Chapter 15

Development of Community Based Alcohol and Other Drug (AOD) Workers in Remote Indigenous Communities in the Northern Territory

Carol Atkinson & Janice Jessen

The detrimental effects of excessive alcohol consumption by Indigenous Australians are well documented in the literature (Brady, 1995; d'Abbs, Hunter, Reser, & Martin, 1994). Contrasted with these findings is research that indicates that the majority of Indigenous people do not drink alcohol (Brady, 1991; d'Abbs et al, 1994; Watson, Fleming, & Alexander, 1988). It is generally agreed that while the majority of Indigenous peoples do not consume alcohol, those that do drink alcohol do so at harmful levels. This statement needs to be qualified further as it is not accurate to assume that all who drink do so in this manner. There is evidence to suggest that moderate drinking styles do exist for some Indigenous peoples (Blignault 1994; National Drug Strategy Household Survey, 1994, Watson et. al. 1988).

The estimated resident population for the Northern Territory, in June 1996, was 181,900, of which the Indigenous population comprises 27.2%. While most of the NT population live in the major centers of Darwin, Katherine, Nhulunbuy, Tennant Creek, and Alice Springs, the reverse is true for the Indigenous population, with 63% living in remote communities, outstations, and cattle stations (ABS, 1996).

A number of Indigenous communities have identified excessive alcohol consumption as an issue of significant concern to them, and have advocated the need for alcohol intervention and treatment services to be available in remote and rural communities. In line with these directions, the Northern Territory Government's Living With Alcohol (LWA) Program has the stated aim of increasing the capacity of Aboriginal communities to provide support and care services for people experiencing alcohol or drug problems (LWA, 2000). This aim includes community education and prevention strategies, early and brief interventions, and non-residential support services, including counselling and after-care services.

Social Context

A further element to be considered in the development of alcohol and other drug programs for Indigenous peoples, is the critical role the social group plays in excessive alcohol consumption patterns and subsequent interventions. For many Aboriginal people, the social construction of identity is determined primarily through belonging to an intricate and complex web of kinship networks, that are binding in a framework of mutual obligation, responsibility, and reciprocity (Bain, 1974; Brady, 1989, 1991; Collman, 1979; Sanson, 1980). In a drinking group where many family members are involved, these relationships, and the value placed on sociability, are critical factors to be considered in the process of behavioural change.

O'Connor (1984) coined the term 'contingent drunkenness,' which directly contrasts with the concept of alcohol dependence or addiction. It is not dependency on alcohol that results in the excessive consumption patterns, but what has been termed a 'group dependency.' Drinking, O'Connor argues, is tied in with kinship responsibilities, and is an important element of exchange, sharing, and belonging to the group. It is generally accepted that rejecting one's previous social networks is a difficult prospect for many people. This is arguably more difficult for Aboriginal people, when it

implies a repudiation of such binding relationships. That is a daunting prospect in a socio-centric culture that values relatedness and the maintenance of relationships. In essence, failure to participate in drinking networks that are composed predominantly of family and kin means rejecting family, hence challenging one's own social identity (Bain, 1974; Brady, 1974; Collman, 1979; Sansom, 1980).

Current service models

We will now consider a range of models to deliver alcohol and other drug services to remote communities. It is important to note that these models are neither mutually exclusive nor prescriptive. The three models include: Urban-based residential programs; the 'visitor-led' model; and remote community-based alcohol and other drug workers.

Urban-based residential programs model

Residential treatment programs require Indigenous people to leave their communities for up to three months, and sometimes longer, in order to undertake the 'treatment.' For many Indigenous people, this can cause significant difficulties, in terms of separation from family and community responsibilities. On the other hand, it is also argued that some separation allows some 'time out,' thereby enabling the person to get away from the group influences that are seen as an important component of excessive alcohol consumption.

Consideration of social context of drinking brings with it a recognition that conformity to the group's behavioural expectations is likely, which means, in essence, re-adopting its behaviour despite the best of intentions and influences of a treatment program. It is therefore argued that change is required at the level of the group, rather than at the level of individual pathology (O'Connor, 1984). Despite this, urban-based alcohol 'treatment' programs continue to focus on treating individuals, and then sending them back to an unchanged environment, "hoping against hope that maybe, somehow, things will be different this time" (O'Connor, 1984, p. 182). People are then further disadvantaged by having few, if any, supports or after-care programs to help them once they return to their communities.

'Visitor-led' model

In contrast to the above approach, this model relies on the provision of services to communities from agencies outside of the community. In respect to the provision of alcohol and drug services in remote communities, this is often at the discretion of the urban-based agency charged with providing the service. Community discussions about alcohol and other drug service delivery have also identified the agency's presence as being disjointed, ad hoc, and uncoordinated (Atkinson, 1998). According to one informant: "There is no point if they don't come out here regularly and often. Just now and again is no use - better not to come" (Atkinson, 1998).

This model of service provision can be likened to an 'all or nothing' approach, that is offered to suit the needs of agencies rather than those of communities. In reality, the service provision ends up as a reaction to a crisis, or is driven by the agency's agenda, rather than being designed to meet the needs of the community. According to one person, "there is a need for community-based services. Kardias [non-Aboriginal people] come and go and at the end of the day we are left with nothing. Or we end up with something we didn't want anyway" (Atkinson, 1998).

In essence, this approach fails to lead to the development of a permanent and ongoing resource for addressing alcohol and drug issues within remote communities. Reliance on a 'visitor-led' model of service delivery is the antithesis of building community capacity.

Remote worker model

To date, more attention has been paid to the above models of alcohol and other drug service provision, with less emphasis on the provision of services by local community-based workers. There is little doubt that remote community based alcohol and other drugs workers are in a pivotal position to create an environment that is more supportive for people to make behavioural change, without necessarily leaving the community. This can occur through the facilitation or extension of alcohol and other drug

prevention activities, and alternatives to drinking and drug taking, including an extension to support networks. Indeed, this is similar to one approach to address petrol sniffing in Central Australia, that was developed by the Healthy Aboriginal Life Team (HALT).

It is in that context that we now present a case study. It is an example of how one community in the NT has attempted to address substance misuse issues in their group. This case study discusses how the ideas emerged, provides a detailed overview of its progress to-date, and explores achievements and pitfalls identified in a twelve-month pilot phase.

Background to Case Study

Indigenous people in a few remote NT communities have, in recent years, been working with LWA Program staff to implement pilot projects that involve the establishment of community-based alcohol and other drug workers in their communities.

In general, these community workers have three main functions. Firstly, to raise awareness and educate community members about the ill effects of alcohol and other substances. Secondly, to provide support and care services, which includes the early identification of problems, the use of brief intervention approaches, appropriate referral mechanisms, and providing on-going support and after-care to people trying to change their behaviour. Finally, to facilitate the development and management of community-based activities, aimed at reducing substance related harm in communities.

Case Study

Context

The community is situated many hundreds of kilometres from the nearest NT town. It has an estimated population of 800-1000 people. The community already has a number of strategies in place to address alcohol-related harm. For example, it operates a community patrol, largely staffed by volunteer workers, to either prevent alcohol-related incidents from occurring (through its presence), or to intervene if alcohol-related disputes occur. The community also has a designated Aboriginal Community Corrections Officer (ACCO). The ACCO often works with people who have to face court as a result of their alcohol or drug consumption. The ACCO also supervises people who have been found guilty of lesser charges, and who are ordered by the court to complete a community service order. This worker does not, however, directly assist individuals to develop a plan to modify their drinking, or drug taking behaviour.

The community had, therefore, identified the need to provide people affected by substance misuse with access to support and care services in the community. People within this community were adamant that most community members would not leave the community to access an urban-based rehabilitation program to address their alcohol or drug problems, unless they were ordered to do so through the criminal justice system. Reasons given included the desire not to stay on another person's country, as well as having work, family, ceremonial, or other socio-cultural commitments.

In addition, people made it clear that going to 'town' was in fact, fraught with the additional danger of being in close proximity to the 'drinking family,' and the concomitant risk of succumbing to family pressure to drink with them. This situation is made worse by being in a town environment, where alcohol and other drugs are both cheaper to buy and more readily available.

Process

The community identified the need to employ local people as community-based alcohol and other drug workers, to facilitate the development and implementation of support and care services. This request was timely, in respect of the government's broad direction of supporting the development of skills and expertise in alcohol and other drug interventions, within remote communities. Supporting this particular community request was also considered important for the following reasons. Firstly, the Community Council was regarded as operating as a functional, representative and cohesive body and was keen to work in collaboration with a number of key players. Secondly the community was

making changes to its 'dry' community status, thus increasing the availability of alcohol in the community. This was partly to minimise the migration of young people to town as a result of being unable to access or consume alcohol in the community. It was also an attempt to curb drink-driving between the community and surrounding liquor outlets. Finally, the Community Council was cognisant of the notion that the alcohol problems would 'not just go away,' and therefore approaches other than total prohibition were required to address these complex issues.
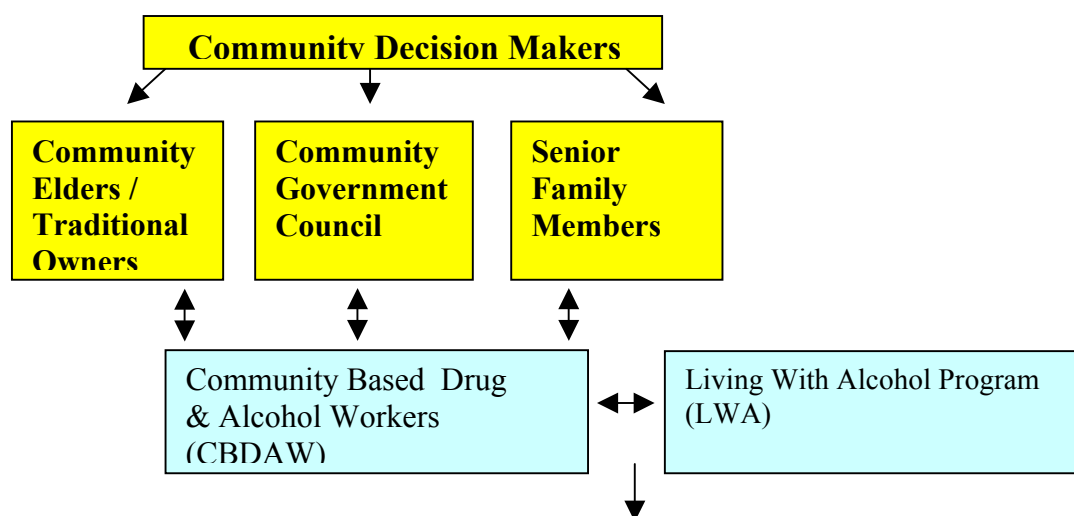
The Community Government Council (an incorporated body that consists of local community members who have been elected by the community), in collaboration with the Council Clerk and LWA, prepared a submission for a twelve month pilot project. Funding was sought to assist the Council, to establish local programs as well as to supplement the Community Development Employment Program (CDEP) wages. (CDEP is a 'work for the dole program' whereby people, in receipt of social security benefits, undertake various community oriented projects in their community. They receive payment in the form of the social security entitlement). The community's commitment to the project is reflected in the Community Councils' decision to offer CDEP positions and associated management and administrative support to the project.

Community decision making processes
From Figure 1, the project operates within a consultative framework that recognises Community Elders, Traditional Owners, Senior Family Members, and the Community Council, as the people who are the decision-makers within the community. Overall, the model is based on an assumption that alcohol and other drug education, training, and community programs, are best provided by skilled local people who are constantly present in the community. Local people are also able to utilise existing community structures, in a way that is culturally appropriate and that can best meet the community's needs. The community workers are supported by the LWA Program to provide the community decision-makers with knowledge of alcohol and other drug interventions, in a way that promotes informed decisions with respect to the development of community programs. Commitment to the project by the decision-makers is fundamental to the success of this project.

The community was successful in securing funds through a community grant from the LWA program, that is administered through the Community Council. In working with the community decision-makers in this way, the project also aims to create links between the alcohol and drug workers and other community initiatives. This is in recognition that substance misuse issues and interventions cannot operate in isolation from the broader public health issues of health, housing, education, employment, nutrition, land, and the legal system.

Figure 1
A community decision-making model

```
                  ┌──────────────────────────────┐
                  │  Community Decision Makers    │
                  └──────────────────────────────┘
          ↙                  ↓                 ↘
┌──────────────┐   ┌──────────────┐   ┌──────────────┐
│ Community    │   │ Community    │   │ Senior       │
│ Elders /     │   │ Government   │   │ Family       │
│ Traditional  │   │ Council      │   │ Members      │
│ Owners       │   │              │   │              │
└──────────────┘   └──────────────┘   └──────────────┘
       ↕                  ↕                  ↕
   ┌──────────────────────────────┐   ┌──────────────────────────┐
   │ Community Based  Drug        │   │ Living With Alcohol      │
   │ & Alcohol Workers            │↔  │ Program (LWA)            │
   │ (CBDAW)                      │   │                          │
   └──────────────────────────────┘   └──────────────────────────┘
                  ↓
```

The workers and LWA work under the direction of the community decision makers to:

- Discuss support and care concepts and identify possible strategies;
- Conduct workshops with decision making group and other community agencies; and
- Develop and implement support and care strategies and programs.

The project is now halfway through its pilot phase, and has not been able to keep to its original time-line. This can primarily be accounted for by the continual changes in the community's infrastructure. That is most notable in the elected Community Council, which in a 12-month period has undergone three complete changes, including three presidents. These difficulties have been compounded by the occupation of the position of Community Council Clerk by five different people. To date, there have also been four accountants and three CDEP coordinators employed in the community, all of whom have been involved in the project under discussion. This means that much time is spent in briefing people on the project.

Issues arising from implementation
In addition to such changes to the Community Council, one of the key issues to consider in the implementation phase is workers' skill level. Given a wide range of needs and concerns in the area of substance misuse, the skill and knowledge demands are high. Whilst there are many strengths that workers have brought to the position, there will be some areas requiring further input. It is encouraging to note that the workers have recently expressed a desire to undertake a specific alcohol and other drug training course.

A further issue, common to all Indigenous communities, is the delay in implementation that can occur through the occupation, by community members, in other community business, such as ceremonies and, unfortunately, deaths and subsequent "sorry business."

Achievements
Tobacco as a priority issue
Even in the early stages of the project, some positive changes and initiatives are evident. One of the most notable outcomes has been in the identification of tobacco smoking as an issue of concern.

Tobacco smoking rates for the Indigenous population are higher than for the general population (ABS, 1997; National Drug Strategy Household Survey, 1994; Watson et al, 1988), and pose a significant health risk. However, tobacco smoking is generally not identified as a priority issue to be addressed by Indigenous communities. Therefore, the community's request for training in this area, and their willingness to implement a community awareness and education campaign, including 'smoke-free' areas, is highly encouraging. This issue has been identified largely through a small-scale community survey that was undertaken by the workers.

Working collaboratively
Collaborative working arrangements are beginning to emerge with the alcohol and other drug workers and other workers in the community. This has resulted in the identification of some shared resources and issues, particularly in respect to alcohol consumption and road safety issues. Another example of collaboration is in relation to the concern for women of childbearing age, who are using alcohol or other drugs. This has resulted in the development of a draft "flip-chart" about alcohol and other drugs during pregnancy, and whilst breastfeeding. This resource has been discussed with women in the community; is currently being adapted; and will ultimately be used by both the workers and the Community Health Centre.

Early support and care activities
With respect to the provision of brief interventions, the workers have been providing other community members with information on substances (alcohol, tobacco, and marijuana) through the use of video materials, pamphlets, discussions, and posters. This initiative needs more time, training, and discussion, before it can be developed into a support and care program.

Support network for remote community based alcohol and other drug workers across the Northern Territory

Thus far, it is clear that alcohol and other drug services in remote communities range from prevention through to the support and care of people who require help to address substance misuse. Through an LWA strategy that involves supporting remote community based workers, it has become apparent that people in remote communities are already providing such services at one level or another (LWA, 1999). The act of recognizing these community actions, and of providing support to assist communities to meet their needs, including in the provision of support and care interventions, fits within a community development model that has empowerment and the development of local structures as its overarching principle (Eade, 1997).

In communities across the NT, workers are employed under the CDEP scheme, or other employment or training schemes, as 'alcohol workers' or allied workers, such as night patrol workers, wardens, and safe-house workers. Many other people are working in a voluntary capacity, with very few being paid a full-time wage. In the main, most workers are not generally employed though the health system, and are professionally isolated, particularly from other workers who operate within a 'community' framework.

To complement the previously discussed case study of assisting a community to employ local community-based alcohol and other drug workers, LWA has identified the need to bring community workers together on a regular basis, to discuss the issues they face, and to provide them with support. Indeed, as one person stated during a series of community discussions, "workers need support - they get too tired from hitting their head against the wall. The problem is too big for one person." (Atkinson, 1998). Generating a support network between people who are working within similar circumstances is the central purpose for holding workshops for remote community workers (LWA, 1999).

A number of regional workshops have been held, and they aim to build on the existing knowledge and skill base. Whilst the workshops provide workers with access to training, they are not simply about meeting a training need. They also provide workers with an opportunity to discuss issues whilst

generating support mechanisms and networks. The evaluations, thus far, have highlighted the importance of this approach, and a newsletter has been established in response to requests for on-going contact (LWA, 1999).

Partly as a way of facilitating support between workers, this newsletter also contains the contact details of the workshop participants. Whilst it is not in the scope of this paper to discuss that particular strategy in any more detail, it is important to mention it because it helps to minimise the isolation that workers experience, in what is arguably a very complex area to be working.

Conclusion

This paper has attempted to provide a brief overview of a number of relevant issues pertaining to Indigenous alcohol and drug usage; a discussion of the limitations of current service delivery arrangements; and an exploration of a new initiative which involves the employment of alcohol and other drug workers in remote communities. A detailed case study outlines how this has been achieved in one community, and a discussion of regional fora of alcohol and other drug workers in remote communities further details what is involved in this ambitious program.

It is important to note that this paper is not arguing for a remote model at the expense of the other models. Rather the authors are of the view that there is significant value in the further development of the community model. While being in the pilot phase for a 12-month period, the achievements to date are encouraging, and need to be seen in terms of a longer-term strategy. This approach has resource implications in terms of equity across remote communities, and requires the allocation of resources, so that communities that identify the need to address substance misuse issues can do so in ways that are appropriate to the community.

This project is based on community development principles, and builds on identified community need. It has strong community decision making and participation processes, and seeks to strengthen community capacity to address its own problems in culturally appropriate ways.

Summary

The aim of this paper is to document community development initiatives undertaken to address substance misuse issues in remote Indigenous communities in the Northern Territory (NT). This paper is describing work in progress that primarily focuses on the early stage of an evolving community development process to provide alcohol and drug services, particularly in the "treatment" domain, in remote NT communities. Treatment in this context refers to counselling and various support and caring activities, which can take place in a variety of settings, such as a residential facility, a health clinic, a women's or community drop-in centre. The context is community development as the paper explores options to address a community defined need to have effective alcohol and other drug programs available to people living in remote communities.

Acknowledgement

References

ABS (Australian Bureau of Statistics). (1996). *Census of Population and Housing: Counts by age/sex for selected areas in the NT*. Canberra: ABS Catalogue number 2018.7.

ABS (Australian Bureau of Statistics). (1997), *National Health Survey: Summary Results, Australian States and Territories 1995*. Canberra: ABS Catalogue number 4368.0.

Atkinson, C. (1998). *Community consultations*. Darwin: Unpublished Report, Living with Alcohol Program.

Bain, M. S. (1974). Alcohol use and traditional social control in Aboriginal society, In B.S. Hetzel, (Ed.), *Better health for Aborigines? Report of a National Seminar at Monash University* (pp. 42-51). St Lucia, QLD: University of Queensland Press.

Blignault, I. (1994). *Learning from non-drinkers: A study of alcohol use and abstinence among Aboriginal people in Perth*. Perth, WA: Department of General Practice.

Brady, M. (1995). *Giving Away the Grog: Aboriginal accounts of drinking and not drinking*. Canberra: Commonwealth Department of Human Services and Health.

Brady, M. (1991). Drug and alcohol use among Aboriginal people. In J. Reid & P. Trompf (Eds), *The health of Aboriginal Australia* (pp. 173-217). Sydney: Harcourt Brace Jovanovich.

Brady, M. (1990). Indigenous and government attempts to control alcohol use among Australian Aborigines. *Contemporary Drug Problems*, *17, 2*, 195-220.

Brady, M. (1989, July). *Drug, set and setting: The Aboriginal context*. National Drug and Alcohol Research Seminar, Sydney.

Collman, J. (1979). Social order and the exchange of liquor: A theory of drinking among Australian Aborigines. *Journal of Anthropological Research 35*, 208-224.

D'Abbs, P., Hunter, E., Reser, J., & Martin, D. (1994). *Alcohol-related Violence in Aboriginal and Torres Strait Islander Communities: A literature review*, *(Volume 8)*. Canberra: National Symposium on Alcohol Misuse and Violence, APGS.

Eade, D. (1997). *Capacity-building: An approach to people-centred development*. London: Oxfam.

LWA (Living with Alcohol). (1999, May). *Workshop for drug and alcohol workers in remote communities*. Darwin: Report Living With Alcohol Program.

LWA (Living with Alcohol). (2000). *Living With Alcohol in the Northern Territory: A framework for action to reduce the costs of alcohol-related harm to the Northern Territory 1991-2000*. Darwin: Northern Territory Government.

Menzies School of Health Research. (1991). *HALT: An evaluation*. Darwin: MSHR.

National Drug Strategy Household Survey. (1994). *Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994*. Canberra: Australian Government Publishing Service.

O'Connor, R. (1984). Alcohol and contingent drunkenness in Central Australia. *Australian Journal of Social Issues*, *19*, 173-183.

Sanson, B. (1980). *The camp at Wallaby Cross: Aboriginal fringe dwellers in Darwin*. Canberra: Australian Institute of Aboriginal Studies.

THS (Territory Health Services). (1996b). *NT Aboriginal health policy*. Darwin: Territory Health Services.

Watson, C., Fleming, J., & Alexander, K. (1988). *A survey of drug use patterns in Northern Territory Aboriginal communities: 1986-1987*. Darwin: Drug and Alcohol Bureau, NT Department of Health and Community Services.