

## 1. BACKGROUND

The 2004 National Drug Strategy Household Survey indicates that about nine out of every 10 Australians, aged 14 years and over, have tried alcohol at some time in their lives, with 84 per cent reporting drinking alcohol in the 12 months leading up to the time of the survey.<sup>1</sup> There is evidence that the majority of Australians who drink alcohol do so at risky levels, such as to intoxication.

People who drink at risky and high-risk levels are at serious risk of short- and long-term health problems and/or premature death.<sup>2</sup> Alcohol-related health effects include injuries, overdose, drowning, and serious conditions including cirrhosis of the liver, pancreatitis, heart disease, kidney disease, blood disorders, brain damage and various cancers.<sup>3</sup>

A significant number of drinkers are also temporarily or permanently disabled from alcohol-related illnesses, injury or attempted suicide.<sup>4</sup> The consequences of alcohol-related harm therefore impact greatly on the financial, social, intellectual, cultural and spiritual wellbeing of individuals, families and communities.<sup>5</sup>

Several surveys have shown that, while Indigenous Australians are less likely than non-Indigenous Australians to consume alcohol, those that do are more likely to drink at risky and high-risk levels.<sup>6</sup> Indigenous Australians are thus more likely to experience the adverse effects of alcohol consumption than their non-Indigenous counterparts – with commensurately higher levels of associated health and social problems within the Indigenous community.

- Between 2000 and 2004 an estimated 1,145 Indigenous Australians died from alcohol-related injury and disease.<sup>7</sup> The average age of death was about 35 years. Indigenous men died from alcohol-related causes at seven times the rate of non-Indigenous men. Women died from causes related to alcohol use at 10 times the rate of non-Indigenous women. Most (210 out of 323 deaths) were due to cirrhosis of the liver.

- Indigenous men were hospitalised for diagnoses related to alcohol use at five times the rate of other men, and Indigenous women were hospitalised for alcohol-related conditions at four times the rate of other women. Three-quarters of these hospitalisations had a principal diagnosis of mental and behavioural disorders due to alcohol use, the most common of which was acute intoxication.<sup>8</sup>

The higher levels of substance misuse and related harm among the Indigenous population are *both a consequence and a cause* of social and economic disadvantage.<sup>9</sup> See Chapter 2, 'Alcohol in an Indigenous context' below for further discussion of these issues.

### **Purpose of this resource**

The *Alcohol Treatment Guidelines for Indigenous Australians* have been developed to give guidance to healthcare providers working with Indigenous clients who are adversely affected by alcohol consumption.

The guidelines are designed to be a reliable source of information and direction that has sufficient flexibility for appropriate situational adjustment.

As such, this resource is offered as a guide for how a healthcare provider might:

- diagnose and provide appropriate treatment for Indigenous clients with alcohol-related problems
- recognise when clients are affected by and need treatment for more than one substance or medical problem
- communicate with and support clients who wish to stop drinking or reduce their alcohol consumption
- provide clients with appropriate health information and resources that may help them minimise short- and long-term alcohol-related effects on their health.

It is important to keep in mind that addressing the problem of alcohol consumption may address the underlying cause of the alcohol related issues. Accordingly, these guidelines also discuss situations where a holistic approach to treatment is required. The challenge for healthcare providers is to achieve the best clinical outcome for their clients while being sensitive to the needs of the wider community.

## Principles upon which this resource is based

These guidelines are based on the following principles:

- 1) All Indigenous clients of all health services have the right to expect and receive treatment for alcohol and other drug problems that is culturally appropriate professional and non-judgmental and uses best practice models.
- 2) Indigenous Australians have diverse cultures, histories and life experiences. There is no 'one size fits all' remedy for alcohol-related problems experienced by individuals or communities and no single approach is necessarily appropriate or suggested.
- 3) Indigenous peoples' worldviews in relation to health and wellbeing must be recognised and respected. Healthcare providers in particular need to understand this. Indigenous Australian definitions and experiences of health are holistic.<sup>10</sup>

*Health is 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. Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.<sup>11</sup>*

- 4) The interventions of healthcare providers must complement strategies being implemented by Indigenous communities

themselves. This approach will have the greatest chance of success.

*Substance misuse interventions ... are most effective when: staff have an understanding of the causes and consequences of misuse, the readiness of individual clients (or communities) to change, the range of interventions and their availability; and when a systematic, holistic approach to the problem is employed. Importantly, this requires an adequate and appropriately trained health workforce.<sup>12</sup>*

- 5) The alcohol-related problems experienced in Indigenous communities must be understood in the context of the ongoing impact of colonisation. Healthcare providers must avoid 'blaming' and 'shaming' Indigenous people for the consequences of colonisation. The trauma from dispossession and disempowerment that has contributed to alcohol and other drug use must be recognised. If the level of substance misuse among Indigenous people is to be reduced, there needs to be a concerted effort to address both substance misuse itself and the underlying social determinants of such misuse.

## How this resource was developed

It is important to note at the outset that there is limited evidence regarding cross-cultural care and communication, and the extent and effectiveness of treatment and intervention approaches to alcohol use and misuse among Indigenous people. There is also limited evidence on the incidence and extent of alcohol use and misuse that comprehensively addresses issues across the Indigenous population.

The range of interventions for Indigenous substance misuse problems has increased. However, few programs and interventions for Indigenous substance misuse have been adequately documented and even fewer have been evaluated. Many evaluations that have been attempted are not culturally

appropriate, which has led to misinformation and often produced more questions than answers.

### Sources of material

These guidelines were developed as an extension of the ideas, information and issues set forth in the *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003–2009* and *The grog book*.<sup>13</sup> The development methodology also included using key background documents, conducting a comprehensive literature review, undertaking a review of health-related clinical guidelines being considered for development, consulting with key stakeholders and seeking input from a National Clinical Reference Group.

For primary background information, the guidelines drew upon *The treatment of alcohol problems: A review of the evidence*, *Guidelines for the treatment of alcohol problems* and *National recommendations for the clinical management of alcohol-related problems in Indigenous primary care settings*.<sup>14</sup>

The literature review was limited to research and other relevant documents (grey material) published in 2004 and 2005. It was conducted using a keyword search for the terms 'Aboriginal', 'Australia', 'Indigenous' and 'alcohol'. Databases searched included PubMed, Blackwell Science by Synergy, Journals @ Ovid, ProQuest 5000 and Expanded Academic ASAP. Grey material included relevant reports, monographs and clinical guidelines. The grey material databases searched were the Drug and Alcohol Services South Australia Library, Australian Indigenous HealthInfoNet, Australian Institute of Aboriginal and Torres Strait Islander Studies, National Library of Australia, National Drug Research Institute, Indigenous Australian Alcohol and Other Drugs Bibliographic Database, and the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet).

Formal consultations were held with a range of key stakeholders, including Indigenous and non-Indigenous healthcare providers,

community members, clinical specialists in mental health and pharmacology, and alcohol-related educators and researchers. Stakeholder consultations took place in several rural, remote and urban locations across Australia.

### **Who these guidelines are for**

These guidelines have been developed for a wide range of healthcare providers located in urban, regional, rural and remote areas. The intended audience includes Indigenous and non-Indigenous healthcare providers who have been trained through universities, hospitals and community health organisations, as well as those who may have received minimal (perhaps on-the-job) training and those who are currently undertaking primary health care certificates.

They were also developed for Aboriginal Health Workers working in general hospitals and in community health or specialist services such as mental health, social and emotional wellbeing, diabetes management and education, sexual health, and alcohol and other drug services. The guidelines will be useful to Indigenous and non-Indigenous doctors, nurses, social workers, project officers, drug and alcohol clinicians, mobile patrol staff, sobering-up unit teams and clinic managers, to name a few.

## 2. ALCOHOL IN AN INDIGENOUS CONTEXT

These guidelines have been developed to help healthcare providers give the best care possible to Indigenous clients who are experiencing alcohol-related problems. Addressing alcohol-related issues with Indigenous people requires approaches that respond to both the underlying determinants and their causes. Therefore, in addition to clinical guidance, it is essential for healthcare providers to have an understanding of the scope of and the context for alcohol misuse in the Indigenous community.

### History, health and alcohol

The underlying causes of the current health status and the prevalence of substance related issues in Indigenous communities are complex. Ill health and alcohol use and misuse among Indigenous people cannot be explained simply by characteristics of individual people. Instead, these issues need to be understood in the historical contexts of colonialism and dispossession, and the contemporary contexts of social factors such as institutional racism and poverty.<sup>15</sup> Indigenous peoples' feelings of despair and helplessness, and their use of alcohol to alleviate these feelings, are a consequence of the marginalisation experienced in the past and present.

During the late 19th and early 20th centuries strategies were introduced in Australia to 'manage' the Indigenous population. The overriding policy objective was assimilation. For example, Indigenous groups were removed from traditional lands to Christian missions and mixed-race children were placed into European care (these children are known as the Stolen Generation). These strategies not only produced dubious social outcomes, but also exposed Indigenous communities to other unexpected risks for which they were poorly prepared, such as alcohol, tobacco and European diseases.

Efforts to address these issues have had limited success for example:

*In 1989 the National Aboriginal Health Strategy (NAHS) Working Party identified alcohol and other substance misuse as one of the major health problems facing Aboriginal people and emphasised that it should be addressed in the context of improving clients' social and emotional wellbeing. Although the Working Party did not set any specific targets, it identified a number of key objectives – including measures to address substance misuse. A 1994 evaluation of the NAHS (which grew out of the Working Party's report) found the Strategy was never effectively resourced or implemented and – although there had been some improvements – Aboriginal health status lagged far behind that of the wider Australian population.<sup>16</sup>*

The concerns about the health status of the Indigenous population continue. As recently as 2007 the Australian Medical Association reported that the life expectancy of the Indigenous community was up to 17 years less than what was expected for the rest of the Australian population

Several other surveys have shown that, while Aboriginal and Torres Strait Islander peoples are less likely than non-Indigenous Australians to consume alcohol, those that do are more likely to drink at risky and high-risk levels.<sup>17</sup>

There is a correlation between domestic violence and drug and alcohol use in Indigenous communities, with 70 to 90 per cent of assaults being committed under the influence of alcohol and other drugs.<sup>18</sup> The nexus between alcohol related issues, extreme and violent behaviour within the Indigenous community and exposure to the criminal justice system continues in a “vicious cycle”.

## Breaking the cycle

The Indigenous community has worked hard to raise awareness of the effects of the long history of socio-economic deprivation. It is the historical treatment of Indigenous people that is linked to their feelings of exclusion and hurt and in turn to alcohol related issues and adverse health outcomes.<sup>19</sup>

The positives of the strong cultural background and values of the Indigenous community must be used to the best advantage of the provider. Strong families and communities that are motivated to protect children and young people and encourage them to access education and employment opportunities, quality health care and a decent standard of living. Many of the illnesses affecting the Indigenous community, including those related to problem alcohol use, have only been relevant to the Indigenous community since the arrival of European society. Traditional values maintained the health and culture of Indigenous Australians for many thousands of years prior to the arrival of European society. These values must be tapped by healthcare providers.

Healthcare providers need to appreciate and understand that they will be dealing with a range of complex alcohol related issues exacerbated by poor health, a history of mistrust and exclusion and often low motivation. In addressing these issues, healthcare providers need to consider several domains of Indigenous wellbeing. These include:

- spiritual
- cultural
- social
- psychosocial
- physical.

Providing care that incorporates awareness of these domains will help to improve the health and wellbeing of Aboriginal and

Torres Strait Islander people, and enhance responses to alcohol-related issues. To achieve this, healthcare providers must actively engage with Indigenous people and organisations, and other care professionals, including counsellors, cultural consultants and mental health workers.

### **Spiritual**

Spirituality is the foundation of Indigenous peoples' identity. Spirituality binds and connects Indigenous people to one another and to their land. The lives of Indigenous people today reflect a spiritual connection to all things (MacKean 2005) This strong spiritual bond provides grounding, a sense of purpose in life and a space for healing, all of which are important in any response to alcohol-related issues with Indigenous people.

Understanding this spirituality will help healthcare providers to act appropriately and establish trust and rapport. Many of the strategies developed to improve health will be more accepted if they are culturally sensitive, focus on the wellbeing of the individual and are directed at rebuilding traditional connections in consultation with the community.

### **Cultural**

Australian Indigenous cultures are amongst the oldest surviving cultures in the world and are closely linked to land, sea and sky. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes as well as ways of living.

Since colonisation, Indigenous cultures have been heavily influenced by other cultures, particularly European culture, and in many cases that influence has not been positive. Indigenous people have had to change and adapt over time. These changes have resulted in many losses in connections to languages, land and family, all of which are central to Indigenous cultures.

Healthcare providers will benefit from partnering with the Aboriginal community controlled health sector, social and emotional wellbeing programs for Indigenous people and national programs such as Link-Up, aimed at reconnecting Indigenous people with family and culture. Cultural identity programs are useful in this context.

## Social

Family and kinship networks are fundamental to Indigenous life. These networks make up the historical and contemporary contexts to the social environments in which Indigenous people live. Many Indigenous families and individuals are struggling to determine how to reconcile Indigenous status with the new non Indigenous Australian society and way of life, and empower themselves.

*Social and emotional wellbeing is a priority because it is strongly linked with the impact of colonisation. It is also linked with trauma, loss, grief and past government policies which brought about the separation of children and families, the loss of land, culture and identity, social inequality, stigma, racism and ongoing losses.<sup>20</sup>*

## Psychosocial

Alcohol use can be viewed as an attempt to relieve the pain, anger and grief experienced by Indigenous people arising from the legacy of colonisation, marginalisation and racism in society, and despair arising from dispossession from land, culture and family, also contribute to the use of alcohol.

Identity, cultural pride, and sense of self and belonging are important to Indigenous people in their own communities, and in Australian society today.

Programs should be developed which respect traditional values and are empathetic, without being patronising. This sense of cultural pride can be leveraged to develop holistic programs not just addressing alcohol related issues.

## Physical

Following colonisation, many Indigenous people have been denied their traditional healthy diet and lifestyles. The introduction of foreign diseases, foods, and psychoactive substances such as tobacco and alcohol, also contributed to the current poor health of Indigenous people, and alcohol related problems seen today.

The likelihood of being able to retrieve this traditional lifestyle is low, but cultural values and many practices continue to be strong to this day, and should be used to influence those requiring treatment for their drinking issues.

Healthcare providers need to consider the holistic needs of their client, and sometimes the wider family group.

### 3. CULTURALLY RESPECTFUL HEALTHCARE

The need for greater cultural awareness in the development and provision of healthcare services to improve the health and social outcomes of Indigenous Australian populations is widely recognised.<sup>21</sup> Working effectively with Indigenous people requires healthcare providers not only to acknowledge history and appreciate diversity, but also to examine their own perspectives on health, other cultures, belief systems and the ways individuals communicate. Healthcare providers need to accept their responsibility provide the best care they can. They should not let their biases and stereotyping affect their decision making in respect of their clients.

This chapter provides a brief introduction to providing culturally respectful healthcare to Indigenous clients, families and communities affected by alcohol-related problems. It should not be considered a definitive source of information and should be supplemented with guidance from Indigenous and other key people who live and work in the locality of your service. The information is presented in two sections:

- developing culturally respectful healthcare settings
- cross-cultural communication in healthcare settings.

For cases where information about specific cultural considerations is needed, refer to the resources section in Part IV: Resources and contacts. The list of contacts is provided who may be able to help with more difficult cases.

**KEY TERMS IN CULTURALLY RESPECTFUL HEALTHCARE****Cultural awareness**

Cultural awareness is having knowledge and understanding of Indigenous history, values, belief systems, experiences and lifestyles. It is not about becoming an 'expert'; rather it is about being aware of the potential for differences, appreciating and understanding differences, accepting that differences exist and how these difference will affect your relationship with the Indigenous community

Cultural awareness is also about understanding traditional Indigenous values and the effect those values have had in developing the Indigenous society we now have.

Cultural awareness also involves personal reflection about one's own culture, biases, and tendency to stereotype.<sup>22</sup>

**Cultural competence**

Cultural competence refers to a healthcare provider's capacity to provide effective care to a client when the two have different cultural backgrounds. Cultural competence involves the healthcare provider integrating their knowledge of Indigenous culture into the clinical context to bring about better health outcomes for their clients. This is with the ultimate aim to reduce the institutional racism that maintains current Indigenous health standards.<sup>23</sup>

**Cultural safety**

Cultural safety refers to a client's perspective on and experience with a healthcare provider. Clients need to feel that their healthcare provider has acknowledged and respected differences of cultural identity, acknowledged the power relationship between healthcare provider and client, and attempted to reduce inequality. Culturally safe practice can only be fully achieved when the non-Indigenous healthcare provider undertakes a continual process of reflection on

their own cultural identity and recognises the impact their culture has on their own health practice.<sup>24</sup>

Unsafe cultural practice is any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual. Clients who feel unsafe and who are unable to communicate effectively may not receive the medical treatment they need.

## Developing culturally respectful healthcare settings

### Why culturally respectful healthcare settings are essential

Although many Indigenous clients prefer to attend Aboriginal Community Controlled Health Services, this is not always the case or indeed always possible. Clients may choose to see their local general practitioner for some health issues and a local Indigenous health service for others, or they may choose to exclusively use one or the other. Sometimes they are required to attend a city or regionally based hospital or a specialist health service some distance from their community.

In all cases it is important that the client's right to choose their service providers is respected and that mainstream services are encouraged to find ways to offer culturally respectful, accessible and acceptable services. If Indigenous clients feel unable to seek or accept treatment or prevention and health promotion services because they consider mainstream services to be culturally unacceptable, a much greater social, physical, cultural and economic cost will affect the client and their families, as well as the wider community.

The relationship between mainstream health services and Indigenous people has been generally poor. Indigenous people continue to be misunderstood, misrepresented and mistreated – often through stereotyping. All health providers in services

accessed by Indigenous people need to be mindful of all underlying issues and may need to be an advocate to ensure that treatment is appropriate and balanced with the needs of the community. For example an explanation may be needed why a large number of people may accompany a client to a healthcare facility.

Healthcare providers and health services should make a commitment to becoming culturally competent, supporting the efforts of Indigenous colleagues, making the physical environment welcoming and being prepared to speak as an advocate in the interests of best health care.

### **Indigenous people and the importance of family**

It is critical that healthcare providers have an understanding of the importance of family and establish family relationships. The ability to use influential family members to assist in treatment design will be very useful.

Indigenous people have a complex system of family relationships, where each person knows their kin and their land. These extended family relationships are the core of Indigenous kinship systems and determine where a person fits into the community. Kinship defines roles and responsibilities for raising and educating children and structures systems of moral and financial support within the community.

Non-Indigenous healthcare providers who do not understand the importance of kinship, as constructed by Indigenous Australians, may be frustrated in their efforts to provide their clients with effective care.

It is important that healthcare providers recognise and understand that whether they live in urban, rural or remote communities, many Indigenous people maintain strong traditional ties with others through 'auntie', 'grandmother', 'uncle', 'brother', 'sister' and 'cousin' relationships. Traditional kinship rules may determine who can give and receive information about a family member, and who can

make decisions on behalf of another. For example, decisions about a child's health treatment may need to be made in consultation with specific family members, who may or may not be the birth parents or direct next of kin. An Indigenous client may therefore present to your clinic or service alone or with one or more family members.

To support contemporary kinship relationships, health services and individual healthcare providers need to be flexible and find ways of providing the best health service to Indigenous clients. These may include:

- having more than one chair available in consulting rooms to enable family or others to stay with the client
- advocating on behalf of the client to allow their choice of support people to be present during physical examinations and medical procedures
- ensuring family members or significant others are welcomed and respected.

### **Providing a culturally respectful setting**

The ability of healthcare providers to provide an environment or setting which respects the Indigenous community values will have a direct correlation with care delivery. Failure to provide this will adversely affect chances of success.

A review of the physical environment may serve to improve accessibility and acceptability of your service to Indigenous clients. You need to consider the diversity of Indigenous clients and groups using your service, and think about the following questions:

- Is the signage in your service culturally appropriate for the local Indigenous community?
- Can Indigenous clients who do not speak or read Standard English easily understand the signage in your service?
- Will displayed artwork or signage be considered acceptable to both Indigenous men and women?

- Is signage displaying instructions, such as ‘no bad behaviour’, done in a non-judgmental way? If signage is not accompanied by community education about the role and philosophy of your service it may not be accepted or have the impact that you intend.
- Does the artwork on display reflect the particular Indigenous cultural backgrounds of the various client groups that visit your service? For example, are dots or lines used, does the artwork picture marine or land animals.
- Are there designated and appropriately signed waiting areas and are treatment rooms to accommodate Indigenous men and women separately required?
- How easy is it for an Indigenous client to know what support services can be provided by your service and how they can access these?
- Is the building able to accommodate flexible visiting hours for Indigenous clients and their family members?
- Can family and support people sit comfortably with Indigenous clients in treatment areas?
- How are the needs of Indigenous clients with children balanced with the needs of those without, in terms of suitable areas for waiting, playing, eating, and resting?

### **Cultural safety of Indigenous staff**

Indigenous healthcare providers are employed in a variety of roles across a broad range of healthcare settings, including general practice and community health clinics, sobering-up units, acute care settings, and emergency response units such as the Royal Flying Doctor Service.

Indigenous healthcare providers may find themselves caught between the tensions of what is expected and accepted by their families and communities, and what non-Indigenous employers and colleagues expect. This can place Indigenous staff in a very difficult,

even untenable, situation at times and often leads to high incidence of resignation or retirement (also known as a high attrition rate) among much-needed Indigenous healthcare providers. High attrition rates occur in urban as well as rural and remote settings and can cause significant harm to health service provision to Indigenous Australians.

Working effectively together in diverse cultural settings therefore requires Indigenous and non-Indigenous healthcare providers to establish partnerships that:

- respect and value the diversity of each others' experiences
- respect and value the diversity of each others' roles
- enable professional information to be shared willingly
- have a common goal to improve clients' health and wellbeing
- encourage self-reflection on personal expectations, values and behaviour
- establish debriefing opportunities to help alleviate stress
- acknowledge the importance of Indigenous Australian holistic concepts of health and wellbeing.

### **Becoming culturally competent**

All non-Indigenous healthcare providers working in Australia should have access to and participate in Indigenous cultural awareness training on an ongoing basis.

Cultural awareness is fundamental to every non-Indigenous healthcare provider's ability to deliver respectful and effective healthcare to Indigenous clients. Training programs should discuss the impact of colonisation and dispossession on the health status of Indigenous people.<sup>25</sup>

### **Communicating through trusting relationships**

Trust and respect are critical in developing and maintaining communications with Indigenous clients. Similarly the ability

to communicate with clients will directly affect the collection of relevant information and delivery of services. Misunderstandings must be minimised.

Direct questioning may be considered by some people to be an inappropriate and discourteous way to start a relationship. The older more respected the person, the less appropriate direct questioning may be. This practice may be unavoidable in many medical contexts; however, all healthcare providers should strive to make interactions as friendly, courteous and non-threatening as possible.

Before asking direct questions of an Indigenous client try, wherever possible, to spend some time building a relationship by chatting about general topics. You might try to talk about where the client comes from, the weather, the local football team, or whether you might have met any of their family in the community and so on. You may be able to make the client feel more comfortable by sharing a little personal information about yourself such as 'I am a grandparent' or 'I like to go to the football too'. These simple words can reassure the client that you are interested in them personally and acknowledge the importance of their relationships with family and community. When this is successfully achieved, a trusting relationship can then exist not only between the client and healthcare provider, but also in many instances, with the family and community.

### **Cross-cultural communication in health settings**

Poor communication between Indigenous and non-Indigenous Australians is a major, but often overlooked, problem leading to what has been described as a 'crisis in health care'.<sup>26</sup> When an Indigenous client is intoxicated and/or has an acute illness associated with alcohol and/or other drug use, communication can present an even greater challenge.

Helping clients to understand the issues surrounding alcohol related health and illness requires healthcare providers to

convey information in ways clients from diverse backgrounds will understand and benefit from. Healthcare providers must develop communication skills that are based on an understanding of the culture and communication styles of their clients.

Views on health and illness are influenced by people's health literacy, culture and life experiences. Unless a client has a European nursing or medical background, they are unlikely to understand complex medical terms or 'jargon'. Instead, you will need to find alternative ways to communicate your message. For example, you might tell a client that you are going to write some notes about them or put something on their arm for a moment or two rather than explaining that you need to take their temperature, pulse and rate of breathing, or measure their blood pressure.

Having some knowledge of different conversation styles within your Indigenous clients' community can also assist you to build relationships with individuals, families and other community members, and to provide effective and beneficial health services.

## Beliefs

Messages that are incompatible with a person's beliefs are rarely accepted. Richard Trudgen discusses this issue at length from the perspective of the Yolgnu people of Arnhem Land in his book *Why warriors lie down and die*.<sup>27</sup>

It is helpful therefore to understand your health beliefs and those of your client. While non-Indigenous healthcare providers may, based on their own beliefs, be convinced of the cause-and-effect relationship between drinking too much alcohol and ill health, not all of their clients will share these beliefs. It is important for healthcare providers to analyse their own beliefs, and cultural biases they might have, even those they may not be consciously aware of.

It is also important for healthcare providers to acknowledge that many Indigenous people do not feel there are alternatives to

drinking and excessive alcohol consumption, even when they are aware of the health risks posed. For many, alcohol is used as a coping mechanism to alleviate feelings of hopelessness and despair, low self-esteem and self-worth.

### **Indigenous languages**

Prior to colonisation, an estimated 500+ Indigenous languages were spoken across mainland Australia and the Torres Strait. Today, there are approximately only 200 remaining known, recorded and/or spoken languages – a devastating result of past policies of child removal, assimilation, and cultural degradation. Indigenous people were discouraged from and often punished for continuing to communicate in languages other than English.

Although many languages have been lost, Indigenous people have worked to ensure the survival of the remaining Indigenous languages. Many have been recorded and translated, and are now being taught to both Indigenous and non-Indigenous people. There are also many languages that are still spoken by Indigenous people yet are not recorded or taught in urban environments.

While it is unrealistic to expect all healthcare providers to learn an Indigenous Australian language, it is important to at least have a willingness to learn about local languages and communication styles. Asking for guidance from appropriate Indigenous Hospital Liaison Officers, cultural and language interpreters and community Elders can be extremely helpful whether you are in a city-based or rural or remote setting.

### **English language and Aboriginal English**

English is the dominant language in Australian healthcare settings; however, there are significant numbers of Indigenous Australians for whom English is not their first language and may even be their third or fourth language. Furthermore, many Indigenous Australians speak Aboriginal English, which is considered a valid and rule-governed variety of the English language<sup>28</sup> but may be difficult

for some non-Indigenous people to understand well.<sup>29</sup> There is a continuum of Aboriginal English dialects ranging from the 'light' varieties that are close to Standard English through to 'heavy' varieties, such as Kriol and Torres Strait Creole.<sup>30</sup>

Non-Indigenous people unfamiliar with regional accents, words and phrases may have problems understanding their clients who speak the heavier varieties of Aboriginal English. However, learning even a small amount of local Aboriginal English and communication styles can help build rapport and ensure that information is conveyed and understood.

## Interpreters

Wherever possible you should use an appropriate healthcare interpreter. As with other linguistically diverse people, Indigenous family members should not be used as interpreters. Client issues may be sensitive and require confidentiality and communicating about health problems may require medical or other specialist knowledge.

See Part IV: Resources and contacts for information on interpreter services.

## 'Indigenous' versus 'Aboriginal and/or Torres Strait Islander'

There are regional and community differences in the words used to identify a person as an Indigenous Australian. While the term Indigenous may be acceptable in some communities, it can be offensive in others. Therefore, it is vital that you ask what the locally preferred term is and use that. Some communities may use 'Indigenous', 'Aboriginal', 'Torres Strait Islander', 'Tiwi Islander' or 'Aboriginal and Torres Strait Islander'. Others may use broader regional names, such as the following:

- 'Anangu' in Central Australia
- 'Koori' in New South Wales and Victoria
- 'Murri' in southern Queensland

- ‘Noongar’ in south-west Western Australia
- ‘Nunga’ in southern South Australia
- ‘Palawah’ in Tasmania
- ‘Yolgnu’ in Eastern Arnhem Land, Northern Territory.

Some communities prefer to identify themselves further by their more localised region, for example the Ngunnawal people of the Australian Capital Territory.

### **Health literacy**

Health literacy is the term used to describe the shared understanding of health-related terms, information and ideas and in the general population is relatively poor. For healthcare providers, many concepts of health and illness discussed with clients will not be well understood, including written information. High school completion rates for many Indigenous Australians are lower than for the general population, resulting in lower literacy rates. This leaves significant numbers of Indigenous adults and young people unable to access health, illness and medication information.

When gathering information from your client, you must constantly check for shared understanding. For example, a client might describe their drinking as ‘social’, which to you means drinking at low level. However, if you ask the client to describe what they mean by ‘social’ drinking, you may well find that their pattern of drinking is excessive.

Checking for understanding should therefore include the client’s understanding of numbers and measures in relation to standard drinks and quantities consumed (for more information on standard drinks, see Part II, Chapter 3, ‘General care’).

Wherever possible, information should be provided verbally as well as in writing and discussed with the client (and others as appropriate). Aids such as photographs, diagrams, drawings or models can be helpful in this context.

## Talking about alcohol

Many modern Indigenous Australian words used to describe alcohol are the same as words for sweet or salty, bitter or burning, or simply water. There may also be local slang terms commonly used to describe different alcoholic substances. For example, in Central Australia 'monkey blood' is often used to describe port and 'lady in the boat' to describe a particular brand of wine sold in four-litre casks. 'BB' is used to describe beer, or 'green can' or 'white can' to describe beer depending on the region or brand of beer usually consumed.

## Knowing local terminology

The Royal Commission into Aboriginal Deaths in Custody found that a number of preventable deaths in police custody, hospitals and other settings were due to the person's intoxication and unrecognised head or other serious injuries, and complications of alcohol withdrawal.<sup>31</sup> These preventable deaths were also due, in part at least, to a lack of knowledge among non-Indigenous police and healthcare providers about local words and communication styles used to tell others about what might have been happening, such as pain and feeling very ill. For example, the words 'dings' and 'horrors' are commonly used in Indigenous communities to describe the serious alcohol withdrawal complication known as delirium tremens (the DTs).

Understanding differences in pronunciation and knowing local words and their meanings is essential for all healthcare providers when working with Indigenous clients. It is especially important that incorrect assumptions and judgments about any individual client's situation and medical condition are not made because of misunderstandings in language or because of cultural stereotypes.

## Cultural sensitivity in information exchange

It is vital that you take time to exchange information with your Indigenous client in a way that is culturally sensitive so that you

can successfully gather all the information you need to provide them with effective and holistic care.

Indigenous Australian communications tend not to cover multiple issues in quick succession. You may need to conduct a health assessment, take a drinking history or give health advice in short verbal exchanges and over more than one consultation. Using slower-paced communication may seem contrary to the urgency of some clinical priorities; however, it may be a 'false economy' not to take this approach.

Short exchanges of information can be especially important when working with clients who are having greater difficulty understanding language and concepts because they are intoxicated or ill. For all population groups, this may also be useful for clients who have a hearing or vision impairment.

### **Three-way talking**

Many Indigenous people use a three-way form of talking to make requests or provide information. That is, they may use a third person as a mediator, such as a family member, to exchange information between them and the healthcare provider. In the clinical setting these three-way communications can be very valuable, as they allow for an exchange of information without embarrassment even though the client may be within earshot.

### **Confidentiality**

If your service employs Indigenous healthcare providers, do not assume that every Indigenous client will want to be referred to those staff members or have an Indigenous worker involved. It is the client's choice as to who should be involved; check with them first before you make a referral to the Indigenous worker or liaison unit.

## Gender

In many Indigenous Australian communities a person's gender can strongly influence the exchange (or not) of sensitive information. Some issues, such as sexual health matters, are kept strictly separated along gender lines – often referred to as 'men's business' or 'women's business'. An Indigenous man may feel offended at being asked questions of a sensitive nature by an Indigenous or non-Indigenous woman, and an Indigenous woman may similarly be offended if asked similar questions by an Indigenous or non-Indigenous man.

It may not always be possible, however, to provide gender-appropriate staff for all clients. In these instances it is important to ensure privacy when having to ask possibly sensitive questions. Remember to keep your voice low if you are unable to use a separate private space. It may also be useful to explain your sensitivity to the situation and, where possible, offer alternatives if care can be provided at a later stage.

This does not mean that men and boys cannot or should not access women's and girl's health information and vice versa, but such information should be handled sensitively and as appropriate for each community and individual. It is therefore vital to seek advice from male and female Indigenous colleagues, Elders and community members about how these topics need to be approached in your workplace and by whom.

## Verbal conversation and communication styles

It is possible that healthcare providers will face different styles of conversation, pronunciations and abbreviations. The following are some examples which people may find useful, but experience will build your vocabulary.

## Questions

English first language speakers tend to accept the direct question-and-answer style often used in healthcare communications (for example: What is wrong? Are you in pain? Are you pregnant?).

Speakers of Aboriginal English however, often structure their questions differently. It is common for a statement to be made followed by a question or question tag. Common Aboriginal English question tags are:

- eh? – Australia wide
- inna? – South Australia
- unna? – south-west Western Australia.<sup>32</sup>

Direct questions are often not used to seek important information. Indirect methods using triggers or hints in statements might be used to find the information needed. For example, you might hear an Aboriginal English speaker ask:

- Not feeling good, eh?
- Pain in head, inna?
- Expecting baby, unna?

## Vocabulary

It is also quite common to find the same Standard English word has a different meaning in different locations. For example, in Central Australia Indigenous people use the word 'cheeky' to indicate someone who is rude, offensive or aggressive. It is not used in the light-hearted way that many Standard English speakers might use it.

Similarly, in many urban communities the word 'deadly' is used to indicate something very good or exciting.

## Pronunciation

You might hear the following pronunciation differences:

- Standard English words beginning with 'th' may be pronounced with a beginning 'd', (for example, there = dere, that = dat).
- Standard English words that start with one of the five vowels – a, e, i, o, u – may be pronounced with an additional 'h' (for example, uncle = huncle).
- Substitution of the Standard English sounds for 'v' and 'f' for Aboriginal English 'b' and 'p'.

## Discourse and care

### Agreeing with your questions

Indigenous people generally strive to maintain easy relationships and to not disappoint or upset other people. This is particularly the case if the other person is seen as carrying authority such as doctors and nurses. An Indigenous client may therefore give an answer of 'yes' to avoid offending – even if the answer should be 'no'.

For example, you may get a 'yes' response if you ask questions like, 'Did you take your medication today?' or 'Have you been trying to cut down on your drinking?' when in fact the real answer is 'no'.

A useful approach can be to initially distance the request from the individual client by making a general statement, such as 'Some people find it hard to cut down their drinking', and then follow up with another question about the client's personal experience of reducing or stopping their drinking, such as 'Can you tell me about what you tried to do to stop drinking and what made it hard for you?'.

In each interaction it is critical to appreciate that there may be times when silence reflects disempowerment, and 'compliance' reflects isolation, fear or misplaced trust.

## Responses to questions

What may be seemingly simple questions to a health care provider may take a long time for a client to comprehend and answer. This is because they will be seriously thinking about what you have asked them, what it means and how to respond best. For Indigenous people, they may also be translating between English and their first language.

In some regions Indigenous clients may need to consider the implications of a particular question carefully, to ensure the most appropriate response. For example, asking 'What is your name?' may require thought about which name is required now for cultural reasons and for what purpose you need their name. Is it a name for a form? Should they be giving an English name or a kinship name? Should they give another name because of their reluctance to say the name of deceased people who shared the same name?

## Anxiety

Some topics can cause anxiety. Questions you ask can carry historical and personal burdens that can particularly affect your Indigenous client's responses. For example, asking what might seem like a simple question such as 'Do you have any children?' may raise serious anxieties for a client who was removed from their family or who knows of others who were removed from their families.

## Moments of silence

Unlike in Standard English, where moments of silence are a sign that the conversation has ended or communication has broken down, silence is often accepted and sought during Aboriginal English discussion.

Try to avoid the temptation to fill in silences and give your Indigenous client enough time to respond, a lack of patience can

cause greater frustration and even devastating health outcomes for the client.

### **Non-verbal communication**

All people use non-verbal communication, or body language. Developing sensitivity to body language is a very powerful way to ensure good communication.

Indigenous people from many regions use body language based on their particular cultural background. Answers can be given using facial gestures indicating yes, no, maybe, a certain geographical direction or range of other responses. In some areas 'hand talk' is used.<sup>33</sup>

If hand talk and/or facial gesturing are used within your community, it is worth the effort to learn some appropriate gestures and when and when not to use them.

### **Eye contact**

Indigenous Australian communication has traditionally been focused on listening; eye contact is not always required to pay attention or show respect for the speaker. There is potential to misread an Indigenous client's avoidance of eye contact as rudeness or disrespect; however, this is rarely the case. For some clients, looking down may in fact be their way of showing respect.

Eye contact between Indigenous Australians may also be governed by strict cultural rules about relationships. You may notice that a client's eye contact is different with family members and Indigenous healthcare providers than with non-Indigenous people.

While it is generally fine to look at Indigenous clients as you talk with them, do not try to force eye contact if it is not given. Sometimes standing or sitting slightly to the side of the client allows ease in communication as neither person will be looking directly at the other. This technique can be useful when you need to discuss sensitive issues.

Seek guidance from Indigenous colleagues, community members and Elders if you wish to learn more.

## **Written and visual communication**

### **Understanding of written languages: Generations and diversity**

Translating health brochures into an Indigenous Australian language will not necessarily bring about a significant improvement in health literacy among Indigenous people.

Written Indigenous languages are a recent development and many older clients cannot read brochures written in their first language. In these cases, providing visual aids and interpretations of written information, can be very helpful.

Also, the number and diversity of Indigenous languages that are spoken and/or translated presents a challenge for production of service and health promotion brochures and materials. It is important to seek the advice of Indigenous colleagues and clients on this material, and to facilitate self-learning of the local Aboriginal languages to help communications.

### **Displaying Aboriginal English**

Each health service and community organisation needs to compile its own list of relevant Aboriginal English words for alcohol, drugs and health terminology. Preparation of these materials needs to draw on the experiences of local Indigenous staff, sobering-up teams, mobile/night patrol workers and volunteers, community police and community members, particularly Elders.

Different groups of people may prefer different drinks. Young people and adults, for example, may have different drink preferences and use different terminology for the same drinks. All of these should be included in any language lists.

Consider displaying a list of the local terminology and related pictures in a highly visible location for staff reference. This locally produced resource is not only a useful orientation tool for new personnel, but may even help to save lives. The list should include the table that shows intoxication and progression of blood alcohol concentration (BAC) with associated signs and symptoms in non-dependent drinkers (see Part II: Clinical management of alcohol problems – Tool Kit).

### **Using Indigenous art**

Indigenous artwork can be a valuable tool for cross-cultural communication. Displaying Indigenous artwork or using it on informational materials can be a way for traditional Indigenous people to recognise culturally inclusive services. It can also be valuable in communicating with people who have poor literacy and reading skills or people who have poor eyesight.

It is important to seek advice from within the indigenous community on the appropriate sourcing and use of Indigenous artwork and artists, and ensure that any works clearly and accurately depict and reflect the Indigenous people that access your services. Also make sure that the story of the artwork does not conflict with traditional recognition of images and symbols.

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