaneously was quite overwhelming for some workers.

"For Aboriginal people working in alcohol and drugs...where it's so intense...the closer they are to the community-face, the more masters they have. And there is no respite from that. The stresses of that can be very overwhelming because of the level of expectation from every direction; from the family, from the broader community, from other community organisations that they are directly involved with."

[FG17; M/F; Ind/non-Ind; Met/R/R]

Community expectations of workers were substantial and involved many explicit, but also implicit, requests and expectations that reflected cultural roles and

obligations that extended well beyond "humbug". For many workers there was an unstated assumption that multiple roles, with all their attendant activities, would be assumed and carried out.

"As Indigenous workers...we're the health worker, we're the counsellor, we're the doctor, we're the aunty, and carer sometimes looking after your cousin running away from the husband who's drunk... at two o'clock in the morning they turn up at your place...and things like that...but then we still function...we still do our work at the same time."

[FG6; M/F; Ind; Met/R/R]

Community expectations were formed in the context of Indigenous disempowerment. That is, Indigenous workers were seen as a valuable resource and a viable option by which to resolve problems that community members often saw as insurmountable and that they felt powerless to address. In this sense, Indigenous alcohol and other drug workers were perceived to be a potent resource. This perception contributed to the high levels of expectation (reflecting high levels of need) but concomitantly also contributed to the pressure and stress experienced by these workers. Hence, as described by one worker, making commitments and keeping them increased community expectations, which in turn put added pressure on workers [Int30; F; Ind; R/R].

"... it can be really hard sometimes with countrymen. With us mob you know, we tend to be a little bit closer than ... not to take on people's issues ... it's a bit hard."

[Int33; M; Ind; R/R]

A senior, non-Indigenous clinician also believed that there can be reluctance from community members to get involved in finding solutions to problems and concerns and instead they rely heavily on the Indigenous worker to deal with it for them.

"Well, you're the drug and alcohol worker, you deal with it! You solve all them problems, you're paid to do it. Why should we get involved?"

[Int10; M; non-Ind; Met/R/R]

Community Expectations – "When you're it"

"Community expectations are quite different from agency expectations— sometimes these may meet, at other times they may be parallel but never meet, or at other times they may be totally divergent."

[Int30; F; Ind; R/R]

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As noted, the intensity of pressure and high expectations experienced by Indigenous alcohol and other drug workers came from many sources but it was often particularly profound for workers in roles where they felt they had sole responsibility for clients or where they were the first one to be called upon to provide assistance. As many Indigenous workers were the sole worker in a service or a region, they were often the only source of support or professional resource and as a result were heavily relied upon by other health and human services.

"When you're it ... the hospital are calling on you, on top of community health service, on top of the police, on top of ambos, on top of your family and the community as well!"

[FG9; M/F; Ind/non-Ind; R/R]

Beyond the demands from colleagues and other services there was another dimension of the Indigenous alcohol and other drug workers' role that entailed their strong sense of obligation to community. Obligation to community was of great importance and significance and is reflected in the extent and level of services provided to community members. It often involved an extensive and all-embracing range of roles, and included a very broad array of professional and personal activities.

"...run errands, use vehicle as public transport"

[Int16; M; Ind; Met]

By virtue of their training, knowledge base, positions held and connections with other services, workers were perceived as a very powerful resource. By default, they often became 'brokers' of information and services and negotiators for their communities. For disempowered communities to have members with a high degree of influence was a highly valued resource. But this also conferred a substantial load and set of responsibilities on the worker involved.

Internal Expectations

For other workers, the issues were a little different; and in many instances reflected their internal drives and motivations. Stress was often a reflection of the frustration of not being able to achieve more and to live up to their own expectations.

Not only were the expectations of others high, sometimes comprising unreasonable and incessant demands, workers also emphasised that what they wanted and hoped to achieve for their community was also very substantial. These workers had an intimate understanding of the needs of their community and the

difficulties they had faced over a long period of time and were driven by a strong desire to achieve positive change and improvements in the health and social functioning of individuals and community.

"...when first started job I would go home at night a bit stressed and think ... I gonna fix it, how can I fix it..."

[Int33; M; Ind; R/R]

Some workers described how often the hardest part of the job was when they felt that despite their best efforts they had failed to achieve significant improvements for their community. Such a sense of failure and futility contributed to low levels of job satisfaction. Given the enormity of the health and social issues with which workers were confronted, not to mention the often intractable nature of alcohol and other drug problems, many workers appeared to have unrealistically high expectations of what they might be able to achieve as an individual worker.

"...despite their best efforts, that when they leave the community there is still overcrowding, inadequate sewerage and water supply; and an overall lack of maintenance."

[FG7; M/F; Ind; Met/R/R]

"...if you look at job satisfaction and what change in health status, and what change in people being able to... over time ... you feel bad, bad! What have you achieved? And it's hard to keep going at times."

[FG9; M/F; Ind/non-Ind; R/R]

Pressure to perform well was also raised as a source of stress for some workers. This type of pressure related to all aspects of workers' roles, but was especially pertinent to the performance of clinical tasks such as treating clients or administering medications. Performance anxiety may be derived from several sources. It may reflect worker inexperience, the quality of the training received, lack of support and mentoring and judgmental scrutiny by other staff. The degree of personal closeness to clients and the deep concern felt for clients and patients clearly added to pressure and responsibility felt for their clients' wellbeing.

"...did I do it right or...? I know the first time I started distributing medication and I'd lay down at night thinking maybe that's the wrong tablet for that person. Next day you see that person starting to develop and eating well and you just go 'he's right'."

[FG6; M/F; Ind; Met/R/R]

Backlash and Blaming

“Community can be a little bit...; because family think you can get a house and this and that for them. So you get a little bit of backlash. But once again, it doesn’t really worry me ... I get a lot of extended family use this service and you hear stuff in the community. Stuff like that. It does get a little bit tricky working in the community. So you have to be able to deal with those issues.”

[Int02; F; Ind; Met]

Pressure was often exerted on Indigenous workers from community members to provide a wide range of support functions and services that might extend well beyond a usual job description. Workers were also held accountable if anything went wrong or if there was an adverse outcome. So, not only were they responsible for ensuring that their prescribed work role was carried out carefully and appropriately, they were also held accountable for the outcomes of the multitude of other activities that community expected them to take on. The greater the diversity of roles and activities, the greater the chances of adverse outcomes and events.

“Biggest stress is being a health worker in your community— they’ve got family, and if anything goes wrong out there, they are the guys who cop it first ... ”

[FG13; F; Ind; R/R]

There was often an element of blame or retribution if a positive or desired outcome was not achieved by the Indigenous worker, regardless of whether they were responsible for that outcome or not, or even in a position to affect the outcome. At times the blame was reported to be particularly harsh, and this further compounded worker stress.

“Communities look to the Aboriginal Health Worker, not the doctors or nurses... ‘you go and talk to the system for us’— and then when things go wrong it comes back to us, the health worker. And there’s a lot of blaming.”

[Int10; M; non-Ind; Met/R/R]

At the same time, there was often both a high level of acceptance of blame and an empathetic understanding of why such attribution of blame (justified or not) might be levelled at these workers. For many workers, blame was both an expression of a cultural norm as well as symptomatic of the extreme distress and powerlessness that community members had experienced over a long period of time.

“When people are in distress they often don’t see their impact on the health worker. It’s just another person to lash out at and be angry with.”

[Int10; M; non-Ind; Met/R/R]

As a result, workers were often resigned to being on the receiving end of harsh treatment and recriminations, as they understood its origins, cultural meaning and significance. Nonetheless, this did not reduce the stress associated with these aspects of their assigned roles.

What needs to happen is more places for Aboriginal workers to come on board. You can share that workload and not carry all of that burden. So you’re not the one who’s out there in the community being questioned by client’s family members on a constant basis.”

[Int13; M; Ind; Met]

Scrutiny of Personal Behaviour

There were not only high community expectations in terms of being available to support community members in a wide variety of ways, there was also pressure to be seen by the community to be behaving or acting in a culturally acceptable manner. As a result, workers felt subject to high levels of community scrutiny. For some, this created another source of considerable pressure.

“Another thing is other people in the community too. They want to know what the health workers are doing after hours, in their family time. Still got people backstabbing health workers— can’t even go out and have a couple of drinks. You’ve got people watching you. They [the community] go and tell the health manager. If you’re not on call, that’s it ... that’s their time. You know you get run down.”

[FG13; F; Ind; R/R]

For alcohol and other drug workers, a high level of community surveillance of personal behaviour was often particularly evident. Strong community views were sometimes held in regard to the consumption of alcohol and there was often a strongly held view that alcohol and other drug workers should be totally abstinent and act as a role model and exemplar for the wider community.

“The community perception that alcohol and drug workers should be teetotallers and shouldn’t be able to go out and have a drink on a Saturday night puts significant stress on the individual workers. Communities could be educated to think

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about how do they [the workers] do their job in a clinical perspective. Not what they are doing on the weekend.”

[Int22; F; Ind; Met]

Workers were often also subject to a high level of observation and scrutiny regarding whether they were fulfilling required community obligations and conforming to cultural norms. This is an experience not usually encountered by mainstream workers; or, where it does occur (such as positions where there is a higher public profile, e.g., police, teachers) it is at a much less intense level than experienced by Indigenous workers in small communities. Some workers reported that they frequently felt judged by the community and held accountable to very high standards of personal conduct.

“...being judged by community, Elders, family, young people when out in public ...[Aboriginal Health Worker] worker is always in the public eye and being held up to high standards such as not being seen drinking alcohol in public. [I've] been told 'you shouldn't be doing that'.”

[Int04; F; Ind; Met]

For some workers, being held up as a role model for the community was a positive and desirable aspect of their job and one from which they derived considerable reward. This was particularly the case for workers who had had a personal background of problems with alcohol or drugs that had been overcome. In these instances, being a role model and a living example of overcoming personal crises with substance abuse was, justifiably, a source of great personal pride.

“Its' also about being a role model for our community, we've been there, done the alcohol, and we're middle-aged!”

[FG10; M/F; Ind; Met/R/R]

However, not all workers felt judged and scrutinised by their community. Some remote workers stated that they did not feel that the community judged them if they saw them in the pub after the end of a hard week. Rather, the community understood how difficult the job was, realised that the worker might not drink to intoxication, acknowledged the seniority of the worker and the respect and support they had from other colleagues. Nonetheless, it was noted that there was scope for the community to be educated about the pressures placed on Aboriginal Health Workers, as in some instances it was thought that the community did not fully appreciate the load that these workers carried.

Some organisations had recognised the importance of this issue and had developed a Code of Conduct regarding public drunkenness, to ensure the credibility of staff who work with alcohol and other drug clients. Staff were required to sign the Code of Conduct as part of their employment contract agreement. In this instance, staff were not required to totally abstain from alcohol, as was the case noted in some other organisations that were based on abstinence treatment models, but were required not to become intoxicated in public [Int33; M; Ind; R/R].

Summary

The expectations and obligations placed on Indigenous alcohol and other drug workers were high, complex and varied. Expectations came from both the strong internal motivations that most workers had to help their community, as well as from external sources, including cultural obligations. Indigenous alcohol and other drug workers were seen as a valuable resource by their community, and as such communities had proprietorial views about these workers that have little parallel in mainstream. In addition, the importance of their default roles as brokers for the disempowered cannot be underestimated.

Boundary Issues

The concept of boundaries for health and human services workers is a fundamental principle that is strongly adhered to in mainstream Australia. However, for Indigenous workers this concept and its application was found to be a source of substantial cross-cultural dissonance. Moreover, it was also identified as a pivotal issue to be addressed in terms of worker wellbeing, stress and burnout.

Indigenous alcohol and other drug workers are very often members of the communities in which they work, connected through kinship, cultural affiliation, or marriage. The depths of these relationships create complexities for workers. Such complexities are intensified by accountabilities to mainstream service providers that are not tailored to meet the needs of Indigenous communities.

"I think one of the hardest things for Indigenous workers is about professional boundaries, because if you're a worker working in a community, whether it be an urban community, a rural remote community, you're connected to that community. You have family in that community, you have friends in that community, you have a whole range of connections and of course everybody knows you ... and so workers are never off duty."

[Int22; F; Ind; Met/R/R]

The distinction between professional and personal boundaries is one of the central differences between Indigenous and mainstream perspectives. For many Indigenous workers, this is an artificial construct that does not exist as part of their reality. The professional self and the personal self are 'one and the same thing', and they do not constitute separate entities.

The issue of being "on-call around the clock", as opposed to working "9-5" was a common source of cross-cultural conflict. It also raised the pivotal question of when does being a "fully committed" worker tip over to becoming an "over committed" worker; how does one recognise when this is happening; how can it be prevented or best managed.

"This 9 to 5 concept, it doesn't happen in Indigenous communities or for workers who are in their communities."

[FG7; M/F; Ind/non-Ind; R/R]

For many mainstream workers, their sense of self is defined and shaped by their professional identity (e.g., 'I am a doctor/nurse/policeperson/mother/gardener'). In contrast, for many Indigenous workers their principal

source of identity is as a 'community member' – personal identity, personal allegiance and commitment is to community first. Other roles and identity are secondary to that.

"You wake up in the community, you go to sleep in the community, you're a community member."

[FG2; M/F; Ind; Met/R/R]

Largely as a result of the passion and commitment almost universally expressed by Indigenous workers it was not uncommon for workers to report how hard it was to turn off. One of the fundamental elements of stress management is 'down time' or 'time out', where day-to-day work pressures cease or recede even if just temporarily. For many Indigenous workers, however, this was hard to achieve.

"Hard to find that off switch."

[FG15; M/F; Ind/non-Ind; Met/R/R]

For some workers, the greatest challenge in setting boundaries was in relation to their own family and the associated demands and expectations that they placed on them. Many workers found that working with their own family – which included extended kinship networks as discussed previously – could be a stressful and "isolating" experience. Family members often did not understand the constraints of the job, and expected help outside the worker's role and outside working hours, especially to deal with crisis situations. Workers in such circumstances reported that they sometimes found themselves "end[ing] up at home in crisis".

"...feel like have to constantly be setting boundaries with family."

[FG9; M/F; Ind/non-Ind; R/R]

In addition to boundaries, workers also had to shift back and forwards between their different roles with the same groups of people. A female health worker in a remote setting commented on how hard it could be to separate family/personal life while fulfilling one's role as a health worker. She described how it was common for there to be family arguments or disagreements over the weekend and then, during the working week, she would have to put those issues to one side and treat family members as a patient. Workers facing similar circumstances relayed how over time they had developed strategies to seek support to help them manage the conflicting demands placed on them.

"...manages now by talking to nurses, and found that it sometimes also helps to talk openly with the patient about the situation, often in the car when dropping them home, and making distinction

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between life as a community/family person and patient/worker relationship.”

[FG10; M/F; Ind; Met/R/R]

For some workers, the relentless demands and the inability to establish culturally appropriate and workable boundaries was a source of stress that was often attributed to leading to burnout. It was also a strong motivator for workers to leave their role as health workers to take on less emotionally draining roles.

“My brother was a health worker, but he left to work in the mines.”

[FG10; M/F; Ind; Met/R/R]

“It’s hard to explain to non-indigenous people what it’s like...working in community can be very difficult, get burnt out sometimes.”

[FG10; M/F; Ind; Met/R/R]

Working Arrangements

“...Aboriginal community sees the whole community as their family; so making that separation is just not as easy.”

[FG16; M/F; Ind/non-Ind; Met/R/R]

The 24/7 nature of the job was repeatedly mentioned. Mainstream concepts of fixed working hours and firm (or at least “firmer”) boundaries between one’s work role and one’s personal life do not apply in many instances for a very large proportion of the Indigenous workforce. This lack of conventionally defined boundaries is even more pronounced for workers who live and work in rural communities where relationships are often closer, either through blood or clan lines and boundaries even more blurred or non-existent for many workers.

“...there is not separation from community and family ... they are all intermingled together.”

[FG16; M/F; Ind/non-Ind; Met/R/R]

“...all of us are connected to the Aboriginal community in every shape and form.”

[Int01; F; Ind; Met]

The high level of connectedness among Indigenous community members was an extremely positive feature, but it was also associated with some distinct disadvantages.

“I do find it a bit hard. That’s where the stress comes because I am related to a lot of people in this town. Some of my clients are my nephews.”

[Int14; M; Ind; R/R]

For example, high levels of connectedness resulted in community members relying heavily on Indigenous workers to provide assistance and in considerably less reticence in seeking such assistance. Assistance might be sought out at almost any time or in any setting. Moreover, assistance would be readily sought for a wide range of problems, not just alcohol and drug issues or even health concerns, but assistance in general. The Indigenous alcohol and other drug worker is perceived as a community resource, and as such, is heavily relied upon.

“It’s 24 hours a day when you’re living and working in the community like that. Because once people know that you’re there, then they’ll come to you about any problem at all, related to the substance use or whatever. They’ll come to you anyway, because you happen to be that person who’s seen as, you know, the straight guy, got more resources, and all the rest of it. So you’re there 24 hours a day for people.”

[FG4; M/F; Ind; Met/R/R]

“...living in a small town and living quite close to a local pub, a lot of ex-clients come over and they don’t know what the time is and they have a yarn. I accept it as being part of where I am. Can be annoying sometimes, and it can be a bit worrying sometimes.”

[Int27; M; Ind; R/R]

For others, however, the issues around boundary setting appeared to be not so much about cultural differences and Indigenous ways of working, but rather reflected the sheer workload, lack of services provided by other staff, and the proximity of many Indigenous workers to the local services.

“We are Aboriginal people that live in the community. The clock doesn’t stop at 5pm for us. I think if you got that ongoing stress in some areas, it’s even worse.”

[Int13; M; Ind; Met]

Nonetheless, establishing boundaries proved to be especially difficult for many workers. Even where workers recognised the toll that persistent demands were taking on them and wished to create firmer boundaries many found it hard to do so.

“...to have that stuff that you’re talking about ... with the community and putting your boundaries in is really difficult when you’re talking about a community like (X).”

[FG9; M/F; Ind/non-Ind; R/R]

"Everywhere I go, in every community I get recognised. People always want to talk to me about alcohol and drugs, even if it is my time out, going fishing or something That's OK, as long as it doesn't get too long and drawn out. Make it short and sweet and say that 'you know, call me on Monday.' Or, come in on Monday and see me because right now I want to go fishing'. People are usually good about it. You get a lot of respect from the clans."

[Int27; M; Ind; R/R; WA]

Close Relationships

The closeness of Indigenous relationships in small communities was also highlighted as potentially problematic in terms of workers attempting to set boundaries. The following poignant story of a worker called out when a young man she had known all her life shot himself illustrates the frustration and pain of having to explain kinship relations that are not understood or recognised by mainstream workers.

"...live in a small town ... I know everyone, am related to everyone. One public holiday, got called out to a young man who'd shot himself, even though there was nothing we could do. I was taken to hospital in shock, ...people asked how I was involved, told them 'what???' That got to me ... these people didn't know what it's like!"

[FG10; M/F; Ind; Met/R/R]

"We work with grass roots clients. Can be sister girls, they can be friends that we have grown up with, they can be even relations and it's very hard."

[FG16; M/F; Ind; Met/R/R]

Multiple Demands

"... you never knock off at 5. You're always on call unless you can get out of town, go for a drive."

[FG10; M/F; Ind; Met/R/R]

Emergency Callouts

In addition to often being available 24/7 or for extended periods of time beyond a regular working day, there was also the issue of 'callouts' or being on call. Moreover, there was consternation expressed about what and who defines a call out. Conflicts had arisen over whether a 'callout' was legitimate and accepted as such and whether the worker would be paid or not for such a call out.

"Emergency callout— you only go for emergencies. That's what they tell you. Someone comes to the door with a sore leg. Well you wouldn't consider that an emergency? But how do you know that they haven't got DVT or got a clot in it? You gotta go check them out regardless. So callout's the biggest [source of stress]."

"Callout, or on call, is the biggest killer of nurses and health workers in the whole of the remote health situation. And it's easy for a [mainstream] worker to sit up there and say 'Oh yeah, but you only go out for emergencies'. I mean there's even been arguments where people have gone out at night, over the years, gone out on a call out, and they've been told that they're not getting paid for that because it's not an emergency. Well what's a f***ing emergency? You don't know if it's an emergency or not until you've checked it out."

[FG12; M; non-Ind; R/R]

Learning to assess the severity of a presentation or request for assistance was an important professional development factor to enable the worker to make a determination about the need for immediate assistance or prioritising for assistance at a later time. So, both learning to refer and defer was a crucial element in professional growth.

"If they talk about suicide, you stop and take time out. Otherwise, if it is not serious it is important to remind people about your own 'time out' time."

[Int27; M; Ind; R/R; WA]

24/7 Commitment to the Job

Many participants felt it was important for them to be available for clients when they were needed and to be afforded the flexibility that would allow them to respond to the community in this way. Failure to be able to do so had potential to form the basis of substantial cultural conflict in some workplaces. For example, one participant commented that she had been told by senior staff that she was not to work after 5pm or if she did so it would be in a voluntary capacity:

"[not] allowed to work after 5pm, and anything she did do after 5pm then would be voluntary."

[FG5; Ind/non-Ind; Met/R/R]

However, she indicated her discomfort with this world-view and stressed that it represented a breach with traditional "black fella ways" of working and it did not accord with her view of how she could or should ethically carry out her various roles and responsibilities to community.

Chapter 4: Sources of Stress

"..don't want to work in white model, not black fella ways."

[FG5; Ind/non-Ind; Met/R/R] (also see Section 9 of this chapter)

This experience of being advised to adopt mainstream approaches and strategies to imposing boundaries was not uncommon. For example, workers in some locations reported being coached not to work 24/7 and they were instructed that the way to achieve this was simply to "go home and close the door" [FG5; Ind/non-Ind; Met/R/R].

A recurrent theme was the difference in cultural ways of working, where mainstream approaches place a heavy emphasis on worker boundaries and limiting availability to clients (i.e., community) to prevent burnout. The clash of cultural ways of working appears to be a key issue that has not been satisfactorily addressed or resolved in many instances and one that requires closer attention.

"just know your own boundaries, and don't get ... it can be really hard sometimes with countrymen."

[Int33; M; Ind; R/R]

Out of hours demands on workers also came from other sources such as Elders. Again, it was clear that there was little option available to Indigenous workers other than to comply with such requests or run the risk of losing respect within the community. If this occurred it would effectively disenfranchise them as functional members of that community.

"... I've had Elders ringing and they want you to come out at 10pm. You can't say no. Once you say no, you lose all respect from the community and that's hard to get back. You just go deal with it. Make sure they're OK. Make sure that the client is OK and pick up from there the next day."

[FG2; M/F; Ind; Met/R/R]

"...for most AHW's the work's 24/7. They might have family that have mental health issues— often support family members going to the psychiatrist and talk for them. Only [mainstream workers] has to see the client maybe once a fortnight— but for Aboriginal Health Workers, they have to deal with them 24/7 because family's always there."

[FG10; M/F; Ind; Met/R/R]

Establishing Professional Boundaries

The challenge of establishing boundaries was often discussed, with the potential ramifications of not fulfilling community obligations raised as an issue of concern.

"...saying no to people alienates community, community leaders and families can have greater expectations."

[Int16; M; Ind; Met]

Many workers reported being approached for assistance outside of their formal working hours and described the common experience of being approached by clients after hours or simply running into them in a social context. Some workers were initially unsure of how to interact with clients outside of work, for example, when out shopping or mixing socially in the community. For some workers, having been trained in appropriate processes to establish and maintain confidentiality enabled them to disconnect from their work role and comfortably engage at a social level [Int04; Ind; Met].

Some of the more experienced workers discussed ways of managing after-hours demands that had worked well for them personally and that also ensured the wellbeing and care of their clients. For some workers, years of experience resulted in them developing efficient but also culturally appropriate and caring ways to deal with demands on their time that arose out of hours.

"...I first started drug and alcohol, years and years ago, ...if you get a call and it's after hours ... I've always found it's easier to deal with when you get the call than to wait for the next day. Sometimes on the next day, it's actually a lot more difficult to deal with. A lot more issues to deal with. I find it's easier to just go and do it. Make sure I settle them down. Make sure they're OK and get a promise that they're going to be alright until tomorrow. Sometimes that may only take half an hour or an hour. By going out and just doing that actually guarantees that they'll be there the next morning. To me, it's just been easier to just go and do it. Make sure they are OK. Make sure they're safe and deal with it the next day."

[FG2; M/F; Ind; Met/R/R]

For other workers, resolving excessive and conflicting demands placed on them necessitated developing compromises that did not involve an outright refusal, but nonetheless created culturally acceptable and meaningful boundaries around the worker's own time. Some workers were clearly comfortable about the ways that they had learned to manage demands on their time that were sensitive and responsive to the needs of the person seeking assistance and that also minimised the imposition on their own time.

"I used to have people knocking at my door after 10.30 at night; but that's part of being an Aboriginal person living in the community. You don't have 9 to 5 hours generally. People know where you live. They'll come and try and access you after hours or on the weekends in the shopping centre and just discuss things with you. But for me I didn't find that a problem. It's generally a quick 5 minute chat, book an appointment with them and away we go."

[Int13; M; Ind; Met]

Approaches made to workers by community members required them to respond in ways that were culturally appropriate and compatible and that did not cause offence or damage their relationship with the client or the community.

"When I get that [approached by clients] I just take it as a social thing. I think of other things to talk about like fishing and hunting and stuff like that. If they do bare their problems, I may well sit, sit and listen to it, but then also give them guidance for seeking other avenues for support. Helps keep time out free and unrelated to work."

[Int32; M; Ind; R/R]

While many participants reported that they worked 24/7, or very long hours well outside regular "office hours", there were others for whom this was not the case. Some workers were actively opting to not work outside their formal hours of work. One worker, for example, described the change to working 9 to 5 Monday to Friday after many years of working shift work.

"The working hours 9 to 5 is pretty good for me Monday to Friday. I am happy with that. I get weekends off and before at my other job 18 years shift work. So this is good."

[Int14; M; Ind; R/R]

Maintaining Confidentiality

An issue related to the conundrum of after hours work was the challenge of maintaining confidentiality. Throughout the consultations, confidentiality emerged as a crucial issue. As the communities are often small and tight knit, there is usually a higher level of knowledge and information sharing than occurs in mainstream Australia. Maintaining confidentiality in such settings is not only ethically important, it also constitutes a particular challenge.

An example of the difficulties of maintaining confidentiality was provided by one participant who

described a typical scenario where a worker goes from one Indigenous service to another. In that situation, if the other service didn't know who the worker's clients were then this was regarded as a positive outcome in relation to successfully maintaining client confidentiality.

"...do you see anybody?' They don't know who I see and that's that confidentiality and that's the most important part of making sure our clients' issues are respected and that their issues are safe."

[FG2; M/F; Ind; Met/R/R]

"If people asked them did you go and see such and such, they will know that someone has said something then they might not come back, someone in their family might know that they're going to see someone, but they don't know what the issues are."

[FG2; M/F; Ind; Met/R/R]

Improved Understanding Needed by non-Indigenous Workers

Some Indigenous workers made a plea for non-Indigenous workers to develop a greater understanding of basic issues such as the importance, and often the necessity, of working beyond standard prescribed hours of work. It was acknowledged, however, that acquiring this understanding by non-Indigenous workers would be difficult, if not impossible.

"Understanding that our role is not just in the working hours but it follows us home 24/7 ... for Wadjella they can probably shut the door to their job at the end of the week for the weekend. But if someone came to us on the weekend then we would help, not just within our role but because its culturally appropriate to do so. No question."

[Sur; F; Ind]

"Although non-Aboriginal people in organisations such as mine have empathy, they will never understand that Aboriginal workers cannot shut off from their work because it's in a small town."

[Sur; F; Ind]

Increasingly, however, there was a sense that the Indigenous workforce would need to change the acceptance of unfettered and unlimited access to their time, simply to ensure that they, as a valuable workforce and community resource, did not burnout. Creating and maintaining realistic and culturally appropriate boundaries was therefore identified in this project as a crucial workforce development issue.

Chapter 4: Sources of Stress

“Have to learn your limitations and learn to enforce them. You cannot help everyone. Have to remember that work is a priority and that you are helping people there, as well have to take time for yourself, as you cannot help others unless you are well.”

[Int03; F; Ind; Met]

A current challenge is to provide assistance to Indigenous or non-Indigenous workers to find a culturally appropriate balance between personal needs and community obligations.

Reframing Cultural Obligations

The challenge of setting professional boundaries is relevant to all workers, but it is particularly pertinent to Indigenous workers given their obligations and connection to the community. Whether alcohol and other drug Indigenous workers are located in urban or remote settings, special challenges and considerations arise.

One participant saw their role as building the capacity of workers to set professional boundaries. The issue of managing boundaries was also described as being of central importance to some training programs, both in terms of an ongoing process and a core training topic.

“...it's about building the capacity and skills of that worker to be able to professionally say to someone 'Come to me in the morning and I'll deal with issue, in the meantime if you're not feeling well, go to the hospital'. That's much more useful than going through a whole lot of words and rhetoric that tends to be written about these sorts of things. It's about giving them [workers] the skills and the confidence [to deal with these situations].”

[Int22; F; Ind; Met]

Developing Skill and Confidence To Set Appropriate Boundaries

To-date it appears that professional boundaries and related issues have been poorly addressed in Indigenous health training programs. A senior commentator noted that 10 years ago when she was initially delivering training it would take a heavy personal toll. However, professional experience coupled with professional boundaries have given her the skills to process issues and not be affected to the same extent by the issues she teaches about. She considered an important component of the training she delivers to be teaching the Indigenous workforce about good boundaries that are culturally secure.

The Indigenous workforce is able to explore this in the workplace, while still being able to balance

it with cultural and social obligations to family and community. It was often heard in the conversations with participants that “Well, I work 24/7”. In contrast to the previously commonplace acceptance and resignation that being accessible 24/7 was the only appropriate and viable way to act in one's community, others are now challenging this position and suggesting alternative approaches and perspectives. An increasingly strong view heard was that Indigenous people should not be subjected to 24/7 demands based on their Aboriginality and cultural obligation.

“... because no one can work 24/7.”

[Int21; F; Ind; Met]

However, it was clear that when issues around setting boundaries had been raised with workers, it was often done in a way that was incompatible with Indigenous ways of working or expectations that existed in this regard. Training courses that addressed boundary issues were often reported to encourage practices that were culturally inappropriate, incompatible or just not feasible:

“Part of the course that we do ...is professional boundaries and some of it is ridiculous. You're telling people don't give out your phone number or address and they live in the community. They got no way out and it seems almost pointless to be saying those things to people because it can't work if they're part of a community and they are going to get their door banged on at three o'clock in the morning if that's what's needed.”

[FG10; M/F; Ind; Met/R/R]

Nonetheless, being in continual demand and always “on” was often found to place extreme pressure on workers, and such continual pressure was seen as a potential contributor to worker burnout.

“I see that as a massive problem with Aboriginal workers, not having time for themselves, and I think it's a big contributor to burnout.”

[FG1; M/F; Ind/non-Ind; Met/R/R]

It was evident in many conversations with Indigenous (and also non-Indigenous) workers that the issue of boundaries was both a source of workplace tension and an area where the underpinning cultural significance was often not well understood. Moreover, it became clear that ways to address this issue that were both culturally sensitive and appropriate and in the best interests of the worker had not been well established or even adequately addressed. This is an issue that warrants priority attention and until this area of conflict and worker stress is tackled it is likely that it will continue to be a source of friction.

An illustration of learning/teaching about boundary setting

Better trained and more experienced workers have learnt how to establish boundaries.

One participant described how when he first entered the alcohol and other drug field he had the opportunity to travel to Alice Springs and participate in a Canadian Indian model of counselling training arranged by CARPU - about 40 people from across Australia, released from work for six one-month blocks. Trainers came from Canada, and used methods based on disease and abstinence models. He described the process of going through that training as “sort of went through a treatment program ourselves”, that required him to have a good look at himself and where he might be lacking, developed an awareness that he can’t support others in need if his own life is in chaos. The course taught him how to separate himself from the job – but he acknowledged that separating one’s self can still be very difficult as XX is a small place and countrymen will often present at CAAPS, but feels he has the capacity to recognise how to manage those situations better.

[Int33; M; Ind; R/R]

Lack of Recognition, Respect and Support

The treatment of Indigenous alcohol and other drug workers in their workplaces was often described in positive terms,⁶ but this was not always the case. The role of the Indigenous worker was also found to be associated with a range of very negative and stressful experiences. The latter were most commonly characterised by a lack of:

1. recognition for work undertaken
2. respect for themselves, their clients and for Indigenous ways of working, and finally by
3. support from co-workers and management.

Each of these crucial issues is a potential source of substantial stress for workers, and each is examined more closely below. Encouragingly, this research project was seen by some participants as a potential vehicle by which greater recognition and acknowledgement might be directed towards Indigenous alcohol and other drug workers.

“Hope this research lets people know exactly what we’re doing on the ground.”

[FG13; F; Ind; R/R]

“... we need something like this so people understand what’s happening.”

[FG13; F; Ind; R/R]

The Importance of Recognition

Consistent with research on worker stress and burnout in other fields, lack of appreciation and recognition were highlighted as important factors that contributed to negative outcomes, including extreme cases such as worker burnout. For many workers, there was a clear and linear relationship between lack of recognition and work-related stress and burnout.

“...people get burnt out because no-one gives them the congratulations.”

[FG6; M/F; Ind; Met/R/R]

A source of great stress for Indigenous alcohol and other drug workers was often not the nature of the work or the work setting (e.g., as determined by geographical location and all its potential challenges and limitations) but rather the more intangible conditions under which workers had to function. Lack of recognition appeared to have a substantial impact

on morale, self-esteem and overall functioning. It also appeared to be strongly correlated with motivations to leave positions.

“... you want a thank you here, go out the front and pick up some poor old lady’s bag of groceries, and put them in her car for her. You might get her to say ‘thank you’, but around here you won’t. And it’s just about recognition. You don’t get recognition, and some days you feel like saying ‘I’m out of here’.”

[FG15; M/F; Ind/non-Ind; Met/R/R]

The value of the work undertaken by Indigenous alcohol and other drug workers was generally acknowledged by clients and the community (and this was greatly appreciated, as highlighted in a later section of this report that explores what workers found to be rewarding).

“Our own people recognise what we do, but it’s the other’s who don’t.”

[FG13; F; Ind; R/R]

There was, however, deep concern about lack of recognition from other quarters such as professional peers and colleagues.

“Yeah, your own people do recognise it, but it’s not them we need to get to recognise.”

[FG13; F; Ind; R/R]

Lack of recognition of Indigenous workers’ knowledge and skills, and of the roles that they actually carried out was a potent source of stress for many workers. It was also reported to be particularly difficult when other workers received recognition that was justifiably due to the Indigenous workers but not afforded to them.

“... lots of good health workers in communities, who are very skilled ... [but] not valued for their knowledge and skills, and training undertaken.”

[FG9; M/F; Ind/non-Ind; R/R]

A major source of frustration for many workers was lack of recognition from their closest working colleagues, most notably their non-Indigenous colleagues, and particularly nurses. Lack of recognition extended to instances where workers felt undermined by the actions taken by nurses. There was also a strong view held that many Indigenous workers had equivalent skills and levels of competence as those exhibited by nurses but that this was not acknowledged. As a result, many of these workers felt frustrated, under-valued and undermined.

6 See Chapter 6 on Rewarding Aspects of the Job.

“What makes me frustrated also is when the nurses come in and they undermine the health workers. They [think we] don’t have the skills or the knowledge. But we do the same job as the nurse. We’re not recognised for those skills.”

[FG13; F; Ind; R/R]

Failure to receive due recognition was often linked to the role of nurses and the workers’ relationships with the Remote Area Nurses (RANs).

“... lots of support for nurses, but little support for health workers based in their own communities.”

[FG13; F; Ind; R/R]

Not only did the Indigenous workers feel that they did not receive appropriate recognition, they also noted that the RANs appeared reluctant to adopt and apply the cultural knowledge of these workers. This further reinforced feelings of disrespect and disregard, and was a source of considerable frustration.

“Some nurses can be quite down putting—tend not want to use cultural knowledge of local workers, and then wonder when there are incidences when the community are banging on the hospital doors wanting to kill a nurse. It’s frustrating seeing this, and seeing that workers are not getting supported from higher up and are floundering ... but they still keep on going.”

[FG9; M/F; Ind/non-Ind; R/R]

As the mainstream group that AHWs work most closely with, and by whom they are often supervised, it was not totally surprising to find a degree of friction between these two groups. But it was disturbing to hear the consistent stories of lack of support from professional peers or supervisors and the commonplace disregard for cultural knowledge. This often manifested itself in terms of the AHWs feeling negative about the nurses, who they often saw as oppressive rather than a source of collegial support.

“... some of us get mistreated sometimes by the nurse. Pressure ... when you’ve got family problems ... and the nurses expect you to be at work on time. That puts pressure on you. And if you’re sick at home, they expect you to be at work. Some of the RN’s don’t understand.”

[FG13; F; Ind; R/R]

Concern was expressed among one group about the inequity between nursing/medical staff and AHWs where leave was involved, with AHWs not receiving comparable support for leave or the benefits of backfill. In many instances, participants saw their professional status as being extremely low and that they were

treated in demeaning ways, particularly in relation to leave issues.

“...when nurses need to take a break or have holidays, they get locums to cover, but not when it’s the health workers [another worker finishes the sentence] only a lowly health worker.”

[FG10; M/F; Ind; Met/R/R]

In some instances, there was open antagonism directed towards nurses from the AHWs, as the former were seen to be doing essentially the same work but receiving both higher pay and greater recognition with more tangible benefits. Incentives to maintain the status quo were also seen in terms of threatening and challenging the advantages currently held by nurses.

“...personally think that some nurses feel that if they train AHW’s up that they’ll lose their jobs—should share the responsibility and work together it’s not about taking anyone’s job.”

[Int15; M; Ind; Met]

When asked if the issue of recognition was about being respected or getting a better level of pay, participants were clear that some of their concerns related to their very low pay level and that was seen as one indicator of a lack of recognition of their worth and the contribution that they made (this issue is addressed in more depth in chapters 4.10 and 5.2). However, they were also adamant that much of their concern related to a lack of respect and professional recognition that was frequently not afforded to them by their non-Indigenous work mates.

“Some of it’s about money. They [nurses] get better money for working night and day [shifts]. But I think that this is changing. There’s not a lot of health workers. A lot of the nurses have to be on 24/7, but when the nurses get stressed-out they whinge about how tired they are. Health workers have to be on call too though. Community would rather listen to their own people, than the nurses. They are communicating in their own language, and they know their own people.”

[FG14; F; Ind; R/R]

In spite of a fairly extensive array of negative comments about nurses, and RANs in particular, there were also some quite positive views. It was noted, for instance, that the RANs were often very impressed with the degree of commitment and dedication shown by the Indigenous workers. The degree of dedication and commitment exhibited by AHWs was recognised and acknowledged by nurses who had:

“...admired the commitment of the AHWs.”

[FG10; M/F; Ind; Met/R/R]

Chapter 4: Sources of Stress

Lack of Respect

A major underpinning issue related to lack of recognition was lack of respect. This was an all-pervasive theme throughout conversations and interviews with Indigenous workers. Lack of respect was identified by many participants as the pivotal source of stress for them. There was a common view that with greater respect and recognition, the plight of the Indigenous alcohol and other drug worker would be greatly improved and associated stressors substantially reduced.

“Don’t get respect as Aboriginal alcohol and drug worker, particularly from other services. We should be proud of who we are, and get respect.”

[FG3; M/F; Ind; Met/R/R]

The Importance of Support

There were also broader and more functional concerns about overall levels of support. Provision of support was seen as an essential element in reducing the stress that workers experienced. The importance of support was highlighted in various ways and at various levels. Some support-related issues focused on the needs of individual workers, while others were about the wider provision of support and services for the community at large. Each of these different but interconnected forms of support is examined below.

One worker described the sense of isolation experienced when she started a new job. Isolation in that instance was largely attributed to the insular way her colleagues worked and the alien culture of her working environment, i.e., little team work, and most workers were housed in individually separated offices and usually with their doors closed.

“Some isolation experienced when first started position— isolation from other workers, office doors closed...not made to feel welcome.”

[Int04; F; Ind; Met]

Receiving appropriate professional support was often reported to be difficult. For rural and remote workers it was made even more difficult due to geographical and climate limitations. In such instances, often the best that could be offered to workers was a form of remote support such as telephone advisory support and counselling or professional contact via phone or email. One worker described how she was directed to seek support via such a telephone service but was clear that it was person-to-person interaction she needed most.

“...sometimes told to ring a health crisis line and get support. But often don’t want to talk by

phone, want to talk to someone face-to-face. And sometimes the person on the other end, they don’t know what you’re going through or know the area.”

[FG10; M/F; Ind; Met/R/R]

In direct contrast to the importance that Indigenous workers placed on connectedness and a sense of belonging, there was a consistent theme of isolation and exclusion. This occurred at many levels, but invariably the experience was negative and at times hurtful.

“We like the job, but ... would like for some people to listen to us, but no one sorta listens to you, you know ... Where do we get our support from?”

[FG10; M/F; Ind; Met/R/R]

In some instances, strategies were discussed that had been put in place to overcome this sense of exclusion. Some of these strategies were at the structural level. For example, when Indigenous alcohol and other drug workers found they were not considered part of the Health Worker group in their state they established an alternative support structure.

“...we set up the Aboriginal Drug and Alcohol network. It’s set up totally different from the forum. The major difference is we have included government and non-government workers in our network. We also take in to account the rehab workers and any Aboriginal workers working in detox. So we are inclusive of all Aboriginal workers working in drug and alcohol.”

[FG2; M/F; Ind; Met/R/R]

Establishing an alternative support mechanism and structure had some important positive implications. For example, it was found that the alternative structure had scope to have input into policy making processes and provision of advice on key matters of interest that would not have been possible previously.

“...influence on policy so we can actually provide advice on policy guidelines and policy development.”

[FG2; M/F; Ind; Met/R/R]

The example above is an important illustration of actions and strategies that can serve to empower workers, and where an initial negative experience of exclusion resulted in a positive outcome through the implementation of alternative structures better suited to the needs of the workers.

The importance of peer support was also noted, even if good management support was available. Co-

worker support, however, was sometimes seen by some participants as a one-way street. A male worker described, for example, how his non-Indigenous colleagues would “come and pick his brain because he is Aboriginal and Torres Strait Islander and has community knowledge”. But when he asked for support this was not reciprocated.

“...no one’s there...”

[FG3; M/F; Ind; Met/R/R]

Reciprocity is an especially important feature of Indigenous culture. It is therefore a source of considerable disappointment when it is not found in mainstream colleagues and society in general.

A senior Aboriginal Liaison Officer described how she had learned to manage some of the overload and burden associated with all Indigenous referrals coming to her by asking non-Indigenous workers to assist. Nonetheless, she still found that it was an uphill battle and while co-workers would respond to her request for assistance, they were still reticent to spontaneously offer support.

“They’ll never go out of their way to offer, but they’ll always do it for me if I ask.”

[FG10; M/F; Ind; Met/R/R]

The onus of responsibility for both procuring and maintaining support networks and mechanisms often fell to the worker themselves, no matter how junior, inexperienced or new to the field they were. Some workers further highlighted that not only did they need to take the initiative in regard to securing support, they also took an assertive lead in terms of forging improved working relations with mainstream workers to help overcome separation.

Solo Workers

Many Indigenous alcohol and other drug services are relatively small and thus challenged by the difficulties associated with running and maintaining any small service. In these types of services, Indigenous workers were often the sole worker in such a role and they often worked in relative isolation.

“... there is a lot of places where there is only one worker.”

[FG2; M/F; Ind; Met/R/R]

Workers in these situations often felt unsupported, with comparatively little professional or collegial support available to them. These workers expressed

a high level of need for support to provide them with professional guidance, to provide them with a highly valued team work environment, and also to help alleviate their workload.

“If you wanted direction, you got no-one to turn to.”

[FG2; M/F; Ind; Met/R/R]

“I think clinicians and health workers need to support each other a lot better...even though they are working alongside each other, they are not supporting each other like they could be.”

[FG9; M/F; Ind/non-Ind; R/R]

The need for substantial levels of support for workers was also a reflection of the nature of the client group (i.e., Indigenous people with alcohol and other drug problems) and the associated stigma and discrimination often encountered by both workers and clients. This often resulted in a high degree of professional isolation, further highlighting the need for even greater levels of support for these workers.

“... workers can find that working with their own family in community can be stressful and ‘isolating’ for worker... clinicians and health workers need to support each other better.”

[FG9; M/F; Ind/non-Ind; R/R]

Even when workers were part of a team, some still experienced personal and professional isolation and received little or no support. This phenomenon was considered to be especially common in the human services delivery field, particularly if working in a rural or remote setting or involved in projects that were transient and one-off – as many Indigenous health projects often are.

“Issue of isolation and possible lack of support for Indigenous workers who are involved in human service delivery in rural and remote locations even though those workers may be part of a team. This may be even more significant if the service/initiative that they are providing is one-off.”

[Int30; F; Ind; R/R]

Summary

Lack of recognition, respect and support were an omnipresent feature of the work life of Indigenous alcohol and other drug workers. It is also an issue that caused extreme distress and stress for workers. A number of strategies were identified to redress this high priority area and these are detailed in Chapter 6.

Working Conditions

In addition to workload, high expectations, lack of boundaries and low levels of recognition and support, as discussed in the sections above, Indigenous alcohol and other drug workers also experienced a range of difficulties in their working situations that were unique to their circumstances. Such difficulties were major contributors to stress and often negatively impacted on the health and wellbeing of these workers. They ranged from factors associated with the geographical location of the work environment, including weather, through to travel and resourcing levels. Some of these factors are outlined below.

Remote Locations and Stress⁷

Many Indigenous alcohol and other drug workers are located in rural and remote locations. This factor alone brings with it a range of potential stressors with which all workers in such circumstances have to contend. Living in a remote location places additional pressures on workers. In part, this stems from the geographical remoteness itself, but also from the increased difficulty entailed in finding time and space for workers to get away from the pressures of the job.

“Live on site at remote facility— to go anywhere it’s 4 hours to XX, 9 hours to visit family. So very difficult to find time to go anywhere— this is a big contributor to burnout, because you end up living and breathing the alcohol and drug scene.”

[FG3; M/F; Ind; Met/R/R]

Working in remote locations further exacerbated the 24/7 demands on workers. As many participants noted, remote workers cannot go home, and some are inevitably on call 24 hours a day. In addition, the community knows that workers are readily accessible to deal with everything from routine matters through

to emergencies. This was repeatedly noted by participants as an aspect of their role that placed considerable pressure on them.

“Remote people can’t go home. They’re on call 24 hours a day. Community know they are there and they feel comfortable going and knocking on the worker’s door even if it’s not an emergency, but that puts pressure on the health worker.”

[Int15; M; Ind; Met]

“... it’s 24/7 in these communities. Burnout is pretty full on. They don’t have the support as well from other workers because of the remoteness.”

[FG6; M/F; Ind; Met/R/R]

A further challenge for participants working in rural and remote areas was lack of a wide range of resources that are usually taken for granted in most work settings. There were often few local support services available to workers in these isolated settings that would be standard in most other settings, such as health, welfare and community services. The absence of these support services further highlights the pressure and isolation under which many workers are often forced to function.

“...remote workers are often a long way away from additional support such as the police or medical treatment for clients.”

[Int15; M; Ind; Met]

The physical arrangements and housing provided for workers in rural and remote locations also added to potential stresses for both workers and management. In many rural communities there was either an acute shortage of suitable housing or very limited options. But more importantly, there were often major differences in the types of housing and accommodation facilities available for Indigenous versus non-Indigenous workers. Facilities for non-Indigenous workers were invariably of a higher standard than the limited stock available for Indigenous workers. Understandably, this was often a source of considerable distress.

“Separation of professionals and non-Indigenous workers does not help build rapport in communities. Houses are physically separated— police, nurses, teachers are all separate from community. But if you want to be part of the community, really be a part of it... If you enter a community, you can see the white fella side cos it’s all high fence and clean— I don’t know how to explain it, it just makes me wild.”

[Int15; M; Ind; Met]

7 In a recent large study of Indigenous wellbeing (AIHW, 2009), there were some observable differences on wellbeing measures, depending on whether respondents lived in non-remote or remote areas. Respondents in remote areas were more likely to report that they felt calm and peaceful, were a happy person, felt full of life and had lots of energy all or most of the time when compared to those in major cities (AIHW, 2009). Conversely, fewer respondents in remote areas reported that they felt none of the positive indicators at all in the past month. While the majority of respondents in non-remote areas reported feeling calm and peaceful, happy and full of life all or most of the time in the previous month, this was in lower proportions when compared to those in remote areas. Proportionally more respondents in non-remote areas reported they felt nervous (10%), without hope (8%), restless or jumpy (14%) and that everything was an effort (18%) all the time in the month before the survey. Those in non-remote areas were more likely to report feeling no positive feelings in the past month. Respondents in non-remote areas also lost more days due to being unable to work or carry out usual activities (AIHW, 2009).

Some participants also highlighted the contrast between workers who fly-in and fly-out and who got to go home to their families versus their counterparts who lived in the communities and who did not experience the same privileges or benefits. Others pointed out that, in part, the stressors experienced by remote area workers were not a phenomenon specific to Indigenous workers; rather, that any worker, Indigenous or mainstream, under similar stressful circumstances and conditions would eventually burnout.

"This will happen to non-Indigenous workers too that go into Aboriginal remote communities, whether you are black or white working in remote communities. They're 24/7. They don't have this clock off time. I was working remotely recently and 11pm people come knocking on the door. That's still 24/7!"

[FG6; M/F; Ind; Met/R/R]

Non-Indigenous workers in similar circumstances, that is, remote locations with little support and high demands, also suffered high levels of burnout. In those instances, it was largely due to the unremitting hours of work and little scope for 'down time'. To further illustrate this point, one worker noted that in rural areas non-Indigenous nurses had a relatively limited 'shelf-life'.

"Life expectancy of nurses out in rural areas is only 2 years. Get burnt out, can't work 18 hour days."

[Int12; M; Ind; Met]

Challenges of the Physical Environment

There was a wide range of challenges associated with the physical environment. In some instances, workers were located in the desert with distances of several hundred kilometres between offices. Working in these locations often necessitated travelling alone; and this too brought a unique set of work-related hazards with it. But not all workers were poorly equipped. Some noted that a recent infusion of funds had allowed procurement of suitable vehicles for remote terrain. So, at least in some respects, there were perceptible improvements occurring.

"It is important to remember that their working environment is in the middle of the desert, and there are hundreds of kilometres between offices and communities, and you are often travelling alone, but we are provided with excellent vehicles to cope with travelling on dirt road which are often poorly maintained."

[Int07; M; non-Ind; R/R]

Another important, and easily overlooked, aspect of living and working in rural and remote Australia were the significant challenges related to seasonal diversity. The changes in the seasons and extreme variations in weather conditions brought with it special challenges; and for many workers, it further highlighted the isolation often experienced on several levels.

"Stresses include the weather/seasons particularly cyclones and flooding— can result in communities being isolated for months at a time."

[FG8; F; Ind/non-Ind; R/R]

The weather in many settings determined what, if any, business could be undertaken. In some locations, heavy rain would regularly halt road transportation, and heat-wave conditions also had to be accommodated. Often, the physical accommodation was not equipped to deal with weather extremes; as noted in several instances there was not always the luxury of air-conditioning.

"...if it rains it is not safe to travel on those roads, and stay put until roads dry. If it is hot; there's little or no business transactions during the heat of the day. In mainstream thinking one would find an air-conditioned building, but we simply do not have those facilities up here."

[Int07; M; non-Ind; R/R]

Similar challenges were noted for people living and working in the Torres Strait Islands, however, in that setting the demands and lack of support facilities were seen to be even greater as it was often not the challenge of road transportation but the necessity of traversing the waterways between the many islands in that region.

"In Torres Strait workers are even more isolated and remote. Can't just get in the car and go to next clinic— need to get in dingy, make sure you've got enough petrol and go. Very hard."

[Int15; M; Ind; Met]

Travel and Transport

There was also considerable stress that was often associated with the enormous distances that workers had to travel in rural and remote communities, as well as vast areas that workers were required to provide services to. While not all workers found the travel a personal impost, for others it was tiring and demanding and an important source of stress.

Chapter 4: Sources of Stress

“Outreach worker has to travel three and a half hours out to the community, plus services seven towns which are one to two hours apart. So a lot of travelling time, and he can only take as time in lieu.”

[FG3; M/F; Ind; Met/R/R]

“In rural areas the difficulty D&A workers face quite often is getting people to rehab and detoxs and coordinating that. In particular for us, it’s at least an hour transport to the nearest place. There’s no public transport to where we go. So it requires a driver or somebody to take people there. But it’s difficult moving people out of their community quite a distance away and there is a lot of resistance to want to do that.”

[FG16; M/F; Ind; Met/R/R]

Geographical remoteness and isolation further added to the stress and burden of workers when they were required to travel for training, or to travel to get clients to services that were not available in their areas.

Travel was also an issue that contributed to stress for workers in rural and remote areas, especially in regard to accessing training and professional development.

“I’m located in Broome and have to travel to Perth for training. Last course was undertaken in weekly blocks. All transport, accommodation, and meals are catered for, but would still rather be able to undertake course in Broome.”

[Int27; M; Ind; R/R]

“Sometimes we have to travel up to three and four hours to find a facility that provides detox. How does the client get there? You got to take them. And what happens when the client leaves? You’ve got to go and pick them up. Then you need the support to do that.”

[FG2; M/F; Ind; Met/R/R]

Transport was identified as another potential contributor to stress both for workers and clients. The impact of travel on participants varied depending on their geographical locations and the transport resources available to them. For instance, good quality vehicles that were appropriate to the conditions and provided by the employer were very positively received. However, in some instances, workers were required to use shared cars that were not always available when needed or totally suited to the tasks they were required for. For outreach workers in these situations, a high degree of stress and frustration was often exhibited.

“... outreach worker is not allowed to use her own car, and has to book a car whenever she needs it. Often she has an appointment with a client, but can’t get there because someone else has taken the car. If had one dedicated car, wouldn’t need to pack and unpack it every day with all the resources.”

[FG15; M/F; Ind/non-Ind; Met/R/R]

“Travel is stressful. Don’t have an appropriate car assigned to her for “going bush”, “going scrub.”

FG15; M/F; Ind/non-Ind; Met/R/R]

“Transport is another issue for remote workers to access training, often only one car for whole of service and may take 2 hours to drive to nearest training provider and then 2 hours back.”

[Int15; M; Ind; Met]

In spite of all the challenges faced by rural and remote workers, many workers nonetheless thrived in these settings.

“...like to experience other communities— even swapped between Central and Top End— really enjoyed it... fascinated by the vast experiences and differences between the Top End and the Desert communities.”

[FG13; F; Ind; R/R]

Limited and Inadequate Office/Counselling Facilities

Unlike most working environments, many Indigenous alcohol and other drug workers did not have the facilities that are taken for granted by others. But this was highly variable. Some settings appeared to be well resourced and well catered for, while others clearly had inadequate resources. Some workers described working environments that were inappropriate for the nature of the roles they were required to undertake, or that lacked basic facilities such as computer and Internet access.

“Doesn’t have internet access at work— has been told they’re not going to get it. Can’t go to websites, can’t download assessment forms etc.”

[FG15; M/F; Ind/non-Ind; Met/R/R]

Other concerns centred around the physical work environment, notably where there was often inadequate space or appropriate rooms/spaces to conduct business in private and to maintain clients’ confidentiality.

“not enough privacy/concern about confidentiality because the workers occupy an open office space area ... [always] trying to find meeting/private rooms to counsel clients.”

[Int31; F; Ind; R/R]

“Small workplace so when clients are there it is really cramped.”

[Int04; F; Ind; Met]

However, not all workplaces suffered from these limitations. In some settings, the facilities were reported to be of a high standard and very appropriate to the needs of the workers and the roles that they were expected to undertake.

“There are good offices in XX with Internet connections. So we are not cut off from the world.”

[Int07; M; non-Ind; R/R]

“[we] have laptops, satellite phones, modems. Vehicles have a car fridge, dual battery systems, first aid, tools etcFeels well resourced. If I prefer I can camp outside community. Will hunt and bring food in for elders: sign of politeness and thanks for letting them into community.”

[Int16; M; Ind; Met]

Workplace Aggression and Violence Issues

Another aspect of AOD work that was identified as potentially stressful for workers related to aggression in the workplace. This was mostly related to the behaviour of clients when intoxicated or under the effects of drugs.

“And it’s the aggression side of things that you have to put up with. It gets a bit stressful. That’s a big thing for me at my work.”

[FG2; M/F; Ind; Met/R/R]

Some workers also spoke about the risks associated with the potential for violence among clients (and occasionally their families).⁸ This was an issue in remote settings, but it was also identified in metropolitan locations.

“...provide an outreach service to the “Long Grass Camps” in Darwin— potential for workers to be physically and verbally abused... have developed a good rapport with the clients and has also learnt to identify the various situations that workers may be confronted with and to respond to those.”

[Int34; M; Ind; R/R]

To some extent, this issue reflects the nature of working in the alcohol and other drug field where aggression and violence occurs among clients periodically. It further underscores the importance of ensuring that workers are well supported and that adequate safeguards are in place to ensure their physical safety at all times. This might involve workplace strategies and workers being trained to identify and pre-empt situations with potential for violence.

Summary

“Community expectations, travel, clients for whom English is a second language can all be stressors for the worker, but also remote workers may not be attending forums in the city as the language difficulties or the training is relevant to their core business.”

[Int15; M; Ind; Met]

The working conditions of Indigenous workers contribute to stress and burnout. This includes, but is no means limited to, working in remote locations, travelling long distances to provide services and associated issues of adequate transport. Workers also have to deal with a number of significant challenges associated with the physical environment, such as limited and inadequate office/counselling facilities and the potential for workplace aggression and violence.

⁸ However, it is also noted that Indigenous workers reported fewer experiences of verbal or physical violence from clients than non-Indigenous workers in the survey conducted as a parallel component of this project (see Duraisingam et al., 2010).

Stigma and Racism

Racism is complex and can be defined in many ways. Racism can be both open and observable (overt) and hidden or disguised (covert), and is captured in behaviour or words which advantage or disadvantage people because of colour, culture or ethnic origin. Racism has been identified as occurring at individual, institutional, and systemic levels. There is evidence that the experience of racism is detrimental for health, but there is relatively little research about the health impacts of racism for Aboriginal and Torres Strait Islanders (Gallaher, Ziersch, Baum et al., 2009; Paradies, Harris, & Anderson, 2008).

“As an Indigenous worker, I’m in the minority. In my workplace I face racism on a daily basis (both covert and overt) from non-Indigenous staff. This racism is presented in all forms, cultural, spiritual, emotional, power, knowledge, skills, systems, processes, practice and historical!”

[Sur; M; Ind]

“Racism is most often based on ignorance—especially some of the behaviours observed of hospital staff towards clients whereby Indigenous clients don’t always get the same level of assistance as that given to non-Indigenous clients.”

[FG9; M/F; Ind/non-Ind; R/R]

A Double Jeopardy

There is a high level of stigma associated with people who use alcohol and other drugs (Roche & Richard, 1991; Skinner et al., 2007), greater than that exhibited towards people with mental health or disability issues. There are often doubts or ambivalence about the “deservingness” of alcohol and other drug clients in terms of rights or priority for care (Skinner et al., 2007). Moreover, such stigma also carries over to the workers who deal with clients or patients with alcohol and other drug problems.

“Stigma of clients transfers to workers—condescended to, ‘just drug and alcohol worker’, no one wants to work with you, not seen as legitimate.”— Non-Indigenous worker.

[FG15; M/F; Ind/non-Ind; Met/R/R]

“... even just being an ATODs client without being Indigenous as well, we’ve really battled, haven’t we ... with attitudes to our clients.”

[FG9; M/F; Ind/non-Ind; R/R]

Indigenous workers, therefore, have to contend with the pre-existing levels of stigma associated with the

nature of the clients’ alcohol and other drug problems, which is sometimes coupled with co-occurring mental health problems. But in addition, they also have to cope with the stigma and discrimination commonly encountered because of their Indigeneity.

Assumptions were also often incorrectly made that all health problems confronting this group were derived from alcohol. This false attribution frequently led to stigmatising and discriminatory behaviours on the part of mainstream services and workers.

“... hospital staff sometimes jumps to the conclusion that all injuries and illnesses are caused by alcohol within Indigenous community.”

[Int20; M; Ind; R/R]

“... need non-Aboriginal people (especially health professionals) to separate alcohol problems from Aboriginality. Often Aboriginal people are treated as being drunks and drunk even when they’re not. Might be mental health problem but still treated as drunk. Need greater understanding of Aboriginal experiences and life— e.g. treat person holistically taking into account spirituality, histories of grief and trauma such as sexual abuse, etc.”

[FG10; M/F; Ind; Met/R/R]

Health services personnel are in no way immune from exhibiting high levels of stigmatising, discriminatory and racist behaviour. Refusal of service to Indigenous clients by mainstream services was a common experience. Sometimes refusal was based on negative perceptions of alcohol and other drug users, at other times it related to the Aboriginality of the client; or both.

“...when an Aboriginal client goes to Accident and Emergency, if they’ve got a drug and alcohol problem they normally get sent away.”

[FG2; M/F; Ind; Met/R/R]

Indigenous workers experience multiple levels of stigma, accompanied by exclusion and isolation. As noted, the alcohol and other drug field is in many ways a highly stigmatised “Cinderella” area on the periphery of mainstream health service. So, too, are alcohol and other drug Indigenous workers often located on the periphery of services. As such, they suffer the exclusion and marginalisation associated with this field, plus the added isolation, discrimination and lack of recognition commonly experienced by Indigenous workers by virtue of their Aboriginality.

Racism

When asked about the impact that racism had on workers, some participants described it as an all-encompassing and all-pervasive phenomenon. While it was not always overtly evident, racism had an insidious presence that was draining and debilitating for workers.

Examples of racism sometimes included subtle, but nonetheless negative experiences encountered with mainstream co-workers.

“... little things like saying g'day. Walk into reception in my region and you say 'how you going?' And, all of a sudden they put their head down, they're not writing anything.”

[FG2; M/F; Ind; Met/R/R]

“...it's always there and it's subtle stuff...”

[Int33; M; Ind; R/R]

“it's hard enough to get people to address their health needs without having to battle that [racism] as well ... “

[FG9; M/F; Ind/non-Ind; R/R]

Mainstream workers were often seen as not wanting to have anything to do with either Aboriginal workers or their clients, and saw them as more work. Some workers reported experiencing high levels of racism when dealing with other health and human services that responded with indifference, irritation through to hostile contempt for Indigenous people in general.

“...another black face coming in— what do they want.”

[FG3; M/F; Ind; Met/R/R]

There were reports of extensive levels of racism in white organisations [Int03; F; Ind; Met]. One senior health professional in a hospital was overheard to openly refer to an Indigenous person in the most derogatory terms. The openness with which such statements are made highlight not only the pervasive

nature of racism, but also the extent to which it is an issue that goes unchallenged and is, disturbingly, seen as unremarkable.

“... constantly struggle with racism being present in health systems ... meant to help ... staff are being paid to provide help ... incredible that it's tolerated, or brushed under the carpet ... you do see it.”

[FG9; M/F; Ind/non-Ind; R/R]

Aside from having to endure blatant racism, and unprofessional and derogatory comments, alcohol and other drug workers pragmatically focused on the fact that it made more work for them when their clients were refused care, as they then had to organise alternatives.

Even in situations where treatment was provided, there was concern about the level of care and quality of treatment received. In some discussions, the view was expressed, albeit with tact and diplomacy, that less than optimal care was received. The body language and non-verbal communication associated with these comments revealed the depth and extent of distress felt about discriminatory treatment received by Indigenous clients.

“Indigenous clients may have burnt their leg or done something and gone to the Emergency and you can see them get treated just that little bit differently to non-Indigenous clients.”

[FG2; M/F; Ind; Met/R/R]

“Aboriginal people want Aboriginal support, and a lot of times that doesn't happen.”

[Int02; F; Ind; Met]

“As you enter white organisations as a Nunga person, I find that I face more racism than I would here, just in that there is constant questioning as to why there is a difference between Aboriginal clients and mainstream clients, and why should they have specialist workers.”

[Int03; F; Ind; Met]

When discussing the ways that alcohol and other drug or generic healthcare system services might discriminate or offer less than standard care to Indigenous clients, participants identified issues including lack of flexibility, through to ill-qualified and unsuited personnel.

“It happens in the way lots of services are ignorant of Aboriginal issues. They don't understand when working with Aboriginal people you have to have some flexibility. A lot of services are just not

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flexible if the Aboriginal client doesn't comply with what they want."

[FG2; M/F; Ind; Met/R/R]

"There are also some people who shouldn't be working in Indigenous communities because they are quite racist. Some can also be quite destructive in that they abuse their role and influence. [There] needs to be more scrutiny of who goes in communities, but often communities are faced with whoever applies gets the job. It's the hardest work, but gets the least qualified of both Indigenous and non-Indigenous people, and then we wonder why it doesn't work!"

[Int10; M; non-Ind; Met/R/R]

Improved understanding of the link between racism and physical and mental health problems is emerging. It is recognised that to address the poor health and alcohol and other drug problems experienced by many Indigenous people, it is of fundamental importance to also address racism. Many health problems are predicated on the existence of racism.

"We now know more about the physiological and mental health consequences of racism than previously— understanding these processes assists in dealing with them and also helps to identify and develop strategies to deal with racism."

[Int26; M; Ind; Met]

"If you have Aboriginal in your name of an NGO they bloody well cane you."

[FG1; M/F; Ind/non-Ind; Met/R/R]

"... try not to let that sort of stuff [racism] affect me as a worker. Sometimes it does: cope by going home to talk to my wife about it, talk to someone at work, or find a white friend and have a yarn to them. 'I s'pose it's just getting it off, instead of carrying it as baggage, get rid of it, get it off your back'."

[Int32; M; Ind; R/R]

In some situations, it appeared that organisations were willing to employ some Indigenous workers, but not too many. Some participants expressed the view that too many Indigenous staff in one organisation was sometimes regarded as undesirable.

"There were two Aboriginal outreach workers, a male and a female, and about three casual workers. Low proportion for the high number of Aboriginal clients. The organisation thought that was pretty high... once again that black face."

[Int02; F; Ind; Met]

"I really felt like a token black by the time I left that place."

[Int02; F; Ind; Met]

Racism and discrimination had a range of effects on workers. Some workers indicated that they tried to perform with extra diligence to avoid criticism or being found wanting. This created additional pressure for workers to always be exemplary.

The level of racism encountered made some Indigenous alcohol and other drug workers more alert and self-conscious and sometimes forced a compromise of fidelity to Indigenous cultural ways of working. This created a different type of pressure for workers and resulted in considerable stress.

"It makes me more diligent in the role that I do to make sure that I am ensuring that what I do is right. I follow the guidelines and stick to the deadlines so that I don't have anyone trying to question me about my work ethics or that I am on 'black fella time' or anything like that. So I always make sure that I am prompt for appointments and turn up for work everyday and if I don't turn up for work I've already rang in... because that's the last thing you want to hear is the receptionist saying which I have heard 'they're not here because of such and such'. It just makes me aware that you're going to have those kinds of people in your workforce regardless. So you just got to keep on top of those things. It's an on-going fight."

[Int13; M; Ind; Met]

Racism and discrimination do not always manifest in typically negative ways. In some instances, people spoke about "reverse racism", which was similarly distressing.

"The kind of racism I see is a bit different. It's a bit reversed. Whereas everything is overcompensated. Like if I do something I get ten thousand emails saying thank you so much you're so wonderful. It's almost embarrassing. Totally opposite to others' experiences. But it's really outwardly embarrassing because they don't do it to anybody else and I am the only Indigenous worker in this mainstream organisation, but everybody does it. It's just they don't know how to cope with it. They want to make sure that you feel comfortable. So everybody goes out of their way. It's as if they are surprised you can get your work done."

[FG2; M/F; Ind; Met/R/R]

In spite of numerous examples of overt and covert racism, participants also noted areas of distinct improvement. For instance, some participants referred positively to being consulted more frequently.

"...good that Indigenous workers now get called in to attend A&E if an Indigenous patient is brought in by ambulance."

[FG9; M/F; Ind/non-Ind; R/R]

Participants frequently made the observation that they thought racism was less likely to be encountered in the community services industry due to similar thinking and goals of individuals who work in these fields, i.e., wanting to help people.

In general, there was a view that racism was more likely to be experienced in the community overall, rather than in alcohol and other drug or human services workplaces. For example, Indigenous people going into shops were likely to be either "ignored or watched like hawks". Or, when workers took clients to the bank, or clinics or Centrelink, they were aware of the palpable sense of difference, of being "other".

"...it's there!"

[Int33; M; Ind; R/R]

One participant talked about growing up in a town which had considerable racial tension and saw it as ever present and inevitable. Again, there was a strong sense of resignation, if not despair.

"... it's a two way thing, always going to have racism"

[Int33; M; Ind; R/R]

It was noted that some people coped with racism better than others, but the all-pervasive experience of racism required Indigenous people to exhibit great resilience and stoicism.

"...it's part of being Aboriginal."

[Int33; M; Ind; R/R]

Nevertheless, multiple layers of stigma and racism pervaded Indigenous alcohol and other drug work to an extent that it both undermined the work undertaken as well as negatively impacting on the health and wellbeing of the workers.

Structural and Systemic Racism

As well as perceptions of racism towards individuals, and in interpersonal relationships, some forms of racism were identified as structural and/or systemic.⁹

Discussion group participants were asked whether they thought that systematic racism existed in the systems in which they worked and whether there was an understanding of Aboriginal ways of working. This revealed a degree of scepticism and cynicism about cultural sensitivity training which was often seen as ineffective and little more than tokenistic.

"In our health service there's compulsory cultural awareness. It's a tick it off, and a lot of people don't really care about Aboriginal issues. They don't care and are not interested or don't want it."

[FG2; M/F; Ind; Met/R/R]

"You find it in services where non-Indigenous people work. They're not culturally sensitive and they don't really listen to the Aboriginal workers. They just want to do things their own way."

[FG2; M/F; Ind; Met/R/R]

"It's hard, well no it's not hard, it's easy really. Non-Aboriginal people have to come to the table now. I'm tired of having to fight for equality, It's time for non-Aboriginal people to come to our table. It was our country first. Our problem, in part, is we don't have the numbers ... "

[Int15; M; Ind; Met]

"We all have to change— it's not just one or two people, it's all of us. I sometimes put up barriers with non-Aboriginal people too. You know, sometimes I don't bother to make comments because people will just shut me down like 'oh, that's just another Aboriginal comment!'"

[Int15; M; Ind; Met]

Summary

A range of entrenched factors have been identified that will require long term, complex and multi-level interventions. These include covert and overt forms of racism in the workplace, and related policies and practices which compromise the cultural integrity of Indigenous alcohol and other drug workers. It is recognised that to address the poor health and associated alcohol and other drug problems experienced by many Indigenous people, it is of fundamental importance to also address racism as a social determinant of ill health.

wellbeing: "There is more to discrimination than explicit racism and racial stereotyping. The long-standing socioeconomic inequality suffered by Aboriginal and Torres Strait Islander people is indicative of systemic and indirect discrimination" (Kelly et al., 2009, p. iii).

⁹ As stated in a recent CRC report on social and emotional

Complex Personal Circumstances

“So we live it too; and it’s not just that we go to work and we go home. We got our own family stuff to deal with as well, let alone workers or clients’ work-related stuff. It’s hard if you live and work in the same community. I have children same age as friends of my clients. Know the parents, know the kids for the last 15 years. It’s hard sometimes to go ‘no, I am not at work today!’” - non-Indigenous worker

[FG1; M/F; Ind/non-Ind; Met]

“We all have commitments, you know at home, look after your family, look after your children, look after your old people, you look after your house too, and working.”

[FG13; F; Ind; R/R]

Work/Life Balance

Various aspects of Indigenous workers’ own family and personal situations impacted substantially on them as workers. As well as increased exposure to life events with the potential to cause serious psychological distress, additional dimensions of Indigenous social and emotional wellbeing differed when compared to other Australians. This included high levels of grief, loss, trauma, abuse, violence, substance misuse, physical health problems, identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism, discrimination and social disadvantage (Social Health Reference Group, 2004).

“Community often forget that you as a health worker are also a member of the community and are suffering just as much.”

[FG10; M/F; Ind; Met/R/R]

Many workers carry huge personal loads in terms of economically dependent children, parents, elders, and other family members, and community commitments. Their personal and family circumstances are further compounded by premature deaths, suicide, violence, stolen children, mental health problems, depression, family illnesses and disability, and also in many instances personal and/or family alcohol and other drug problems. These are crucial issues and potential contributors to workers’ stress levels.

“Aboriginal workers not only have to deal with the person but also the person’s family and their community and the multitude of related issues. They are not dealing with just the individual, but also the individual within their cultural/familial and community context. This may include, in many

instances, generational alcohol and other drug problems. The impact of this on Aboriginal workers may not be well understood by non-Aboriginal people.”

[Int26; M; Ind; Met]

Current and historical personal and family circumstances are important factors in terms of workers’ wellbeing. Balancing and resolving these demands can be very difficult.

“We’ve got our own extended families and expectations, as well as managing clients. In the end, have to choose between taking care of family, or taking care of clients.”

[FG4; M/F; Ind; Met/R/R]

“Work life balance is probably the same as people in other communities. It’s outside work stuff that you have to put up with as well.”

[FG2; M/F; Ind; Met/R/R]

Family and community support was seen as essential, yet it was also often a source of mixed feelings and complex relationships. As such, support came with a set of demands and obligations.

“... you need a strong community, and a strong family. Two sets of legs, you know.”

[FG12; M; non-Ind; R/R]

“... if you’re seen as the one with income, they’ll ask you for money all the time.”

[FG12; M; non-Ind; R/R]

Close relationships, and subsequent high degrees of empathy exhibited by Indigenous workers towards clients and community, also contributed to elevated levels of stress. This was particularly noted among the female workers.

Difficulties for Workers with Young Families

A large proportion of the Indigenous alcohol and other drug workforce is female, as is the case for the non-Indigenous workforce in this sector.¹⁰ Female workers tend to have more family and domestic responsibilities, including child care responsibilities but often extending well beyond this to include broader family and support roles.

10 Roche and Pidd (2010) reported that approximately two thirds of the Australian alcohol and other drug workforce is female and aged in their 40s. Although no specific data are available for Indigenous workers, the proportion of females is believed to be similar, but younger: see data in Duraisingam, V., Roche, A. M., Trifonoff, A., & Tovell, A. (2010). Indigenous Alcohol and Other Drug Workers’ Stress, Burnout and Wellbeing: Findings from an online survey. Adelaide: National Centre for Education and Training on Addiction.

"Hard when you go home, and too tired to talk with your family, and you say 'it's work' and they say 'that's no excuse, you've clocked off now'. You need support from your family."

[FG4; M/F; Ind; Met/R/R]

"Family members often don't understand the constraints of the job and expect help outside of working hours ... end up at home in crisis... feel like I have to be constantly setting boundaries with family."

[FG9; M/F; Ind/non-Ind; R/R]

"...it can be hard to separate family and personal life and fulfilling the role of health worker. Might be family arguments over the weekend and then during the week you have to put that to one side and treat them as a patient."

[FG10; M/F; Ind; Met/R/R]

Difficulty was often noted in achieving and maintaining a balance between work, family and community commitments, especially for the significant numbers of single mothers employed as alcohol and other drug Indigenous workers.

"... hard as a single Mum, working full time 5 days a week, rely on after hours care and long day care. Can be stressful. Find setting a routine with children helps to give me time. Management need to be aware of complexity of Aboriginal families, family obligations and community obligations, deaths, dealing with Families SA as a foster carer. Helps if management are Aboriginal or are culturally aware."

[Int04; F; Ind; Met]

Many Indigenous services were aware of the extra family load carried by a large proportion of their staff, especially female staff and those who were single parents. A number of services had put strategies in place to accommodate the special needs of these staff. One service described how it supported the single mothers in it's employ by providing extra support in areas such as financial management, debriefing and offering workplace flexibility that allowed workers' children to stay on work premises in family emergency or crisis situations.

"... have a lot of single mothers on staff, and have made arrangements for them to be able to access short term loans from agency's funding bucket to cover emergencies; ... has no idea what it's like for single parent Nunga woman. Think this flexibility helps to make staff feel more supported. Assist staff to access professional help for personal

issues, and be personally available for staff to yarn. Hope they're never afraid to come and talk to me."

[Int05; F; Ind; Met]

"Organisation does support all staff in that. For example, teachers are on strike today, so CEO sent out an email to say if you need to bring your children in that's okay, and other times she's said to everyone, if you need to bring sick children into the office that's okay too. When I was with Centrelink and in a similar situation, there was hardly any support for me. Even when I could work away from the office— for example working by telephone with the Islands, they wouldn't let me."

[Int15; M; Ind; Met]

"I think most AHWs learn to put up defence walls to try not to let the family/community/work stuff get to them."

[FG10; M/F; Ind; Met/R/R]

Even with a range of workplace supports and with understanding management, many workers still found it difficult and demanding to juggle conflicting demands on their time.

"Finding [it hard] balancing family, community and work difficult at the moment. Came to Adelaide with my family— family have now gone back. Organisation did support me— helped me find a nice house and supported me when my children left. That's why it's so difficult feeling like I want to leave. I have a commitment to the organisation because they've helped me a lot. But concerns me that maybe I'm putting their interests above my own now. May be it'd be better if I did leave."

[Int15; M; Ind; Met]

Older and more experienced workers seemed better able to put work and family commitments into greater perspective. While little consolation to workers with dependent children and family, many of the conflicting roles and demands were resolved once the worker's children had grown up and were living independent lives. Workers in this situation reported that they now had greater flexibility in relation to work commitments and were able to more readily meet the demands of the job requirements [Int30; F; Ind; R/R].

The impact of personal life events on workers' equilibrium cannot be underestimated. Work related matters often resonated within families, and vice versa.

Chapter 4: Sources of Stress

“Once there are personal problems that happen within your own family or extended family it’s like you’re balanced for a minute and then the personal stuff comes in and then it just tops you over, because for me personally, it compounds all the issues that you are dealing with in your work environment as well. But it takes the personal thing that’s happened to compound it and bring it to the surface.”

[Int01; F; Ind; Met]

Some workers also had firsthand experience of alcohol and other drug-related domestic violence and sexual abuse. This was a source of considerable distress for workers if they also had to deal with clients in their work role where domestic violence was involved, as was often the case for many Indigenous workers. Separating personal experience from work roles and responsibilities in such situations was reported to be difficult and challenging, even for highly trained, experienced and well-supported workers.

“... my children, because of my domestic violence, are products of domestic violence. I am always involved in their domestic violence. So, it’s really hard for me to try and work out that line. To come to work and then having to deal with family issues.”

[Int02; F; Ind; Met]

“The hardest part being a woman alcohol and drug worker is working with women and they overlapping. And burnout and stress levels is high. Got children and their children have been taken away [by DHS]. We’re D&A workers and we’re in at DHS all the time and courts and it’s something that is ...”

[FG16; M/F; Ind; Met/R/R]

A history of alcohol and other drug use by workers or their family members also contributed to workers’ stress when dealing with clients with similar issues. Alcohol and other drug use was also often underpinned by trauma and grief issues and alcohol and/or drugs were frequently used as a way to block out pain and grief.

“When people have trauma and grief, they’re not too certain how to deal with it, so drinking and smoking marijuana is a way to block out that grief and trauma. It becomes a habit or becomes problematic when they use it to block out their problems, or they become addicted to it.”

[Int28; M; Ind; R/R]

“...on a personal level we are also confronted with alcohol and drug problems within our own families ... part of seeing the destruction of what that can do within our own families. The awful thing about this is people like me see our families going through the system as users of the system.”

[Int01; F; Ind; Met]

“Drugs and alcohol are a big element in suicide and the disruption on Aboriginal families. It’s a big problem.”

[Int14; M; Ind; R/R]

Some participants also expressed concern about the perpetuation of inter-generational patterns where children were learning negative coping strategies.

“...clients, community members and myself, we know that we are teaching our children same things [negative coping behaviours] that we were taught.”

[FG10; M/F; Ind; Met/R/R]

The Workers’ Paradox

Paradoxically, work-related stress experienced by alcohol and other drug workers may also contribute to increased levels of alcohol and drug use among overworked and under-supported Indigenous workers. As with many groups of workers, alcohol (and to a lesser extent drugs, such as cannabis) may be used to help alleviate work-related stress and pressure.

Little attention has been directed to the effect that work-related stress has as a contributory factor to alcohol and drug use among Indigenous workers. There is a significant duty of care owed by employers to the welfare and wellbeing of their staff in this regard.

“We are expecting our staff to look after Aboriginal people who are just as ill as what some of our staff may be. As a result of this, from my own personal experience when there’s issues going on in your own personal life you tend to either smoke more or you will go and drink more alcohol.”

[Int01; F; Ind; Met]

“To me that’s a real problem, a major problem. And as a health sector we don’t look after them.”

[Int01; F; Ind; Met]

High levels of sick leave and absenteeism were noted among Indigenous alcohol and other drug workers. This was attributed to several factors but included the stress of trying to balance a demanding work life, which entailed many pressures and often long hours, while also managing a complex personal life with significant responsibilities and obligations.

“... they tend to get sick, which is part of the issue. People tend to get ill more so than in the mainstream type organisation, because of stress.”

[Int06; M; Ind; Met]

“Because of all the added burdens of community expectations, family expectations, work and the fact that there is no separation and so they tend to be sicker. And whether they then take the time off to recover is not necessarily there either. Or, then they get really guilty, because they are not at work.”

[Int06; M; Ind; Met]

Some workplaces provided Employee Assistance Programs (EAP). However, these were reported not to work very well for Indigenous workers. Some participants raised questions about how to best address these problems and to identify what other services should be put in place.

“We currently have the Employee Assistance Program in place for counselling but in terms of looking at the health of our Aboriginal Health Workers we don't do that very well.”

[Int01; F; Ind; Met]

“Essentially, it's about the workers and the wellbeing of the staff and healing of staff. If we as a health sector are expecting our health workers to look after sick people if they're not well themselves, physically or socially, how can we expect them to do that.”

[Int01; F; Ind; Met]

The statement above clearly encapsulates the essence of this project.

There were many indicators of workers doing well in spite of the great pressures they were under, demonstrating impressive resilience and having developed a wide array of well-honed survival skills. Conversations with participants, however, clearly suggested this was not the case for all workers.

Summary

A range of complex personal factors and circumstances can contribute to worker stress. This includes the challenge faced by workers to maintain an appropriate work/life balance. This can be particularly difficult for a workforce that is relatively young and inexperienced and where family demands and relationships play a highly influential role.

In dealing with these complex personal circumstances, it is not unusual for Indigenous workers to experience high levels of absenteeism and sick leave.

Loss and Grief and Sorry Business

"It's a bad sad too ... "

[FG13; F; Ind; R/R]

"That's a big one, the grief and loss. It's so big! We all suffer trauma as workers. From what's happened to us and trying to work with a client who is suffering from the same traumas. You're re-living your own trauma as you are going, and then learning to deal with your own trauma, and trying to keep that separate from the clients is really, really hard."

[FG16; M/F; Ind; Met/R/R]

Loss and grief is an issue of profound salience to Indigenous people. It is a broad and complex issue that encapsulates ancestral, inter-generational, suppressed and unresolved grief that is ongoing, little understood and often not well addressed. It is another pivotal source of stress for Indigenous alcohol and other drug workers. A major challenge facing workers is reconciling not only their own but also their clients' unresolved and ongoing grief and loss issues.

"...high levels of grief in the community. This can become overwhelming."

[FG9; M/F; Ind/non-Ind; R/R]

The high premature death rate among the Indigenous population inevitably involved a disproportionately large number of funerals that workers were required to attend as part of their cultural obligations.

"Obligations different between white and black people— that's the difference. It's not compulsory for white people to go. It's up to the individual. But that's not Aboriginal way. It's that dual accountability— you have to be accountable as a department employee but also to your community. There's an expectation and commitment to family and community out there."

[FG13; F; Ind; R/R]

These shared losses also had an all-pervasive aspect to them that permeated the workplace environment. There was often a contagious and debilitating impact of these frequently experienced community losses.

"Constant funerals and 'everyone is stressed' can add to the stress of the workplace."

[Int03; F; Ind; Met]

"With... funerals every week... the community was shell-shocked."

[FG9; M/F; Ind/non-Ind; R/R]

The ever-present nature of the collective experience of loss cannot be underestimated. It manifested in high levels of depression and other forms of personal and social psychological distress.

"A lot of people going through stress, sorry time and depression."

[FG13; F; Ind; R/R]

"Aboriginal workers' grief and loss— I know it's a major problem. I would say without a doubt there are workers suffering from high levels of social and emotional distress."

[Int01; F; Ind; Met]

"Could be two funerals in a week or three in a month— and they [white people/managers] just think 'ah, what ... again!?' They've got to understand the system. It's not just about proper biological brother or sister. It's about skin relationships you have to go, to pay your respects."

[FG13; F; Ind; R/R]

For Aboriginal Health Workers there was an added burden of responsibility, as the onus of healthcare and community wellness rested largely with them. But as many community members experienced high levels of physical and psychological health problems this was often an insurmountable challenge. Helping to resolve one health problem was often obliterated by the emergence of another health problem in the same individual.

"... dealing with multiple health problems [is] difficult for workers. Poorer health mean community becomes exposed to more funerals. Or, one health problem might be fixed, but a week later the client has died from another health problem and you're attending their funeral."

[FG9; M/F; Ind/non-Ind; R/R]

The Stress of Loss and Grief

Participants described the impact of funerals on those who lived and worked in small country towns and tight communities. They also highlighted the difficulty entailed in attempting to explain to non-Indigenous people, including their managers, the significance of such deaths when the nature of the relationships were not part of mainstream society's understanding of typical social relationships and family structures.

"In a town like XX if you had two funerals in a town where everyone knows one another, that's hard ... Then just imagine being in a small community and there's a death, and everyone is related to each other in some way, through blood or skin."

[FG13; F; Ind; R/R]

So, not only were the deaths of community or kinship members a source of great pain and sadness, there was also the added burden of having to explain the importance and impact of these relationships and their loss to colleagues and managers. Having to justify grief reactions and the need for time out added to the distress.

"...Then someone asks what relation they [the deceased] are to them [the worker]! Don't understand kinship and skin relationships— they ask 'well is that your brother, or your sister, or what'. It's very hard for health workers."

[FG13; F; Ind; R/R]

There was also a growing awareness that the crucial issues around loss and grief had not been dealt with appropriately. While it is increasingly acknowledged that there is a very high premature mortality rate among Indigenous communities, including a high death rate among children and youth, there is comparatively little attention directed towards dealing with the attendant grief issues. Suppressed and unresolved loss and grief issues emerged from this project as areas warranting priority and appropriate intervention.¹¹

"... grief and loss stuff has never been dealt with properly— there's no getting on with it!"

[FG10; M/F; Ind; Met/R/R]

"... they don't have as many deaths in the non-Indigenous community. But I think they also seem to have and know how to plug into counselling or support groups that are out there. Whereas for whatever reason the Aboriginal workers don't tend to go to those sort of places."

[Int06; M; Ind; Met]

Sorry Business

Sorry Business also had a significant impact on the work environment in terms of what could be undertaken and what is proscribed by traditional laws and protocols. For example, it was highlighted how certain jobs could not be undertaken when Sorry Business was happening. All workers, Indigenous and mainstream, were required to adapt to these requirements when working in such settings. One female worker reported how she and her female co-workers had to 'hide' while there was Men's Business happening in their community. They were notified when Sorry Business was happening. Centrelink staff would also be notified when clients might be coming in for hardship payments to allow them to travel to funerals [Int15; M; Ind; Met].

During discussions about Sorry Business, some participants noted just how profound and extensive its impact could be for some workers, and how infrequently the full extent of its implications was appreciated. It was evident that more attention to this pivotal issue is pressingly needed.

Many Levels of Loss and Grief

There were many layers of loss that extended well beyond the loss of a loved and revered family or community member. Loss could also incorporate the loss of language, culture, tradition and a sense of connection. The high rate of incarceration¹² among community members also entailed loss and grief issues, loss of freedom, loss of dignity, and loss of respect among others.

"...Sorry Business does impact on me— primarily around loss of language, family connectedness and country. I feel sad that I don't know how to speak my tongue and that my parents hadn't been able to learn that either, both having been raised on a mission. ...sometimes there is conflict with other Aboriginal workers because I didn't have those skills, but it's not my fault that I can't speak in my tongue."

[Int04; F; Ind; Met]

11 In saying this it is also noted that several important initiatives have been undertaken in Australia in this regard, including for example, the work of Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. 2009, Living on the Edge: Social and Emotional Wellbeing Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People, Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin; and Dr Tracey Westerman's work in WA and Rosemary Wanganeen's in SA.

12 The NATSIHS 2004–05 found that having a family member sent to or currently in jail affected 19% of respondents, and was highest (25%) in remote areas. After adjusting for age, the rate of imprisonment in 2007 for Indigenous prisoners was 1787 per 100,000 compared to 134 per 100,000 for other Australians, making Indigenous people more than 13 times more likely than other Australians to be in prison (AIHW, 2008) and 21 times more likely in Western Australia. The proportion of prisoners who were Indigenous was highest in the Northern Territory (84%) and lowest in Victoria (6%).

Chapter 4: Sources of Stress

“For me because I am living out of my direct community, I’ve missed a lot of that. For me, that’s something that hasn’t had a lot of impact on me. I guess my Mum shields me from that in a way as well. She takes more of the brunt of the Sorry Business on my behalf while I am down here. But for the workers who are in more remote areas they have to fit their work around Sorry Business. It’s something that’s already had an impact on one of our intakes for residential. Someone passed away and there was Sorry Business going on for that week. There was no clients that week and we actually flew some people up there to do the residential work. So that had an impact on that service.”

[Int13; M; Ind; Met]

For other workers, however, there had been only a relatively limited impact of Sorry Business. Such different scenarios highlight just how varied experiences can be and the importance of tailored and flexible strategies in this area to respond to workers’ needs.

Bereavement Leave

Acknowledgement of kinship and skin relationships in regard to bereavement leave and entitlements is a challenge for Indigenous alcohol and other drug workers who often have to prove an association in order to attend funerals.

“It’s very hard for health workers. Could be two funerals in a week or three in a month— and they [white people/managers] just think ‘ah, what ... again!?’ They’ve got to understand the system. It’s not just about proper biological brother or sister etc, it’s about skin relationships. A lot of people take leave without pay. The Department needs to understand.”

[FG13; F; Ind; R/R]

In terms of functional implications for services and organisations, family and community expectations and protocols to attend funerals result in the need for a larger allocation of bereavement leave than would usually be the case in mainstream services. The need for additional bereavement leave is often not understood by non-Indigenous colleagues and managers and not well accommodated in most awards and conditions of employment. This is often a source of significant friction between workers and management. One participant named this problem “dual accountability”, that is, where one is accountable to both their community and to their employer.

Summary

While loss and grief and Sorry Business are important issues for Indigenous people they are not always well understood by non-Indigenous workers and managers. This places further stress on Indigenous workers who have to deal with the grief associated with loss of a family member, plus the additional burden of explaining and justifying family kinship and Sorry Business to non-Indigenous colleagues and employers.

Culturally Safe Ways to Work

A recurrent theme among Indigenous alcohol and other drug workers concerned culturally safe ways to work. Lack of acknowledgement of Indigenous ways of working and cultural safety was often reported. Not being able to work and function in a manner that accorded with Indigenous cultural norms was a source of considerable stress for many workers. There were numerous work-related matters that fell under the umbrella of cultural safety. They included:

- holistic approaches to care
- gender
- age
- spiritual issues
- perceptions of time
- the importance of sociality and informal norms.

Indigenous sovereignty claims call for non-Indigenous Australians to “give ground” and accept a plurality of ways of “doing business”. Historically, however, there is little precedence for this; rather the reverse has tended to occur with the appropriation of Indigenous knowledge by mainstream without a concomitant acceptance of Indigenous leadership and values. Some commentators have described a double violence inflicted on Indigenous society, which not only kills part of a living system but actually disables the capacity of a living system to repair itself.¹³

“There appears to be a psychological blockage in the mind of the Australian community about Indigenous issues. No matter how we try to explain things the issues don’t seem to register with many people and [health] staff. Don’t know what’s going to trigger a change.”

[FG10; M/F; Ind; Met/R/R]

Respect for Indigenous Ways

Many participants reported that Indigenous ways of working were not commonly understood or respected. This was a source of anguish and hostility in the workplace especially where different ways of working collided. Moreover, many workers reported reluctance by mainstream workers and services to adopt, or even acknowledge, Indigenous ways of working. Such intransigence perpetuate systems that contribute to the poor health of Indigenous people.

“Have to argue the point all the time. It’s like you’re constantly fighting.”

[FG2; M/F; Ind; Met/R/R]

“Sick of it always being Aboriginal ways having to adapt to white, mainstream ways. Wish it would happen the other way round for once.”

[Int15; M; Ind; Met]

“Burnout I think comes from fighting the system.”

[FG7; M/F; Ind/non-Ind; R/R]

For some participants, stress was not about workload, lack of down time, or community expectations; rather, for these workers it was related to the systems within which they worked. Specifically, the lack of understanding about Indigenous ways of working by the mainstream ‘white’ system within which they worked had a detrimental impact on worker wellbeing.

“Working for a ‘white’ organisation with little understanding of Indigenous people.”

[FG7; M/F; Ind/non-Ind; R/R]

In some instances, mainstream workers were resistant to input or change in regard to Indigenous ways of working. Many mainstream workers were of the view that they had received cultural sensitivity training and were adamant that they were culturally aware – a position that made change particularly difficult to achieve.

“... when you try to talk to them about cultural issues they say, oh yeah, I know that! But they don’t really understand it.”

[FG9; M/F; Ind/non-Ind; R/R]

This perception was often not shared by Indigenous workers who had substantial criticisms of current cultural sensitivity training and organisational requirements in this regard. Such training sometimes constituted little more than a cursory workshop (often conducted by white workers) that allowed this issue to be ‘ticked off’ for quality assurance requirements.¹⁴

“...they’ve probably had cultural awareness training— but that’s just a tick box. People going into remote communities need to know about Sorry Business, Women’s Business, Men’s Business, initiation time.”

[Int15; M; Ind; Met]

13 Deborah Bird Rose (2004) Reports from a wild country: Ethics for decolonization. Sydney, UNSW Press.

14 It is noted that there is an increasingly improved understanding of what constitutes best practice in terms of cultural competence training. See for example: Farrelly and Lumby (2009) A Best Practice Approach to Cultural Competence Training.

Chapter 4: Sources of Stress

In terms of identifying ways forward, it was often noted throughout this project that cultural awareness training was of limited benefit.

“Cultural awareness training is not overcoming terrible attitudes that they hold onto.”

[FG10; M/F; Ind; Met/R/R]

Further to a perceived lack of a fundamental understanding of cultural issues and cross-cultural differences, there was also concern about a level of cultural imperialism exhibited by some services. This included a lack of understanding of the importance of the processes of inclusion and consultation; which in concrete terms meant that Indigenous workers were sometimes not included in essential consultative and decision-making processes. Working with Indigenous communities, whether the worker is an Indigenous or mainstream worker, often necessitates greater negotiation than might be required in a more linear, structured and hierarchical mainstream setting¹⁵ and a heightened appreciation of the collective nature of processes in contrast to the more individually oriented approach of mainstream services.

“... some mainstream services think they are the experts on Aboriginal health, and don't need to consult with Aboriginal people and peak bodies.”

[FG10; M/F; Ind; Met/R/R]

Encouragingly, however, some interviewees indicated that Indigenous ways of working were increasingly respected and that some positive changes were occurring in this regard. For example, Indigenous cultural ways were increasingly incorporated into training programs for mainstream workers.

“... Indigenous ways of working and knowing are respected and are being incorporated into training more.”

[Int33; M; Ind; R/R]

¹⁵ *Materialism, Individualism and Globalisation*
Western culture is readily identifiable by two defining features: materialism and individualism. Both are increasingly common as global phenomena. And both seem closely associated with dissatisfaction, anxiety and alienation. Consumerism offers its own remedy in the form of more consumption including more consumption of alcohol and other drugs (Eckersley, 2006). The trend towards individualism and lack of social connectedness, and its impact on behaviours such as risky drinking, has also been highlighted by numerous commentators in recent years (Roche, 2006). Putnam (1995) in his well known critique of modern American life, *“Bowling Alone: America's Declining Social Capital”*, argues that people do not see as much of each other these days as in the past and that this is detrimental to both society as a whole and the wellbeing of individuals. Conversely, Indigenous Australians are characterised by a philosophical position of connectedness or relatedness which stands in stark contrast to a post-modern Western focus on individualism.

“You can get some people to understand.”

[FG2; M/F; Ind; Met/R/R]

Nonetheless, difficulties continue to arise from different cultural ways of working. This was especially noted in situations where non-Indigenous workers with more formal qualifications (such as nursing) either exercised rigid views that were not culturally sensitive or appropriate or held more senior positions. Often culturally safe ways of working required subtle and less direct ways of interacting with colleagues and clients. This issue alone illustrated the vast gaps in cultural knowledge and understanding among many mainstream workers.

“Some nurses have their own ideas and values ... and they force those onto the health workers. For example, the way they speak to the health workers. They don't understand that directness is not right. It's stuff like the tones of voice, or just talking. Some workers feel nurses 'too wordy, too much big language'.”

[Int15; M; Ind; Met]

Some Indigenous workers described how they were unclear of their role in relation to new non-Indigenous workers (often a nurse) who joined their service. The approach taken by Indigenous workers in such situations of uncertainty was often to hold back and wait to see what was requested of them. This reticence was then often incorrectly interpreted as laziness or uncooperativeness, when in reality it was giving the new worker space while patiently waiting to respond to their needs and directions. Because of the high turnover in staff, especially non-Indigenous staff, this was a scenario that was played out over and again.

“... because of the big turnover of staff— a lot of our AHWs who've been out there for years find it hard. Often feel undermined. AHWs have been there for a long time, and when a new nurse comes in they'll [AHWs] stand back and they won't do anything until they are included. If RANs don't see the workers participating and running on the floor, they get labelled as 'oh ... they don't want to do anything!' But for the health workers it's like 'hang on...what are we going to be doing, what does this new nurse want of us? Are we going to be working with the old people, or doing outreach work or what?' It's been a problem for health workers. They feel like they are getting left behind— we've been not utilised to our capacity!”

[FG13; F; Ind; R/R]

Holistic Approaches to Health¹⁶

From an Indigenous perspective, issues pertaining to health and wellbeing are systemic and not derived from limited knowledge parameters. As such, wellbeing must be addressed systemically. Holistic, connected and inclusive approaches form the cornerstone of Indigenous views of the world in general, and of healthcare in particular. However, lack of holistic approaches to health and healthcare were often noted as a major source of dissonance between Indigenous and mainstream alcohol and other drug workers. Indigenous workers had a heightened awareness of the importance of holistic care and approaches to care that incorporated “the whole person/community, mind, body, soul, spirit” [FG9; M/F; Ind/non-Ind; R/R].

“Treat the person holistically, taking into account, spirituality, and histories of grief and trauma such as sexual abuse.”

[FG2; M/F; Ind; Met/R/R]

Reflecting this perspective on health, there was a corresponding view that healthcare services should be similarly holistic and integrated and that more services were needed that had this broader orientation.

“...need more holistic approach from government services and NGOs in communities.”

[FG9; M/F; Ind/non-Ind; R/R]

Most Indigenous workers expressed a strong preference not only for a holistic approach to care but also for a comprehensive approach to client engagement and support. In practical terms, this might involve spending several consecutive hours, or even a whole day, with a client. However, this approach can be difficult to accommodate in rigidly defined and structured mainstream models of service delivery that are predicated on substantially shorter periods of engagement with a client.

“... when we see clients we have got to limit amount of time of 90 minutes as a maximum amount of time that we’re allowed to spend on a client per visit. Sometimes those visits can exceed 90 minutes. They can exceed up to 3 hours or more when you are trying to deal with a whole range of issues that the client is facing and generally the client presents at the 13th hour.”

16 The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage (South Australian Aboriginal Health Partnership, 2004).

So these are things that have to be done there and then and not over numerous visits that fit within that allocation. If it’s seen that when they look at the data sets that you’re spending X amount of time with particular clients on a on-going basis then you’re questioned about that and you have to explain why you are doing that and also clients expect to have a full holistic approach presented to them when they come to see us. They expect you to do everything. They want you to do things about their housing, or to assist them in those areas and sometimes we’re only sent to do certain specific things and it’s meant to be the responsibility of Housing to do that component of the client’s request. But we often get called in to help out in that situation and with that you do get questioned about those kinds of things too. Just the restrictions that are put on you by the government.”

[Int13; M; Ind; Met]

Perceptions of Time

Time was another area where radically different world views and perceptions exist. This difference flowed over into what constituted “work time” or a “working day”. Defining what constituted an appropriate use of time was often a major source of stress and frustration for workers, and a predictable source of conflict.

Indigenous workers stressed the importance of flexible approaches to work time and rejected the rigid constraints of a typical 9-5 work day. Having work life dictated by the clock was anathema to many Indigenous workers, who were intrinsically motivated to work in the best interests of their clients or community to achieve improvements in their health and wellbeing, and wished to do so with autonomy and flexibility.

“Being autonomous, don’t have to clock in and clock out. Just get the job done the best I can the ways I knows— may be down at a mate’s place during work time asking how to fill out a form ...”

[Int12; M; Ind; Met]

“...the system we work in, which is driven by the clock.”

[Int01; F; Ind; Met]

Working by the Compass, Not the Clock

Diametrically opposed world views were captured by one participant who described how it was important for Indigenous workers to work with their clients by the “compass” not the “clock”. The compass analogy represented a multi-dimensional and multi-directional

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approach where the worker and the client could move in many different directions simultaneously. In contrast, the “clock” driven orientation of the white mainstream system was seen as linear, uni-directional and extremely limited in focus and scope. Insufficient effort has been directed towards reconciling these fundamentally different world views and ways of working, and predictably they regularly collide.

“... when you’re working with Aboriginal people you need to work by the compass. Cos, Aboriginal people will take you north, east, south and west in one spin and then they’ll go back to north and south. The system that health is bound by, therefore so are the employees, are very much driven by the clock. So how do Aboriginal people work with Aboriginal people— using that compass metaphor. When the white system is saying ‘you can’t do that cos you’re driven by the clock’. It adds stress to the worker.”

[Int01; F; Ind; Met]

Work Environment and Setting

Not only were important cultural differences noted in relation to abstract constructs such as time, they were also manifest in more concrete components of the working environment. For example, the freedom to be able to counsel people outdoors was something that several interviewees highlighted as a positive aspect of their working environment. An informal setting was something that both Indigenous workers and clients regarded highly.

Informal modes of interacting were also valued by Indigenous workers. For instance, the informality of having “a talk” rather than interacting in a more formally defined clinical mode also seemed to improve client acceptance. To do this, workers needed greater flexibility in how and where their work role was carried out.

“Need to have this flexibility where you work to get results... Being in an office 9 to 5 is like sitting in a box and things don’t change. You don’t get any results.”

[Int12; M; Ind; Met]

“... a lot of Aboriginal people are all about networks and connecting.”

[Int09; M; Ind; Met]

“If agencies and departments can let their workers run with what they think they should do if they’re in a job for full time employers they should let their workers try and run with what they want to do for 3 or 4 months to see if they can make themselves happy within the position meaning that if they’re not happy in the position let them see if they can mould their own position within the position to see if they can be more happier and see if it works for them and their clients. They need to be given the opportunity to see if it works for them first because if they are not happy, they’re stressed out.

You do what you think is required to get the message out there to the community and the manager won’t pressure you and if it works it works and if not you might re-evaluate that’s including the hours you work that includes everything to do with working there. Put a bit of responsibility back on the worker instead of being answerable to the XX.

If you have been in the job for so long around whatever, drugs and alcohol, and a lot of people do this and just don’t realise they go to work and they might not even work but they just go because it’s another day another dollar type thing but if you can make a person happy at work where they create their own position as long as they are within reason you’ll find they might be a lot more happier and they look forward to going to work and they might miss work you know when they go on holidays and stuff. But they got to create their own position.”

[Int14; M; Ind; R/R]

The workplace literature on autonomy of workers and satisfaction is very clear that this is a principal determinant of job satisfaction and a predictor of retention. The concept of worker autonomy for Indigenous workers, however, takes on an additional dimension and level of significance. Autonomy in its many guises is strongly linked to self-determination and overcoming or redressing power inequalities.

Unsurprisingly, many respondents indicated that they preferred working for an Indigenous organisation because of the extent of support and understanding of family issues, adequate provision of funeral leave, and a general understanding of community pressures. There was also little likelihood of friction over the fundamental ways that work would be done.

“... other organisations don’t have the flexibility that we have. Case managers have an RDO if they work on weekends. Time off for personal issues/ carers leave can be negotiated.”

[Int05; F; Ind Met]

“... it’s really good. I get out there and mix with the community as well, you know, not just stuck behind the computer doing work, and I like... that’s what I like, because you can actually get out and about, and I’ve got two sites that I work from.”

[Int04; F; Ind’ Met]

“... cultural ways of working are very important. Cultural respect polices, traditional obligation policies, staff are encouraged to sit on community and cultural boards— keeps our traditional roots— that’s why we got the exemptions too, helps keep us a traditional organisation. Not aware of any others who are still traditional— would like to see it taken up more.”

[Int05; F; Ind; Met]

Organisational flexibility was highlighted as a highly valued aspect of some Indigenous working environments.

“Our community has more sort of social issues so there is a lot of community obligations you have to meet. Does impact on work. This organisation is supportive, cannot prepare for things like that. Needs organisation to be responsive to needs at the time.”

[Int03; F; Ind; Met]

“Helps if management are Aboriginal or are culturally aware. Working in a women’s service, and an Aboriginal women’s service, management has been more flexible and understanding. Currently working on policies and procedures with second work site to be more understanding of Aboriginal workers and encourage them to think in an Aboriginal way.”

[Int04; F; Ind’ Met]

General Stress and Frustration of Alcohol and Other Drug Work

Services that operated in a manner that was not perceived to be culturally safe or appropriate often failed to provide a service in which clients felt comfortable enough to remain. The high turnover rate observed in many services was due in part to lack of cultural security and safety, and was a source of considerable stress for workers.

As for many workers in the alcohol and other drugs field, the deflating experience of seeing clients go through cycles of recovery followed by relapse was also a source of stress. For many Indigenous workers, client “failure” (most commonly conceptualised in terms of relapse) was often attributed to the lack of culturally appropriate services.

“... I think it’s more frustration than anything else. The services that are successful in our region now are too difficult for Aboriginal people to get into and it’s not set up in culturally appropriate manner. And quite often in those circumstances, where we have successfully got some Aboriginal clients into a service, they are there no more than 24-36 hours and they are gone. When they should be at that service for at least a week to get any benefit.”

[Int13; M; Ind; Met]

Examples were provided of services that were successful in ensuring cultural security in terms of language, the nature of the information offered and gender matching of workers and clients.

“...we try to be cultural and provide cultural security and engage translators even though these folk can speak English we think it’s cultural if information is delivered in their language.¹⁷ We do try and do what the community wants, but we are a bit restricted in having female workers.”

[Int6; M; Ind; Met]

For many workers, appropriate alcohol and other drug treatment required attention to a wide range of causal and contributory factors. Most importantly, it also involved the role of the family. Many workers highlighted how important it was to involve the family in the whole assessment and treatment process. Again, this was a major point of difference between Indigenous and mainstream services. From a mainstream perspective, involvement of the family in alcohol and other drug treatment has been largely overlooked until relatively recently (Dawe, Atkinson, Frye et al., 2007; Scott, 2009; Trifonoff, Duraisingam, Roche, & Pidd, 2009). Traditionally, the client, and the client alone, was the focus of attention.

“With our people who have alcohol and other drug issues there’s also an element of mental health that comes with that. So we are dealing with high levels of co-morbidity as well as chronic disease. What we don’t have is services in place that we can refer our people where not only the individual gets looked after for their recovery in terms of mental health and alcohol and other drugs, we don’t have these systems or services in place that cater for the family.”

[Int1; F; Ind; Met]

17 Indigenous people in remote Australia are more likely to report speaking an Indigenous language (42%) than those in non-remote areas (2%), and to report difficulties in communicating with service providers, with 19% and 8% respectively (Australian Bureau of Statistics, 2004).

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Organisations that have a philosophy that respects clients' rights also reinforced workers' confidence in being able to deal appropriately with all clients. This also made it easier for clients to accept the assigned worker(s) and the services that were being provided.

Out of Their Own Lands

Due to the limited availability of services, Indigenous clients were often required to travel some distance to receive alcohol and other drug treatment and care. There was seldom little acknowledgement of what it meant for these clients to be "out of their own lands" and often in a foreign nation with all the attendant disorientation and homesickness that that could entail. It is only recently that there has been increased understanding on the part of mainstream Australians of the significance of country and the quintessential nature of the relationship between country, health and wellbeing.¹⁸

"Clients from our region have to travel to another region with different groups of Indigenous people and out of their own lands, which is an issue in itself because of the different weather and different country."

[FG6; M/F; Ind; Met/R/R]

This was a major source of stress for workers who felt that by referring clients to culturally unsafe services they were failing to provide appropriate care for their clients.

"Fellas get homesick, it's not the right place for everyone to go to. They need to get healthy on all levels, not just drinking, and they need good food that suits them and not strange food."

[FG6; M/F; Ind; Met/R/R]

A better understanding of the importance of not being placed in alien settings and locations and removed from one's own country would help facilitate the restoration of health and wellbeing of many clients (Garnett and Sithole, 2007). Connection to country and behaviours that are related to country, are now recognised and understood to be an important determinant of health and central to wellbeing, for both clients and workers.

"These fellas don't want to go because when you go to these places you have to pay to go to these rehab places. Some of the people have houses. They think: how am I going to pay rent and live over there and support my family here too. Families sometimes can't go with them as well. So they say: 'No, I don't want to go'."

[FG6; M/F; Ind; Met/R/R]

Some workers encountered cross-cultural difficulty not necessarily because they were 'traditional' but because of their family connections. An example of such a dilemma was where a male worker left a foetal alcohol workshop he had been invited to attend because he didn't feel that it was his role or that he could talk to women about drinking during pregnancy because it's 'Women's Business'. The worker was not uncomfortable about this issue. His father, however, was a traditional man and the worker felt concerned that if it was known that he was talking about Women's Business there could be repercussions.

There is an important challenge here in terms of how to support workers to be involved in such areas but in ways that will not contravene important cultural norms.

"It's certainly not taking into consideration the cultural fact, because when you are working in a big area and big community not taking into consideration that you need a male and female worker taking in the cultural factors. They certainly don't take that into account. Certainly about 90% don't take that into consideration."

[FG2; M/F; Ind; Met/R/R]

Age and Gender

Other elements of culturally sensitive service provision highlighted by participants included factors related to the age and gender of both workers and clients. Ensuring that there was an appropriate age and gender match for specific issues and circumstances was essential in many settings.

"Age and gender appropriateness of worker is important. For example, if a young urban worker was asked to work with an older woman who had lived on lands— would feel that was disrespectful— also found in previous job in accommodation young Aboriginal men did not like working with a woman— didn't like women's authority. Not to say that can't work with these client groups but clients need to be able to have a choice and request another worker if they like without fear of offending worker."

[Int04; F; Ind; Met]

¹⁸ See for example the report: Indigenous Health and Wellbeing: The Importance of Country (Ganesharajah, 2009).

In Indigenous societies, age is a pivotal construct replete with significance and meaning that has little parallel in mainstream Australian society. In fact, Western society demonstrates an inverse set of values in relation to age, with primacy placed on “youth” and “youthfulness” (Roche, Bywood, Borlagdan et al., 2008). In contrast, Indigenous Australians greatly value and hold in high esteem the elderly: it is age that is revered not youth.

For example, greater emphasis is placed on differences in age and life experience rather than qualifications. In non-Indigenous Australian society, formal qualifications largely determine status and seniority; but in Indigenous society, where few people have historically possessed formal qualifications, age is a principal determinant of social status.

The alcohol and other drug field is characterised by contentious issues. Not unexpectedly there are both cultural and inter-generational conflicts over controversial harm reduction strategies such as the provision of clean needles to injecting drug users. Importantly, however, younger Indigenous workers are likely to be more heavily influenced by and obliged to comply with the views of Elders in their community than is the case for mainstream workers.¹⁹

“...older Aboriginal peoples’ values... they didn’t like the clean needle exchange, not understanding ‘No we don’t want to give out needles, we don’t want to encourage’ ... Being a young Aboriginal person you are affected by what the community see and thinks.”

[FG17; M/F; Ind/non-Ind; Met;R/R]

In addition to age-related cultural differences, gender and perceptions of appropriate gender-based roles were also an important point of divergence. In some parts of Australia, gender issues and the need for segregated services and programs was much more pronounced than in other areas. In instances where there is only a solo worker, and that worker is male, it may only be possible for him to work with male members of the community and sometimes only his clan or family group. The same gender-based constraints can also apply to mental health workers in such settings.

In light of this, some participants noted the need for separate services as well as gender-specific workers.

“Impact of cultural business is different in different parts of the country— Up north Men’s and Women’s Business, it’s acknowledged and practiced. Down south it’s seems to be more about men’s and women’s camps, and stuff like that. It’s less about initiation and more about giving men a chance to sit together to support each other, even around stuff like men’s health. Women seem to have a better grip on things, in the community and in their workplace. But for men it’s harder to find time and space to come together.”

[Int15; M; Ind; Met]

“Where such important and strongly held traditional boundaries and other protocols exist, some communities might need several different substance workers to address the needs of the whole community.”

[Int10; M; non-Ind; Met/R/R]

One participant highlighted the importance of ensuring that adequate funding was provided for gender-specific positions. They noted that one of the services that they provided dealt with suicide prevention and that as a male worker they were not able to deal with issues around female suicide. This worker further suggested that female clients needed a voice and a female worker they could talk to. However, current funding only allowed for one worker to be employed [Int14; M; Ind; R/R].

“A major challenge involves working with female clients and trying to involve their partners in the ‘Long Grass Camps’- a male worker recognised the limitations that he has in relation to dealing with ‘women’s business’. Usually deals with this by involving his Coordinator who is female.”

[Int34; M; Ind; R/R]

A recurrent theme was the lack of understanding on the part of funding bodies of the importance of allocating sufficient funds to support two positions, one male and one female. In mainstream services, this is mostly a non-issue. An understanding of gender sensitivity issues by mainstream funders and policy makers might extend to issues related to sexual function or reproduction, but there appeared to be comparatively little comprehension of the importance of this issue beyond that.

¹⁹ It is noted that there is a larger proportion of young workers among the Indigenous than the mainstream alcohol and other drug workforce.

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“...also a lot of mainstream co-workers and training providers don’t understand the need for two health workers, one male and one female, and that it’s not appropriate for men or women to do some jobs. Still a lot of cultural Women’s Business and Men’s Business like women’s surgery and men’s surgery.”

[Int15; M; Ind; Met]

There was a strong call for more Indigenous-run services that could adequately cater for the needs of both male and female clients and that would operate along culturally appropriate lines.

“I do think there should be an office here for Aboriginal women and Aboriginal males about drug and alcohol services here in our region run by the state not run through anything else. Aboriginal people should run it; and the reason I say that is because [of] that bridge factor between Aboriginal and non-Aboriginal and it will change over the years, but not just yet.”

[Int14; M; Ind; R/R]

“Being the only Indigenous worker at my organisation, there are times when I am overwhelmed and would appreciate another Indigenous worker [male] to enable our clients have a gender choice of staff.”

[Sur; F; Ind]

“Eventually we will get a co-worker, someone to work with me female clients. She can take on the female clients if there are any. Currently deal with male and female clients; however would be better if there was a female counsellor for them to talk about female issues with.”

[Int32; M; Ind; R/R]

Greater Latitude Afforded non-Indigenous Workers

While there are many Aboriginal protocols that are important to be followed, and can result in severe opprobrium if not conformed to by an Indigenous worker, there is a much greater level of flexibility afforded to the non-Indigenous worker. This latitude afforded to the non-Indigenous worker was described to us as follows:

“...white fellas can blunder in, but Aboriginal workers need to/will wait for invite— white workers can be forgiven for not following protocols.”

[Int10; M; non-Ind; Met/R/R]

However, for the Indigenous worker, particularly when working within their own community or clan group, strict adherence to importantly held social protocols was essential and needed to be carefully maintained and respected. The workforce development implications of this are described in Chapter 5.

Summary

“If you want to be a doctor you can go to uni and be it, you can put on a Santa suit and be Santa. But you can’t be a blackfella”.

[Int14; M; Ind;R/R]

Cultural respect and cultural safety is of fundamental importance to Indigenous workers and is also relevant to non-Indigenous workers. The level of significance it holds is often under-estimated by non-Indigenous people. Working towards being culturally proficient in cross-cultural practice, improves relations between cultures, promotes self-determination for Indigenous people and is an essential element in any strategy designed to improve services for Indigenous communities and workers.

A guide to working towards culturally safe practice for organisations can be found in the final chapter of this report (see Figure 2.).

Funding, Job Security and Salaries

In addition to a range of personal, social, and cultural factors, a set of logistical and infrastructure issues also cause considerable stress and distress for workers. These include funding, job insecurities and the very low pay rates that Indigenous healthcare workers attract.

This part of the report deals with stress factors related to the economic environments in which many Indigenous services operate and their implications for worker wellbeing, stress and burnout.

The following broad areas are addressed:

- General Funding Issues
- Infrastructure and Resource Limitations
- Measures of Outcomes
- Reporting and Compliance
- Short-term Appointments
- Salaries and Other Financial Implications.

“And it’s funding, it comes back to funding. Closing the gap, you know. Have you heard that talk? Closing the gap? Well, I think it’s widening, because we’ve had money taken away from our programs— \$3.8 billion. There’s no e-subs anymore, you can’t get any short term programs to alleviate any problems or anything. So ‘Closing the Gap’ should have a sign underneath it – ‘All bullshit.’”

[FG4; M/F; Ind; Met/R/R]

General Funding Issues

Many workers and managers saw funding arrangements as the largest contributor to worker stress and burnout. A common source of pressure felt by workers related to organisational and programmatic funding arrangements.

“...seen a change in the job and pressure on organisations over the years— now more bureaucracy which contributes to burnout. Large contributor to this is the funding arrangements for programs and organisations.”

[Int33; M; Ind; R/R]

Lack of funding was identified as a major concern and source of stress for many workers. This is consistent with recent research findings in The Overburden Report: Contracting for Indigenous Health Services (Dwyer, O’Donnell, Lavoie, Marlina, & Sullivan, 2009) which found that more so than other health services

funding for community controlled health services were characterised by fragmented funding, from a variety of complex and varied sources with a disproportionate amount of time dedicated to preparing and processing funding reports.

“Aboriginal health will never get any better if you don’t put the resources. The AMA are saying if you don’t invest more money into Aboriginal health, it’s not gonna get better. It’s another form of structural or systemic racism. Again, it’s not the interpersonal, [it’s] non-Aboriginal people not taking serious Aboriginal health. Therefore it doesn’t feature in their own values and morals which then doesn’t translate into any of the programs, plans and strategies being developed and looking at things like the Aboriginal health impact statement and getting that embedded into the systems where it would be used in the health sector.”

[Int03; F; Ind; Met]

Disappointment was expressed that there had been little change over the past 10-20 years in relation to funding cycles, with governments still focused on three-year funding. New funding rounds supported new programs of work. There was also a perception, particularly among communities, that pilot programs were unlikely to continue even if they had achieved positive results, while other programs with minimal success continued to get funded. It was maintained that better evaluation was required to determine what should constitute success or failure of a particular program. This approach would also improve partnerships between the funding body and recipients [Int22; F; Ind; Met].

“There’s not enough money put in to drug and alcohol workers because there’s not enough money put into drug and alcohol users. I don’t believe they’re a priority because of all the stereotyping that’s attached to them— Junkies aren’t vote winners.”

[FG15; M/F; Ind/non-Ind; Met/R/R]

The nature of short-term alcohol and other drug program funding caused considerable stress for Indigenous workers. Many workers expressed their frustration at a lack of financial support and commitment from funding bodies, and the actuarial approach often taken to assessing progress.

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“Funders only care about the number of people who go through the service, emphasis on quantity over quality. You can see a lot of people, but your success rate is going to go down.”

[FG4; M/F; Ind; Met/R/R]

The issue of secure, ongoing funding was also highlighted by a non-Indigenous participant who described how not only were current funds inadequate, but that increased funding needed long-term planning, continuity and sustained input to achieve significant improvements.

“As far as funding goes, it is not secure. It is not enough and you have to put a lot of work into getting it renewed and trying to ask for more. But it will never be enough, because the needs in this area will outstrip demand for many years to come. If they were to treble our funding, we couldn’t spend it in the next year logistically. Making significant long-term changes have long lead times.”

[Int07; M; non-Ind; R/R]

Funding differentials were noted between mainstream and Indigenous alcohol and other drug organisations. Frustration was expressed when a well-funded mainstream organisation asked for help in dealing with Indigenous clients when that organisation already received funding specifically to provide services to Indigenous clients. In such situations, it was argued that funding should be provided to the Indigenous organisation to care for Indigenous clients [FG16; M/F; Ind; Met/R/R].

Concern was expressed about the recent trend for funding for Indigenous client services to be directed to mainstream services rather than provided to community controlled organisations. This shift was noted by numerous participants and is contrary to contemporary thinking in regard to the need to develop the capacity of both the Indigenous workforce and Indigenous services.

There was frustration about the reporting mechanisms imposed by funding bodies. In some instances, there was so much reporting required against expenditure that some organisations employed staff specifically for this purpose. Reporting requirements also tended to vary from year-to-year, placing additional pressure on workers and organisations to keep up-to-date with constantly changing requirements.

A related source of frustration was the continual change in the funders’ key contact staff. As a result, organisations had to repeatedly explain their role,

function and funding requirements to different personnel [Int6; M; Ind; Met].

“If we got the appropriate funding to do the work that we should be doing, and if we got the backup support, you’d get more [client] completions. You’d get more satisfaction.”

[Int28; M; Ind; R/R]

The issue of having to constantly fight for funding sources was cited as a source of stress for some workers. They noted that this took them away from their core role of serving their community [FG4; M/F; Ind; Met/R/R].

“Increased paperwork and more accountability, takes time away from the clients ... find this quite sad.”

[Int33; M; Ind; R/R]

The challenges associated with applying for competitive grants, including the long processing and assessment period, were key concerns. Some funding processes took up to two years to advise if an application had been successful [FG17; M/F; Ind/non-Ind; Met/R/R].

Participants were increasingly despondent about spending time writing lengthy funding bids for which there was no guarantee of funding.

“You spend all this time putting together submissions and sending them in, and then get rejected. It’s really frustrating, and it’s time you could spend on other things.”

[FG4; M/F; Ind; Met/R/R]

Delays in advice about funding were common. One organisation was notified of an offer of funding three months after their previous contract had expired, during which time their organisation operated on its cash reserves not knowing if they would get continued funding. Funding bodies did not appear to appreciate the negative and stressful impact that this had on organisations and their staff [FG1; M/F; Ind; Met/R/R].

Such situations were compounded where there were multiple funding sources. Organisations were further hamstrung, as they could be penalised or have their funding cut if they tried to source alternative funding [FG1; M/F; Ind; Met/R/R].

Conversely, there was a perception that funding bodies did not always comply with their own guidelines. For example, progress payments were not made promptly after receiving deliverables or progress reports. In this context, some funding bodies were perceived as operating by a double standard [FG1; M/F; Ind/non-Ind; Met/R/R].

Infrastructure and Resource Limitations

Funding problems limited the provision of services and support to clients. Lack of adequate funding meant organisations could not provide appropriate infrastructure and the resources required to ensure quality care and this was a source of stress for workers.

From an organisational perspective, funding limitations impacted on travel; provision of work vehicles; suitable IT support; dedicated work stations, personal computers, and access to the Internet. Many organisations appeared to be operating on shoe-string budgets where there were no financial resources for backfill to enable staff to attend training or cover annual leave in spite of strong, self-evident cases of high need.

“There are lots of hidden costs in training that aren’t recognised, both for the organisations and for individuals. There is no money to back fill positions. Even if there was could you get someone for a short term basis? There are costs if the person has to go to Brisbane for training. They continue to get their salary. AbStudy picks up some costs but there are a whole lot of others issues including if you have a large family that is dependent on you. They are disincentives to training.”

[FG17; M/F; Ind/non-Ind; Met/R/R]

There were additional financially-based challenges faced by workers who provided client outreach services. These included lack of access to laptop computers, mobile phones and suitable vehicles for rural areas. Workers were often required to supply these items themselves. Such under resourcing was seen to be the result of short-term thinking by decision-makers and administrators and viewed as likely to set up Indigenous people and programs to fail [Int12; M; Ind; Met].

“Worked with Centrelink for 10 years, Perth, NT, Queensland, but rules are made in Canberra. No consideration for remote area. No job networks members. Now there’s no CDEP, so what are people who aren’t health workers or employed meant to do for a job?”

[Int15; M; Ind; Met]

Outcomes Measures

Funders were perceived as placing unrealistic expectations on new programs to deliver immediate outcomes and to demonstrate improvements in Indigenous health within short time periods. One organisation was asked to demonstrate significant

outcomes in the first six months of an 18 month program. This placed pressure on workers to write reports, validate data, measure change along a short timeline and to report on indicators that were neither realistic nor relevant to their work [FG7; M/F; R/R].

A discrepancy was noted between the reported outcomes wanted by the funding body and the positive outcomes that were actually being achieved by the service. Reporting formats and requirements often made it difficult to report on the number of lives that were being saved or the number of people kept out of prison – the outcomes of importance to workers [Int14; M; Ind; R/R].

Alcohol and other drug programs were often funded annually and were performance or outcome based. Where program outcomes deviated from those anticipated such programs were likely to be discontinued. As a result, workers described how they spent more time on computers to provide the required compliance reports and less time seeing clients [Int28; M; Ind; R/R].

“...alcohol and other drug programs are mostly funded on an annual basis, and if the outcomes aren’t what funders expected then projects will not be refunded. That’s stressful for workers.”

[Int33; M; Ind; R/R]

There was concern that when funding bodies identified a program that was not working, they were likely to close it down. It was suggested that funding bodies should try to identify why such programs were not working, determine if the program may have failed because it was not adequately funded in the first place and to provide more funding if appropriate [FG4; M/F; Ind; Met/R/R].

“If something’s not working, they don’t try to fix it, they just close it down.”

[FG4; M/F; Ind; Met/R/R]

Participants expressed concern that some managers had accounting/financial management backgrounds and were not clinicians. These managers were inclined to see things in monetary terms and not in relation to client outcomes and this reflected on the agency’s orientation and ultimately on the workers’ roles. Some workers were frustrated that final decisions about service provision were often based on funding [FG16; M/F; Ind; Met/R/R]. While this is common tension between administrators and clinicians, it was seen to be amplified in relation to Indigenous alcohol and other drug services due to severe funding constraints relative to need on the one hand and the high level of commitment and motivation by Indigenous workers on the other.

Chapter 4: Sources of Stress

Participants in one focus group were especially vocal about their frustration with the current constrained funding climate, and raised the issue of feeling “shamed” that they were not able to provide adequate or appropriate services to clients.

“In a nutshell...we as workers are frustrated. We’re angry. We’re just stymied at doing anything meaningful. Then we get shamed because we’re trying to deliver a service we know has got no real end to it or no real outcomes for our clients.”

[FG4; M/F; Ind; Met/R/R]

In addition to feelings of shame, frontline workers often personally bore the brunt of community anger and disappointment over poor, or absent, services.

“You’ve got all these community expectations, but you can’t promise them something that the government isn’t going to give you. So they’re angry, and it’s really stressful for you.”

[FG4; M/F; Ind; Met/R/R]

Short-Term Funding

The majority of services provided by participants were supported through annual, bi-annual or tri-annual funding cycles. Such short-term funding cycles created considerable stress at many levels. There was frustration that short-term funding did not provide health services and communities with realistic timeframes to address the complexities of alcohol and other drug use among Indigenous clients.

“There’s a two-year grant. The first year, it’s networking and promotion. Second year, you finally get to do something for the community. And then it stops!”

[FG1; M/F; Ind/non-Ind; Met/R/R]

“Three years isn’t long enough to make an impact, [funding commitment] should be something like 8-10 years.”

[Int14; M; Ind; R/R]

These concerns were also echoed by a non-Indigenous manager who noted the demoralising impact that the withdrawal of funding can have on communities. He had observed a community controlled organisation having extreme difficulty engaging community in new initiatives and programs following such an experience [Int10; M; Non-Ind; Met/R/R].

Short-term funding also precluded organisations from offering long-term contracts as incentives to retain experienced staff. The prevalence of short-term appointments hampered succession planning and

development of career pathways for staff, as it was not clear what positions staff could aspire to within an organisation.

“People are always moving on because pay is not very good ...”

[Int03; F; Ind; Met]

Throughout this project, short-term appointments were often cited as contributors to staff turnover. Smaller organisations were particularly vulnerable to losing a number of staff at a single point in time. In one example, the cessation of program funding resulted in five staff losing their positions. Some participants felt the short-term nature of appointments (and programs) contributed to a general sense of dissatisfaction and stress. It also impacted on the workloads and support available for colleagues who were still employed.

“What I find difficult is the thought that when the program finishes suicide will still be hereNow I don’t mind if they cut my reins, I’ll do what I have to but there are those that are still gonna be here and the elements of suicide are gonna still be here. That’s what I don’t like and I do get stressed about it a bit.”

[Int14; M; Ind; R/R]

Others expressed frustration at the prevalence of short-term appointments, especially for sole workers. Such arrangements were perceived to be “token gestures” made by policy makers and funding bodies. Participants also acknowledged that being employed as a solo Indigenous worker was a significant contributor to worker stress and exposed them to a higher risk of burnout.

“Until we get proper support mechanisms and are properly funded to decrease the workload on one individual, or two individuals, stress is here forever. Burnout’s here forever. And it’s funding, it comes back to funding.”

[FG4; M/F; Ind; Met/R/R]

Participants described how lack of ongoing funding and the possibility of losing their job was a matter of great distress and impacted on their physical, social and emotional health and wellbeing.

“I was awake at night, grinding my teeth and stuff, because [the uncertainty is] quite a scary thing.”

FG17; Ind/non-Ind; Met/R/R]

“I’ve been sick as a dog for ages. It’s all stress related. So most definitely it impacts on my health. It impacts on my wellbeing, it impacts on my relationships with other people, and how I view things.”

[FG1; M/F; Ind/non-Ind; Met/R/R]

Salaries and Other Financial Implications

Indigenous healthcare workers attract some of the lowest rates of pay in comparison to other healthcare professionals, adding to the pressure of difficult working conditions. In 2007, the Australian Services Union undertook a comparison of 12 selected community service occupations. In that comparison, Aboriginal Health Workers received the lowest average weekly pay (\$547.76) of all 12 groups: lower than children's care workers (second lowest at \$570.09), social workers (\$909.89), welfare and community workers (\$877.54) and counsellors (\$905.95) (Australian Services Union, 2007).

"...the greatest issue is disparity of salary across NGOs, community and government. For example, government salaries have incremental increases allowing for promotional opportunities but NGOs are not able to provide these incentives."

[Int22; F; Ind; Met]

Pay levels for senior executive positions in small community controlled health organisations were also often low, with some reporting that they received a salary equivalent to unqualified workers with no supervisory responsibilities working in government health services. Furthermore, some organisations had not received a core funding increase for 10 years, making it difficult to pass on salary increases [Int05; F; Ind; Met].

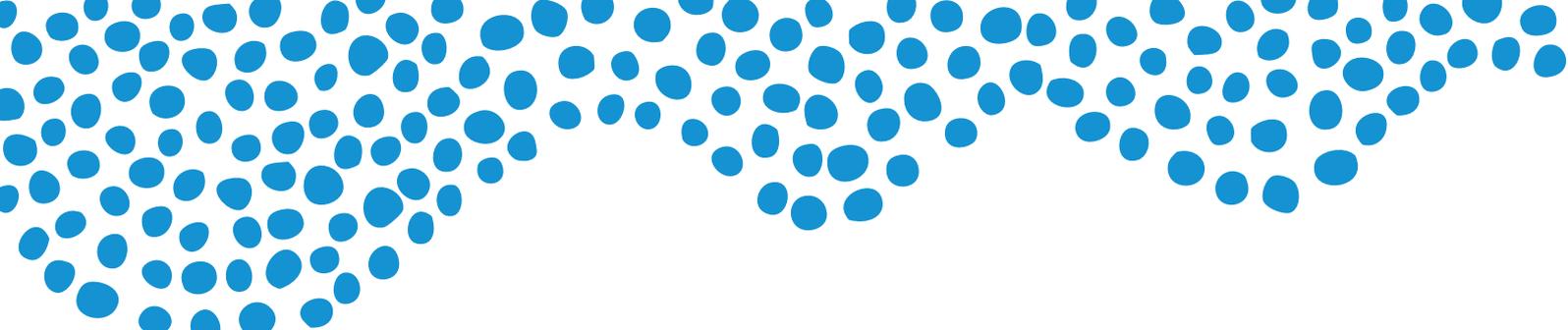
One worker noted that they could be earning more money if they were employed by a government organisation rather than their current organisation. This was due in part to their organisation's uncertain funding situation coupled with the organisation only being able to offer short-term employment contracts (between six to 12 months in duration) [Int3; F; Ind; Met]. The issue of lack of funds or entitlements for overtime was also raised [FG3; M/F; Ind; Met/R/R] as was the need for further research to examine the impact of short-term and stop-start employment on access to superannuation and long-service leave [Int22; F; Ind; Met].

A further problem reported by non-government organisations was that they would employ and train new staff only to see them 'poached' by government organisations. This was not considered surprising as government positions offer better salaries, which in turn assisted workers to meet their own financial responsibilities [Int28; M; Ind; R/R].

In contrast, some participants reported that their organisation was committed to paying above award wages to all staff as a way of recruiting and retaining workers [FG16; M/F; Ind; Met/R/R].

Summary

Lack of adequate funding, both short-term and ongoing, along with financial reporting requirements were key issues of concern for Indigenous workers. These factors combine to impact on the job security of many workers (many of whom were only able to be offered short-term employment contracts) which in turn caused them great stress. Perhaps most importantly, Indigenous alcohol and other drug workers are poorly paid which adds further pressure to a workforce that is already experiencing a range of other significant challenges.



Chapter 5: Workforce Development Strategies



This chapter provides a brief overview of strategies relevant to the Indigenous alcohol and other drug workforce. It outlines some broad strategies that may assist in reducing stress and improving the wellbeing of this workforce. It highlights a range of issues of critical importance, including building the capacity of the workforce to improve the health of Indigenous Australians. The chapter explores some of the workforce approaches that reflect the issues raised by participants as impacting on their wellbeing, including:

1. Capacity building
2. Salary
3. Recruitment, retention and turnover
4. Career paths
5. Role clarity
6. Qualifications and training issues
7. Mentoring
8. Clinical supervision
9. Debriefing
10. Team and co-worker support.

Indigenous workers are a crucial segment of the alcohol and other drug workforce and they carry a particularly heavy load. They are often not highly trained or well supported but nonetheless are required to carry out a wide range of demanding roles. In addition, they are often “on call” 24/7 and as a result many experience high levels of stress and burnout.

Table 10. Ten Principal Workforce Development Strategies to Facilitate Indigenous Alcohol and Other Drug Worker Wellbeing and Reduce Work-Related Stress

Factors	Descriptor	Response Strategies
1. Capacity Building	Building capacity of workers, organisations and communities to provide culturally appropriate (Indigenous) and culturally safe (mainstream) alcohol and other drug services is a crucial social determinant of health.	Address organisational funding issues to provide continuity of funding, provide sufficient funds to allow appointment of adequate numbers of staff, implement appropriate workforce planning, and management and leadership training programs.
2. Salary	Recognition of work demands and the unique role played by this workforce to improving the overall health status of Indigenous people through more equitable salaries across all sectors.	A move to parity of salaries for all levels of staff across all sectors including government, community controlled and non-government health services.
3. Recruitment, Retention and Turnover	Complex and difficult work and employment conditions, especially in remote areas, create a constant strain on alcohol and other drug workers and acts to discourage new recruits from entering the field and fuels high turnover.	Promote a positive image of the alcohol and other drug field. Recruit Indigenous high school students into tertiary education pre-employment workshops, support for literacy and numeracy, pre-vocational courses, introductory, job rotations, and flexible traineeship and apprenticeship on-the-job programs that involve managers in additional responsibilities.
4. Career Paths	Lack of career pathways and opportunities for professional advancement for Indigenous people in alcohol and other drug work was commonplace and compounded recruitment and retention challenges.	Create new staffing categories that workers can aspire to that provide incentives and promotional and further skill development opportunities.
5. Role Clarity	Very broad and overly inclusive roles and lack of role clarity were common.	Better definition of worker's roles within their organisations are required. Providing resources to support workers through clinical supervision, mentoring and debriefing could be achieved at relatively low cost.
6. Qualifications and Training Issues	Alcohol and other drug workers often did not have sufficient knowledge or adequate access to training. Training at higher levels was also indicated.	Extend the focus beyond the level of Certificate III and Certificate IV and also provide management training.
7. Mentoring	Mentoring was recognised as a valuable professional development tool.	Implement mentoring as a standard support strategy.
8. Clinical Supervision	Clinical supervision was recognised as an effective strategy to prevent or manage stress but was not widely implemented.	Implement clinical supervision as a standard strategy to prevent or manage stress. Develop Indigenous-specific clinical supervision guidelines for the alcohol and other drug sector.
9. Debriefing	Debriefing was recognised as an effective mechanism to reduce stress; however debriefing opportunities and preferences were highly varied and often found to be non-existent.	Identify and promote various forms and sources of debriefing suitable for Indigenous workers and their working contexts.
10. Team and Co-Worker Support	The need for diverse forms of support for workers was a priority.	Provide worker support at various levels and in various forms including mentoring, clinical supervision, formal and informal debriefing opportunities as well as recognition of good work.

Capacity Building

The Australian Census conducted in 2006, identified that the Indigenous population comprised approximately 517,200 people or 2.5% of the total Australian population (ABS, 2007). However, Indigenous people accounted for only 1% of the total number of Australians employed in the health sector²⁰ in 2006 (AIHW, 2009). These figures clearly represent a large shortfall in the number of available Indigenous healthcare workers.²¹ This places tremendous pressure on the limited number of Indigenous workers employed in key health roles.

"We don't have many Aboriginal alcohol and drug workers. I believe that to create a workforce to meet the demands of the health services we need to develop a workforce that is well equipped to deal with people who have alcohol and drug problems and chronic disease."

[Int1; F; Ind; Met]

Throughout this project, all participants were cognisant of the workforce shortfall, and expressed a strong desire for capacity building of the Indigenous alcohol and other drug workforce at multiple levels, including:

- Individual health workers
- Community controlled organisations
- Mainstream organisations
- Local communities
- Indigenous Australians as a community.

"One of the things we don't do well is about building that capacity in those rural and remote communities.... Need a skilled workforce from community who could provide assistance to the community to manage alcohol and other drug issues, rather than having fly-in fly-out professionals. This is not sustainable. Need substantive positions and salaries located in community, [to] build the economic base in community. It's not about being teacher's aides or volunteering; it's also not about excluding [fly-in fly-out] professionals entirely, they'll always have a place, but changing how communities can manage issues at a local level. We need long term strategic planning for communities."

[Int22; F; Ind; Met/R/R]

²⁰ From a total of 548,384 people employed in the health sector in 2006, 5,538 identified themselves as Indigenous.

²¹ This disparity is further illustrated in an examination of the ratio of Indigenous staff to Indigenous clients at the Royal Darwin Hospital where 60% of inpatient beds are occupied by Indigenous people, but only 3% of the hospital's 1300 staff are Indigenous (Bauert, 2005).

Participants consistently described building workforce capacity as one of the most important strategies needed to improve Indigenous Australians' health and wellbeing, and to achieve better health outcomes individually and for the community in general.

"Employment for us helps us ...you probably eat better, you look after your health more."

[FG10; M/F; Ind; Met/R/R]

However, provision of additional funding alone to expand alcohol and other drug positions will not be sufficient to increase capacity. One manager in a remote health service cautioned that building capacity needs to be considered within the local environmental context, especially in remote communities, where there are barriers such as obtaining housing and where additional infrastructure costs were needed to support new positions.

"... to build a house in this area probably costs about \$1/2 million. We had new positions they [the government] gave us, but we've got no accommodation for anyone. And whilst there was money for new buildings it's going to take another 18 months to build."

[Int10; M; Non-Ind; Met/R/R]

Lack of physical space to accommodate greater numbers of staff was a recurrent theme raised by rural workers; however, it was not unique to remote area services. An urban female CEO described challenges in providing office and work space accommodation.

"...employ a new trainee as the government is giving money for that. But where do I put her? Have thought of saving a client house as a program area but that disadvantages the community. We'd have one house less for community when they need it most. It's a catch 22!"

[Int5; F; Ind; Met]

When building workforce capacity in both remote and urban areas, it is also necessary to be mindful of traditional cultural protocols. For example, enabling workers to maintain gender and age boundaries, kin obligations or avoidance relationships, while offering clients an effective service, may require multiple staff positions.

"If as a young urban worker I was asked to work with an older woman who had lived on the Lands, I would feel that was disrespectful I also found ... [working] in accommodation, young Aboriginal men didn't like working with a woman. They didn't like women's authority. That's not to say that I can't work with these client groups, but clients need to be able to have a choice and request another worker if they like without fear of offending."

[Int4; F; Ind; Met]

"We need more males in this field to assist with male clients for Men's Business."

[Sur; F; Ind; Met]

Current capacity building initiatives, such as offering health traineeships and providing experienced workers with management qualifications, were seen as important steps in addressing worker stress.

"[We] have got young ones coming into the field. Three trainees, one male and two female; that's taking some of the pressure off us."

[FG13; F; Ind; R/R]

One senior clinician highlighted the importance of training primary healthcare staff in alcohol and other drugs and mental health.

"... Aim instead is to broadly up-skill the primary healthcare workforce. They are most critical in mental health and alcohol and other drug health because they see people regularly."

[Int25; M; non-Ind; Met/R/R]

The establishment of the new Aboriginal Health College in New South Wales was seen as an initiative that would provide new opportunities for appropriate Aboriginal health training. However, some participants questioned whether managers would have the funds and resources to enable staff to attend training at the College.

Beyond providing employment, support and professional development to Indigenous workers, it was also recognised that Indigenous organisations required capacity building initiatives at an organisational level.

"It's not just about building capacity within [X], it's trying to build capacity in Aboriginal organisations as well."

[FG17; M/F; Ind/non-Ind; Met/R/R]

Some Indigenous organisations and groups emphasised the need to build the capacity of non-Indigenous groups and agencies that had key roles in providing health services to Indigenous clients. A multi-pronged approach, including capacity building initiatives for Indigenous workers, Indigenous organisations and by non-Indigenous agencies, was considered to be important as many of the services that Indigenous clients and communities required would inevitably be provided by mainstream services. It is essential that these services are competent to provide culturally appropriate care.

"There's also this misconception in mainstream [Australia] that Aboriginal people will solve Aboriginal problems. Clearly, that's not the case. Essentially I see my role as improving the workforce and recruiting more people into the health sector; but also about building a non-Aboriginal workforce that is competent and able to deliver services to Aboriginal people."

[Int1; F; Ind; Met]

However, no case was made to increase the competency of mainstream services and non-Indigenous people at the expense of building capacity among Indigenous services. Conversely, participants in one focus group expressed concern at an increasing trend for Indigenous alcohol and other drug services to be tendered to mainstream non-government organisations. This often occurred because Indigenous organisations did not have the capacity to provide the services themselves, and there was no system in place to help them develop that capacity [FG17; M/F; Ind/non-Ind; Met/R/R].

In several focus groups, the prevalence of fly-in fly-out health workers was noted as a barrier to building capacity in communities, although some positive changes were also noted. For example, one national health organisation built on fly-in fly-out health workers had recently implemented new policies and processes to increase the numbers of workers living in the communities [FG8; F; Ind/non-Ind; R/R].

Other positive examples were provided by a youth-focused program manager who pointed out that their alcohol and other drug prevention program incorporated a range of capacity building strategies, including training up local community members to achieve greater impact and sustainability.

Chapter 5: Workforce Development Strategies

"We go out to communities and work with school teachers and other relevant community members, showing them how to use resources such as Sniffing and the Brain. Community members are then able to teach, in language, according to their own cultural protocols. Training local people is much more effective."

[Int33; M; Ind; R/R]

Generational sustainability was also being built through modelling and mentoring at the community level. Throughout this research project, it was common to observe participants sitting in focus groups who

were not workers; rather, they were relatives of other workers who were there to learn by observing, sharing and participating in important decision-making processes. One Elder provided the following insight into this practice:

"Whenever I go to community business, I try to take my daughters along, so they can take over from me ...don't want to be doing this forever! Want to one day be sitting in a rest home."

[FG5; F; Ind/non-Ind; Met/R/R]

Salary

Nearly all Indigenous workers interviewed for this project were adamant that they were not receiving adequate or appropriate pay levels. To appreciate how low the pay level is please turn to Chapter 4.10 that provides details of salary levels for human services workers. Indigenous alcohol and other drug workers receive salaries significantly lower than child care workers.

"They just pay you a mere pittance."

[FG15; M/F; Ind/non-Ind; Met/R/R]

"Our awards are a joke really compared to other people in the community working in the same positions, same roles and same needs who are on wage brackets of treble of what we earn."

[FG16; M/F; Ind; Met/R/R]

"Government need to realise that they need to start paying Aboriginal people for what they are really worth, especially those that are genuinely out there in their communities, paying them what they are worth."

[FG5; F; Ind/non-Ind; Met/R/R]

Poor pay rates were juxtaposed with the exceptional demands placed on workers, which in addition to the "emotional labour" noted earlier also included excessive amounts of unpaid "after hours work".

"They're 24 hour workers and we pay them a pittance to do ... you know."

[FG6; M/F; Ind; Met/R/R]

In describing a heavy work load with multiple demands relative to their pay rate, one worker explained that while their commitment was to their work and community, they nonetheless expected to receive a salary commensurate with their skills and effort.

"...I do it of course. In saying that, I would [expect to] be given a reasonable rate of pay to meet the work that is expected of me and I am performing on a daily basis in the service. I've been told that [with] funding restrictions that can't happen... [We] are grossly underpaid."

[FG16; M/F; Ind; Met/R/R]

While many staff seemed prepared to accept low payments, at least for limited periods of times, others predictably moved on to better paid positions. At one level this was a positive thing, in that it provided opportunities for professional growth and advancement. It nonetheless often meant that the remaining staff were often the least experienced and

skilled and thus needed substantially greater levels of support.

As identified in the survey component of this project, Indigenous workers were generally younger and less experienced than their non-Indigenous counterparts. Generally, younger and less experienced workers require higher levels of support, supervision and training, and importantly, are more prone to the effects of work-related stress.

"Poor pay makes it difficult to retain staff. Left with staff who need constant supervision, don't have skills and experience."

[Int5; F; Ind; Met]

Some participants voiced concern that low wages in remote communities contributed to poor community health outcomes and acted as a motivator for skilled workers to move to other locations that offered better remuneration. This pattern further depleted the limited workforce available in rural and remote areas.

"We're still not getting the right wages... that leads to a lot of burnout to young people where they start looking for other jobs, better jobs, which then they leave their community, and their community suffers because of it."

[FG6; M/F; Ind; Met/R/R]

Salaries varied considerably across settings and organisations. This was a source of substantial dissatisfaction and is highlighted as a pivotal issue warranting attention and remediation.

"... the greatest issue is disparity of salary across NGOs, community and government. For example, government salaries have incremental increases allowing for promotional opportunities but NGOs are not able to provide these incentives."

[Int22; F; Ind; Met/R/R]

Concern about lack of parity in salaries and awards and inequitable pay rates was illustrated by one non-Indigenous worker who described problems in their organisation that resulted in a regular drain of workers from their service to better paid positions in mainstream services.

"At our work, we've had a few issues with rehab staff leaving because of the pay compared to mainstream.... You can't get what you would get in a mainstream organisation because the manager's only getting this much, and then the CEO's only getting this much, and you want something that's above even their pay."

[FG15; M/F; Ind/non-Ind; Met/R/R]

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There was also a strong and well-founded perception that non-Indigenous workers generally received higher pay. One worker described how when she complained to a non-Indigenous worker about this, the response was:

“Why should you get more? Just because you’re black.”

[FG15; M/F; Ind/non-Ind; Met/R/R]

Another participant noted that gaining new qualifications such as a Certificate IV in Alcohol and Other Drugs was not rewarded with a pay increase [FG15; M/F; Ind/non-Ind; Met/R/R].

Salary issues stand out as a pivotal factor contributing to worker stress and compromising levels of wellbeing. These issues warrant action and intervention and were described further in the discussion on funding in Chapter 4.10.

The case for increased salary levels pivots on the unique access that Indigenous alcohol and other drug workers have to their community. They represent the most valuable and viable option currently available to address the health inequities experienced by Indigenous people. For this pragmatic reason, if for no other, a strong case exists to move toward salary parity.

Recruitment, Retention and Turnover

Another key workforce development issue related to recruitment, retention and turnover. Difficulties in recruiting staff and filling vacancies were commonly reported across all jurisdictions. A strong view was held that there were not enough new workers coming into health in general, and into the alcohol and other drug field more specifically. Even where funding and resources were made available to increase staff numbers, agencies often reported difficulty in being able to achieve their full staff complement.

"We've only ever held the Health Worker workforce capacity above half way. Even though we've got those positions, we've never reached 100% capacity for various reasons."

[FG13; F; Ind; R/R]

It is difficult to estimate the actual size of the Indigenous health workforce. The National Aboriginal Community Controlled Health Organisation estimates there to be over 1,500 Aboriginal Health Workers nationally in 2010 (NACCHO, 2010). The number of Aboriginal Health Workers over the past decade has doubled, growing from 853 in 2001 (AIHW, 2009) to 1,500 in 2010. It is anticipated that these numbers will continue to increase into the future, especially as the emphasis on Indigenous education and training increases.

As identified in the earlier section on capacity building, it is evident that a significant increase to the critical mass of the indigenous health workforce is needed. Without a greater number of workers to share the workload, organisations will remain hampered in their ability to provide adequate and appropriate client services.

"If someone is ill or if you take holidays, there's no-one to do your work. If a worker goes on holidays and he's the only one that does drug diversion... then there are no diversions occurring in that period."

[FG1; M/F; Ind/non-Ind; Met/R/R]

In spite of ongoing concerns about the adequacy of staff numbers and recruitment challenges, participants acknowledged encouraging signs in terms of increased recruitment of Indigenous workers into health, including in remote areas.

"... there are many young people coming into the health field... [with]... some fabulous stuff happening."

[FG5; F; Ind/non-Ind; Met/R/R]

Participants stressed that increasing the numbers of workers was important for various reasons, including the positive impact that expanding the workforce can have on the heavy workloads of existing staff. Some participants identified the need for positions in health to be made more attractive to new recruits, especially younger workers and local community people, and for such positions to be appropriately remunerated.

"Retaining health workers is a big part of the job, also is recruitment of the younger people. Trying to get them to see that being an Aboriginal Health Worker is an attractive job... Important to try and make role as attractive as possible, and one thing that you can do is make sure that they get paid properly. Really, really important that the community see some progress and they see jobs for them[selves]."

[Int17; F; Ind; R/R]

In addition to significant recruitment challenges, there were also problems with staff turnover. This was referred to by one worker as a "continual bleeding out" of existing staff. A range of factors contributed to high turnover including lack of job security and tenure, and poor working and employment conditions. Turnover creates a substantial drain and impost on Indigenous alcohol and other drug services and health services in general.

"The training we provide tends to go to people who are already employed in this sector and then there's a big turnover of those people. A continual bleeding out of people with skills, because of lack of security, lack of employment conditions. It's like we are on a treadmill."

[FG17; M/F; Ind/non-Ind; Met/R/R]

Another factor that impacted on stress levels of alcohol and other drug workers was the frequent change in staff. Community members sometimes avoided new nurses and locums and preferred to rely on the local health workers for support. Community members often preferred to deal with workers with whom they were familiar and comfortable and avoided new staff because establishing new relationships was considered unproductive and a waste of time because of high turnover rates.

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“Nurses and locums are constantly changing in communities— always frustration for workers... From community’s perspective they think ... ‘What’s the point of getting to know this person, why should I? We just get to know them and they’re gone’.”

[Int15; M; Ind; Met]

Work-related stress that escalated to burnout was identified as a major contributory factor to low retention. Turnover, in some instances, was noted to be very rapid with some workers only staying in their positions for relatively short periods of time. Various workforce development strategies designed to contribute to reducing or minimising worker stress and thereby improve recruitment and retention of the Indigenous workforce are needed.

“These health workers, not just health workers, they get burnt out so quick and they leave.”

[FG6; M/F; Ind; Met/R/R]

Impulsive and ill-considered staff appointments also contributed to high turnover rates. Such appointments were seen to be a result of managers feeling pressure from community to fill vacancies immediately due to a perception that “any person in the job is better than no person at all” [Int10; M; Non-Ind; Met/R/R]. Other managers commented not only on the difficulty of recruiting new staff but also the challenge of acquiring appropriate staff. Some described strategies they used to seek suitable candidates. This included selecting staff on the basis of ability, expertise and character and also included their quest to find workers with personalities and inter-personal styles that were suited to alcohol and other drug work.

“Recruiting staff is complicated. Generally identify people we would like to include on the team, and then try and work around the system. My experience has not been positively reinforced by traditional recruitment process... often miss out on the thing that makes the best workers— their personality!”

[Int25; M; non-Ind; Met/R/R]

In an effort to improve recruitment, some services offered a range of incentives that included enhanced training opportunities and extra leave.

“... good access to staff training and get six weeks [paid] leave a year... good recruitment and retention strategy to encourage people to work in a difficult field in a difficult location.”

[Int33; M; Ind; R/R]

“... need to offer traineeships and cadetships within community to train as health workers.”

[FG9; M/F; Ind/non-Ind; R/R]

At a broader level, the impact of the national and international nursing shortage, and the resultant high turnover of non-Indigenous nurses also had ramifications for Aboriginal Health Workers and a knock-on effect on other Indigenous health services and workers. The global shortage of this key workforce group created instability at various levels, including uncertainty for health workers regarding their team structures and roles expected of them within the team.

“...problems retaining nursing staff has a huge flow-on effect for primary healthcare centres. Aboriginal Health Workers are impacted by the turnover of nursing staff. They start to question, ‘who’s going to be at work today?’”

[Int25; M; non-Ind; Met/R/R]

“... because of the big turnover of staff, a lot of our health workers who’ve been out there for years find it hard ... For the health workers, it’s like ‘hang on...what are we going to be doing? What does this new nurse want of us? Are we going to be working with the old people, or doing outreach work or what?’ It’s been a problem for health workers.”

[FG13; F; Ind; R/R]

Overall, increased recruitment and appointment of Indigenous workers at all levels was highlighted as being of fundamental importance. This included appointment of frontline workers through to senior practitioners, policy workers and managers.

“The next best thing will be getting Indigenous health workers as managers— likely to bring back health workers to the clinic. When they see black faces managing the clinic, they’ll probably want to come back.”

[FG13; F; Ind; R/R]

While the need for a critical mass of Indigenous workers was identified as a crucial component in ensuring adequate service delivery, it was also noted as an important element required to overcome systemic racism.

“Well I think if we had more Indigenous people working ...in every field, it would start breaking down the barriers. It would be good if we had more police officers, solicitors and lawyers.”

[Sur; F; Ind; R/R]

Career Paths

A key concern expressed by many participants was the lack of career pathways for Indigenous people in alcohol and other drug work. Perceived lack of opportunities for professional advancement further compounded recruitment and retention challenges, which contributed to staff shortages, which in turn impacted on workload and stress levels of existing staff. These concerns were raised by both experienced senior workers and relatively new recruits and were identified as yet another source of stress.

“The restriction on career structure; that is a major stress on a lot of our health workers.”

[FG9; M/F; Ind/non-Ind; R/R]

“There’s not much of a career path in drug and alcohol. There should be. I am amazed because it’s such a big issue all over Australia and probably all over the world, but you when you go to see someone, it’s like, ‘you just work in drug and alcohol’ and that’s it.”

[Int14; M; Ind; R/R]

“Even when you do have access to good training and qualifications, it is very difficult to get a good job with career path and security.”

[Sub; F; Ind]

Several participants commented on perceived inequities in career paths for those entering the alcohol and other drug field, compared to other health fields, and also between the government, community controlled and non-government sectors. Lack of career paths and options for professional progress inevitably resulted in a significant drain of workers away from the NGO sector and community controlled organisations to better paid and more secure positions in government organisations.

“[We are] losing lots of young alcohol and other drug workers in XXX to mental health— to government systems where the pay is much better. Community Controlled Organisations have less funding, so lower wages. And poorer career paths too, because they never get their request for more positions; senior positions that new workers can aspire to.”

[FG3; M/F; Ind; Met/R/R]

“Over the years we have had quite a few Aboriginal people working with us, one of the frustrations is we can’t really compete with the public service for salaries. There are much better opportunities for workers in other fields but we have been able to build capacity, not in the drug and alcohol field, but in the broader Aboriginal community. It’s a frustration not being able to better retain workers when there are better conditions and salaries on offer.”

[FG17; M/F; Ind/non-Ind; Met/R/R]

While there were relatively few positive comments made in regard to career paths for Indigenous workers in the alcohol and other drug sector, there was consensus that the introduction of the National Aboriginal Alcohol and Other Drug Worker Training Program and the establishment of Indigenous alcohol and other drug worker networks (e.g., Koori Alcohol and Other Drug and ADAN Leadership Groups) were positive strategies in terms of establishing future pathways.

The establishment of the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) in January 2010 was also welcomed. The Association is tasked to support members in the development of career pathways and ensure representation in the National Regulation and Accreditation of Health Professionals’ Scheme (NACCHO, 2010).

Role Clarity

Very broad and overly inclusive roles were common among Indigenous alcohol and other drug workers. This was often accompanied by a lack of role clarity. Broad and ill-defined roles were a source of ambiguity, confusion and stress for workers, and in some cases led to burnout.

“Every [health] initiative is chucked at health workers. Health workers are expected to contribute to all portfolios. Stressful expectations from government, on top of community expectations.”

[FG12; M; Ind; R/R]

“Aboriginal Health Worker is meant to be able to resolve every problem. Basically become a counsellor, the drug and alcohol worker, the mental health worker and yet if you compared that to mainstream, they would never ever allow that to happen and yet the poor old Aboriginal Health Worker has to wear many different caps to work with the individual and the family.”

[Int1; F; Ind; Met]

Discrepancies between documented job and person specifications and the specific roles that workers actually carried out were also identified as significant stressors.

“As an Aboriginal Health Worker there’s always confusion about what you are actually allowed to do and what you can’t do. Whether you’re stepping over your boundaries.... [And when] it came back to reporting about what you’ve been doing ... it seemed like you were getting 20 questions about why you were doing that, and basically having to justify why you did it. When it’s basically in your J&P why you’re supposed to be doing these types of things.”

[Int13; M; Ind; Met]

Participants used phrases such as “jack of all trades”, “juggling multiple roles” and “wearing 101 hats” to describe the multiple components involved in their roles.

“Health workers are expected to know everything from sexual health to audiology to being able to transport people to being able to dress injuries.”

[Int12; M; Ind; Met]

One issue that was particularly contentious was that of workers providing clients with transport as part of their role. On one hand, some participants perceived provision of transport to be a critical element of the

worker-client relationship, and a car provided a less intimidating environment in which to counsel clients and build rapport.²² They reported that being able to support clients with transport enabled them to provide holistic care that addressed clients’ social, health and other needs. However, other participants regarded provision of transport as having no direct connection to alcohol and other drug treatment, and maintained that transport should be provided by transport workers for whom this was a specifically designated role. There was clear potential for friction around this issue and it warrants pre-emptive attention in policies and individual workers’ job descriptions.

It was evident that greater attention needs to be directed to specific elements of workers’ roles, with cultural considerations made clear. However, this is not always a straightforward exercise, especially when dealing with issues that are implicitly understood and that cannot readily be captured in a position description. It was suggested that team leaders needed to be educated about health workers’ job descriptions, as some team leaders and managers expected health workers to undertake tasks outside of their designated role [FG9; M/F; Ind/non-Ind; R/R].

“Some of these things are not in the job descriptions, can’t be written in there because they are unwritten ways of working.”

[FG16; M/F; Ind; Met/R/R]

Lack of role clarity was also a significant contributor to stress for new recruits, as well as for workers whose role involved liaison with other services.

“...finding parameters of a job and finding a way forward takes time, otherwise you find yourself asking ‘what the hell am I doing here?’”

[FG11; M; non-Ind; R/R]

“Marrying up those expectations of another agency about what you should or could not be doing and which sometimes can be based on their lack of knowledge of your role, or lack of knowledge about legislative provisions that guide or limit your role. Being able to negotiate your way through all those expectations is a feat in itself.”

[Int30; F; Ind; R/R]

22 This comment should also be viewed in light of the observations made about the inadequate work environments in which many workers were required to counsel clients, notably where there was a lack of private soundproof rooms.

There was a common perception that Indigenous workers were often appointed to positions for which they may not have adequate skills, generating considerable discomfort for the individual worker placed in this position. This was also a source of stress for those with whom they worked.

“...common to see people given position titles and they don’t understand what they are meant to be doing, and they don’t have the skills, because of pride and their own expectations, they can become defensive. This can create awful lot of stress and burnout for Aboriginal workers.”

[Int10; M; non-Ind; Met/R/R]

Role clarity was also an important workforce development issue for some workers in mainstream settings who worked with Indigenous people. For example, one younger female worker commented that she felt discomfort in the workplace due to endlessly justifying her specialist role to colleagues

who continued to inappropriately refer non-Indigenous people to her, despite reminders that her role was to specifically work with Indigenous clients. This persistent struggle made her feel unsupported by her colleagues and she described how “it does wear you down, and you feel like you don’t want to go in [to work] today” [Int3; F; Ind; Met].

Overall, there were several sources of confusion and tension in regard to workers’ roles. In some instances, it stemmed from lack of precision on the part of the organisation. Vague, non-specific roles resulted in high levels of pressure. Conversely, some workers wanted the flexibility to be able to push their role boundaries to allow maximum scope to serve their communities. Sometimes managers were seen to be at fault for wanting and expecting too much. Careful attention is needed to address these issues at organisational, award and individual levels, while also taking into account cultural issues and implications.

Qualifications and Training Issues

A diverse range of views was expressed about the types of training available to and needed by Indigenous alcohol and other drug workers. Some participants felt that workers did not have sufficient alcohol and other drug knowledge, or adequate access to training, especially when compared to mental health workers. This view was consistent with findings from NCETA's recent review of alcohol and other drug and mental health training (Roche, Duraisingam, Wang, & Tovell, 2008) which found substantially more training opportunities available in mental health compared to alcohol and other drugs.

Nonetheless, the importance and value placed on training was often highlighted, albeit with some concerns about its limitations.

"We don't have a ridgy-didge training policy ... I think the intent of most of us is that we want as much training as possible...It is vitally important for all staff to keep the training going."

[FG16; M/F; Ind; Met/R/R]

It was frequently noted by Indigenous participants that non-Indigenous people placed considerable weight on formal qualifications and that this reflected Western values and a different world view. Many Indigenous participants highlighted that traditionally this was not a perspective they shared and that they placed greater emphasis on life experience.

"Qualifications only matter in the Western world. For Indigenous communities, it's experience that matters."

[Int12; M; Ind; Met]

"In the Western society ... status as a worker is measured by what qualifications they have. As Aboriginal people we are not measured that way. It's about our cultural knowledge and how we frame that."

[Int13; M; Ind; Met]

"It's the old argument about Ngangkari coming into a hospital system and how you value them, as you value a doctor who's studied for 7-8 years and the comparisons. You could say, 'Well the Ngangkari, they have studied that their whole life, not just for 7-8 years'. It's how you balance that and how you work out on how you are going to pay them."

[Int13; M; Ind; Met]

When discussing the emphasis on qualifications by non-Indigenous people, one interviewee highlighted the importance of knowing "Aboriginal ways" and stressed that formal training was neither relevant nor helpful in that regard. Aboriginal ways and traditional knowledge were transferred and acquired through oral and experiential processes.

"When it comes to a certificate they could be AHWs or psychiatrists, it doesn't matter. There is no qualification for knowing Aboriginal ways. That's passed on through sight, hearing, speaking. It's follow the leader ... They [white people] put it in writing...we [Aboriginal people] put it in words!"

[Int15; M; Ind; Met]

Differences in learning styles were also noted. University was seen by some as foreign to Aboriginal oral learning styles. Correspondingly, the need for greater value to be placed on Indigenous knowledge, with less emphasis on Western qualifications, was often highlighted.

In contrast, however, some Indigenous participants also placed substantial value on their qualifications. Increasingly, there is a significant push by Indigenous leaders for Indigenous people to recognise the value of education, training and qualifications. Contemporary thinking by Indigenous leaders and others maintain that this will be the principal pathway forward to equality in general and better health specifically (Gallaher et al., 2009).

"I've actually got a little piece of paper that says I am qualified to work in Community Services. To me that's a big thing."

[Int2; F; Ind; Met]

Greater acknowledgment of Recognised Prior Learning (RPL) and previous experience was also an issue raised by older experienced workers who had trained as health workers when the profession was first established. These workers were aware of many changes that had occurred over the past decades and voiced frustration that their earlier qualifications were no longer considered sufficient and that the goal posts were seen to be constantly changing.

"From a mainstream point of view you can't get a job unless you're qualified which makes it even more difficult for the Aboriginal person to try and enter the health sector. RPL needs to be more widely recognised as a legitimate qualification for Aboriginal people to enter the workforce but it's still not embedded in policies and procedures which can be another form of systematic and structural racism. It's like beating your head up against a brick wall, we think 'Geez, didn't we talk about this last year'."

[Int1; F; Ind; Met]

"Changes to national competencies, the [health worker] qualifications— shifting the goal posts all the time— lot of us have those basic skills, trained in the 1970s, now they've shifted the goal post again. Important to know how to work with the doctors and good team work, but they've shifted again."

[FG13; F; Ind; R/R]

Many workers were found to have very little support in their workplace. Their training and development opportunities were often quite limited, in spite of common views to the contrary. One participant described her perception that Indigenous alcohol and other drug workers were often considered by other health professionals to be "the great over-trained" [Int23; F; non-Ind; Met]. She went on to explain that it was not a case of being "over-trained"; rather that more "Aboriginal-specific" training programs were required. As a trainer in Indigenous alcohol and other drug issues, she was particularly conscious of how disempowerment and racism impacted on the teacher-student relationship among workers undertaking new qualifications.

"There's all this disempowerment that has occurred through the Stolen Generations and a complete lack of rights in Australia that really are poorly addressed. So people come into a program and are really disempowered; and, in fact, I'd say that 90% of the Aboriginal students were frightened of me because I was the teacher and when they have been at school they have had poor experiences.... It's a barrier that I had to break down before the learning could occur."

[Int23; F; non-Ind; Met]

Other participants commented on their desire to see an increase in Indigenous-specific training programs run by Indigenous trainers, and felt that this would ensure that the content of the program would be more relevant to their work.

"... some training courses are just a waste of time attending. It's not relevant, it's mainstream, not about Aboriginal community, not learning anything new and rarely has Aboriginal content or context."

[FG10; M/F; Ind; Met/R/R]

"... generally know that if training is being offered by Aboriginal trainers it will be relevant."

[FG10; M/F; Ind; Met/R/R]

In some areas, there were reports of very positive training experiences that not only addressed crucially important areas but also facilitated invaluable networking opportunities. The latter was consistently noted as one of the most important elements of any training and professional development opportunity.

"...have had good training in IRIS, FASD and mental health assessment tools, but would like more. [Training was] not only about getting together people for training purposes but also to provide time to build networks and share experiences."

[FG9; M/F; Ind/non-Ind; R/R]

However, positive training experiences were contrasted with less positive experiences, especially in rural and remote areas where there were few training opportunities available.

"...not much training or support available for people living in the country or remote areas."

[FG5; F; Ind/non-Ind; Met/R/R]

Some workers described how fortunate they felt to have been able to undertake helpful training that had held them in good stead and helped reduce work-related stress.

"...fortunate to have undertaken the CARPU training back in 92-93. Skills helped to maintain some sort of sanity in my life."

[Int33; M; Ind; R/R]

There was a strong desire for new and innovative training in alcohol and other drug issues. Some participants maintained that most training currently available was based on outdated resources and information. They were keen to see new training opportunities with updated and expanded content.

"... nothing new and innovative. We have to wait for trainers to arrive from overseas or do off-the-shelf stuff that has already been done to death. Would love fresh training opportunities ... bring it on! Would relish it! Would love it!"

[FG9; M/F; Ind/non-Ind; R/R]

Chapter 5: Workforce Development Strategies

The need for readily available, high quality and culturally appropriate training was considered particularly important in light of increased levels of recruitment, and the expanding alcohol and other drug knowledge base and emphasis on evidence-based practice.

"...most of the workers that are coming on that I see don't have a lot of knowledge around drug and alcohol. They've got a broad range of skill sets that they have learnt through the courses. But for the type of job they are doing which is specific to drug and alcohol they don't have the full knowledge around that, so they do need to do further training."

[Int13; M; Ind; Met]

Appropriate training for Indigenous alcohol and other drug workers often involved much more than standard training programs might entail. For example, one senior worker who had conducted numerous training programs for Indigenous alcohol and other drug workers noted that they had to address a range of personal and sensitive issues among the trainees that extended well beyond what might be encountered in mainstream training events.

"... use clinical skills all the time in delivering training because the workforce have difficult issues and circumstances they are managing in their own family and community lives as workers."

[Int21; F; Ind; Met/R/R]

In terms of training issues, a significant number of workers not specifically employed in alcohol and other drug or mental health services wanted to increase their understanding of co-morbidity to help them provide a better service to the community. Participants who were experienced in working with clients in drug and alcohol rehabilitation settings believed that having undertaken short courses, such as mental health first aid skills and dealing with aggressive clients, had been especially beneficial to their confidence, competence and safety as workers.

One female survey respondent identified the need for co-morbidity training as important for making her job easier.

"More in depth training in the dual diagnosis area, more culturally appropriate material (dvd, books, etc)."

[Sur; F; Ind; R/R]

It should be noted, however, that simply having access to dual diagnosis training was not without its pitfalls.

"Mental health is going to have to work with drug and alcohol workers because of the dual diagnosis shift... you won't be able to work in drug and alcohol soon without having a dual diagnosis qualification, but the course is much harder than it should be."

[FG15; M/F; Ind/non-Ind; Met/R/R]

Participants expressed concern that if a dual diagnosis qualification became mandatory, this would place extra stress on workers by increasing their workload without an increase in pay or recognition.

Table 11. briefly summarises the different types of professional development and training opportunities that participants supported.

It is important to note the divergence that has occurred in the alcohol and other drug field over the past two to three decades. Increasing support for workers with professional training and qualifications contrasts with earlier times when the field was largely populated by workers with a previous problem background in alcohol or drugs. A major shift has occurred, with movement away from endorsement of personal experience (of alcohol and drugs) as a 'qualification'.

Many workers emphasised their desire to have their Indigenous knowledge recognised as a specialist skill set. It was noted that qualifications were not a necessary ingredient in the specialist skill sets of Indigenous workers. Nonetheless, ongoing training and learning opportunities were considered important for maintaining and enhancing competency levels, and also provided workers with a sense of satisfaction.

Recognition of the distinctive nature of the Aboriginal Health Worker role would not only help workers in their relationships with other services, it would also help them construct boundaries with community members and peers thus ensuring some crucial "time out", as well as a greater sense of satisfaction and achievement with their own role.

A key feature of the Indigenous alcohol and other drug workforce is their unique ability to influence the health status of the most compromised groups in Australia today. There is great scope to more appropriately recognise the invaluable contribution made by these dedicated and hard working professionals.

Table 11. Preferred Training and Professional Development Topics

Alcohol and Other Drug Specific	Other
Understanding why clients use alcohol and other drugs to self-medicate	Integrating issues of maintaining confidentiality and building trust in agencies in remote communities
The Stolen Generations and its effect on alcohol and other drug use and loss and grief	Indigenous counselling skills
Parental alcohol and other drug use and it's impact on children	Suicide prevention
Alcohol and other drug use and domestic violence	Using information technology in the workplace, e.g., writing emails, searching the internet
Using community development models to convey alcohol and other drugs and mental health messages to individuals, families and communities	Understanding stress: e.g., providing basic information about the body's flight or fight reactions. How to identify when you are stressed and ways of managing stress

Mentoring

In spite of what is known about the benefits of adopting a broad workforce development approach, relatively few participants identified mentoring, clinical supervision and debriefing as strategies employed in their workplace to prevent or manage stress. In almost all instances, participants were of the opinion that mentoring, clinical supervision and debriefing needs were not being met. On the contrary, new workers were commonly described as “being thrown in the deep end” without the provision of supports such as mentoring [FG3; M/F; Ind; Met/R/R].

When mentoring did occur, the participant was most likely to work in a government organisation, be part of a formal professional network or have had many years experience working in Indigenous health. Despite recognition of the potential value of mentoring, it was still noted as largely absent or poorly executed.

“Don’t think we are good at providing good mentorships.”

[FG9; M/F; Ind/non-Ind; R/R]

“Need more Indigenous professionals attending for mentorship to health workers.”

[Sur; F; Ind; R/R]

Mentoring was generally accepted as an important strategy that all organisations could adopt to improve worker wellbeing. In particular, mentoring could provide vital peer support for isolated workers and create an environment that increased collaboration between health workers and other workers including doctors and nurses.

“Mentoring is important, and changes need to be made to how upskilling is done – it’s more beneficial to work side by side rather than expecting Aboriginal people to learn through formal education institutions.”

[Int10; M; Non-Ind; Met/R/R]

The value of mentoring was generally endorsed by senior workers. Some managers and senior stakeholders noted how important they considered mentoring to be, and reported their personal experience in having established mentoring programs.

“...built in a mentoring program for a new worker.”

[Int10; M; Non-Ind; Met/R/R]

The advantages offered by mentoring were highlighted by one younger worker who commented that mentoring provided him with access to a range of personal and professional development opportunities that were supportive and helped him grow professionally.

“...a cross fertilisation of skills and knowledge, both clinically and socially and emotionally. Then when I’ve been challenged personally, I felt like I had a supportive work environment and the skills to keep on working.”

[FG9; M/F; Ind/non-Ind; R/R]

Establishing mentoring programs often necessitated finding external funding to provide a mentor, particularly as the mentoring required for many workers was often long term and relatively intensive. This has important resourcing, funding and planning implications.

“...What often needs to happen is that people don’t know how to organise their work, they are not sure how to start work. Good mentoring may need a meeting every Monday morning to plan the week. For people who don’t really understand their roles, mentoring needs to be a full time job and you may need to work with them for a year.”

[Int10; M; Non-Ind; Met/R/R]

When implementing mentoring programs it was considered important to ensure that a good match was made between the mentor and mentee. Where this did not occur it was likely that mentoring would fall away, as in cases where there were mismatches according to age or gender.

“...older Aboriginal man and a younger woman – mismatch.”

[Int10; M; Non-Ind; Met/R/R]

In some instances, it was easier to establish a mentoring relationship between a non-Indigenous worker and an Indigenous worker as the social protocols in terms of the appropriateness of a “match” (e.g., in terms of gender, age, clan) did not apply, or would be treated with greater flexibility.

Scope exists to disseminate information to Indigenous organisations about the value of mentoring and relatively inexpensive strategies can be implemented to make this possible. NCETA resources on mentoring²³

23 National Centre for Education and Training on Addiction (NCETA) (2005). *A mentoring resource kit for the alcohol and other drugs field*. Adelaide, South Australia: National Centre for Education and Training on Addiction, Flinders University. Email nceta@flinders.edu.au for free copies. Todd, C. (2005). Mentoring. In N. Skinner, A.M. Roche, J. O’Connor, Y. Pollard, & C. Todd (Eds.), *Workforce*

may be useful in this regard as well as Primary Health Care Research and Information Service's (PHC RIS) mentoring factsheet.²⁴

²⁴ Workforce development TIPS (Theory Into Practice Strategies): A resource kit for the alcohol and other drugs field. Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University. Download from <http://www.nceta.flinders.edu.au/wdt/>. PHC RIS, McIntyre, E., Mills, J. (2009). Fact Sheet: Mentoring matters. Adelaide: Primary Health Care Research & Information Service. Order free copies from <http://www.phcris.org.au/publications/order.php>

Clinical Supervision

"I think one of the critical elements in all of this, no matter where you train, or who you train with, or whatever, it's about clinical supervision. Good clinical supervision is a must, no matter what level of training you're at."

[Int22; F; Ind; Met/R/R]

The need for better resourcing to allow workers to undertake clinical supervision was often noted to be of fundamental importance, together with the need for Indigenous-specific clinical supervision guidelines to be developed for the alcohol and other drug sector. To the best of our knowledge, the latter have not been developed and there is scope for this to be undertaken in the near future. Success of clinical supervision is most often determined by an organisation's commitment to ensuring that the supervisor and supervisee have the time and resources available to undertake clinical supervision. Participants identified the need for regular clinical supervision meetings (e.g., weekly or fortnightly), and for resources, such as a clinical supervision manual and a supervisee workbook for personal reflection.

However, a range of barriers to good clinical supervision were outlined and these included resourcing, and organisational support and endorsement.

"Supervision is sometimes incorrectly viewed as being an add-on extra. In fact, it needs to be viewed as a requirement for all frontline workers and should be costed into an organisation's structure."

[Int26; M; Ind; Met]

One experienced Indigenous clinician maintained that clinical supervision for Indigenous workers involved several components, including:

- a. programs and sessions that are well established, regular, well organised and offered on either an individual or team basis;
- b. the person providing the supervision needed to be suitably trained/qualified.

The clinician noted that it was sometimes advantageous if supervisors were external to the organisation. Indigenous workers also needed to be provided with cultural supervision to recognise the differences between non-Indigenous and Indigenous ways of working; this might also include cultural mentorship through the involvement of Elders [Int26; M; Ind; Met].

"Culturally appropriate clinical supervision would be essential to this service."

[Sur; F; Ind; R/R]

Clinical supervisors can come from a wide range of backgrounds, including psychologists and registered nurses. However, the hierarchical nature of systems where nurses and health workers were co-located in remote clinics may not be conducive to good internal clinical supervision relationships. In such circumstances, alternative resourcing and approaches to clinical supervision may be required.

There were mixed views regarding whether clinical supervision was most effective when provided by staff that were internal or external to the organisation. There were also divergent views about the appropriateness of non-Indigenous people providing clinical supervision to Indigenous people. For some, clinical supervision from a non-Indigenous colleague was not a viable or appropriate option.

"I've had really good supervision but not from non-Aboriginal people. They don't understand how we feel. ...And by the time you explain to them what's been happening, they look at the time and the session is finished."

[FG16; M/F; Ind; Met/R/R]

"Need more clinical supervision available for workers, by Indigenous supervisors who know the Indigenous languages and culture."

[FG3; M/F; Ind; Met/R/R]

Others felt that non-Indigenous supervisors were appropriate for some workers, on the condition that they had sound cultural awareness. Such supervisors needed an understanding of the pressures that Indigenous workers felt from their family, community and workplace. It was considered important that workers were not required to use valuable clinical supervision time to constantly explain these pressures.

"What makes good supervision for Aboriginal people? That they [non-Indigenous supervisors] are culturally aware. They have an understanding of what kinds of things we go through."

[FG16; M/F; Ind; Met/R/R]

"Team leaders must have the ability to supervise, monitor, and provide all staff with culturally safe way to debrief Aussie way or Murri way."

[FG9; M/F; Ind/non-Ind; R/R]

“Not enough culturally aware supervisors out there. Non-Indigenous supervisors can be alright to talk to for some things, but for others, they’re too naive, they don’t understand.”

[FG3; M/F; Ind; Met/R/R]

While there is increasingly strong interest in clinical supervision (Roche, Todd, & O’Connor, 2007) as an important workforce development strategy, potential challenges exist when introducing it into a service or agency. There are common misunderstandings about the nature of clinical supervision.

“Clinical supervision is not just a clinical thing. It’s the support that is given to people. When we did some training, people started talking about clinical supervision and then about the clinic tablets, medicines and everything else and we had to explain and say ‘no, scrap the word clinical’. You need to explain ‘support’ and ‘supervision’.”

[FG6; M/F; Ind; Met/R/R]

Potential flaws identified in some current clinical supervision practices often centred on the

misinterpretation of Indigenous ways of working. Where this fundamental understanding was lacking, clinical supervision processes were likely to fail.

“I have a new supervisor this year and it has been difficult with the way the supervisor role is and has no understanding of Indigenous culture and society.”

[Sur; F; Ind; R/R]

In general, there was strong and widespread support for clinical supervision. In many instances, good and appropriate systems appeared to be in place that could be emulated elsewhere. In other cases, there was considerable scope to enhance the provision of culturally appropriate clinical supervision to Indigenous alcohol and other drug workers.

“We are lucky here. We get supervision.”

[Sur; F; Ind; Met]

“Excellent clinical supervision and culturally appropriate supervision is provided.”

[Sur; M; Ind; Met]

Debriefing

Another important workforce development strategy related to mentoring and clinical supervision is debriefing. Participants frequently acknowledged the importance of debriefing as a mechanism to reduce stress; however, debriefing opportunities were highly varied and often found to be absent.

"In the reality of our work environment and the stress workers are under, you can't do that [debriefing]. We don't have time to reflect; let alone 'let's sit down and have a debrief'. So it contradicts itself, because the system we work in, which is driven by the clock, doesn't allow us to do that."

[Int1; F; Ind; Met]

Some participants reported good access to colleagues and supervisors for formal and/or informal debriefing sessions, whilst others felt they had few or no options for debriefing. Some workers preferred to debrief with staff within their organisation, and others wanted to debrief only with an outside person.

A number of participants reported seeking out their own debriefing supports through work-related networks. Several workers sought out colleagues from other organisations to debrief with, in addition to the formal debriefing available to them from their supervisors. Some participants also used their smoke breaks to informally debrief with colleagues. The heavy reliance on smoke breaks for networking, social support and debriefing has important implications for workplaces who do not offer alternative debriefing opportunities. It is an issue that also warrants particular attention given the current emphasis on smoking cessation for Indigenous people and across health settings. Unless specific debriefing strategies are implemented within workplaces, many of these workers will be left without a suitable outlet for debriefing and may experience more stress.²⁵

In one community controlled service, a team leader encouraged the alcohol and other drug staff to access the service's Social and Emotional Wellbeing

25 The NATSIHS 2004–05 found that 50% of Indigenous Australians were smokers. Smoking was more commonly reported among males and females in every age group when compared with the non-Indigenous population. Overall, Indigenous Australians were more than twice as likely as others to be current daily smokers. Indigenous respondents who had experienced more than one life stressor in the past 12 months had higher rates of current daily smoking (54%) than did those reporting only one or no stressful circumstances (46%). Those reporting high levels of psychological distress were more likely to be smokers (32%) than non-smokers (20%) (Australian Bureau of Statistics, 2006).

Counsellors. Other services employed independent external providers on a regular basis.

"This has worked extremely well and has been a key factor in staff retention and in maintaining team cohesiveness and worker wellbeing."

[Int30; F; Ind; R/R]

"Debriefing is offered both internally or externally and find that this has supported the workers in their role."

[Int31; F; Ind; R/R]

Many participants also found the process of informally debriefing with family and friends after work highly beneficial as it helped them to "switch off from work".

Remote area workers voiced greatest concern about the limited debriefing opportunities available to them.

"Sometimes happy to seek support from the nurses but sometimes feel like they think you're whinging, or that they've heard it so many times before that you feel like you are talking to yourself."

[FG10; M/F; Ind; Met/R/R]

Workers, especially those in remote areas, were most concerned about not having access to debriefing after critical incidents, for example, where they were a witness to violence or trauma. The debriefing and support required by workers was often for extremely serious and disturbing incidents, in addition to more routine work-related matters.

"Still remember first fatal car accident I attended. No one I worked with... no one called to say 'Are you OK? Do you need help?'"

[FG12; M; Ind; R/R]

One experienced remote worker wanted debriefing programs implemented similar to those that were offered to police and paramedic staff after attending a critical incident.

"Like to see debriefing programs for AHWs, especially around suicide. Police and paramedics leave the scene and get debriefing opportunities. We need something like that!"

[FG10; M/F; Ind; Met/R/R]

As noted throughout this report, the quality of interpersonal relationships is paramount to Indigenous workers. It is unlikely that more impersonal modes of communication for debriefing after stressful incidents, such as telephone counselling, are likely to be adequate or satisfactory for Indigenous alcohol and other drug workers.

"You're sometimes told to ring a health crisis line and get support. But you often don't want to talk by phone; you want to talk to someone face-to-face."

[FG10; M/F; Ind; Met/R/R]

"They're not aware of particular community protocols or dynamics so they are not going to be able to give good or relevant advice."

[FG13; F; Ind; R/R]

Examination of the debriefing strategies and mechanisms in place for other workers in rural and remote settings is warranted to identify opportunities for extrapolation and application with Indigenous alcohol and other drug workers.

Team and Co-Worker Support

The final workforce development strategy identified as important to Indigenous alcohol and other drug workers was support. There is a substantial literature on the importance of team and co-worker support in general. This workforce development strategy is seen to be of even greater relevance to Indigenous workers than it is to the generic alcohol and other drug workforce. The need for diverse forms of support for workers was depicted in numerous ways and at various levels.

Lack of organisational support for Indigenous alcohol and other drug workers was also noted.

"I've seen the way drug and alcohol workers are isolated and not supported and not getting supervision and not able to get the right training they want."

[FG2; M/F; Ind; Met/R/R]

Very remote workers felt especially isolated, and had observed the considerable negative impact such isolation had on other health workers, to the point where some workers were unable to continue working.

"What the health workers don't have out there... they don't have any support...how do they deal with bullying...conflict? ... They take leave without pay or quit."

[FG12; M; Ind; R/R]

The opportunity to participate in Indigenous-specific alcohol and other drug professional networks was a valuable support strategy for many workers.

"...coming to this leadership group and getting the support through all these guys here, plus the symposium which is fantastic. Because it makes it Indigenous-specific, it helps in the workplace a lot."

[FG2; M/F; Ind; Met/R/R]

Many participants were explicit about the importance that the availability of support had for them as workers, and identified various sources from which such support might come.

"You need to figure out who you can trust [in your organisation] and have a 'breakdown' with."

[FG8; F; Ind/non-Ind; R/R]

"Workers get strength from their shared experience, having support groups, getting involved with community, families, friends, colleagues."

[FG9; M/F; Ind/non-Ind; R/R]

Managers were also often a source of support for workers, although it was also noted that only some managers came from a drug and alcohol background and could provide advice and debriefings. Other managers did not have relevant backgrounds or skill sets (for example, one participant's manager was previously an accountant). [FG15; M/F; Ind/non-Ind; Met/R/R]

"My workers know that I am available any time... that gives them a bit of a peace of mind in knowing that if there is some kind of drama ... they can get on the phone to me straight away."

[Int13; M; Ind; Met]

Some workers were clear that they had not only been provided with good levels of support but they had also been given the flexibility and freedom to function in their work role in ways they considered to be culturally appropriate.

"I have to say they are very supportive of me and they have left me to my own elements to do what I do; and for that I am thankful."

[Int14; M; Ind; R/R]

For some workers, support and a sense of empowerment also came from having supportive co-workers and from the nature of their relationships with other key workers. For example, one worker described how they were:

"...really lucky; there is only one and a half alcohol and drug workers where I am but the psychiatrist, if they have a client with a few alcohol and other drug problems, will call us in and ask our advice and that really empowers you and other workers [if your co-workers] will say 'I don't know a lot, but I'll introduce you to our alcohol and drug workers'."

[FG16; M/F; Ind; Met/R/R]

The importance of support was also reinforced by non-Indigenous participants, one of whom described how joining a professional network helped overcome their sense of isolation.

"...joined a network of other local drug and alcohol workers, and had found that fantastic. Before that I felt really isolated."

[FG15; M/F; Ind/non-Ind; Met/R/R]

Another non-Indigenous participant noted that managers and non-Indigenous staff needed to provide better support to Indigenous workers due to the increased complexities of their roles.

“Thing we need to do most is support Aboriginal people. Problems they face are much more difficult than for mainstream workers.”

[Int10; M; non-Ind; Met/R/R]

The type of support received and needed by Aboriginal managers was also addressed. The extent of support provided to managers to cope with the higher levels of stress experienced in their jobs has received relatively little attention. NCETA has examined this issue in some of its earlier work on alcohol and other drug managers' experience of stress and burnout (Duraisingam et al., 2007).

One manager was cautiously affirmative when asked whether support was available to her from other Indigenous managers. This worker indicated that due to a position held on a board for several years she had been able to access support from other board members, and they had been able to set up an informal CEO alliance. However, there remained substantial gender-based challenges.

“... I find it a little bit difficult for me, because it's sort of a bit of a men's club, they like to go and drink their red wine and gossip and all that. I'm totally different to all that!”

[Int5; F; Ind; Met]

For Indigenous women managers there were clearly additional challenges and work pressures that required special forms of support not readily available through more traditional mechanisms. Nor were such needs likely to be fulfilled through mechanisms available to non-Indigenous managers. As a result, this often left Indigenous women managers:

“...feel[ing] very isolated and unsupported.”

[Int5; F; Ind; Met]

At the national level, concern was expressed that support structures that previously existed had deteriorated.

“... worse now ATSIC has gone, CDEP has gone, MSO has gone. Can't see the light at the end of the tunnel— lost all the training and stuff. If something's not working, they don't try to fix it, they just close it down.”

[FG4; M/F; Ind; Met/R/R]

Workforce Development Strategies Summary

Throughout this project, participants identified a range of positive and strongly endorsed workforce development strategies that are being implemented around Australia, such as the roll-out of national Indigenous Alcohol and Drug Worker training and the establishment of the National Aboriginal and Torres Strait Islander Health Worker Association. However, these strategies alone will not be sufficient of themselves to improve Indigenous alcohol and other drug workers' wellbeing.

Key workforce development areas require significant attention to achieve more equitable and supportive conditions for Indigenous workers. This includes the development of more appropriate and precise role descriptions within organisations, and provision of resources to support workers such as clinical supervision, mentoring and debriefing. The latter could be achieved at relatively low cost.

However, issues such as encouraging new workers into the field, developing career pathways and subsequently offering improved salaries for Indigenous health workers will require a longer term and more substantial investment by governments, policy makers, planners and organisations. Developing mechanisms to support Indigenous health service managers will also be vitally important in the coming years to avoid an exodus of stressed and burntout Indigenous managers.

A coordinated national approach is required to address the wide range of relevant workforce development issues. This approach should involve specific culturally appropriate workforce development strategies that:

- increase the number of Indigenous and non-Indigenous alcohol and other drug workers who deal with Indigenous Australians
- engage and build alcohol and other drug skills and knowledge of other Indigenous health and human service agencies
- expand the role and capacity of Indigenous communities to effectively identify and address community alcohol and other drug issues.

In particular, strategies are required that extend the focus beyond the training of existing Indigenous workers at the level of Certificate III and Certificate IV (as important as this is) to incorporate a broad and comprehensive recruitment and capacity building strategy. This could include the following strategies:

1. recruit Indigenous high school students into tertiary education
2. provide managerial training
3. mentoring and support programs
4. pro-active leadership identification and training programs
5. advanced skill development at postgraduate level.

Workforce Development Checklists

The primary aim of Indigenous workforce development is to facilitate and sustain the Indigenous alcohol and other drug workforce by targeting organisational structures so that cultural needs and Indigenous knowledge is respectfully transferred into workplace policy and practice. To assist Indigenous workers and organisations to achieve this end, NCETA has developed checklists as a resource to identify Indigenous workforce development issues. Please refer to Appendix 6 for "A Workforce Development Checklist for Indigenous Alcohol and Other Drug Workers".

Chapter 6: Rewarding Aspects of the Job

This chapter provides an overview of aspects of the work roles of Indigenous alcohol and other drug workers that were found to be rewarding. This is followed by a section that addresses the strategies used at the individual and organisational levels to reduce work-related stress and to enhance worker wellbeing. This latter section also provides a set of strategies and recommendations for implementation by individuals, organisations and funders to help tackle some of the causal and contributory factors associated with work stress, and to optimise the efficacy of this valuable workforce and to safeguard their health and wellbeing.

“First thing, always for me, is to help my people.”

[FG12; M; Ind; R/R]

A primary focus of this report was to determine the factors that contribute to the wellbeing, stress and burnout of Indigenous alcohol and other drug workers. Indigenous workers' wellbeing was influenced by their cultural resilience, their commitment to community, and by acknowledging their connection to the past, present, and future of all Indigenous people.

Participants in this study were a diverse group of workers. They shared an intrinsic motivation to work for and with the Indigenous community, with whom they felt unified in heart and spirit. Although their work was invariably hard and demanding, it was nonetheless rewarding in many respects. This section depicts some of the many ways in which workers found their work to be rewarding.

Overall, rewarding aspects of Indigenous alcohol and other drug work included:

- Being connected to community and being able to build relationships
- Reciprocity – both the receipt and giving of knowledge
- Advocating on behalf of communities and/or peers

- Providing mentoring and training opportunities to Indigenous (and non-Indigenous) colleagues
- Creating new services and opportunities for communities and/or peers
- Ensuring non-Indigenous organisations and peers worked in culturally accountable ways with Indigenous people
- Partaking in decision-making and problem-resolution processes
- Engaging in ethical employment within Indigenous communities.

Indigenous workers reported that their primary motivation to work in the alcohol and other drugs field was to help their people, enhance community services, and improve Indigenous health outcomes and life expectancies.

“You’re there because you want to be there for your people. You want to try and make a change...”

[FG10; M/F; Ind; Met/R/R]

“...if I didn’t enjoy doing what I do and didn’t respect the fact that it’s helping those most in need in our community, well then, I wouldn’t be doing it...”

[FG16; M/F; Ind; Met/R/R]

Working With and for the Community

Reciprocity

Respondents emphasised the importance of undertaking work that allowed them to maintain their connections with Indigenous communities they were either a part of or affiliated with. The system of reciprocity, whereby workers were able to both give to and receive from their communities was extremely important to worker wellbeing. Indigenous ways of learning through sharing stories featured prominently in the context of alcohol and other drug work with Indigenous clients.

"We learn a lot off them too. They learn off us of course, but we learn a lot off them. We learn it's not a one-way thing, where we expect them to listen to us, but we've got to listen to them too. We hear their stories."

[Int28; M; Ind; R/R]

"It's really good. I get out there and mix with the community as well, you know, not just stuck behind the computer doing work... that's what I like."

[Int4; F; Ind; Met]

Some workers were clear that they valued and enjoyed their work. Field work was also enjoyable for many, as it presented opportunities to address alcohol and other drug issues within the context of the community and because it took alcohol and other drug workers out of the office and into the community.

"... it's pretty good. The days are different with us, 'cause we're out in the communities, we go and do training out there. We're working with the kids ... there's always something different ... and if you get a good team which counts too ... we all get on pretty well together ... we all know about each other's families and that sort of stuff ... with work, everyone knows what's expected of them ... so if someone needs support we can jump in and help them."

[Int33; M; Ind; R/R]

For outreach workers, engaging with community members helped build rapport and familiarity and enhanced the community's recognition and acceptance of the worker's role. Workers felt that the appreciation received from community members made their work highly rewarding. Client recognition of workers' support and advocacy skills was also a

valued acknowledgement of their dedication and hard work.

"The rewarding thing is when they (Indigenous people) come up to me in the community and they say, 'thanks for helping us!' ... that sort of stuff, that's rewarding. That's the stuff you can't measure on quarterly reports."

[Int14; M; Ind; R/R]

Community Acceptance

Community acceptance was an important reward for many Indigenous workers. It was noted that acceptance can take time and was often likely to be expressed in simple but very meaningful ways. Indications of community acceptance included being asked by community members to sit on committees to represent them. For some Indigenous workers, being told by community members they were suitable representatives was an indication of community acceptance.

"...it's them saying you are the right person for the job."

[Int17; F; Ind; R/R]

Engaging in community consultation was noted by Indigenous alcohol and other drug workers to be a significant predictor of acceptance and success. Participating on committees enabled them to work with Elders, and to be involved in decision-making processes regarding allocation of funds for Indigenous alcohol and other drug programs. The positive growth of the community through consultation processes improved the working lives of Indigenous alcohol and other drug workers, and the operational practices of agencies in which they were employed.

"...it's about imparting knowledge of processes to community; giving them a chance to vocalise any concerns, talk about the process."

[Int22; F; Ind; Met]

Changes in Service Delivery

Many workers expressed satisfaction in seeing health service delivery models adapt to become more responsive to client needs. This evolution of services was largely attributed to the establishment of consultative and advisory groups with Indigenous community representatives. There was a strong sense of pride and achievement in being part of solutions to improve Indigenous health and increase access to services.

"We've really got it happening. More services are now available in the community. In the 1990s mental health services came out once a month, now services come everyday, and child and youth are there, dual diagnosis come weekly, and they have alcohol and drug rehab services as well, and workforce has increased there as well. I know that people [the community] are becoming aware, like health aware, of alcoholism in the community, and [the] opportunity to rehabilitate and to heal. Something I've noticed in last two years, no maybe five years ... the awareness is there now, and people are becoming more resourced!"

[FG9; M/F; Ind/non-Ind; R/R]

One worker commented that despite many work-related stressors, they remained optimistic about the future. Optimism was built on recognition that change was happening, albeit slowly [FG16; M/F; Ind; Met/R/R].

Another Indigenous worker noted that the satisfaction they got from their position extended beyond their ability to help the Indigenous community to collaboration with other organisations and workers, and that this form of bridge-building and collaboration was very rewarding.

"I look forward to creating something new . . . All the workshops I do is about collaboration, working together, networking. I love white Australians and I love black Australians, so if we work together because we are the first bunch of people here and we're pretty cool, laid back, few shrimps on the barbie kind of stuff, so, yeah, let's all work together, I am sick and tired of all this separation that keeps happening. My main job is to be like billy glue ..."

[Int09; M; Ind; Met]

Working in a Team

For many workers, their primary reward was contributing to the wellbeing of Indigenous people through working to 'close the gap'. In addition, being part of a dynamic team environment was a further advantage [FG10; M/F; Ind; Met/R/R]. Workers commented that the shared passion and commitment of colleagues in assisting Indigenous people was an important motivator [FG7; M/F; Ind/non-Ind; R/R].

"... great team... pleasure to come to work... to work with professional people who are all on the same page, and who all have the same sort of focus."

[FG9; M/F; Ind/non-Ind; R/R]

Being part of a team and having positive relationships with colleagues made the job more rewarding by:

- being able to share successes with other team members [Int32; M; Ind; R/R]
- working collectively to address Indigenous disadvantage [FG5; F; Ind/non-Ind; Met/R/R]
- yarning with team mates and sharing their experiences in alcohol and other drug work [Int01; F; Ind; Met]
- successfully advocating on behalf of other Indigenous staff [Int01; F; Ind; Met].

'Making a Difference in Someone's Life'

"People come in broken, they walk out fixed."

[Int12; M; Ind; Met].

Working with clients, particularly one-on-one, and helping them to achieve positive outcomes was affirming for workers, and was a significant incentive for many workers. Seeing clients whose lives had previously been dominated by alcohol and drugs now living, working, and participating in community activities was rewarding [Int07; M; non-Ind; R/R].

"When you've seen people's lives dominated by a substance, and they're actually living for or where their next substance is coming from, and they change into being, you know they are turning up to work three days a week. They are participating in community activities ... they're actually playing a sport. And so you find their lives, there is more to their lives than the substance, where once, the substance is what they lived for."

[Int07; M; non-Ind; R/R].

Many people spoke passionately about being involved with Indigenous clients and communities and helping them to become stronger. Participants found it particularly rewarding to contribute to a client's success and then see them leave an alcohol and other drug program sober and focused.

"The most rewarding bit for me is when clients exit a program, knowing you've made a difference to their lives, and they feel good about that."

[FG4; M/F; Ind; Met/R/R]

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It was especially rewarding when clients were encountered some years after alcohol and other drug treatment and they were doing well and were healthy and functional members of the community. This was particularly rewarding, given the chronic nature of the disorder and the propensity for relapse.

"...you don't see somebody for two or three years and you see them after a couple of years and they're being sober. And you think great, they're doing fine. And that's the most rewarding thing ... when I see people completing and staying successfully off the drugs and alcohol for a few years ... It makes it worthwhile working here."

[Int27; M; Ind; R/R]

Improving the health of Indigenous men was especially important for some workers, who felt men had been missing out on services and positive health outcomes [FG12; M; non-Ind; R/R]. For others, the focus was on seeing progress and development occur among families and children.

"parents, families, communities want to see children/people get an education and getting community and family involvement in understanding the needs of a student is critical."

[Int22; F; Ind; Met]

One interviewee talked about the rewards of their work that centred on youth work:

"Working with young people and being part of some of the fun things we do. Different opportunities that I am able to expose them to. The learning and the joy you see on their faces when you take a group of Nungas out to learn to surf and they're just laughing and having heaps of fun. But then also the education side where they're asking questions about sniffing or things that they are dabbling in but they're thinking I might do that. So every so often they ask questions 'what does it do to me?' Just seeing them grow."

[FG6; M/F; Ind; Met/R/R]

Mentoring Opportunities

The opportunity to either engage in or provide mentoring was also regarded as important and rewarding. The need for increased mentoring opportunities was often remarked upon. Delivering training and watching trainees develop into effective practitioners was also a rewarding part of the job. Watching other Indigenous workers graduate and following their progress was described as a great incentive by workers.

"...seeing people grow and develop, becoming effective workers. Seeing people graduate, and becoming familiar with them as part of the [x] network, and hearing about what they are doing, implementing programs, how they grow. That is a highlight ... Good to see things change at a policy level and good to have a senior management group who ensure change occurs."

[Int21; F; Ind; Met]

Positive Strategies: 'I have been given a story ...'

Recognising and Managing Stress

Participants exhibited a growing level of awareness about work-related stress and many talked about proactive strategies in place to prevent stress or deal with it at its early stages of development.

"Learn to take care of yourself. It's about knowing yourself and how you operate. Recognise when you're under pressure and or feeling stressed out, and share your needs with others, build supports."

[Int22; F; Ind; Met]

While some workers stated that managing stress was an individual responsibility, others recognised the role of the workplace in helping Indigenous employees recognise stressors, as well as providing them with opportunities to 'unpack' contributors to stress, anxiety, depression and burnout [Int01; F; Ind; Met].

"...as an Aboriginal population, because we all carry a burden of stress, anxiety, depression and burnout it would be really useful if we could have opportunities made available to staff to actually start unpacking what that means to them."

[Int01; F; Ind; Met]

It was also suggested that regardless of whatever stress prevention or management strategies were adopted by workers, the key issue was to ensure they remained committed to it and applied it on a regular and consistent basis [Int22; F; Ind; Met].

Personal Stress Management

Interviewees identified several important ways in which Indigenous workers could minimise their stress levels. Workers highlighted the importance of knowing themselves, recognising symptoms of stress, understanding what factors and events triggered stress and applying strategies to lower stress levels. One worker recommended that prior to entering the alcohol and other drug workforce, workers should 'examine their own lifestyle, personal development and holistic wellbeing; taking into account their physical, mental and emotional health and their spirituality' [Int33; M; Ind; R/R].

"Before you can change, you need to know yourself. So if you know yourself, you can make changes and you can understand where you are at and what you are going through. If you can't do that then you are constantly stuck in a rut... Talk, communicate, no point bottling things up inside of you."

[Int32; Ind; R/R]

Recognising the Strength and Resilience of Indigenous Individuals and Communities

Many Indigenous workers also noted the strength and resilience that was a part of their culture and described the ability of Indigenous people to overcome some extraordinarily difficult experiences. The importance of culture and spirituality was a key element in maintaining worker wellbeing, as was regularly sharing positive stories/strategies with other workers.

"Aboriginal spirituality and keeping self in touch with culture, in turn helps in keeping families strong."

[Int33; M; Ind; R/R]

The close family and community bonds that typify Indigenous Australians were consistently found to be a great source of strength and resilience. Sharing their culture with younger members of their community and teaching nieces and nephews cultural ways, together with the support received from the 'grannies', were identified as positive strategies [FG6; M/F; Ind; Met/R/R].

Maintaining family bonds and telling and hearing their stories was a key element in workers' spiritual wellbeing. One interviewee talked about the personal story that they had been given by their traditional grandparents and how they used this story to manage stress and move forward in a positive way. The story was also their personal journey.

"I am not stopping until I head back to the Territory. I have to soak up all this info, all this knowledge, go back, distribute it and then retire. So I don't care what happens between now and then ... but I am not laying down and copping it. I am going to keep going, because traditionally I have been given a story and I will be finishing that story off."

[Int09; M; Ind; Met]

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Humour

Laughter was regarded by a number of participants as an essential strategy to remain positive and resilient. It was seen as a 'feel good thing'. It was suggested that workers should try to laugh with their clients.

"Aboriginal people joke all the time. It could be about a death, but we try and make something funny about it, just to cheer everyone up. It's good to have a cry, but you have to laugh too."

[FG10; M/F; Ind; Met/R/R]

Humour was also used within the workplace as a strategy to manage distressing events and to keep more minor irritations in perspective.

"Keep that communication link open then it's good. I try not to let bickering, little bickering things get me down. I tend to override that with my laughter and my jokes and having fun sort of thing you know. I think that is one of the key issues in a stressful job like this is to have fun and enjoy doing it. That way everybody is getting something out of it. It is a win-win situation, not a win-loss situation."

[Int32; M; Ind; R/R]

Realistic Appraisals

Several workers acknowledged that stress was simply a part of their role and that Indigenous workers needed to accept that they would be regularly confronted with stressful situations [Int32; M; Ind; R/R; Int27; M; Ind; R/R]. As described above, the situations in which Indigenous workers experienced stress were many and varied. Stress was experienced through:

- living and working in the community
- being approached 24/7
- effects of loss and grief, and sorry business, and
- dealing with culturally insensitive, and sometimes racist, staff members, management, and external organisations.

While it was noted that constructing boundaries within Indigenous communities was difficult, more experienced workers recognised the importance of knowing what they personally could and could not do, and acknowledged that it was not possible to help everyone.

"Have to learn your limitations and learn to enforce them. Cannot help everyone. Have to remember that work is a priority and that you are helping people there as well. Have to take time for yourself as you cannot help others unless you are well."

[Int03; F; Ind; Met]

In order to manage demands and expectations from peers and managers, it was also considered essential to learn how to prioritise. One remote worker indicated that the positive strategy they utilised most was to take regular breaks. This worker also emphasised the importance of self-regulation and self-evaluation.

"Nobody's going to stop you if you wanna work more... Basically you have to pace yourself."

[Int31; F; Ind; R/R]

Several interviewees noted that dealing with other agencies could be stressful. One worker described how they had learned to manage the stress of dealing with external agencies by becoming increasingly assertive and persevering, and if necessary demanding to be seen and heard by a higher authority.

"If someone has an issue with me talking to them, or if they don't like me, I go to somebody else. I don't deal with them. I just go to someone else in that department. I will always go higher. There are ways and means around everything."

[Int32; M; Ind; R/R].

A similar stress management strategy involved urging Indigenous people to stand up for their rights when they were challenged by management and work colleagues. However, one interviewee advised that in doing so it was equally important to "know when they were wrong, to admit it, to seek assistance and to move on" [Int09; M; Ind; Met].

A senior non-Indigenous worker indicated that when based in remote communities the following stress management techniques had worked for them:

- not encouraging clients to visit them at home after hours
- trying not to take on a 'family' role with other community members
- understanding their place and role in the community by recognising what they are able to do as a non-Indigenous person
- taking the time to engage in recreational activities
- having a supportive partner
- remembering that "it's not your community, you're a guest there."

[Int10; M; non-Ind; Met/R/R].

Table 12. Individual Stress Management Techniques

Traditional	Take time out to participate in a traditional activity Go home to community Practice your spiritual understanding of the world
Recreational	Take time out to participate in an enjoyable activity Listen to music Meditation, yoga, breathing exercises Go for a walk with a friend/dog Have a regular massage
Social	Share knowledge; learn new things Have a close personal support network Spend time with family Visit friends Eat well, go out for dinner Laugh
Domestic/Personal	Take a nap Turn off phone, lights, TV; spend time alone Do not answer the door Enjoy a movie or favourite TV show Go for a long drive Gardening Have regular medical checks Practice healthy living (i.e., do not smoke, drink, use illicit drugs)
Work-related	Have a coffee and debrief informally with work mates Have a routine Take one day at a time Consider things from another perspective Accept your limitations Look forward to the end of the working day; do not take work home

Workplace and Organisational Strategies

Workers identified initiatives that could be adopted at the organisational level to decrease stress and enhance worker wellbeing. Some initiatives focused on team building and ensuring that workers felt respected and supported within the workplace. Other proposals were broader and suggested that workplaces could become more proactive in addressing inequalities experienced by Indigenous workers. Some of the positive workplace and organisational strategies identified are outlined below.

Proactive Management

Participants identified a range of management strategies that were conducive to reducing worker stress and creating a positive and supportive work environment. These required a proactive and positive approach to dealing with staff and included being attuned to staff needs [FG16; M/F; Ind; Met/R/R].

“With my organisation, I think it’s the best I’ve worked with since I’ve worked in health, the all round support that we get from people in all different areas of the organisation is great. It seems like they can’t bend over backwards far enough to help you out..”

[Int13; M; Ind; Met]

Being responsive to the needs of staff was noted as extremely important for the continued development of the Indigenous alcohol and other drug workforce.

“Aboriginal workers need that bit of understanding in their jobs in order to support their communities and advance.”

[Int03; F; Ind; Met]

Reflecting the distinctive nature of the stressors and constraints that confronted Indigenous workers, interviewees identified that workplaces needed to:

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- adopt more flexible working conditions
- regularly consult with staff about their workloads and working conditions
- augment workers' skills by providing opportunities for learning and ongoing professional development
- coordinate with other services to streamline administrative and clinical processes, as well as to provide greater networking opportunities
- provide employees with incentives to help them manage and reduce their stress levels, and redress systemic inequalities.

Flexible Working Arrangements

Many Indigenous workers highlighted that to manage their levels of stress it was important to be able to balance work, family and community commitments. Equally important was the view that management needed to be aware of the complexity of issues confronting Indigenous families. It was noted by one participant that this situation could be greatly assisted if management were also Indigenous or if they were culturally aware and sensitive [Int04; F; Ind; Met].

Workers indicated that greater flexibility in work arrangements, additional leave entitlements, and working hours that accommodated client and community needs lessened their burden significantly and had a positive impact on worker wellbeing [FG15; M/F; Ind/non-Ind; Met/R/R: Int29; F; Ind; R/R]. Additionally, workers reported that they had a greater sense of loyalty to organisations that implemented flexible arrangements and permitted greater autonomy and responsibility [FG10; M/F; Ind; Met/R/R].

Regularly Consult with Staff about their Workloads and Working Arrangements

Involving staff in decision-making processes was also highlighted as a successful strategy to reduce stress [Int04; F; Ind; Met]. A non-Indigenous worker commented that involving staff in the resolution of problems allowed them to gain 'ownership of the process' [Int25; M; non-Ind; R/R] and to bring creativity to their role and minimised the challenging nature of the work.

"Traditionally, decisions about solutions are made at a higher level and ... mandate down the solution, which may or may not work at the local level. This destroys the capacity of other levels of the system to problem solve. The more rigid and more defensive the system, the more constrained people are, and the less satisfied, so if you can create an environment which people feel their creativity is respected, I think you're going to win."

[Int25; M; non/Ind; R/R]

Increasing the number of team members, ensuring that workloads were more evenly distributed and decreasing paperwork often reduced stress levels [Int27; M; Ind; R/R: FG3; M/F; Ind; Met/R/R].

Other positive strategies for reducing stress included being given opportunities to undertake relief work and having good relief staff available. Such strategies eased worker pressure and had the added benefit of enabling workers to be able to learn from other workers and community members [FG13; F; Ind; R/R].

Opportunities for Learning and Ongoing Professional Development

Many workers spoke about the positive impact of opportunities to attend training [Int02; F; Met: Int04; F; Ind; Met]. An Indigenous alcohol and other drug researcher talked about the rewards of working in that area, including learning about research, being exposed to the university environment, and learning about different methodologies [FG17; M/F; Ind/non-Ind; Met/R/R]. However, it was noted by one senior manager that "organisations also need to be involved in understanding what the [worker] will be studying" [Int22; F; Ind; Met]. Understanding the skills and knowledge of workers was considered essential in managing expectations of the organisation and staff, as well as ensuring that the needs of the organisation and staff were complementary [Int22; F; Ind; Met]. Further to this, consulting with staff about their needs assisted the organisation to raise competency standards which, in turn, improved services provided to clients [Int17; F; Ind; R/R].

Coordinate with Other Services

Many workers emphasised the importance of building relationships with other services. While relationships were initially developed to provide more comprehensive assistance to clients, several workers also described how developing these relationships provided them with informal debriefing opportunities and an opportunity to share information.

“... talking about forming relationships with the other networks, we need to form a working relationship with mental health network, sexual health network and start talking to the Aboriginal health workers because we are all doing work separately and that’s one of the areas we need to improve and could be simple such as developing clinical supervision guidelines for mental health professionals and drug and alcohol workers.”

[FG2; M/F; Met/R/R].

Interviewees from a service in Western Australia spoke about the substantial improvements in assessment and screening within their organisation over the last few years that cross referral with other agencies had helped produce. Working with other agencies not only ensured that clients were receiving the most appropriate care, it also increased staff safety and improved feelings of wellbeing [Int27; M; Ind; R/R].

Providing workers with networking opportunities and professional and personal support to reduce their geographical and professional isolation was highlighted as an important stress management strategy [Int26; M; Ind; Met]. This was seen as particularly important in rural and remote areas and in situations where workers were asked to take on complex and demanding cases. Strategies for working more collaboratively included undertaking joint assessments, joint debriefings, and providing informal support such as being able to talk about family and related issues [FG9; M/F; Ind/non-Ind; R/R]. Joining a network of workers or regularly engaging with other workers was considered a simple yet highly effective stress reduction strategy. This was seen as a powerful way to reduce the sense of isolation many workers had experienced [FG15; M/F; Ind/non-Ind; Met/R/R]. Regular worker forums provided an opportunity to share concerns and problems and learn from each other on an ongoing basis [FG13; F; Ind; R/R].

Employee Incentives

Some workers suggested innovative workplace programs to reduce stress levels, maintain wellbeing and improve the physical health of Indigenous workers [Int01; F; Ind; Met]. A workplace physical fitness program could be beneficial given the significant link between physical fitness and reduced stress, and could also be used to convey health promotion messages. Raising awareness of stress-related illnesses/diseases such as hypertension, heart disease, kidney disease, and diabetes was considered particularly important for Indigenous workers who often did not have a comprehensive knowledge of

either their own or their family’s health history [Int31; F; Ind; R/R].

Another suggested strategy was provision of workplace funded private health benefits for permanent employees. In addition to the lifestyle improvements that such an initiative might provide, this could be used as an incentive to attract new workers [Sur; F; Ind].

The provision of clinical supervision, mentoring and debriefing were increasingly valued and integral parts of normal practice. Some interviewees indicated that their organisation utilised an independent external provider to conduct individual sessions with staff. It was further noted that implementation of a staff counselling service resulted in greater retention of staff, increased team cohesion and worker wellbeing [Int30; F; Ind; R/R].

Recognition of Achievement and Effort

Creating Specialised Indigenous Workplaces

Many Indigenous workers highlighted the importance not only of recognising their own successes, but also of having others acknowledge their achievements.

“We should pat ourselves on the back for even a little job.”

[FG6; M/F; Ind/non-Ind; Met/R/R]

Participants explained that it was vital that Indigenous alcohol and drug workers viewed themselves in a more positive and professional way. One respondent clarified that Aboriginal Health Workers were specialist workers who worked with Indigenous alcohol and other drug clients. That is, instead of just referring to themselves as Indigenous workers, the specialist knowledge and skills that they brought to the role needed to be acknowledged. Further to this, recognising Indigenous health work as an area of expertise would lend authority to the Indigenous knowledge and skills required for the role, and could potentially improve the way workers were perceived by colleagues from other disciplines. It was also noted that creating the notion of an Indigenous specialist should not be dependent upon the attainment of qualifications [FG2; M/F; Ind; Met/R/R].

Several ways of legitimising the role of the Aboriginal Health Worker were discussed. These suggestions included the following:

Chapter 6: Rewarding Aspects of the Job

1. Translating Indigenous knowledge into practice

One option offered was for workplaces to develop policies and procedures which redressed the distinctive stressors of Indigenous employees by ensuring that:

- impact of systemic racism and discrimination was lessened
- nature and complexity of their work was understood and supported
- relationships with their families and communities was facilitated
- the workplace was enhanced as a safe place for clients and the community to visit [Int26; M; Ind; Met].

Some Indigenous workers highlighted that the inclusion of traditional knowledge and practices was increasingly implemented in workplaces but there was still room for improvement. One Senior Indigenous Educator described how she “found it important to develop skills of students to participate in developing policy and procedures within the organisational setting” [Int22; F; Ind; Met] within the training that she provided.

“I deal with the Ngangkari and there are ‘procedures’ for working with them. Was a word of mouth agreement, but had to put it into writing as policy and procedure, as hospitals need to know what the Ngangkaris are doing, so with their permission we know what we can say and can’t say.”

[Int15; M; Ind; Met]

2. Registration of Aboriginal Health Workers

Other workers suggested that the registration of Aboriginal Health Workers should be considered. The benefits of registration would include:

- having a professional code of conduct (similar to doctors and nurses)
- professionalisation of the workforce with workers having more clearly defined roles [Int13; M; Ind; Met].

3. Workplace exemptions from the Equal Opportunity Act

One interviewee discussed the significance and effect upon the workplace of gaining an exemption from the Equal Opportunity Commissioner. The interviewee considered that an exemption was necessary to keep the workplace traditional.

“cultural ways of working are very important. Cultural respect polices, traditional obligation policies, staff are encouraged to sit on community and cultural boards— keeps our traditional roots— that’s why we got the exemptions too, helps keep us a traditional organisation. Not aware of any others who are still traditional— would like to see it taken up more.”

[Int5; F; Ind; Met]

Table 13. Organisational Strategies to Support Staff Proposed by Participants

1.	Provide training that focuses on stress management techniques
2.	Offer pampering sessions to staff (e.g. neck massages)
3.	Allow staff to take cultural leave, including taking time off for Sorry Business and funeral leave to enable them to be able to grieve properly
4.	Provide Rostered Days Off (RDO) for case managers if they have worked on the weekend or done overtime
5.	Provide staff with flexible working arrangements
6.	Support access to professional development
7.	Ensure provision of clinical supervision, ideally with external providers
8.	Provide appropriate debriefing
9.	Encourage and foster collegial support
10.	Facilitate professional and social networks
11.	Acknowledge the work and achievements of staff
12.	Provide staff with an extra week’s paid leave at Christmas as an added bonus
13.	Provide staff with a number of training opportunities, for example First Aid, conflict resolution
14.	Pay for workshops and all training costs
15.	Create informal networks with other nearby health workers for debriefing and support. Organisations could support this by formalising networks with Memoranda of Understanding (MOU), have organisational policy, make a commitment to support time and other resources required for workers to participate in these networks
16.	Schedule training opportunities in regional areas to have a weekend before or after.

Summary

Despite the stressors and challenges, many Indigenous workers found their work offered them the opportunity to build relationships with communities and be part of a healing process. For some Indigenous workers it also offered the opportunity to reconnect with their language and culture. For many workers, advocating on behalf of and creating services for their Indigenous clients afforded a sense of pride and fulfilment because they “made a difference”. Some workers commented on the significance of having a shared team focus and the importance of being able to share successes with their team.

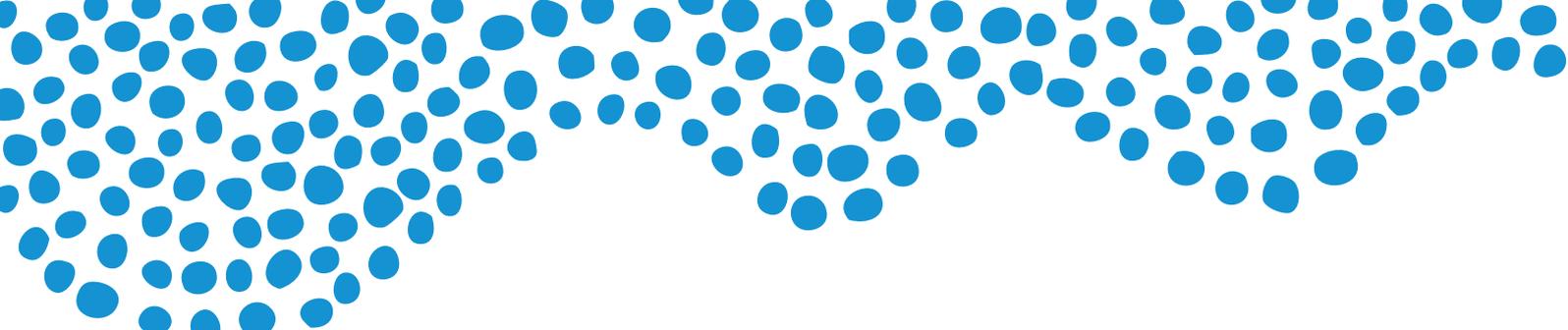
Improving outcomes for the Indigenous community was such a strong motivation for many workers that it allowed them to overcome great personal and professional challenges. In surmounting many challenges, workers often drew strength from their Indigenous spirituality and called upon traditional stories handed down to them. Being able to share their culture with each other and their non-Indigenous peers was an important strategy for maintaining the wellbeing of Indigenous workers.

While a number of participants described some personal strategies for maintaining wellbeing, most

emphasised the greater role that workplaces could undertake in this regard. Many of the strategies advocated focused on making workplace practices more Indigenous-specific in terms of:

- flexibility for workers to engage with clients on their terms (i.e., outreach services, out of hours work)
- recognition of the complexity of Indigenous workers' personal experiences
- inclusion and consultation with Indigenous staff regarding workplace policies and procedures, and
- adequate leave provisions to allow workers to participate in cultural obligations without incurring undue penalties.

Further to this, some innovative strategies were suggested that aimed at improving the mental health and wellbeing of the Indigenous workforce. While it may not be likely that some of these suggestions will be adopted at a systems level, there are great advantages for workplaces to be proactive and encourage staff to participate in joint physical activities and promote health awareness. These activities need not be costly and could be as simple as meeting one hour earlier each morning to go for a walk together, debrief informally, and plan activities and tasks for the day.



Chapter 7: Moving Forward

Beyond Cultural Competence Towards Cultural Proficiency

A major source of stress for Indigenous alcohol and other drug workers was the lack of cultural competence on the part of colleagues and mainstream services. Cultural awareness has been described by Aboriginal academic and psychologist, Associate Professor Dennis McDermott, as being aware of cultural difference and cultural diversity and having an understanding or knowledge of another culture. Importantly for health professionals, cultural awareness involves an understanding that cultural differences may necessitate a different approach to people of that other culture.

“Cultural awareness training is not overcoming terrible attitudes that they hold on to”.

[FG10; M/F; Ind; Met/R/R; SA]

Cultural awareness training was often a requirement and standard practice; however, it was noted throughout this project that while cultural awareness training was needed for mainstream workers it was found to be of limited benefit. More sophisticated and comprehensive efforts are required to overcome racism. There is also a contemporary move to progress beyond cultural competence to cultural proficiency.

The “Cultural Competence Continuum” (shown in Figure 2) details the principles of ascending levels of proficiency that offer a more comprehensive approach to cross-cultural awareness. The cultural competence continuum illustrates the progressive steps involved in evolving from a state of cultural destructiveness, to cultural blindness, to a stage of cultural competence. The key characteristics of each of these three stages are:

1. **cultural destructiveness** - identified by policies that led to the Stolen Generation *to*
2. **cultural blindness** – where there is no understanding of cross-cultural forces and misunderstandings *to*

3. **pre-competence/competence** where there is recognition of one’s own cultural blindness and attempts to become culturally competent which may lead to tokenism.

Within a cultural competence and cultural proficiency framework, Aboriginal and Torres Strait Islander cultures are held in high esteem and seen as positive forces.

Knowledge, together with understanding, is a precursor to cross-cultural competence. Cultural awareness continues to develop and grow as individuals become more adept in cross-cultural situations. Achieving cultural proficiency relies on individuals, organisations and systems integrating the following fundamental principles into practice and policy:

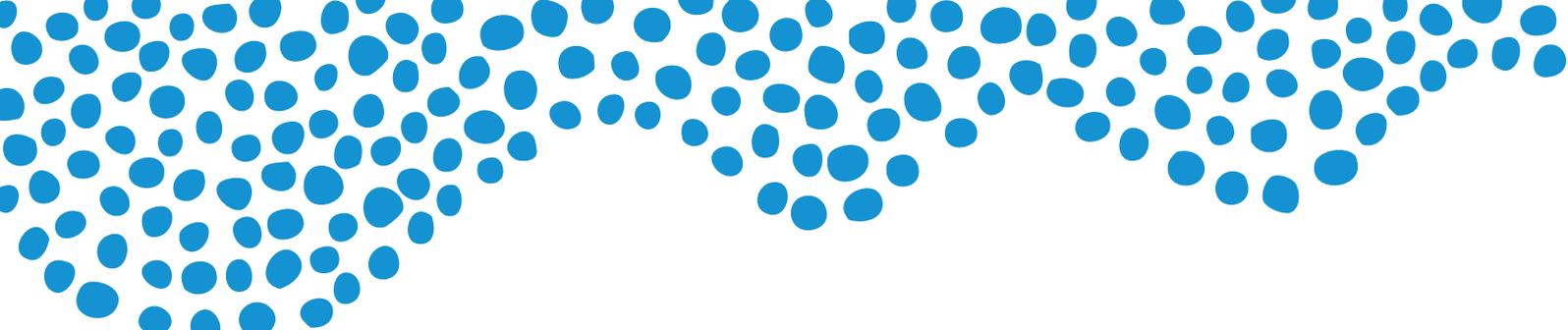
- Cultural Awareness – knowledge with understanding
- Aboriginal Self-Determination - development of respectful partnerships
- Cultural Respect – attitudes and values
- Cultural Responsiveness – ability and skills
- Cultural Safety – A key aspect of cultural safety is awareness by individuals and organisations of the power dynamics of cross-cultural interaction (Bamblett, 2008).

An understanding of the “Cultural Competence Continuum” (see Figure 2) is an initial step in laying the groundwork for meeting the challenge of effectively moving beyond cultural competence to cultural proficiency.

An opportunity currently exists to plan for a culturally proficient system of healthcare that would greatly improve services to the Indigenous community, and that would at the same time provide essential support to Indigenous alcohol and other drug workers.



Figure 2. Cultural Competence Continuum
(modified from Cross, Bazron, Dennis, & Isaacs, 1989)



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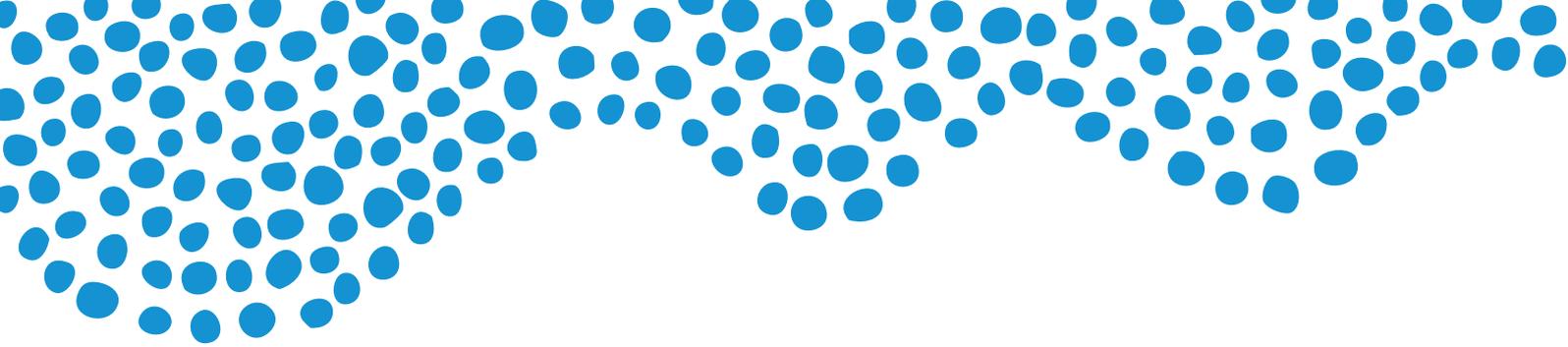
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Appendices

Appendix 1

Indigenous Alcohol and Other Drugs Workers' Wellbeing, Stress, and Burnout Project

The National Centre for Education & Training on Addiction (NCETA), Flinders University, is conducting a nation-wide project on well being, stress, and burnout among Indigenous and non-Indigenous front line workers who work in the alcohol and other drug field or in a related field.

This study is designed to investigate factors which contribute to well being, stress, and burnout among Indigenous and non-Indigenous alcohol and other drug workers.

We would like to invite you to participate in either an interview or focus group at your workplace (whichever you would find more convenient or preferable). We anticipate that no more than one hour of your time on one occasion would be required. We would like to audio tape the interview or focus group if we have your permission to do so.

Some of the interview questions involve potentially sensitive topics, and you could experience emotional discomfort when answering these questions. Before the interview commences, you will be provided with a list of local counselling options in case you experience emotional discomfort during or following the interview.

Your involvement is completely voluntary and any information you provide will be treated in the strictest confidence. You will not be individually identifiable in any subsequent reports or publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

A report of the overall findings of the study will be publicly available through the Australian Government Department of Health and Ageing.

If you have any questions, please do not hesitate to contact Donna Weetra on: tel (08) 8201 7538, email donna.weetra@flinders.edu.au or Amanda Tovell on: tel (08) 8201 7543, email amanda.tovell@flinders.edu.au.

This research project has been approved by the Aboriginal Health Research Ethics Committee (Ethics project officer: Alwin Chong, ph (08) 8132 6700, email alwin.chong@ahcsa.org.au), the Aboriginal Health Research Ethics Committee (Secretary: Kylie Hayward, ph: (02) 9212 4777, email: ethics@ahmrc.org.au), the Western Australian Aboriginal Health Information and Ethics Committee (Secretariat: Avril Lowenhoff, ph: (08) 9222 2303, email: avril.lowenhoff@health.wa.gov.au) and the Flinders University Social and Behavioural Research Ethics Committee (Secretary: Sandy Huxtable, ph (08) 8201 5962, fax (08) 8201 2035, e-mail sandy.huxtable@flinders.edu.au).

Benefits

This study aims to increase the understanding of systems, organisational and individual factors which negatively and/or positively contribute to the overall wellbeing of Indigenous health workers.

The results of this study will be made available to inform future workforce development initiatives that are undertaken by the Australian Government Department of Health and Ageing and other key organisations.

Risks

We do not foresee any risks associated with you participating in this study. Some of the interview questions involve potentially sensitive topics. If any particular question makes you uncomfortable, you may choose not to answer it. You are also free to stop the interview at any time.

Publication

We intend to present the results of this study to colleagues at conferences and other meetings, and publish the results in journals or other reports. The aim of publishing the results is to inform organisations and individual workers about effective ways to increase well being and reduce stress and burnout in the Indigenous alcohol and other drug workforce. Information in any reports or publications will be provided in such a way that ensures that you cannot be identified.

Thank you for your attention and assistance.



Prof. Ann Roche
Director
National Centre for Education and Training on Addiction (NCETA)
Flinders University, Australia

Appendix 2

CONSENT FORM FOR PARTICIPATION IN RESEARCH (by interview)

For participant

I.....

being over the age of 18 years hereby consent to participate as requested in the 'Participant Information Sheet' in the research project on *Indigenous Alcohol and Other Drug Workers' Wellbeing, Stress and Burnout*.

1. I have read or I have had the information read to me that has been provided.
2. Details of the procedures and any risks have been explained to my satisfaction.
3. I agree to an audio recording of my interview.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
 - I may not directly benefit from taking part in this research.
 - I am free to withdraw from the project at any time and I am free to decline to answer particular questions.
 - While the information gained in this study may be published as explained, I will not be identified, and any individual information about me will remain confidential.
 - I may ask for the audio recording to be stopped at any time, and I may withdraw at any time from the session or the research without disadvantage.

I would like my name to be included in the list of acknowledgements

Participant's signature.....Date.....

I would like to receive a copy of the final results of the research. Please email/mail me a copy to:

For research staff

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name.....

Researcher's signature.....Date.....

Appendix 3

CONSENT FORM FOR PARTICIPATION IN RESEARCH (by focus group)

For participant

I.....

being over the age of 18 years hereby consent to participate as requested in the 'Participant Information Sheet' in the research project on *Indigenous Alcohol and Other Drug Workers' Wellbeing, Stress and Burnout*.

1. I have read or I have had the information read to me that has been provided.
2. Details of the procedures and any risks have been explained to my satisfaction.
3. I agree to an audio recording of the focus group.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
 - I may not directly benefit from taking part in this research.
 - I am free to withdraw from the project at any time and I am free to decline to answer particular questions.
 - While the information gained in this study may be published as explained, I will not be identified, and any individual information about me will remain confidential.
 - I may ask for the audio recording to be stopped at any time, and I may withdraw at any time from the session or the research without disadvantage.

I am happy for the research team to take photographs of the focus group for use in publications and presentations.

I would like my name to be included in the list of acknowledgements

Participant's signature.....Date.....

I would like to receive a copy of the final results of the research. Please email/mail me a copy to:

For research staff

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name.....

Researcher's signature.....Date.....

Appendix 4

Interview Schedule

Opening

Introductions. Thank you for making the time available to share some of your experiences, thoughts, and views with us.

Acknowledgement of traditional owners of land.

We understand that there could be a range of issues you might like to comment on, so our chat might last for about 30 to 45 minutes. This is a very informal relaxed conversation, so please let me know if you want to raise any particular issues or if you would like to have a break at any stage.

We would appreciate it if you could turn off your mobile phone so we don't get interrupted, but if you don't want to, that's fine.

Explain what the project is about, as per the Participant Information Sheet, and the types of questions to be asked. A lot of the questions are about general aspects of your work role, but wherever possible please relate the questions to dealing with alcohol and other drug issues.

Remind participant that they are free not to answer particular questions, or to discontinue their participation at any time. Ask participants to sign the consent form and request permission to audio tape the interview. Explain why we need the signed consent form and what we're going to do with the recording (analyse it to pull themes together and pull out quotes). Everything you say will be anonymous and confidential – you won't be identifiable in any of the quotes or any other part of the report or other publications.

For the issues we'll cover, we're interested in both:

- 1) Your experiences, and
- 2) What you think could be done better / what changes could be made.

Indigenous Workers

General Work Role

1. Can you tell me what your job is, what your work involves?
2. Do you work mostly on your own, or as part of a team?
3. How long have you been doing this job or type of work?
4. What did you do before this job?
5. How much of your role involves working with Indigenous clients?
6. What aspects of your job do you enjoy or find rewarding?
7. What aspects do you find difficult or stressful?
Possible examples:
 - i. Community expectations
 - ii. Travel
 - iii. Clients for whom English is not their first language

Alcohol and other drug issues

8. Can you tell me what kind of alcohol and drug issues you deal with in your job? For example, do you encounter intoxicated clients, do you get clients whose family members have drug or alcohol problems, or clients trying to give up smoking, things like that?
9. Some workers find dealing with alcohol and drug issues rewarding, but it also can be challenging. What is it like for you?

Training and Professional Development

Now I'd like to chat about training and professional development. By this we mean any training sessions, conferences, or networking or any other activities that help you develop in your job.

10. Have you received any training in alcohol and drug issues? If so, what training? (prompt if necessary to include TAFE, university, short accredited & non-accredited courses)
11. If so, how suitable and adequate was this training?
12. Can you tell me about the access you or other workers in your service have to relevant training?
13. Is there any additional training or professional development that you think would be valuable to you?
14. What sort of clinical supervision and debriefing opportunities are available to you?

Work Role and Work Conditions

15. Can you describe your work place and work conditions?

Possible examples:

- i. Physical work environment (rooms, noise, etc.)
 - ii. Management expectations and support
 - iii. Team and co-worker support and relations
 - iv. Working hours / workload
 - v. Being approached by clients out of hours
 - vi. Reporting / paperwork requirements
 - vii. Funding (if needed, prompt around sufficiency, security)
 - viii. Pay
 - ix. Career paths
 - x. Role clarity (Something like: "How clear is your role? Does it match with the tasks you have to do?")
16. If you are comfortable in doing so, can you describe any experiences or observations you may have had of racism in the workplace, for example from management, colleagues, clients or other services.
 17. How have these experiences impacted on you as a worker?
 18. Dealing with work, family and community commitments can be hard for many people in the workforce. What's it like for you?

Cultural Issues

19. In the submissions and survey, one of the issues that came up was that cultural differences can be stressful if Indigenous ways of working, and ways of knowing, aren't understood or respected. What's this like for you?

Possible example: So for example, some Indigenous workers reported feeling that non-Indigenous workers placed too much emphasis on qualifications. What do you think?

20. Some workers also reported feeling stressed because of acceptance issues with clients, for example, younger workers working with older clients. What's this like for you?

Possible other examples:

- i. gender issues with clients
 - ii. relationships with traditional healers
21. What impact do sorry business and loss and grief issues have on you as a worker?
 22. Has your organisation put in place any positive strategies that help or support Indigenous workers - particularly in dealing with drug and alcohol issues?
 23. Do you think any of these factors we've talked about [recap for the participant if necessary] might be different for Indigenous and non-Indigenous workers, and if so, in what ways?

Appendix 4

Wrap Up

24. Are there any other issues related to workers' wellbeing, stress and burnout that you would like to raise?
25. What for you are the most important points that you really want us to take away from today's session?

Provide participants with Bush Crisis line resources and local counselling contacts in case they experience any distress.

Check how the participant is feeling.

Non-Indigenous Workers

General Work Role

1. Can you tell me what your job is, what your work involves?
2. Do you work mostly on your own, or as part of a team?
3. How long have you been doing this job or type of work?
4. What did you do before this job?
5. How much of your role involves working with Indigenous clients?
6. What aspects of your job do you find rewarding?
7. What aspects do you find difficult or stressful?

Possible examples:

- i. Community expectations
- ii. Travel
- iii. Clients for whom English is not their first language

Alcohol and drug issues

8. Can you tell me what kind of alcohol and drug issues you deal with in your job? For example, do you encounter intoxicated clients, do you get clients whose family members have drug or alcohol problems, or clients trying to give up smoking, things like that?
9. Some workers find dealing with alcohol and drug issues rewarding, but it also can be challenging. What is it like for you?

Training and Professional Development

Now I'd like to chat about training and professional development. By this we mean any training sessions, conferences, or networking or any other activities that help you develop in your job.

10. Could you tell me about the access you or other workers in your service have to relevant training?
11. Is there any additional training or professional development that you think would be valuable to you?
12. What sort of clinical supervision and debriefing opportunities are available to you?

Work Role and Work Conditions

13. Can you describe your work place and work conditions?

Possible examples:

- i. Physical work environment (rooms, noise, etc.)
- ii. Management expectations and support
- iii. Team and co-worker support and relations
- iv. Working hours / workload
- v. Being approached by clients out of hours
- vi. Reporting / paperwork requirements
- vii. Funding (if needed, prompt around sufficiency, security)

- viii. Pay
- ix. Career paths
 - x. Role clarity (Something like: “How clear is your role? Does it match with the tasks you have to do?”)
- 14. If you are comfortable in doing so, can you describe any experiences or observations you may have had of racism in the workplace, for example from management, colleagues, clients or other services.
- 15. How have these experiences impacted on you as a worker?
- 16. Dealing with work, family and community commitments can be hard for many people in the workforce. What's it like for you?

Cultural Issues

- 17. In the submissions and survey, one of the issues that came up was that cultural differences can be stressful when Indigenous and non-Indigenous ways of working, or ways of knowing, are different. What's this like for you?
- 18. Some workers also reported feeling stressed because of acceptance issues with clients, for example, younger workers working with older clients. What's this like for you?

Possible other examples:

 - i. gender issues with clients
 - ii. relationships with traditional healers
- 19. What impact do Indigenous clients' loss and grief issues have on you as a worker?
- 20. Has your organisation put in place any positive strategies that help or support workers - particularly in dealing with Indigenous drug and alcohol issues?
- 21. Do you think any of these factors we've talked about [recap for the participant if necessary] might be different for Indigenous and non-Indigenous workers, and if so, in what ways?

Wrap Up

- 22. Are there any other issues related to workers' wellbeing, stress and burnout that you would like to raise?
- 23. What for you are the most important points that you really want us to take away from today's session?

Provide participants with Bush Crisis line resources and local counselling contacts in case they have experienced any distress.

Check how the participant is feeling.

Appendix 5



Indigenous Alcohol and Other Drug Workers Wellbeing Project

Are you:

- 1) an Indigenous frontline alcohol and other drug worker or general health worker in an alcohol and other drug organisation or allied sector,

or

- 2) a non-Indigenous frontline alcohol and other drug worker or general health worker in an alcohol and other drug organisation or allied sector, and a substantial proportion of your client base are Indigenous,

... then we need you!

You are the best person to tell us about what factors in your job affect your health and well being.

What is involved?

We are looking for workers to participate in face-to-face interviews or focus groups (we will visit your workplace) to discuss what you find challenging or rewarding about your work, and other factors that affect your well being or causes stress at work.

No more than 1 hour of your time would be required.

What are the benefits?

This study aims to increase the understanding of systems, organisational and individual factors which negatively or positively contribute to the overall wellbeing of Indigenous health workers.

The results of this study will be made available to inform future workforce development initiatives that are undertaken by the Australian Government Department of Health and Ageing and other key organisations.

What are the risks?

We do not foresee any risks associated with you participating in this study. Some of the interview questions involve potentially sensitive topics. You do not have to answer any question that makes you feel uncomfortable. You are also free to stop the interview at any time.

How will we share the results?

We intend to present the results of this study to colleagues at conferences, workshops and other meetings, and publish the results in journals or other reports. The aim of publishing the results is to inform organisations and individual workers about effective ways to increase well being and reduce stress and burnout in the Indigenous alcohol and other drug workforce.

A report of the overall findings of the study will be publicly available through the Australian Government Department of Health and Ageing.

Who is NCETA?

NCETA is a research centre that works as a catalyst for change in the alcohol and other drugs field. The Centre's mission is to advance the capacity of human services organisations and workers to respond to alcohol and other drug related problems.

The research team are:

(L to R, top): Toby Freeman, Donna Weetra, Ann Roche, (L to R, bottom) Amanda Tovell, Alan Trifonoff.

Contact us

To get involved, please contact us at:

Email: donna.weetra@flinders.edu.au

Phone: (08) 8201 7538



Appendix 6

A Workforce Development Checklist for Indigenous Alcohol and Other Drug Workers

Little is known about factors that effect Indigenous alcohol and other drug workers' wellbeing, but, anecdotal evidence indicates that Indigenous workers are placed under considerable work pressure. The National Centre for Education and Training on Addiction (NCETA) has studied Indigenous alcohol and other drug workers' wellbeing, stress, and burnout. This project uses the NACCHO definition of Aboriginal Health:

“Aboriginal health” means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.

Background and Context

Indigenous Australians are at high risk of health and social problems associated with alcohol and other drug use. Indigenous Australians are often marginalised in terms of healthcare services and other forms of social inequities (e.g., income, housing, education, and employment). Compared to non-Indigenous Australians, a larger proportion of Indigenous Australians live in remote areas where health services are limited. Cultural differences can add to difficulties in accessing culturally safe healthcare and alcohol and other drug services.

Indigenous people are also under-represented in the health workforce. Indigenous people comprise 2.5% of the population, but represent only 1% of the health workforce. This places additional stress on Indigenous workers.

There have been few investigations into the wellbeing of Indigenous alcohol and other drug workers. There is also limited research on Indigenous workers' experiences of dealing with clients with alcohol and other drug issues and the impact that this may have on them as workers. Further to this challenge, Indigenous alcohol and other drug workers face in regards to their work is not isolated to client based service delivery. A resounding factor which contributes to stress and burnout is dealing with non-Indigenous staff in terms of racism, lack of knowledge of Indigenous culture and “lifeways”, and paternalistic attitudes.

Indigenous alcohol and other drug workers may experience a greater range of stressors and pressures in their work roles than non-Indigenous alcohol and other drug workers. The role of an Indigenous alcohol and other drug worker can involve an especially heavy burden. Further, the work that is undertaken by Indigenous alcohol and other drug workers is often complex and demanding, and can entail very personally relevant issues including:

- loss and grief
- trauma
- stigma, and
- social disruption.

To assist Indigenous alcohol and other drug workers and organisations to appropriately address some of these issues it's important to take a broad workforce development approach. To this end, the following checklists have been developed as a user-friendly tool.

Indigenous Workforce Development

The primary aim of Indigenous workforce development is to facilitate and sustain the Indigenous alcohol and other drug workforce by targeting organisational structures so that cultural needs and Indigenous knowledge is respectfully transferred into workplace policy and practice. Furthermore, Indigenous alcohol and other drug workers require structures which acknowledge their commitment to family and community.

“Indigenous workforce development is about taking a multi-faceted approach to address the range of historical cultural factors impacting on the ability of the Indigenous workforce to function with maximum effectiveness in responding to alcohol and other drug related issues. Indigenous Workforce development should have a systems focus, targeting individuals, their families and communities, as well as organisations and structural factors rather than just addressing education and training of individual Indigenous workers.”

Any attempt to comprehensively understand the experiences of Indigenous workers in the alcohol and other drug field must be understood from a historical context. An understanding of the history of colonisation and its ongoing impact on Indigenous Australians, including its contribution to alcohol and other drug use is essential. The policies and practices of past governments are also central to conceptualising contemporary issues faced by Indigenous alcohol and other drug workers. Failure to understand and acknowledge Indigenous issues within a historical context continues to be frustrating and hurtful to the Indigenous workforce.

A multi-level approach is needed as illustrated in NCETA's 6-level model shown in Figure 3. Figure 3 shows how each of these different levels of Indigenous WFD intervention involved inherently different issues. The 6-level model comprises:

- the individual
- the family
- the community
- the team
- the workplace
- the organisation

A guide to using the checklists

These checklists explore Indigenous alcohol and other drug worker related issues, and have been categorized into two checklists, one for Indigenous workers in Indigenous organisations, and another for non-Indigenous organisations. The checklists are broad ranging, but not exhaustive, incorporating some questions which may assist to consider cultural competencies.

Questions have been tabled for Indigenous alcohol and other drug workers to help identify both strengths and weakness in regards to :

1. Level of professional support for Indigenous alcohol and other drug workers
2. Level of organisational support for Indigenous alcohol and other drug workers
3. Levels of support from and to non-Indigenous workers in regards to supporting Indigenous alcohol and other drug workers.

Separate checklists have been developed for Indigenous alcohol and other drug workers depending on whether employed within an:

- Indigenous organisation, or
- Non-Indigenous organisation

Whilst there are broad questions relating to workforce developments which are relevant to both, questions relating to cultural competencies are presently asked in context of the work place. Experiences vary between Indigenous alcohol and other drug workers who are employed in either a non-Indigenous or Indigenous organisation.

The checklist No.1 for Indigenous workers in **Indigenous organisations** may be useful to:

- Discuss existing workplace policies in regard to bereavement, ceremonial, and cultural leave
- Evaluate cultural accountability of non-Indigenous staff to Indigenous staff
- Identify relevance of training, ongoing professional development
- Assess levels of organisational and managerial supports for Indigenous workers
- Determine whether Indigenous ways of working and knowledge are being incorporated into Indigenous alcohol and other drug practice
- Identify factors which may impact on Indigenous workers stress and burnout.

Appendix 6

The checklist No.2 for Indigenous workers in **non-Indigenous organisations** may be useful to:

- Open up discussion about the need for policies relating to bereavement, ceremonial, and cultural leave for Indigenous employees within non-Indigenous organisations.
- Evaluate cultural accountability of non-Indigenous staff to Indigenous staff
- Determine and address education and training needs of non-Indigenous staff
- To determine supports for Indigenous workers with regard to community consultation, and incorporating Indigenous ways of working.
- Assess levels of organisational and managerial supports for Indigenous workers
- Identify factors which may impact on Indigenous workers stress and burnout.

There may be other workforce development issues of particular relevance to specific situations. Nonetheless, these checklists provide a useful jumping off point in the development of positive and comprehensive cultural practices and approaches. They are also a useful workforce development training tool and can be used to instigate initial discussion and plans.

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Australian Institute of Health and Welfare. *Health and community services labour force 2006*. Canberra: AIHW. Cat no. HWL 43; 2009

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Henry BR, Houston S, Mooney GH. *Institutional racism in Australian healthcare: A plea for decency*. Medical Journal of Australia. 2004;180:517-9.

Gray D, Saggars S, Atkinson D, Stempel P. *Substance misuse and primary health care among Indigenous Australians*. Perth: Office of Aboriginal and Torres Strait Islander Health; 2004

NACCHO's Memorandum and Articles of Association as amended 9 March 2006 also from the National Aboriginal Health Strategy (NAHS) 1989.

Trewin D, Madden R. *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2005*. Canberra: Australian Institute of Health and Welfare 2005. Report No.: 4704.0.

An Indigenous Workforce Development Checklist No.1

Indigenous Alcohol and Other Drug Workers in Indigenous Organisations

1. Do you regularly consult with Elders in your community?
2. Does your workplace consult with community to identify current alcohol and other drug trends within specific Indigenous communities?
3. Does your workplace assess community needs and invest in developing services accordingly?
4. Do you feel your workplace is well accepted by the community?
5. Are Indigenous ways of working incorporated into alcohol and other drug programs in your workplace?
6. Are you involved in workplace planning, and community development processes?
7. Does your workplace have strategies to incorporate Indigenous knowledge into policy and procedures?
8. Does your organisation facilitate access to culturally relevant training / professional development?
9. Does your workplace have policies and procedures to ensure worker safety in working with clients?
10. Do you have an adequate bereavement / compassionate leave policy in your workplace?
11. Do you have an adequate ceremonial leave policy in your workplace?
12. Do you have an adequate leave policy in your workplace to participate in NAIDOC week celebrations?
13. Do your managers/supervisors support networking, building and maintaining community relationships?

14. Do your clients have access to culturally appropriate alcohol and other drug services?
15. Does your workplace have grievance procedures to deal with worker and/or client complaints?
16. Are you able to access cultural healing practices for clients and workers?
17. Do your managers/supervisors understand and support community obligation?
18. Does your workplace have policies and procedures to address racism?
19. Does your workplace give recognition to Indigenous knowledge, and lived experiences of Indigenous alcohol and other drug workers?
20. Are non-Indigenous managers/supervisors/co-workers culturally accountable to Indigenous workers?
21. Does your workplace have processes to recruit appropriate non-Indigenous staff?
22. Does your workplace have policies to ensure confidentiality?
23. Do have policies to employ culturally safe practices within your workplace?
24. Do you incorporate gender appropriate practices in your organisation?
25. Does your workplace have Indigenous specified positions?
26. Does your workplace support/create career paths for Indigenous alcohol and other drug workers?
27. Does your workplace have EAP (Emergency Assistance Program) for Indigenous alcohol and other drug workers to access counselling services?
28. Does your workplace have a high rate of staff turnover?
29. Does your workplace regularly evaluate programs and cultural work practices?
30. Do you have flexible work arrangements?
31. Do you participate in clinical supervision?
32. Do your supervisors/managers recognise signs of work stress in Indigenous workers?
33. Do your managers/supervisors encourage self-care activities to enhance worker wellbeing?
34. Do you have access to mentoring?
35. Does your job specification accurately reflect the task you undertake in your role?
36. Are you adequately supported by non-Indigenous co-workers?
37. Do you feel your salary is adequate for the work you do?
38. Do management/supervisors have realistic expectations of your work?
39. Do you have a manageable workload?
40. Do you regularly undertake performance appraisals?

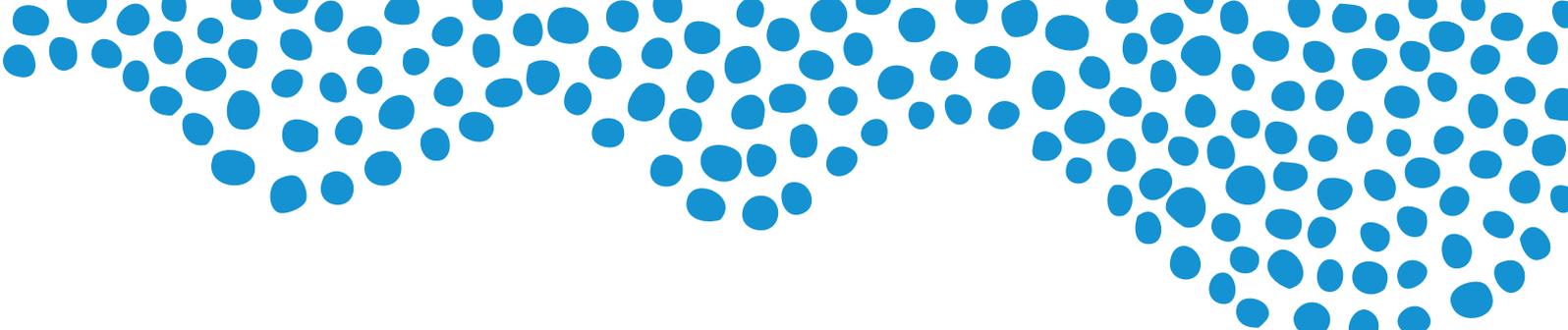
An Indigenous Workforce Development Checklist No.2

Alcohol and Other Drug Workers in Non-Indigenous Organisations

1. Is consultation with Elders facilitated in your workplace?
2. Does your workplace consult with community to identify current alcohol and other drug trends within their local Indigenous communities?
3. Does your workplace assess local community needs and develop services accordingly?
4. Do you feel your workplace is well accepted and accessed by the community?
5. Are Indigenous ways of working recognised and utilized in your workplace?
6. Are you involved in workplace planning, and community development processes?
7. Does your workplace have strategies to incorporate Indigenous knowledge into program development for Indigenous clients?
8. Does your organisation facilitate access to culturally relevant training / professional development?

Appendix 6

9. Does your workplace have policies and procedures to ensure worker safety when working with clients ?
10. Do you have an adequate bereavement / compassionate leave policy in your workplace for Indigenous workers?
11. Do you have a ceremonial leave policy in your workplace for Indigenous workers?
12. Do you have a leave policy in your workplace for Indigenous workers to participate in NAIDOC week celebrations?
13. Do your managers/supervisors support networking, building and maintaining community relationships?
14. Do your clients have access to culturally appropriate alcohol and other drug services?
15. Are you able to access cultural healing practices for clients and workers?
16. Do your managers/supervisors understand and support your commitment to community?
17. Does your workplace have policies and procedures to address racism?
18. Does your workplace give recognition to Indigenous knowledge, and lived experiences of Indigenous alcohol and other drug workers?
19. Are non-Indigenous managers/supervisors/co-workers culturally accountable to Indigenous workers?
20. Does your workplace have processes to recruit and retain appropriate non-Indigenous staff in Indigenous focuses alcohol and other drug programs?
21. Does your workplace have policies to ensure client confidentiality?
22. Do have policies to implement and evaluate culturally safe practices within your workplace?
23. Does your workplace understand gender appropriate practices for Indigenous clients?
24. Do you regularly undertake performance appraisals?
25. Does your workplace have an Indigenous employment strategy?
26. Does your workplace support/create career paths for Indigenous alcohol and other drug workers?
27. Does your workplace have EAP (Emergency Assistance Program) for Indigenous alcohol and other drug workers to access counselling services?
28. Does your workplace have a high rate of staff turnover?
29. Do you evaluate and report on cultural work practices within the organisation?
30. Do you have flexible work arrangements?
31. Do you participate in clinical supervision?
32. Do you have access to mentoring?
33. Do your managers/supervisors encourage activities to enhance worker wellbeing?
34. Does your workplace have grievance procedures to deal with worker and/or client complaints?
35. Does your job specification accurately reflect the task you undertake in your role?
36. Are you adequately supported by non-Indigenous co-workers?
37. Do you feel your salary is adequate for the work you do?
38. Do management/supervisors have realistic expectations of your work?
39. Do you have a manageable workload?
40. Do you regularly undertake performance appraisals?



Useful Websites and Resources

Websites

Australian Indigenous HealthInfoNet
<http://www.healthinfonet.ecu.edu.au/>

National Indigenous Drug and Alcohol Committee (NIDAC)
<http://www.nidac.org.au/>

Australian Government Health
Alcohol: <http://www.alcohol.gov.au/>
Tobacco: <http://www.quitnow.info.au/>
Illicit Drugs: <http://drugs.health.gov.au/>

Cooperative Research Centre for Aboriginal Health (CRAH)
<http://www.craah.org.au/>

Books

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