Partnerships between mainstream mental health services and Aboriginal and Torres Strait Islander organisations

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We acknowledge the Traditional Owners of the lands upon which this work was produced, the Gadigal people of the Eora nation, the Darumbal people, and the Dabee people of the Wiradjuri nation. We pay our respects to ancestors, Elders of the past, and Elders of the present.

The views expressed in this report are those of Yulang Indigenous Evaluation, not the National Mental Health Commission.

The work described in this report took place in 2021 and 2022. Since that time, the National Mental Health and Suicide Prevention Agreement came into effect and other changes to the landscape have taken place.

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1 Executive summary

Executive summary

Partnering to provide holistic health care respecting Aboriginal and Torres Strait Islander cultural protocols

Aboriginal and Torres Strait Islander health organisations deliver health care in a much more holistic way than do most mainstream mental health services – they are holistic, intergenerational, and connected to identity, culture and Country. These services are often run by boards of Aboriginal and Torres Strait Islander people elected from the local community, to represent local community needs, rights and aspirations. They reflect the way Aboriginal and Torres Strait Islander people see mental health, which includes cultural concepts of health and wellbeing, and in many ways is different to how non-Indigenous people see mental health. For these reasons, among others, Aboriginal and Torres Strait Islander people often want to be cared for by Aboriginal and Torres Strait Islander people, and value Aboriginal and Torres Strait Islander-led services. However as state, territory and national policies recognise, Aboriginal and Torres Strait Islander health services are not adequately funded to meet need.

On the other hand, mainstream mental health services, including government mental health services, have often reported low numbers of Aboriginal and Torres Strait Islander people accessing them. That is because, in general, they offer services that do not accord with the worldviews, rights, cultures and protocols of Aboriginal and Torres Strait Islander people.

If mainstream mental health services develop effective partnerships with Aboriginal and Torres Strait Islander organisations, this can help them move some way towards redressing this disjunction. Partnerships can have significant benefits for mainstream mental health services, in that they can learn about the needs of their clients and ways to meet them, and they can learn about holistic care, which will be of benefit to all clients, Indigenous or not. Partnerships can provide Aboriginal and Torres Strait Islander organisations with resources to extend their reach, and might provide access to specialised services they may not otherwise have access to.

But if partnerships are tokenistic, that could be worse than no partnership, as it could increase levels of distrust among Aboriginal people and communities.

Project overview

This project was funded by National Mental Health Commission, and was designed to examine partnership types and structures that exist between mainstream mental health services and Aboriginal community controlled health organisations (ACCHOs), and to document a small number of existing partnerships, drawing out critical success factors common to these.

Methods used to gather information included reviews a wide range of published and online information, and direct engagement with service providers involved in partnerships. Material from these was used to both document key features of partnerships as well as develop narratives about specific partnerships.

This report builds on existing knowledges by Aboriginal and Torres Strait Islander experts in partnership that can support mainstream mental health services and ACCHOs to work together in partnerships. Some complex yet necessary issues are explored, including identifying where power could and should lie in partnerships, how this fits with Aboriginal and Torres Strait Islander people's right to self-determination and how to respect Aboriginal and Torres Strait Islander people's cultural concepts of health, social and emotional wellbeing and mental health.

Power and principles in partnerships

There are many different types of relationships between organisations, but the term 'partnership' should be reserved for relationships that are substantially equal. Because mainstream organisations tend to be larger and better funded than Aboriginal and Torres Strait Islander organisations, mainstream services wanting to enter partnerships should take time to critically reflect, identify and acknowledge imbalances in power. Partnerships work well when power is shared, or when power is vested in Aboriginal and Torres Strait Islander Elders and leaders to support their right to self-determination. As examples in this report demonstrate, there are many ways mainstream organisations can and have rectified power imbalances, including through:

- Aboriginal and Torres Strait Islander leadership and intergenerational transfer of knowledge
- prioritising Aboriginal and Torres Strait Islander people's views and voices in discussions
- working to develop principles on which the partnership should operate.

It is also important that the work the partnerships is seeking to support arises from and is supported by local Aboriginal and Torres Strait Islander peoples and organisations. To achieve these features, Aboriginal and Torres Strait Islander organisations will have protocols they will expect mainstream organisations to follow – examples are shown in this report. Common elements of these include:

- viewing and centring of Aboriginal and Torres Strait Islander cultures as a source of strength and healing
- rectifying assumptions, negative perceptions and racism that underscores colonisation and colonialism
- respect for and use of Aboriginal and Torres Strait Islander Elders' knowledges, evidence and practices
- development of strong relationships built on time, trust and respect.

This is likely to result in services that are more relevant to Aboriginal and Torres Strait Islander people and cultures.

Partnerships can exist in many ways, and mainstream mental health services wishing to form partnerships will need to work locally to understand an Aboriginal and Torres Strait Islander organisation's staff, resources and the communities they serve.

Westernised processes and contractual relationships used by mainstream businesses are unlikely to be effective. The mainstream workforce usually needs preparation and support to understand how rights to self-determination of Indigenous peoples are operationalised in practice, and to develop the conditions for culturally safe care.

Diverse partnerships in this report

This report provides examples of partnerships between mainstream organisations and Aboriginal and Torres Strait Islander organisations – the *Looking Forward Moving Forward* project, the Indigenous Mental Health Intervention Program, headspace Broome, Headspace Inala, Wadamba Wilam, Wyiliin ta, and a cautionary tale from Winnunga Nimmityjah Primary Healthcare. These cases exhibit tremendous variety, highlighting there is no one approach. They have grown in response to local need and to the local environment, and have changed over time. We highlight important points to note from each example.

Evaluation in accordance with the Indigenous Evaluation Strategy of the Productivity Commission (2020) will help contribute more examples and is essential for strengthening long-

term partnerships that support the rights of Aboriginal and Torres Strait Islander peoples to self-determine ways forward.

For future development

Again, mainstream mental health services stating they are committed to providing services for Aboriginal and Torres Strait Islander people, or who wish to partner with Aboriginal and Torres Strait Islander organisations, need to critically reflect on their own ways of planning and operating. Over time, this will allow them to understand their own individual and organisation culture, which is the prelude to understanding others.

In addition to understanding their own culture, mainstream mental health service providers will need to understand:

- the importance of family, community, culture and Country to Aboriginal and Torres Strait Islander people
- the importance of and processes for community control and self-determination
- the conceptualisation of health, social and emotional wellbeing and mental health
- the importance of holistic care and the breadth of services required.

They will need to do the work to understand generalities about working with Aboriginal and Torres Strait Islander people and organisations, then about the local population they wish to support.

About the authors

Yulang Indigenous Evaluation is an Aboriginal-led consultancy that works with communities and clients to research and evaluate policies and programs that affect Aboriginal and Torres Strait Islander people. Yulang is the Wiradjuri word for ripple … we have used it to signify our belief that all we do has an impact, and that even small changes for the better can lead to changes both upstream and downstream.

Yulang is led by Professor Megan Williams PhD, who is Wiradjuri and palawa through her father's family and has more than 20 years' experience working on programs and research to improve the health and wellbeing of Aboriginal and Torres Strait Islander people, particularly in the criminal justice system. Megan is Associate Dean (Indigenous), Professor of Public Health (Indigenous) and Head, Girra Maa Indigenous Health Discipline, Faculty of Health, UTS.

The minority partner is Dr Mark Ragg MBBS BA, a non-Indigenous man with long and varied experience in health, policy and research. Mark has worked as a doctor in emergency departments, as a journalist with the *Sydney Morning Herald* and as a consultant to governments and NGOs on health policy, on program design and on communications. He has also sat on the NSW Mental Health Review Tribunal. He is Adjunct Fellow at Girra Maa Indigenous Health Discipline, Faculty of Health, UTS.

II Report scope and methods

Report scope and methods

This report was funded by the National Mental Health Commission as part of its efforts to improve access to quality mental health and wellbeing services for people living in Australia.

Scope of work

This project was to examine partnership types and structures that exist between mainstream mental health services and Aboriginal community controlled health organisations (ACCHOs), and to document a small number of existing partnerships, drawing out critical success factors common to these .

Over the past decade, ACCHOs and other Indigenous-led organisations have published principles and processes that allow respectful and functional partnerships to develop.

While these principles and processes have some common elements, they are also quite diverse, reflecting the diversity among Aboriginal and Torres Strait Islander peoples in Australia. We sought to respect this diversity in partnerships, and convey that there is no one standard approach to working in partnerships or working with Aboriginal and Torres Strait Islander organisations. Instead, rather than responding to the particular situation of different organisations in different parts of Australia.

As a strategy for respecting the diversity of Aboriginal and Torres Strait Islander people across Australia, we rely words of the organisations, often with direct quotes. Their work reiterates that there is no single approach to partnerships to promote in a report like this.

This report is aimed at mainstream mental health services that recognise that they need to develop processes to better meet the needs and rights of Aboriginal and Torres Strait Islander people, in accordance with existing policies and evidence.

Terminology

We use the term 'partnership' to describe a relationship between organisations that are more or less equal. So, for example, a mainstream service that contracts an Aboriginal organisation to provide a staff member at a clinic is not, for the sake of this report, in partnership with that Aboriginal organisation. If that Aboriginal organisation has a strong and equal voice in determining what services are provided, and when, and where, and how, and who by, then that could be considered a partnership.

We use the name 'Aboriginal people' where it aligns with use by particular organisations, and use 'Aboriginal and Torres Strait Islander people' when more referring to all sovereign First Peoples, Indigenous peoples of Australia.

The term ACCHO is used throughout this review to describe Aboriginal community controlled organisations providing primary health care to Aboriginal and Torres Strait Islander peoples. Other commonly used terms such as Aboriginal Community Controlled Health Services (ACCHS), Aboriginal Community Controlled Organisations (ACCOs) and Aboriginal Medical Services (AMSs) exist with some, although only relatively minor, differences in meaning (CREATE, 2020).

Methods

This report and the selection of case studies was informed by several sources and strategies.

Literature review

We conducted a search of published literature and a wide range of other printed and online grey literature for information on partnerships between mainstream mental health services and Aboriginal and Torres Strait Islander organisations, with a focus on identifying resources by Aboriginal and Torres Strait Islander organisations and authors. We:

- searched websites of peak Aboriginal and Torres Strait Islander organisations and of large mainstream mental health services
- searched a range of well-cited texts on Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing, and their reference lists
- used professional and personal networks to source information and to seek case studies on partnerships.

These strategies provided information that is summarised in the chapters on 'why partner' ' experience and expectations' as well as the case studies.

We sought and received regular feedback from the National Mental Health Commission. A mid-project meeting with Bardi psychologist Professor Pat Dungeon, who is also a Fellow of the Australian Psychological Society and Director at Gayaa Dhuwi provided feedback on scope, concepts, progress and case study selection.

Case studies

The development and reporting of case studies was guided by Indigenous research texts (Denzin, Lincoln, & Smith, 2008; Njeze, Bird-Naytowhow, Pearl, & Hatala, 2020), health research texts (Bowling, 1997), qualitative research texts (Angrosino & Mayes de Perez, 2003; Gagnon, 2010; Lincoln & Guba, 2003), research on partnerships (Cooper et al, 2007; Wallerstein et al, 2019) and case study examples about Aboriginal and Torres Strait Islander people's health and wellbeing (Cullen et al, 2020; Haswell et al, 2013).

The case study conceptual framework was bounded by the human rights of Indigenous peoples (United Nations, 2008), leadership statements of the Coalition of Peaks, and the Ngaa-bi-nya Aboriginal evaluation framework (Williams, 2018). Ngaa-bi-nya has a checklist of items in four domains relevant to the establishment and evaluation of Aboriginal and Torres Strait Islander health and support organisations. Ngaa-bi-nya identifies contextual landscape factors, resourcing factors, ways of working and learnings among Aboriginal and Torres Strait Islander organisations that are relevant to identify in partnerships with mainstream organisations, particularly if power is vested in Aboriginal and Torres Strait Islander leadership.

We developed each case study with permission of the organisations involved, drawing on published material and conversations with key staff, who approved the final text. We focused on partnership structure and relationships, project processes and outcomes, and management and operations, and the way they support services for and by Aboriginal and Torres Strait Islander people. No locally culturally sensitive information was sought, collected or reported.

Fifteen partnerships were identified as potential case studies using the methods listed above, and seven are included in this report. Some services and partnerships were not progressed due to lack of evidence and resources available about them, or the limited capacity of

organisations to respond to requests. Partnerships are dynamic and depend on many factors, people and resources at one time, and have their own needs. There is no reflection at all on partnerships *not* featured in this report.

III Understanding health care delivered by Aboriginal and Torres Strait Islander organisations

A true understanding of the vital work of Aboriginal and Torres Strait Islander health services, along with an understanding of the environment in which they operate, is needed before partnerships can be considered.

The expertise of ACCHOs

ACCHOs are Aboriginal and Torres Strait Islander community controlled organisations that are governed by a board elected from the local community in the spirit of self-determination, and are likely to reflect and express the wishes of the local community. They are the predominant form of Aboriginal and Torres Strait Islander service providers.

There are other types of Aboriginal and Torres Strait Islander service providers, including:

- Aboriginal medical services that are not community controlled
- Aboriginal and Torres Strait Islander community controlled organisations who focus on wellbeing issues and determinants of health, such as the impacts of the criminal justice system – these are often referred to as ACCOs, or Aboriginal community controlled organisations
- Aboriginal and Torres Strait Islander owned private businesses that focus on health and wellbeing.

But most of the small amount of research that has been funded about Aboriginal and Torres Strait Islander services has examined ACCHOs.

Generally speaking, Aboriginal and Torres Strait Islander people want to be cared for by Aboriginal and Torres Strait Islander people (Larke et al., 2021) and attend Aboriginal and Torres Strait Islander-led services (Cox Inall Ridgeway, 2020). One estimate of a decade ago found that ACCHOs provide primary care services to between a third and a half of the Aboriginal and Torres Strait Islander population (Dwyer et al., 2011).

There is a growing body of evidence about the many successful outcomes of ACCHOs, and some data that demonstrates how they outperform mainstream services in recognising and dealing with chronic diseases (Panaretto et al, 2014; Thompson et al. cited in Mackey et al., 2014).

As well as evidence for success in providing comprehensive primary health care, ACCHOs have a vital role in:

- prevention and early intervention of poor mental health
- addressing risks for developing and worsening of mental health problems
- enabling access to primary and specialist mental health services and allied health care
- facilitating the transition of service users across the primary, specialist and acute interfaces
- connecting service users with the range of community-based social support services
- working with mainstream community mental health and hospital services to enhance the potential for cultural safety through provision of cultural mentorship, advice and training placements for all staff
- working as part of multi-agency and multidisciplinary teams aimed at delivering shared care arrangements (NATSILMH, 2017).

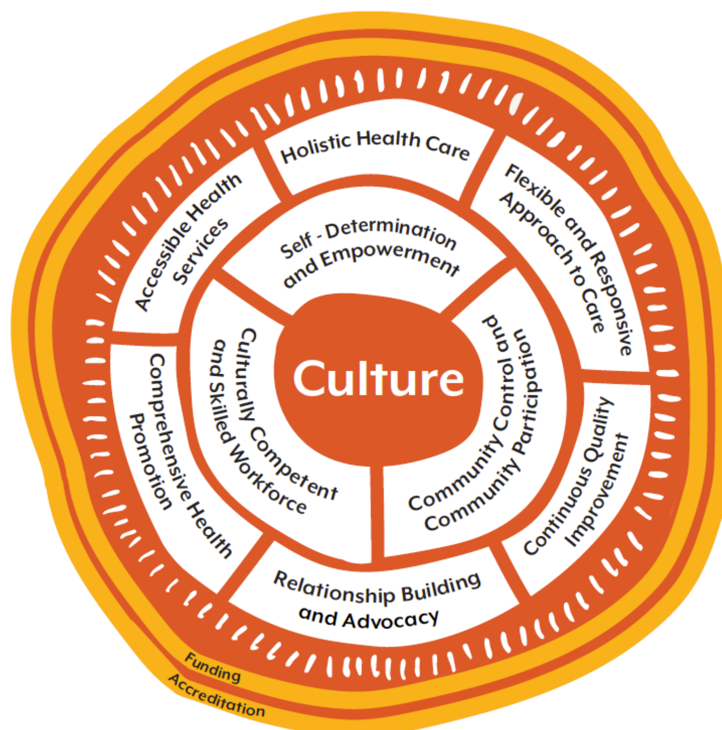
ACCHOs are well placed to provide accessible, culturally safe care because they:

- are operated by, are situated in and reflect local Aboriginal and Torres Strait Islander communities and cultures
- are controlled by an Aboriginal and Torres Strait Islander community-based board, elected by community members, to lead responses to local issues
- are affordable, as they largely bulk bill for medical services (Dudgeon et al, 2018).

Aboriginal and Torres Strait Islander cultures are central to health service delivery within ACCHOs. Cultures are embedded across health care delivery (see Figure 1) through:

- focusing on the needs of individuals, families and communities
- respecting gender-based cultural protocols and needs
- creating welcoming and family-friendly environments
- incorporating local cultural values, protocols, ceremonies and spirituality in programs and services
- having processes for local community to be empowered to shape ACCHO services
- employing Aboriginal and Torres Strait Islander staff and supporting their leadership
- using local Aboriginal and Torres Strait Islander language, arts, and resources
- developing health promotion and prevention resources relevant to local communities
- ensuring many ways learning between Aboriginal and Torres Strait Islander and other colleagues (Bailey et al, 2020; CREATE, 2020).

Figure 1: ACCHO values, services and the centring of culture



Source: CREATE, 2020

A systematic review of qualitative evidence by several Aboriginal and Torres Strait Islander researchers and their collaborators (Gomersall et al., 2017), with guidance from the leadership group of the National Health and Medical Research Council Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE), sought to understand what Aboriginal people valued about ACCHO health care compared to mainstream primary health care services. The main benefits of ACCHOs they reported are outlined in Table 1.

Table 1: What people value in ACCHOs

Finding	
ACCHOs' accessibility was highly valued	Proactive service provision such as outreach services and home visits, staff who were easily contactable, and staff meeting patients in public areas such as shopping centres.
	Culturally safe care by providers who spent time getting to know needs, developing shared understandings, respected Aboriginal culture, and created an environment that supported service users to feel comfortable.
	A welcoming environment in which service users saw other community members familiar to them, and who understood them, both in the waiting room and in the clinical space, which supported a sense of belonging. ACCHOs can serve as social meeting places, for events and gatherings where friends offer and receive support.
The way ACCHOs delivered care was highly valued	Clients experienced and valued staff taking their time with them.
	ACCHOs deliver care in a way that was responsive to their background by people who understood them, supporting them to feel known, a sense of belonging, more confident, less anxious, cared for, accepted, supported and encouraged.
	Ongoing care and support were available for various problems in a client's life over time, and that of families, over generations.
Qualities of ACCHO staff were highly valued, such as being Aboriginal, and understanding Indigenous clients and therefore behaving respectfully	Clients valued the behavioural qualities of staff: respectful and non-judgemental manner, taking time to understand the family background and listen to needs, with sensitivity, kindness, reassurance and trustworthiness.
	Clients valued the Aboriginal identity of many of the staff and the employment of Aboriginal Health Workers, with Aboriginal boards and management teams.
A comprehensive, holistic approach to health care was highly valued.	Non-clinical services such as social services, cultural events and group activities such as events, camps and cultural activities were valued.
	Clients felt they had increased confidence, enhanced knowledge about how to manage health and wellbeing and actively engaged in health decision-making, with pride in being part of the local Aboriginal community and its health service, seeing better health outcomes, and better mental health.

Source: Gomersall et al., 2017

That review summarised Aboriginal and Torres Strait Islander people's perceptions of care in mainstream health services as:

- lacking respect

- lacking a shared understanding between service users and providers
- feeling discriminated against, both in the open areas and in the clinical space
- feeling a lack of reciprocal trust (Gomersall et al., 2017).

The value of leadership by Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people display strong leadership on mental health and wellbeing. For example, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) group was formed in 2014 (NATSILMH, 2017; 2018), respecting the principles of the *Wharerata Declaration* of 2010 (Sones et al, 2010) which identify holistic, community-based and cultural approaches to mental health and wellbeing, with Indigenous peoples' leadership.

The *Wharerata Declaration*, the NATSILMH group and the *Health in Culture – Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* (NATSILMH, 2017) and *Health in Culture – Policy Concordance* documents (NATSILMH, 2018) all acknowledge that partnerships between mainstream mental health services and Indigenous organisations must occur.

The NATSILMH documents outline the types of directions required to achieve improvements in mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people and reduce inequities compared to other people in Australia. They outline the importance of 'embedding and supporting Aboriginal and Torres Strait Islander leadership from within the Australian mental health system' (NATSILMH, 2018, p. 5).

This is essential so that 'Aboriginal and Torres Strait Islander people access the best of both' the worlds of mainstream mental health and Aboriginal and Torres Strait Islander-led services (NATSILMH, 2018, p. 5).

In Australia, the one non-negotiable element that underpins successful suicide prevention activities among Aboriginal and Torres Strait Islander people, with suicide prevention seen as one important element of mental health promotion, is that 'the processes associated with design and implementation be empowering to Aboriginal and Torres Strait Islander communities' (Dudgeon et al., 2018, p. 5).

This sense of empowerment was also identified internationally, with one study, also about suicide and particularly among young people in almost 200 Canadian First Nations' communities in British Columbia, examining community-level protective factors. They found the following features of empowerment were essential:

- a measure of self-determination
- access to traditional lands and cultural materials and knowledges
- a measure of local control over health, education, policing and child welfare services
- community facilities for the preservation of culture
- elected band councils composed of more than 50 per cent women (Chandler & Lalonde, 1998).

The study found that communities where all of these protective factor indicators were present had no cases of suicide. Conversely, where communities had none of these protective markers, youth suicide rates were many times the national average (Chandler & Lalonde, 1998).

That self-determination was the strongest single protective factor (Chandler & Lalonde, 1998), along with the rights of Aboriginal and Torres Strait Islander people to to self-determine policies and programs that affect health and wellbeing (United Nations, 2008), the right to access health care that meets needs (United Nations, 2008), and the desire of Aboriginal and Torres Strait Islander people to be cared for in Indigenous-led services (Cox Inall Ridgeway, 2020) reinforces the value of Aboriginal and Torres Strait Islander leadership.

Concepts of health, mental health, and social and emotional wellbeing

While mainstream organisations discuss mental health, many Aboriginal and Torres Strait Islander organisations discuss social and emotional wellbeing. Consensus is emerging about how the two concepts fit together.

The concept of health

In the 1970s, ACCHOs began to document for mainstream health providers what health means to Aboriginal people. The following definition is in the constitution of the National Aboriginal Community Controlled Health Organisation (NACCHO) constitution, guiding the work of ACCHOs and often cited in government and research documents:

> *'Aboriginal health' means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community. It is a whole of life view and includes the cyclical concept of life-death-life.*
> (NACCHO, 2011, pp. 5-6; emphasis in original; cf National Aboriginal Health Strategy Working Party (NAHSWP) 1989, p. ix)

With this holistic, intergenerational and cultural definition of health, Aboriginal and Torres Strait Islander organisations have continued to resist efforts to narrow the understanding of health to the biomedical model (Gee, Dudgeon, Schultz, Hart, & Kelly, 2014). On the other hand, western understandings of health are slowly shifting, in a very small way, towards the Aboriginal and Torres Strait Islander understanding of health, as evidenced by the Alma-Ata Declaration (International Conference on Primary Health Care, 1978) and the conceptualisation of the social determinants of health, largely credited to Marmot (2005). Despite this shift in academic and public health practitioner thinking, mainstream health systems remain largely unmoved. They are populated by silos of health issues and services with specialisations, disconnected systems and few efforts to directly address issues regarding family, spirituality and connection to Country, or the collective identity that Aboriginal and Torres Strait Islander people have, and connection to community wellbeing.

The concept of social and emotional wellbeing

The concept of social and emotional wellbeing (SEWB) used in this report relates to work published by Aboriginal psychologist and research fellow Dr Graham Gee, with Bardi

psychologist and Professor Pat Dudgeon, Gamilaroi psychologist and consultant Dr Clinton Schultz, Bagala psychologist Amanda Hart and experienced researcher and trainer Kerrie Kelly. Gee et al. (2014) argue that SEWB and mental health are not equivalent concepts, rather that SEWB is a complex and multidimensional concept that extends beyond issues of mental health and mental illness. Mental health can be an important component of SEWB, but is only ever one component. A diagrammatic representation of SEWB was first produced in 2013 and has been widely used with minor modifications since. The SEWB model that informs this report is in Figure 2.

Figure 2: Social and emotional wellbeing

Source: © Gee, Dudgeon, Schultz, Hart and Kelly, 2013, p. 6

Gee et al. (2014) note that the separation of the domains of SEWB are somewhat artificial, and that each of the domains may be considered differently among different Aboriginal and Torres Strait Islander peoples. However the diagram has been well-used and reproduced, and gives the mainstream health sector a way to understand SEWB.

The Aboriginal Health Council of Western Australia (AHCWA) notes that while the concept of SEWB does vary between different Nations and regions, and with different stages of the life cycle, common elements are that it:

- is holistic and acknowledges Aboriginal and Torres Strait Islander cultures and spirituality
- is inclusive of, but broader than, mental health
- affirms a strong link between collective and individual wellbeing
- recognises the transgenerational impacts of history and collective trauma. (AHCWA, 2021).

As indicated in Figure 2, the presence of the political, historical and social determinants are important to acknowledge here, because of the influence they have on SEWB, as well as on mental health. That is, SEWB and the mental health of Aboriginal and Torres Strait Islander people cannot be considered without understanding the devastation brought by colonisation and colonialism, the ongoing impact of systemic and interpersonal racism, the impact of forced child removals on connections to family, identity and Country, and the ongoing failure to address all these issues adequately.

It is also worth noting that the SEWB framework affirms a stronger association between individual and collective wellbeing than is generally acknowledged in mainstream understandings of health (NATSILMH, 2017).

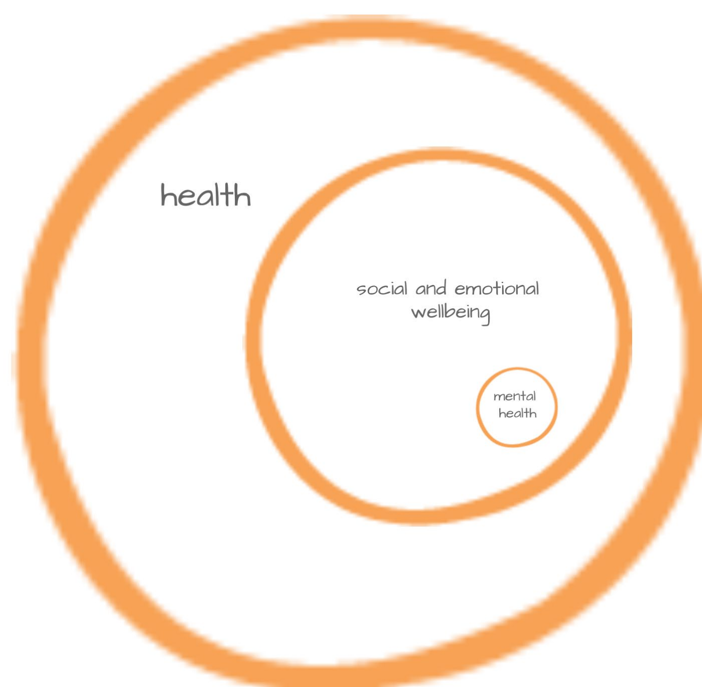
But SEWB is itself a narrower concept than the NACCHO definition of health that was described in 'the concept of health' section above. And, while Figure 2 indicates SEWB includes spirituality and connections to knowledges and actions and the spirit of ancestors, and to culture and Country the focus of SEWB services is often on strengthening an individuals' connection to these things. SEWB is often addressed through projects and programs rather than reforms aimed at 'bringing about the total wellbeing of their community' that the Aboriginal definition of health expects (NAHSWP, 1989; NACCHO, 2011).

Achieving total community wellbeing requires multiple levels of empowerment including in the general community, in education, housing, employment, community, justice and economic sectors, among health workforces, political systems and evidence – all of which ACCHOs contribute to, particularly through peak state, national and territory representative bodies that advocate for equity (Jackson Pulver, Williams, & Fitzpatrick, 2019).

Relationship between health, SEWB and mental health

The relationship between the three concepts can be imagined as in Figure 3.

Figure 3: Relationship between health, SEWB and mental health



Source: Williams & Ragg, 2021

Figure 3 illustrates the relationship between Aboriginal and Torres Strait Islander people's health, SEWB and mental health. Health is seen in its broadest sense, and generally reflects the concept holistic, intergenerational and cultural definition of health that ACCHOs use in organising their services and providing care. In this, SEWB is situated within this broadest definition of health, and mental health is seen as one element of SEWB, with SEWB also including emotional and physical wellbeing as well as connection to family, kind, Country and culture (see Figure 2).

Figure 3 helps explain why, when engaging with Aboriginal and Torres Strait Islander people accessing health services, a range of other issues may be seen as impacting on the mental health of an individual, and that it is difficult to 'treat' mental health conditions of an individual without making plans for addressing other underlying and presenting social issues. Most Aboriginal and Torres Strait Islander people are affected in some way by ongoing child removal by governments, deaths in custody, or environmental issues such as land degradation and removal of water from rivers. Importantly, Figure three has the three rings, or boundaries, on it, around mental health, SEWB and health. These offer some freedom – that a mainstream mental health clinician need only have specialised skills in this field, and has much to offer about mental health. They are not expected to also address SEWB or cultural concepts of health more broadly. But, because SEWB and health affect mental health, partnering with others with expertise in these domains will reinforce their specialised role. The more clinicians understand and respect their own and others' professional boundaries, the more integrity and trust there can be to make a shared agreement about the ways forward for quality health care for Aboriginal and Torres Strait Islander people (Bennett et al., 2013; Williams, 2018). In turn, Figure 3 also explains why therapeutic approaches that rely heavily on medication will have limited appeal and effect.

Table 2 describes how mainstream mental health services generally sit in relation to SEWB, and how Aboriginal and Torres Strait Islander health organisations generally sit in relation to SEWB.

Table 2: Relationship between mainstream mental health services, Aboriginal and Torres Strait Islander health services and SEWB

Domain	Description in mainstream terms	Mainstream mental health services' relationship to the domain	Aboriginal and Torres Strait Islander health services' relationship to the domain
Connection to body	Physical health – feeling strong and healthy and able to physically participate as fully as possible in life	Priority area in Fifth National Mental Health and Suicide Prevention Plan, and considered by some practitioners, but not yet part of standard service	Strong component of care
Connection to mind and emotions	Mental health – ability to manage thoughts and feelings	Basis of mental health services	Strong component of care
Connection to family and kinship	Connections to family and kinship systems are central to the functioning of Aboriginal	Individual approach neglects this. Made more difficult by confidentiality provisions	Strong component of care

Domain	Description in mainstream terms	Mainstream mental health services' relationship to the domain	Aboriginal and Torres Strait Islander health services' relationship to the domain
	and Torres Strait Islander societies		
Connection to community	Community can take many forms – a connection to community provides opportunities for individuals and families to connect with each other, support each other and work together	Connection sometimes considered by practitioners, but few organisational links	ACCHOs can play a significant role in strengthening connection to community
Connection to culture	A connection to a culture provides a sense of continuity with the past and helps underpin a strong identity	Connection sometimes considered by practitioners, but few organisational links	Strong component of care
Connection to Country	Connection to Country helps underpin identity and a sense of belonging	Connection sometimes considered by practitioners, but few organisational links	Strong component of care
Connection to spirituality and ancestors	Spirituality provides a sense of purpose and meaning	Connection sometimes considered by practitioners, but few organisational links	Related to holistic philosophy of care that underlies ACCHOs

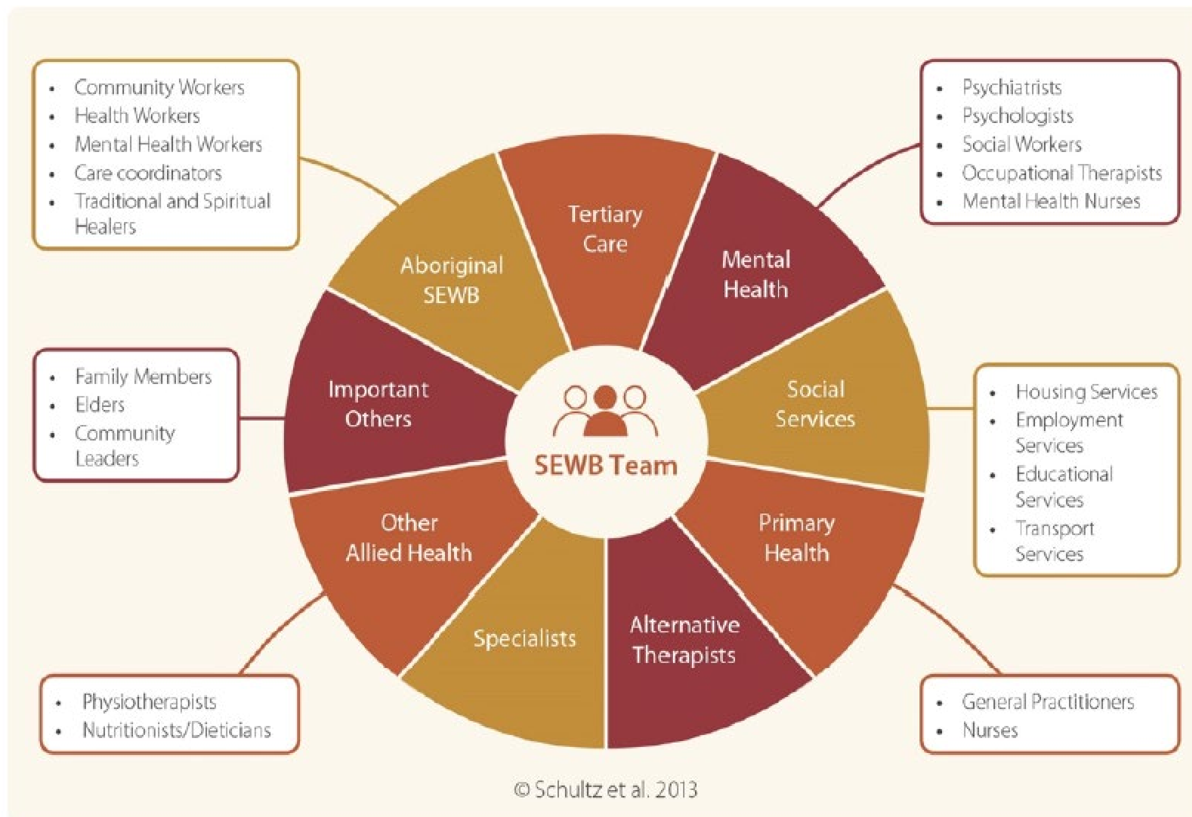
Sources: Commonwealth of Australia, 2017; Gee et al., 2014; Ragg & Williams, 2021

Structuring a service to provide social and emotional wellbeing care

ACCHOs have developed to meet the needs of their communities. The 'community control' element is real – ACCHOs answer to boards that comprise elected community members, and generally have strong links with Elders, Traditional Owners and other community leaders.

Figure 4 was developed by members of the Australian Indigenous Psychologists Association to describe a SEWB service. In reality, it also reflects the workforce and relationships of many ACCHOs (see, for example, AHCWA, 2021).

Figure 4: A SEWB service structure



Source: © Schultz et al., 2013, cited in AHCWA, 2021, p. 8

Some of the services shown in Figure 4 are provided by staff within the ACCHO, some are provided through partnerships and other relationships, and some by referral. For example, the mental health service of Australia's first ACCHO, the Aboriginal Medical Service at Redfern, says it is 'staffed by professionals who aim to support and promote the social, emotional, spiritual and cultural wellbeing of Aboriginal people and community', and offers 'psychologists, psychiatrists and social workers', along with:

- assistance with funeral arrangements
- assistance with Legal Aid
- assistance with Centrelink, forms and support
- assistance and referrals for homelessness
- assistance dealing with government organisations
- court support
- counselling and support
- domestic violence support
- health promotion and advocacy
- liaison with probation and parole and prisoners
- liaison with Department of Housing
- personal women's business (Aboriginal Medical Service Cooperative, 2022).

That broad range of services is what is required to meet the mental health and social and emotional wellbeing needs of Aboriginal and Torres Strait Islander people.

These actions of ACCHOs are wide-ranging and often developed over many years. They are also designed at local levels to match local resources, to ensure they are realistic and sustainable. In mainstream services, multidisciplinary mental health teams are usually led by a doctor, psychiatrist or clinical psychologist, and the medical model is in the fore. In ACCHOs, Aboriginal people usually lead teams, whether they are doctors or not. They may be an Aboriginal health worker or an Aboriginal mental health clinician, and this is often negotiated depending on the particular needs of the client.

Implications of this chapter

Aboriginal and Torres Strait Islander people see mental health differently than do non-Indigenous people. Aboriginal and Torres Strait Islander health services deliver health care in a much more holistic way than do most mainstream mental health services. Aboriginal and Torres Strait Islander people largely want to be cared for by Aboriginal and Torres Strait Islander people, and value Aboriginal and Torres Strait Islander-led services.

All this means that mainstream mental services wishing to provide care to Aboriginal and Torres Strait Islander people, or who wish to partner with Aboriginal and Torres Strait Islander organisations, need to critically reflect on their own ways of thinking, being and doing. Over time, this will allow them to understand their own individual and organisational culture, which is the prelude to understanding somebody else’s.

They will need to understand:

- the importance of family and community to Aboriginal and Torres Strait Islander people
- the importance of community control and self-determination
- the conceptualisation of health, social and emotional wellbeing and mental health
- the importance of holistic care and the breadth of services required.

They will also need to have Aboriginal and Torres Strait Islander leadership, either in their own service or by partnering with Aboriginal and Torres Strait Islander organisations.

IV Why work in partnerships?

Why work in partnerships?

Partnerships are needed because of gaps and failings in current health care approaches. Partnerships have many benefits, and national, state and territory health policies recognise this. But it is wise for mainstream organisations to proceed slowly and carefully, for the right reasons and attuned with recommendation of Aboriginal and Torres Strait Islander leaders, so as not to make health and social inequity worse.

Current failings in mainstream health care

Aboriginal and Torres Strait Islander people have long had ways of promoting health and wellbeing, as well as identifying and addressing trauma, and what mainstream services describe as mental health issues.

These have centred Aboriginal and Torres Strait Islander cultures' connections to Country, have drawn on strengths of cultures, and have involved many processes and resources for healing. Actions have been based on evidence, involving clear protocols for intergenerational transfer of knowledges and local leadership in interpreting meanings for people, place and timeframe (Carson, Dunbar, Chenhall, & Bailie, 2007; Mazel, 2016; Nakata, 2007; Williams, 2021).

Colonisation by British forces from 1788 brought profound disruption to Aboriginal and Torres Strait Islander peoples' lives and cultures, denigrating and denying humanity, rights, knowledges and practices (Chesterman & Galligan, 1997; Tripcony, 2000). Settler colonialism brought and still perpetuates the separation of mental health and wellbeing from physical health, reinforced by 20th century developments in medicine, psychiatry and psychology, and by the use of drugs, restraints and seclusion in the treatment of illness. A separation was also enforced between those employed to create health, and the person deemed as ill. Power structures reflect western biomedicine's dominance, and the tools of mental health services reflect and reinforce western ways of working (Heffernan, Andersen, & Kinner, 2015).

To say the changes have proved ineffective is an understatement.

Around the world, biomedical models and approaches have failed Indigenous peoples (Anderson et al., 2016). Some governments now acknowledge their failings, either explicitly (see, for example, Health and Human Services Victoria, 2017) or implicitly (see for example, NSW Department of Planning, Industry and Environment, 2020). So, too, do some western-trained clinicians (see for example, Hunter, 2020).

Reasons for these failings include:

- distrust of mainstream and government services due to past and continuing policies and practices of discrimination, racism, negative staff attitudes and forced removal of children (Health and Human Services Victoria, 2017)
- a failure of service providers and service delivery processes to understand, respond to or prevent the historical context and pervasiveness of colonialism, racial oppression and social disadvantage (Health and Human Services Victoria, 2017)
- inflexible models of service delivery (Human Services and Health Victoria, 2017), yet poor investment in Aboriginal and Torres Strait Islander models of care and services (Alford, 2014; NACCHO and Equity Economics, 2022)

- a declining and inequitable investment in prevention (Public Health Association of Australia, 2021)
- western psychiatric classification systems that deny and poorly match issues experienced by Aboriginal and Torres Strait Islander peoples (Gee et al, 2014)
- the use of inappropriate assessment and diagnostic tools (Health and Human Services Victoria, 2017)
- lack of service coordination and integration between primary mental health and specialist clinical services (National Mental Health Commission, 2014).

Mainstream mental health services have been told, for at least 30 years, how they need to develop so that Aboriginal and Torres Strait Islander peoples can be confident in their willingness and ability to provide care for them. Since 1989, national and state policies have quoted the holistic Aboriginal definition of health (discussed in section III). For example, the *National Aboriginal and Torres Strait Islander health plan 2021-2031* (Australian Government, 2021), which is relevant to all mainstream services, uses this definition of health.

But definitions and information are not enough. The mainstream health workforce needs to develop the skills to work with Aboriginal and Torres Strait Islander people (Jackson Pulver, Williams, & Fitzpatrick, 2019) and there are a range of cultural safety frameworks and guidelines to support this (e.g.). However, plans for the skills development of the mainstream health workforce must occur locally to be as relevant to local Aboriginal and Torres Strait Islander people as possible, but there is no clear plan as to how this will happen (Jackson Pulver, Williams, & Fitzpatrick, 2019).

Some areas of health and its determinants are worsening (Productivity Commission, 2021). Overall, Aboriginal and Torres Strait Islander peoples experience higher levels of poor health and wellbeing and health risks (Australian Bureau of Statistics, 2019) compared with the general population (Australian Institute of Health and Welfare, 2020) but are under-represented in accessing health and support services (e.g., Davy, Harfield, McArthur, Munn, & Brown, 2016) and are also under-represented in the mainstream health workforce (NSW Public Service Commission, 2019).

The result is infrequent contact of Aboriginal and Torres Strait Islander peoples with primary health care and early intervention services (Australian Institute of Health and Welfare and National Indigenous Australians Agency, 2020). When mental illness does occur, if not identified and responded to early and prevented from worsening, it often leads to 'acute, episodic and chronic mental illness … [with] major disruption for individuals and their families across all areas of their lives' (Health and Human Services Victoria, 2017, p. 18).

The failure to better develop mainstream mental health care is not a failing of Aboriginal and Torres Strait Islander peoples or organisations. In a complex historical and policy context, mainstream health services and their staff must learn how to develop and sustain services that meet the rights, expectations and needs of Aboriginal and Torres Strait Islander peoples, and achieve health and wellbeing (AHPRA and National Boards, 2020). Table 3 below provides important information about benefits of partnerships – how partnerships bring benefits not only to Aboriginal and Torres Strait Islander people seeking mental health support but also to mainstream organisations and services providers seeking information about how to understand and engage with Aboriginal and Torres Strait Islander cultures and people.

Potential benefits of partnerships

Partnerships can have benefits for all involved. They are likely to improve access for Aboriginal and Torres Strait Islander people to mainstream mental health services, and are also likely to improve understandings of Aboriginal and Torres Strait Islander cultures among mainstream mental health services and staff. Table 3 summarises key points from a range of publications describing potential benefits.

Table 3: Potential benefits of partnerships to individuals and services

Benefit to Aboriginal and Torres Strait Islander organisation	Benefit to Aboriginal and Torres Strait Islander community members	Benefit to mainstream community members	Benefit to mainstream mental health services
Builds clinical capacity of staff and service	Improves access to services	More holistic services	Builds cultural capacity of staff and service
Helps reduce institutional racism	Helps reduce institutional racism	Helps reduce institutional racism	Helps reduce institutional racism
Local cultures and Elders direct and participate	Access to services that reflect local cultures and meet needs	Access to services that meet needs more effectively locally	Better understanding of the specific needs of the community
Staff professional development	Easier access to, transition between, and simultaneous use of services	A larger pool of skilled and connected professionals	Staff professional development
Increased knowledge and skills	Increased consistency and continuity of service	Access to Aboriginal and Torres Strait Islander health professionals	Increased knowledge and skills
Development of collegial and supportive relationships	A larger pool of skilled and connected professionals	Development of relationships, knowledge and sense of belonging	Development of collegial and supportive relationships
Demystification of professions	Wider range of health care types to use	Wider range of health care types to use	Demystification of professions
Increased career opportunities	Access to quality and culturally safe health care	Access to safe health care	Increased career opportunities
Greater flexibility for targeting and prioritising services and needs			Greater flexibility for targeting and prioritising services and needs
Improved service profile and status in the community			Improved service profile and status in the community
Transfer of trust between services			Transfer of trust between services

Benefit to Aboriginal and Torres Strait Islander organisation	Benefit to Aboriginal and Torres Strait Islander community members	Benefit to mainstream community members	Benefit to mainstream mental health services
Greater scope for risk sharing			Greater scope for risk sharing
Ability to achieve objectives beyond single services' abilities			Ability to achieve objectives beyond single services' abilities
Reduced duplication of work and administration			Reduced duplication of work and administration
Increased capacity for innovation and creativity			Increased capacity for innovation and creativity
			Increased input and participation by Aboriginal and Torres Strait Islander people in the governance and use of the health service organisation

Sources: Jackson Pulver et al. (2019); Pleasance et al. (2014); Taylor & Thompson (2011); Wardliparingga Aboriginal Research Unit (WARU), 2017

Partnerships also have broader benefits to the health system, to funders and to government. Table 4 describes some of these.

Table 4: Broader potential benefits of partnerships

To …	Potential benefit
Health system	Greater reach
	Greater coherence
	Prevention of problems becoming entrenched or worsening
	More holistic perspective through inclusion of Aboriginal and Torres Strait Islander viewpoints
Funders and government	Reduced public expenditure through reduced duplication
	Reduced number of contracts
	Greater success in achieving whole of government objectives, including tackling 'wicked problems'
	Movement towards reducing health disparities

Sources: Pleasance et al., 2014; WARU, 2017

Potential to support rights

Partnerships can support the right of Indigenous peoples to self-determine policies and programs that affect health and wellbeing, and the rights generally of all people to access health care that meets their needs, which have been described and agreed to in two United Nations declarations (1976, 2008).

Potential to improve cultural safety, responsiveness and security

The word 'cultural' in the terms cultural safety, cultural responsiveness and cultural security in Australia most often refer to Aboriginal and Torres Strait Islander cultures. It follows that organisations developed by and for Aboriginal and Torres Strait Islander people are centred on, accountable to and seek to promote Aboriginal and Torres Strait Islander cultures, with an innate knowledge of Aboriginal and Torres Strait Islander peoples' cultural strengths. ACCHOs are especially well positioned to provide the conditions for cultural safety for Aboriginal and Torres Strait Islander people using them, because, as discussed earlier, they are operated and governed by Aboriginal and Torres Strait Islander people. Mainstream organisations partnering with ACCHOs have the potential to improve the cultural safety of the services they provide, by learning from and centring Aboriginal and Torres Strait Islander cultures, and being able to apply health professionals' guidelines and frameworks more readily and realistically to their local contexts.

The Australian Health Practitioner Regulation Authority's (AHPRA) *Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*, for example, says that cultural safety can only be defined and evaluated by Aboriginal and Torres Strait Islander service users, and that it is 'critical to enhancing personal empowerment' (2020, p. 9). AHPRA defines culturally safe practice as the 'ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism' (AHPRA & National Boards, 2020, p. 9)..

Beyond cultural safety's focus on the experience of service users lies the concept of cultural security, with a focus on mainstream healthcare governance being inclusive of Aboriginal and Torres Strait Islander people, and the:

> *brokerage of moral obligations into every point in the organisation so that protocols for cultural safety operate in every service pathway to create and sustain culturally secure environments for Australia's First peoples.* (Lock et al., 2019)

The main purpose of that definition 'is to bring a cultural voice – the human cultural perspectives of Aboriginal peoples – into Australian healthcare governance' (Lock et al., 2019).

In addition to cultural safety and security, the Australian Indigenous Allied Health Association (IAHA) have championed the concept of cultural responsiveness. This is about how 'health professionals, organisations and systems respond to an Aboriginal person, and their family and other supporters' in any therapeutic encounter 'to promote and maintain cultural safety'. Further, 'it is innately transformative and must incorporate (knowing), self-knowledge and behaviour (being) and action (doing)' (IAHA, 2019, p. 3).

It is essential that mainstream mental health services clearly define how they intend to support the conditions for cultural safety, cultural security and cultural responsivity. This takes dedicated time critically reflecting on the organisational culture, resources available and resources needed. This also means critically reflecting on what staff development plans already exist,

whether and how training and support for respectfully working with Aboriginal and Torres Strait Islander people and organisations could be added to this, and how monitoring, evaluation and continuous quality improvement will occur.

Partnerships are part of national, state and territory policy

In 2004, the Australian Health Ministers' Advisory Council (AHMAC) Standing Committee on Aboriginal and Torres Strait Islander Health Working Party developed its first *Cultural Respect Framework 2004-2009*, which included principles of holistic care, Aboriginal and Torres Strait Islander community control, mainstream health sector responsibility and working together in partnership, as well as localised decision-making, building capacity of health services and communities, and ensuring accountability. AHMAC renewed its 2004-2009 framework in 2016, and included clear statements about the importance of partnerships:

> *Effective partnerships between Aboriginal and Torres Strait Islander people, governments, primary health care networks, and service providers underpin the development and delivery of culturally respectful services.*
>
> *Collective efforts across the health sector in partnership with Aboriginal and Torres Strait Islander people and organisations address the broader social determinants of health.* (Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee, 2016, p. 5)

Partnerships are discussed and/or required:

- in all of the most recent federal, state and territory health planning documents (Luke et al., 2020)
- at all levels of health planning and delivery as part of the *National Aboriginal and Torres Strait Islander health plan 2021-2031* (Australian Government, 2021)
- as part of Standard 9 in the *National practice standards for the mental health workforce 2013* (Victorian Government Department of Health, 2013).

When partnerships are absent, the Australian Commission on Safety and Quality in Health Care says:

> *When Aboriginal and Torres Strait Islander people are marginalised and not engaged in decision-making, the result is ineffective use of resources, both human and financial, with limited improvement in outcomes.* (WARU p. 7)

A note of caution …

Many Aboriginal and Torres Strait Islander people and communities have had experiences with mainstream organisations who enter their lives, make promises with good intentions but find strategies do not go to plan, and they withdraw. Paternalism and the 'white saviour' syndrome is well known, and poorly regarded (Bennett et al., 2013; Nakata, 2007). Paternalism views Aboriginal and Torres Strait Islander people as experiencing inequities and worse health than

other people in Australia because Aboriginal and Torres Strait Islander health organisations, models of care, cultures and/or people must be problematic (Jackson Pulver et al., 2019).

This 'deficit discourse' informs and brings about ill-conceived plans for change (Fogarty, Lovell, Langenberg, & Heron, 2018). Past official Australian Government policy periods in relation to Aboriginal and Torres Strait Islander peoples, of protectionism, segregation, assimilation and integration, all positioned Aboriginal and Torres Strait Islander peoples as less able, less deserving and more needing of intervention and by European settlers and western models (Jackson Pulver et al., 2019). The denial and denigration of Aboriginal and Torres Strait Islander cultures still informs health service delivery, particularly because Aboriginal and Torres Strait Islander knowledges are largely missing from current health education curriculum at tertiary levels, and so are missing from the skills of many graduates (Manton & Williams, 2021).

Health professionals practising now, and many recent graduates, are not educated in or skilled in Aboriginal and Torres Strait Islander health models or working in partnerships with Aboriginal and Torres Strait Islander organisations (Manton & Williams, 2021). But power in the mainstream health setting lies with these health professionals because they constitute the majority of employees, and because Aboriginal and Torres Strait Islander people are under-represented (NSW Public Service Commission, 2019).

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) warns that:

> *Tokenistic involvement of Aboriginal and Torres Strait Islander people doesn't lead to better services for Aboriginal and Torres Strait Islander families. It can, in fact, hold up progress, as the appearance of partnership masks deeper mistrust, maintains power imbalance and fails to promote reconciliation. Achieving better outcomes requires a shared commitment to building deeper, respectful and more genuine relationships.* (SNAICC, 2014, p. 8)

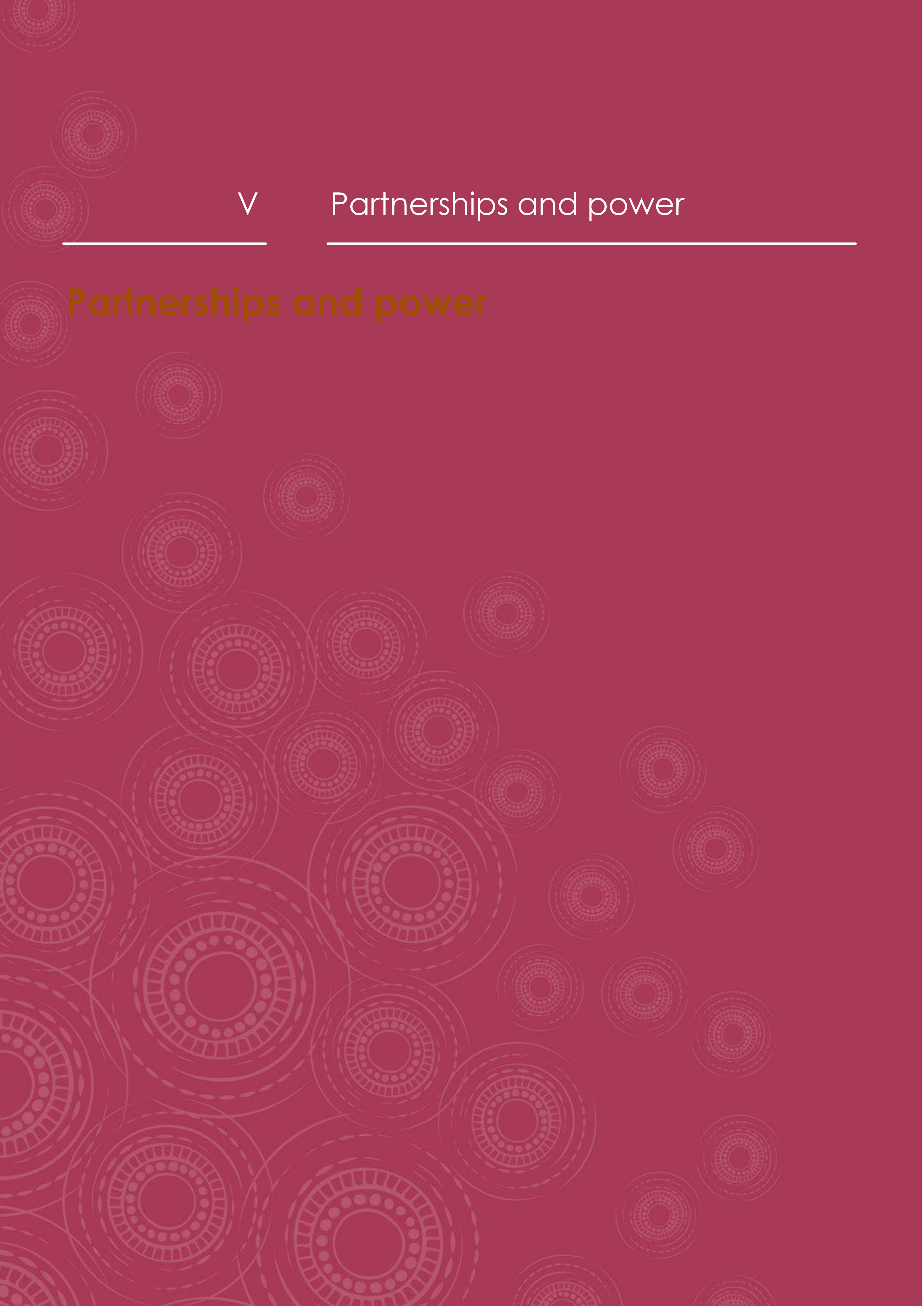
In other words, if organisations are not seeking partnerships for the right reasons and for the long term, it is better if they do not engage, at least not until they are prepared and ready.

Implications of this chapter

Partnerships are necessary because mainstream mental health services often do not meet the needs of Aboriginal and Torres Strait Islander people. Yet ACCHOs and other Aboriginal and Torres Strait Islander health services are not adequately funded to meet need either, despite their models of care being based on Aboriginal and Torres Strait Islander cultures and creating the conditions for cultural safety. State, territory and national policies recognise this.

Partnerships can have significant benefits for mainstream mental health services, in that they can learn about the needs of their clients and ways to meet them, and they can learn about holistic care, which will be of benefit to all clients, Indigenous or not. Partnerships can provide Aboriginal and Torres Strait Islander organisations with funding and person-power to extend their reach, and might provide access to specialised services they may not otherwise have access to.

But if partnerships are tokenistic, that could be worse than no partnership, as it could increase levels of distrust among Aboriginal people and communities, waste scare resources and time in the context of gross health and social inequities, and risk reducing use of mainstream services by Aboriginal and Torres Strait Islander people.



V Partnerships and power

Partnerships and power

There are many different types of relationships, and only some of them can truly be called partnerships. In true partnerships, power is shared. And the contractual arrangements used can have a significant impact on satisfaction.

Possible relationship types

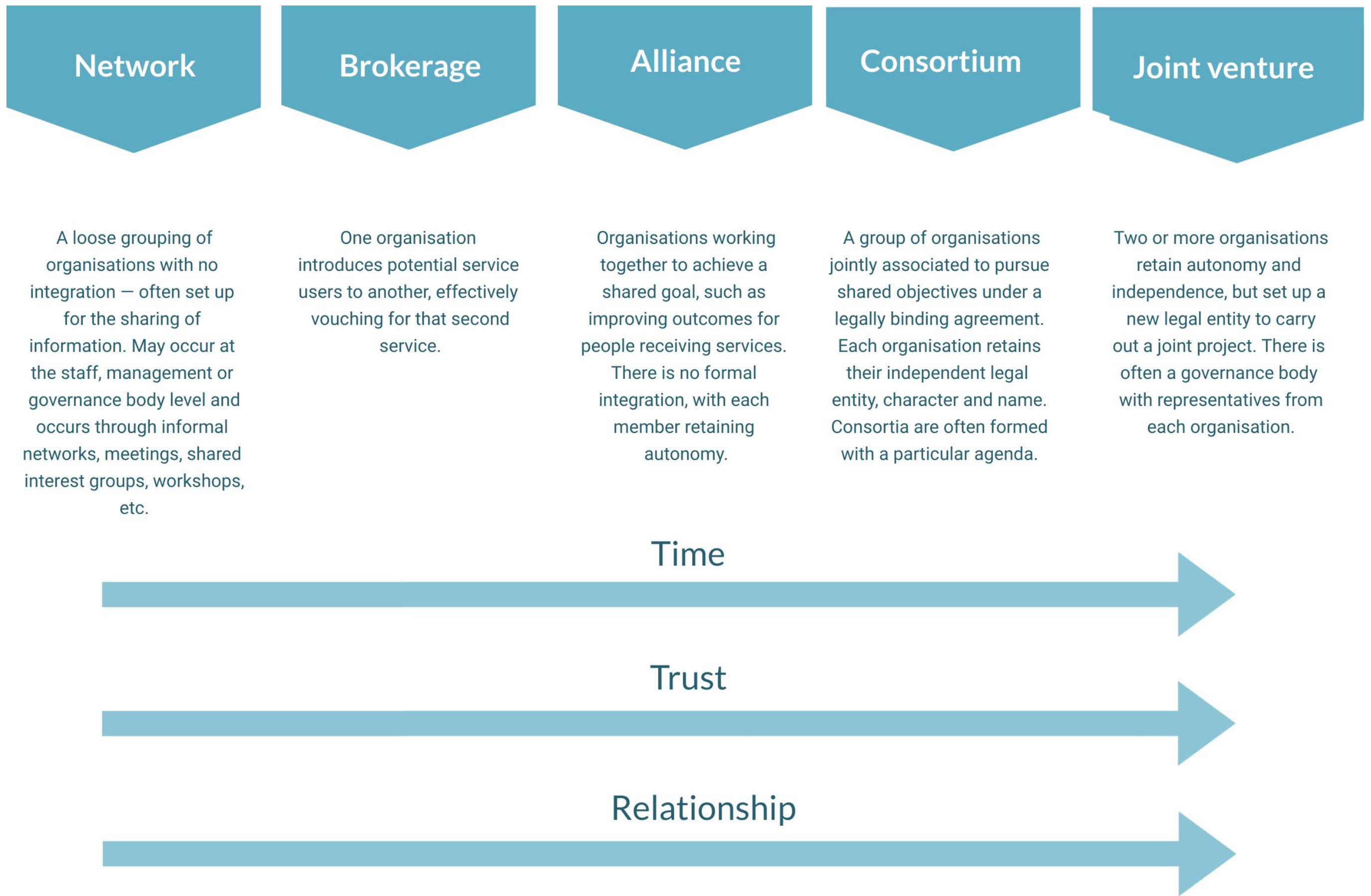
After more than a decade of empirical research on service delivery in the Australian legal assistance sector, Pleasance, Courmarelos, Forell, & McDonald (2014, p. 69) describe many different types of collaborations:

> *Services may be joined-up formally (through contracts or memoranda of understanding) or informally (through practice), episodically or continuously, horizontally (e.g. as with separate specialist services) or vertically (e.g. as with generalist and specialist services), within sectors or between sectors, visibly or invisibly, physically or remotely, voluntarily or forcibly, for private purpose or for social goals, and they may be joined to any extent on a continuum that extends from near complete separateness to full integration. Services may also be joined-up internally, within organisations, and externally, between organisations…*

This multiplicity of collaborations and relationships also exists in the health sector.

Figure 5 describes several types of relationships that are common in the health sector to support health care. They range from a network, which is a loose grouping of organisations generally formed to share information, through brokerage, alliance, and consortium to joint venture, where a new legal entity is often formed to carry out a joint project. All of these exist in the Australian health sector, and in arrangements for Aboriginal and Torres Strait Islander health care. Collaborations and relationships varying according to local leadership, decision making, timing and resources, as well as skills of the workforce and types of needs of community members.

Figure 5: Collaborative relationships by structure



Source: Adapted from Pleasance et al., 2014; SNAICC, 2014a

Organisations involved in relationships towards the left of Figure 5 have more autonomy, while those involved in relationships at the right, which can be considered true partnerships, demand more time and trust.

Some partnerships change structure over time, as shown in the case studies below. For example, a number of ACCHOs in a regional area may have worked together cooperatively for some time, before deciding to form a consortium. That consortium may be unincorporated initially, before becoming incorporated.

Redressing power imbalances in relationships

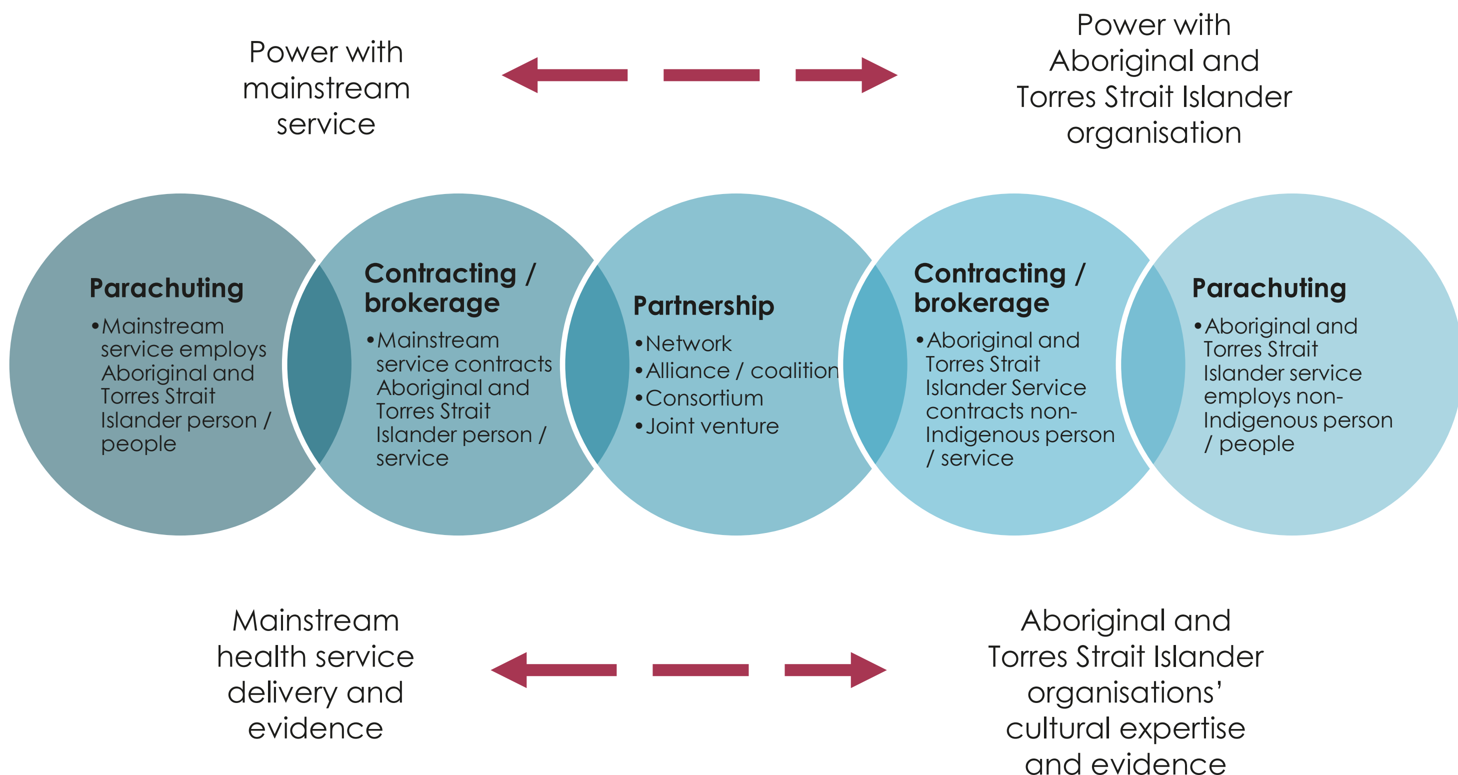
Michael Coutts-Trotter, secretary of NSW Department of Premier and Cabinet, and former secretary of Department of Communities and Justice, spoke at a national Health Justice Australia conference in 2019 about the positionality of government.

> *We have to acknowledge our errors and be really open about that. We have to lay down some of the extraordinary powers we hold and work hard to make ourselves available and accountable to the people we serve. In our agency, most of [the people we serve] are at the absolute margins of the community, and unless we work really hard to make it possible for them to approach us, they can't and they won't.* (Ragg, 2019)

Figure 6 shows that power is experienced occurs on a spectrum, from little power vested in Aboriginal and Torres Strait Islander organisations when compared to mainstream services, to equal or more power being with Aboriginal and Torres Strait Islander organisations when compared to mainstream services.

Figure 6 also summarises some of the current strategies used to engage Aboriginal and Torres Strait Islander staff in mainstream organisations, and mainstream staff in Aboriginal and Torres Strait Islander organisations. In Figure 6, partnerships represent a negotiated space between two extremes of 'parachuting' a single Aboriginal and/or Torres Strait Islander staff member into a government service with little scaffolding or support, or similarly parachuting a non-Indigenous person into an ACCHO. Both of these risk isolation, stress and worldview clashes, unless well supported and negotiated. Contracting and brokerage can offer somewhat more flexibility than embedding an employee in an organisation.

Figure 6: Power in relationships



In partnerships, if the locus of power is with the mainstream service, the risk is that mainstream and biomedical thinking and processes will dominate and will negate, minimise or erroneously apply selected parts of Aboriginal and Torres Strait Islander cultures. This discourages Aboriginal and Torres Strait Islander people from using the mainstream service and erodes the conditions for cultural safety.

If power is with Aboriginal and Torres Strait Islander organisations and is not supported either in principle, practice or through resourcing by mainstream service partners, an undue burden is on Aboriginal and Torres Strait Islander organisations, particularly in the context of their under-funding compared to demand and need.

Mainstream organisations openly discussing, negotiating and where necessary ceding power to Aboriginal and Torres Strait Islander organisations is foundational to demonstrating commitment

and improving the quality of the relationship. As the diverse case studies later in this report demonstrate, this can occur in partnerships where each partner identifies and negotiates how they contribute, and where they have power in leading and in supporting others to lead. This requires a commitment to communicating openly and honestly (Haswell et al., 2013) as much as it does to redressing power and decision-making structures, relationships and outcomes that are unequal and/or discriminatory (Burton, 2012).

In any partnerships, negotiated and agreed roles for all parties are essential, as is the reflection of diversity of Aboriginal and Torres Strait Islander peoples, including involvement and leadership of local Aboriginal and Torres Strait Islander Traditional Owners, Elders, and other community leaders, and across generations.

Alternatives to partnerships

Many mainstream services wanting to improve their responsiveness to the needs of Aboriginal and Torres Strait Islander people have used alternative approaches to partnerships, including using brokerage services and what is colloquially known as ‘the black parachute’. While these are at times used, they present risks to respectful engagement that partnerships require.

Brokerage service

A brokerage service is a service that connects individuals to a health care or social service, bridging a gap in the social structure and empowering that individual to access and use a range of resources (Thomas et al., 2019). Brokerage services can be used when health and social services have not adapted sufficiently to the needs of disadvantaged or marginalised groups of people. They can be effective in improving access, partly because of their advocacy for the individual (Thomas et al., 2019).

An evaluation of one brokerage service in south-western Sydney, which aimed to support Aboriginal and Torres Strait Islander people to access mainstream health services, said those people who used the service found it useful, and that it increased their access to health care (Dennis et al., 2015).

While brokerage services are useful, perceived limitations include the limited power of a brokerage service to improve and reform the existing structures and organisations (Dennis et al., 2015). In other words, the mainstream service doesn’t have to change to meet the needs of Aboriginal and Torres Strait Islander people if it can employ a brokerage service to guide and support Aboriginal and Torres Strait Islander people who use that mainstream service.

Black parachute

A ‘black parachute’ is a colloquial term that describes the employment of a single Aboriginal and/or Torres Strait Islander person in a mainstream health service (Williams et al., 2022). It is an approach taken at times by organisations that wish to improve their services to Aboriginal and Torres Strait Islander people, or that wish to meet Aboriginal and Torres Strait Islander staff targets, and increase the diversity of their workforce.

This approach can be effective if the organisation is seeking to genuinely change its workforce and practices, and if the first Aboriginal and/or Torres Strait Islander employed is simply the first of many. That would require that the only Aboriginal and Torres Strait Islander person is well supported by a management that is investing in educating itself and its workforce about Aboriginal and Torres Strait Islander ways of knowing, being and doing.

But it is not useful if tokenistic, or if the Aboriginal and/or Torres Strait Islander person is parachuted into a workplace that is culturally unsafe. Aboriginal and Torres Strait Islander people have higher separation rates from government organisations than non-Indigenous people (NSW Public Service Commission, 2019).

The person who fills the role of the black parachute is often precariously positioned in the organisation, often with a manager not trained or experienced in supervising Aboriginal and Torres Strait Islander staff or working in partnership with Aboriginal and Torres Strait Islander organisations (Bailey et al., 2020; Williams, Ragg, & Manton, 2019). This renders Aboriginal and Torres Strait Islander staff culturally isolated, and exposed to:

- unfair treatment, as 38% of the Aboriginal and Torres Strait Islander workforce reports
- hearing racial slurs, as 44% of the Aboriginal and Torres Strait Islander workforce reports
- appearance racism, in which they receive comments about how they look or 'should look' as an Aboriginal and Torres Strait Islander person (Diversity Council Australia/Jumbunna Institute, 2020; Williams et al., 2019).

They might also experience forms of identity strain, which is the strain Indigenous employees feel when they themselves, or others, view their identity as not meeting the norms or expectations of the dominant culture in the workplace (Diversity Council Australia/Jumbunna Institute, 2020).

They are also more likely to experience the cultural load of being an Aboriginal and Torres Strait Islander person in a mainstream organisation. Cultural load is a type of burden, that adds up over time to be a threat to Aboriginal and Torres Strait Islander staff wellbeing (Diversity Council Australia/Jumbunna Institute, 2020). Cultural load can occur when Aboriginal and Torres Strait Islander people are seen as:

- responsible for care and/or service to all Aboriginal and Torres Strait Islander clients/patients/customers
- responsible for efforts to improve the cultural knowledge and safety of the workplace
- representative of all Aboriginal and Torres Strait Islander peoples in Australia
- representative of the employer by Aboriginal and Torres Strait Islander peoples and held responsible for the employer's actions (Williams et al., 2022).

The following quote highlights the burden one Aboriginal and Torres Strait Islander staff member of a mainstream organisation experienced, being isolated and under pressure to bring about change related to issues embedded much deeper that what was in the scope of their role or power to change:

> *It's not our job to be the educators and make the workplace more inclusive. That just gives us more of a workload than anyone else and puts our jobs and career at risk for not meeting normal work KPIs. Otherwise, recognise and reward differently the load that we carry on behalf of everyone else.* (Diversity Council Australia/Jumbunna Institute, 2020)

Contracts: relational or business focus?

One of the most important considerations is whether a partnership aims to operate within a purely business environment, or whether it seeks to be based on relationships.

In a purely business relationships, the focus is on what work will be done for what payment. In a partnership that focuses on relationships, the work that is done arises from shared understanding

of what is needed and how to do it. Service levels agreements, memorandums of understanding and contracts – what could be called the contractual environment – tend to reflect how the relationship is seen.

Relational contracting environments, rather than business-focused contractual environments, are considered most relevant to Aboriginal and Torres Strait Islander cultures (Lavoie, Boulton, & Dwyer, 2010), with Aboriginal and Torres Strait Islander cultures described as being relational cultures (Sheehan, 2011).

Relational contracting environments offer a greater degree of self-determination and local responsiveness, and yield a better environment for addressing the persistent health inequalities which exist between Indigenous and non-Indigenous peoples (Lavoie, Boulton & Dwyer, 2010). The differences between the two are described in Table 5.

Table 5: Complications and benefits of the different contracting environments for Aboriginal and Torres Strait Islander organisations

	Business-focused contractual environments	Relational environments
Context	Organisations access funding for programs through a number of separate classical contracts to fund a complement of primary health care services	Funding agency engages with a provider in a long-term flexible contract to fund a core set of ongoing primary health care services
Nature of funding	Short-term, competitive, can be unstable from year to year	Long-term, non-competitive, population-based, stable
	Funder allocates funding to meet nationally defined priorities	Promotes priority setting based on the pattern of needs experienced by patients and their relationship with the provider
Priority setting	Funding agreements focus on individual interventions (e.g. immunisations) or single activities (e.g. workshops)	Promotes comprehensive primary health care and population approaches (e.g. prevention, health promotion, primary care treatment and rehabilitation services)
Monitoring	Explicit output requirements facilitate contract monitoring for single contracts	Contract monitoring more challenging for purchaser and costs may offset transaction cost savings
	Reporting requirements associated with multiple contracts are onerous	Reporting requirements can be lower
Transaction costs	High administrative costs associated with a single contract are compounded with multiple contracts	Relational contract carries lower transaction costs for both the funder and provider, may be partly offset by relationship-building and negotiation costs
Risk	Higher financial risk for the provider, who bears the responsibility to secure and acquit funding	Considerable management risk for purchaser in case of non-performance, and viability risk for the provider if the contract is not renewed

Source: Lavoie, Boulton, & Dwyer, 2010, p. 672

Relational contracting environments offer ACCHOs more flexibility to do the work that is required in the way that it is required, while classical contracting demands that work is reported in a way that suits the funder, but may not reflect the work done.

Implications of this chapter

There are many different types of relationships between organisations, but the term 'partnership' should be reserved for relationships that are substantially equal. Because mainstream organisations tend to be larger and better funded than ACCHOs, mainstream services wanting to enter partnerships should recognise the current imbalances in power, and seek to redress that by consciously ceding some of power to the Aboriginal organisations. This is likely to result in services that are more appropriate for Aboriginal and Torres Strait Islander people.

Partnerships should be built on a contracting environment that is relational, rather than classical. In other words, it acknowledges that relationships are important to Aboriginal and Torres Strait Islander societies, and that a purely business relationship based on a written contract is unlikely to succeed.

Some organisations seeking to work with Aboriginal and Torres Strait Islander communities and organisations employ Aboriginal and Torres Strait Islander people when they have not done so before. Being the only Aboriginal and Torres Strait Islander person in a mainstream organisation can result in enormous pressures on that person, and can be unsatisfactory. Mainstream organisations planning to employ Aboriginal and Torres Strait Islander people for the first time should spend time learning from Aboriginal and Torres Strait Islander authors and organisations what is at stake, and how to reduce risks.

VI Experience and expectations

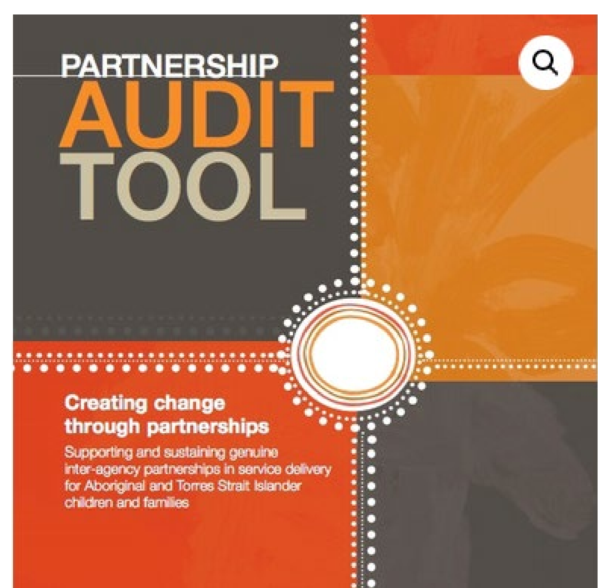
Many Aboriginal and Torres Strait Islander organisations, who have worked in partnership with mainstream services, have documented the principles, practices and protocols that support effective partnerships. The following are practices and protocols supported by a range of urban and rural organisation from different jurisdictions.

SNAICC's body of work on partnerships

The Secretariat of National Aboriginal and Islander Child Care is a national body with a diverse membership of Aboriginal and Torres Strait Islander community-based child care agencies, multi-functional Aboriginal children's services, crèches, long day care child care services, pre-schools, early childhood education services, early childhood support organisations, family support services, foster care agencies, family reunification services, family group homes, services for young people at risk, community groups, voluntary associations, government agencies and individual supporters. It is the peak body for Aboriginal and Torres Strait Islander children. SNAICC members often have in partnership arrangements with other organisations.

Over the past decade, SNAICC has carried out and published a substantial body of work on partnerships[1], including:

- *Working and walking together: Supporting family relationship services to work with Aboriginal and Torres Strait Islander families and organisations* (SNAICC, 2010)
- *Opening doors through partnerships: Practical approaches to developing genuine partnerships that address Aboriginal and Torres Strait Islander community needs* (SNAICC, 2012)
- *Developing capacity through partnerships* (AbSec and SNAICC, 2013)
- *Partnership training manual: Creating change through partnerships* (SNAICC, 2014)
- *Partnership audit tool: Creating change through partnerships* (SNAICC, 2014)
- *Applying for funding for Aboriginal and Torres Strait Islander child and family services: A guide to best-practice partnerships between Aboriginal and Torres Strait Islander and non-Indigenous organisations* (SNAICC, 2020a)
- *Creating change through partnerships: An introductory guide to partnerships between Aboriginal and Torres Strait Islander and non-Indigenous organisations in child and family services* (SNAICC, 2020b).



[1] All images in this section are sourced from https://www.snaicc.org.au

SNAICC's principles for successful partnerships

In a recent paper, SNAICC identified eight interrelated principles that form the building blocks of successful partnerships between Aboriginal and Torres Strait Islander organisations and non-Indigenous services (SNAICC, 2020a). These follow in Table 6, with an explanation of what they require.

Table 6: Principles and practices of successful partnerships

Principle	This requires ….
Commitment to long-term sustainable relationships based on trust	Significant time is spent building relationships between staff, organisations and community. Partners commit to ongoing relationship, not only an activity or project.
Respect for Aboriginal and Torres Strait Islander cultures and history	Commitment to build cultural understanding, to consult and listen to the local community, and to value Aboriginal and Torres Strait Islander knowledge and professionalism.
Commitment to self-determination for Aboriginal and Torres Strait Islander peoples	Empowering Aboriginal and Torres Strait Islander communities to lead response to child and family needs. Building Aboriginal and Torres Strait Islander community, organisation and workforce capacity.
Aim to improve long-term wellbeing for Aboriginal and Torres Strait Islander children, families and communities	Identifying and sharing respective strengths in supporting children and families. Partnership resources viewed as community resources and shared for the benefit of children and families.
Shared responsibility and accountability for shared objectives and activities	Negotiated and shared vision is developed. Partners jointly develop indicators of success and work together to monitor and evaluate progress.
Valuing process elements as integral to support and enable partnership	Agreements clarify commitments, roles and accountability. Time and resources are allocated to joint planning, review, and partnership development.
Redressing unequal or discriminatory relationships, structures and outcomes	Recognising that Aboriginal and Torres Strait Islander disadvantage reflects historical and continuing discrimination, and working to correct resulting power and resource imbalances.
Working differently with Aboriginal and Torres Strait Islander children and families	Developing cultural competence and safety in service delivery. Recognising non-Indigenous approaches are often not the best way to engage and support Aboriginal and Torres Strait Islander families.

Source: SNAICC, 2020a, p. 6

SNAICC's key questions

SNAICC says key questions for non-Indigenous organisations to ask themselves before committing to partnering with an Aboriginal and Torres Strait Islander organisation are:

- Would we be competing with an Aboriginal and Torres Strait Islander organisation?
- Do we have an existing partnership or relationship with an Aboriginal and Torres Strait Islander organisation?
- Are there clear expectations about the partnership?

- Is the partnership with the Aboriginal and Torres Strait Islander organisation based on a long-term commitment to mutually agreed objectives or outcomes?
- Does the program funding reflect the views and aspirations of the intended beneficiaries? (SNAICC, 2020a)

Key questions for Aboriginal and Torres Strait Islander organisations must ask themselves before partnering with a non-Indigenous organisation are:

- Do we have the skills and capability necessary to lead the delivery of the relevant services for children and families in our community, and if not, is a partnership the best way to support our delivery and capacity development?
- Are prospective partners committed to working respectfully in ways that are culturally safe for our organisations, and for our community?
- Do prospective partners share our commitment to building capacity, skills and leadership in the local Aboriginal and Torres Strait Islander community? (SNAICC, 2020a)

Essential content for any funding application includes:

- community engagement and participation
- clear identification of roles and responsibilities
- accountability and evaluation
- a clear exit strategy
- building the capacity of Aboriginal and Torres Strait Islander organisations (SNAICC, 2020a).

SNAICC's strategies to build and maintain genuine partnership

SNAICC describes the strategies required to build and maintain genuine partnerships.

1. Build your and your organisation's cultural competence
2. Spend time building respectful relationships of trust with Aboriginal and Torres Strait Islander people and communities and their organisations
3. Listen and learn from Aboriginal and Torres Strait Islander peoples to determine how you can support capacity for community-led responses
4. Establish the processes, governance structures and accountability required for effective and sustainable partnerships (SNAICC, 2020b).

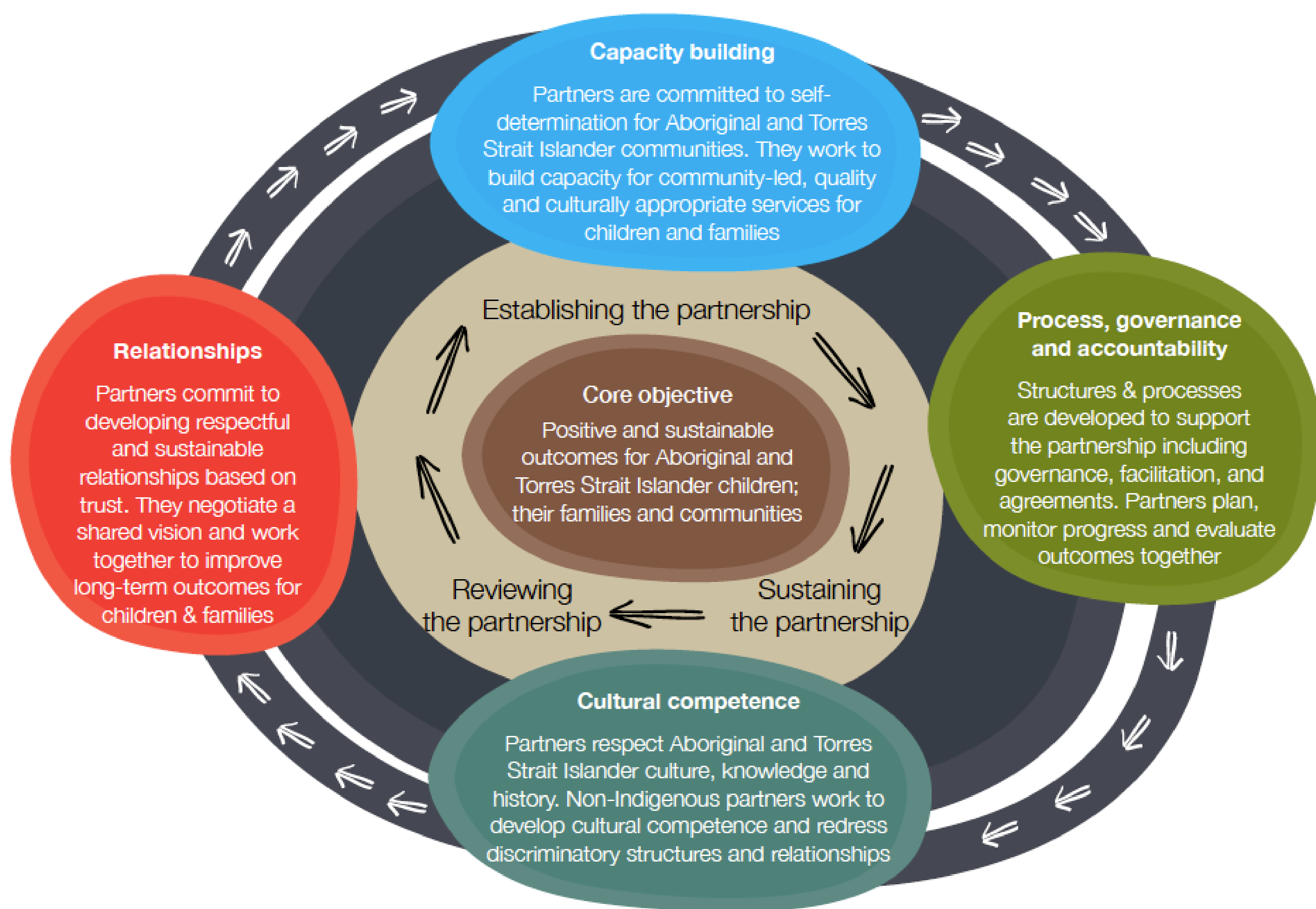
SNAICC's *Creating change through partnerships: An introductory guide to partnerships between Aboriginal and Torres Strait Islander and non-Indigenous organisations in child and family services* (2020b) is an excellent resource, and applies equally to the mental health sector as it does to the child and family services sector.

SNAICC has also developed a draft statement of commitment for SNAICC recommends that non-Indigenous organisations wishing to work in partnership with Aboriginal and Torres Strait Islander organisations make special commitments that, if kept, will enable a stronger partnership. It has published draft text for organisations to consider using (SNAICC, 2014, pp. 13-14), reproduced in Appendix 2.

SNAICC's framework for genuine partnership

SNAICC has developed a framework for developing genuine partnerships, which is shown in Figure 7. The figure shows a shared core objective, and a cycle of establishing, sustaining and reviewing the partnership itself. It also describes the key elements: capacity-building; relationships; cultural competence; and process, governance and accountability.

Figure 7: SNAICC's framework for partnership development



Source: SNAICC, 2020b, p. 8

APO NT's partnership principles

APO (Aboriginal Peak Organisations) NT is an alliance comprising the Central Land Council, Aboriginal Housing NT and the Aboriginal Medical Services Alliance of the NT.

The alliance was created as a forum for advocacy regarding the Northern Territory Emergency Response, which drastically curtailed the independence of Aboriginal and Torres Strait Islander peoples in the Northern Territory. It strives to set a jurisdictional agenda, rather than responding to government policy initiatives, programs and service delivery (APO NT, n.d.).

APO NT seeks to work with non-Aboriginal organisations to strengthen and rebuild an Aboriginal-controlled development and service sector in the NT. It developed principles to guide the development of a partnership-centred approach for non-Aboriginal non-government organisations engaging in the delivery of services or development initiatives in Aboriginal communities in the NT. These principles embody a community development approach, and draw on the *United Nations Declaration on the Rights of Indigenous Peoples* (APO NT, n.d.).

Non-Aboriginal organisations such as NGOs must acknowledge and agree to these principles before members of APO NT will work with them. They must agree to:

- consider their own capacity to deliver effective and sustainable outcomes in the NT context
- recognise existing strengths and capacity of Aboriginal NGOs and identify how they can contribute to further developing this capacity
- research existing Aboriginal service providers and development agencies before doing anything
- seek partnerships with Aboriginal NGOs and not compete
- be guided by the priorities of the Aboriginal NGO in developing the partnership
- recognise, support and promote existing development practice
- work with Aboriginal people to create strong and viable Aboriginal organisations
- ensure Aboriginal control rather than consultation
- have a clear exit strategy
- ensure robust evaluation and accountability (APO NT, n.d.).

As of 2020, 24 mainstream organisations had signed up to the principles (APO NT, 2020).

Malparara: Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara Women's Council's model of working

Aboriginal women of the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Lands created NPY Women's Council in 1980 to give a voice as well as create a vehicle to harness the collective agency of the women. [2]

A service delivery, advocacy and support organisation, with a significant profile of advancing reform in areas they work, NPY Women's Council is governed and directed by Aboriginal women, leaders and passionate consumer advocates, from across 26 desert communities in the cross-border regions of Western Australia, South Australia and the Northern Territory.

In 1994 the council incorporated under the federal *Aboriginal Councils and Associations Act 1976 (ACA Act*). The original membership application nominated 25 women from the 'three sides' of the NPY region. In 2007 the *Corporations (Aboriginal and Torres Strait Islander) Act 2006 (CATSI Act)* replaced the ACA Act.

Today the organisation governs a range of activities and services around child development, youth programs, family violence, disability, traditional healing, and making practical improvements to women's lives including increased income through promoting traditional arts such as weaving. It has a multi-million-dollar budget. For more information, see https://www.npywc.org.au. The collective agency combined with regular consumer advocacy is a powerful and enviable learning loop for the organisation.

Membership of the organisation is open to any Aboriginal woman who is at least 16 years of age whom the directors consider having sufficient cultural or family ties to the region. An applicant must also be deemed by the directors to be of good character and willing to follow the rules and guiding principles of the organisation. From the membership, 12 directors are elected by secret ballot every two years with equal representation from each of two states and one territory that comprise the region.

NPY Women's Council uses a model of working called 'Malparara' (meaning 'friendship' or 'companion' or 'partnership'). Developed by senior Aboriginal women, the model invites workers to pair up to share skills, experiences and knowledge so to enhance the effectiveness of the council's activities and services and ensures that the concerns and problems of local communities are listened to and addressed properly. The pairing up with senior Aboriginal women and sometimes men with non-Indigenous workers, is an optimal dynamic that does deliver extraordinary experiences. The council also recognises the power of pairing people, with diverse skills, backgrounds and experiences, so for example two non-Indigenous workers, as another variation of the model, this pairing can also bring to the fore significant learning and insights within the service and governance model of the council.

[2] This report is reproduced with permission from Dudgeon, P., Calma, T., Milroy, J., McPhee, R., Darwin, L., Von Helle, S., & Holland, C. (2018). *Indigenous governance for suicide prevention in Aboriginal and Torres Strait Islander communities: A guide for primary health networks*. Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Black Dog Institute, pp. 24-25. Image is sourced from https://www.npywc.org.au

Mainstream non-Indigenous partners generally brought knowledge to partnerships of how to navigate mainstream services and programs. Despite this valuable contribution, however, Malparara does not assume that mainstream ways of dealing with issues are the only or the best ways. Further, it is not aimed at 'teaching' the Aboriginal partners the skills of their non-Indigenous partner. Instead, it recognises and values the knowledge, skills and resources of local Aboriginal people, seeing these as critical inputs to better activities and services, that work in culturally safe and effective ways.

The work of NPY Women's Council is an example of how Indigenous culture goes hand in hand with good corporate governance. For example, the organisation's service development approach includes:

- Kulilkatinyi (considering something over a long period of time)
- Nyakukatinyi (looking for something as one goes along)
- Palyalkatinyi (making something as one goes along)

This process ensures services that are developed and delivered by the organisation are continually reviewed and improved.

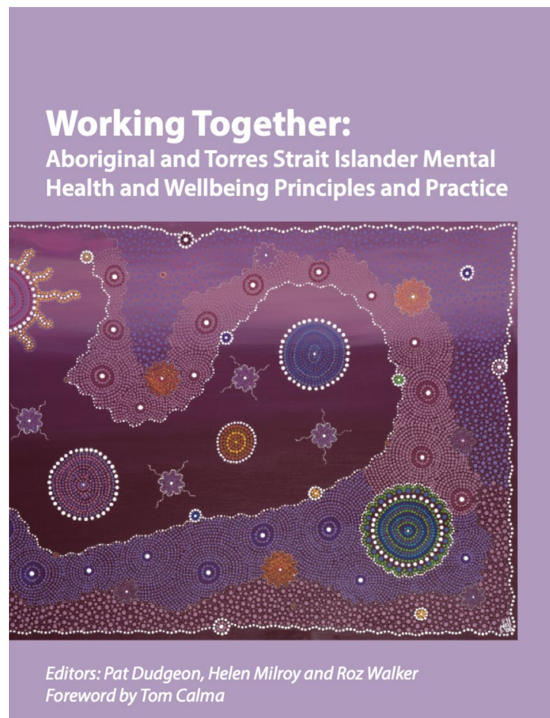
The organisation's constitution includes guiding principles for organisational, member and employee behaviour, these are:

- Ngapartji ngapartji kulinma munu iwara wananma tjukarurungku – respect each other and follow the law straight
- Kalypangku – conciliatory
- Piluntjungku – peaceful and calm
- Kututu mukulyangku – kind-hearted
- Tjungungku – united
- Kunpungku – strong.

All partnership members are invited to attend an annual general meeting in a bush location, to receive reports from directors and staff and to provide referrals, responses to service delivery and ongoing input on issues that affect them and their families. Members also attend an annual women-only law and culture meeting organised at remote locations in the region. These gatherings provide an opportunity for women from the region to come together to celebrate and consolidate their traditional cultural practices and identity.

Working together

The text *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (Dudgeon, Milroy, & Walker, 2014) was written to inform and guide mental health professionals seeking to or already working with Aboriginal and Torres Strait Islander people and organisations.



Working together says that to meet mental health practice standards and the standards of relevant professions to provide equitable services for Aboriginal and Torres Strait Islander peoples, health services and health professionals have a professional and ethical responsibility to:

- increase the competence of their staff and the organisation
- form partnerships with local ACCHOs who have more cultural understanding and may be considered more appropriate by community members
- employ Aboriginal health workers, Aboriginal mental health workers or other Aboriginal and Torres Strait Islander health professionals within the organisations.

On working in partnership, the authors say that:

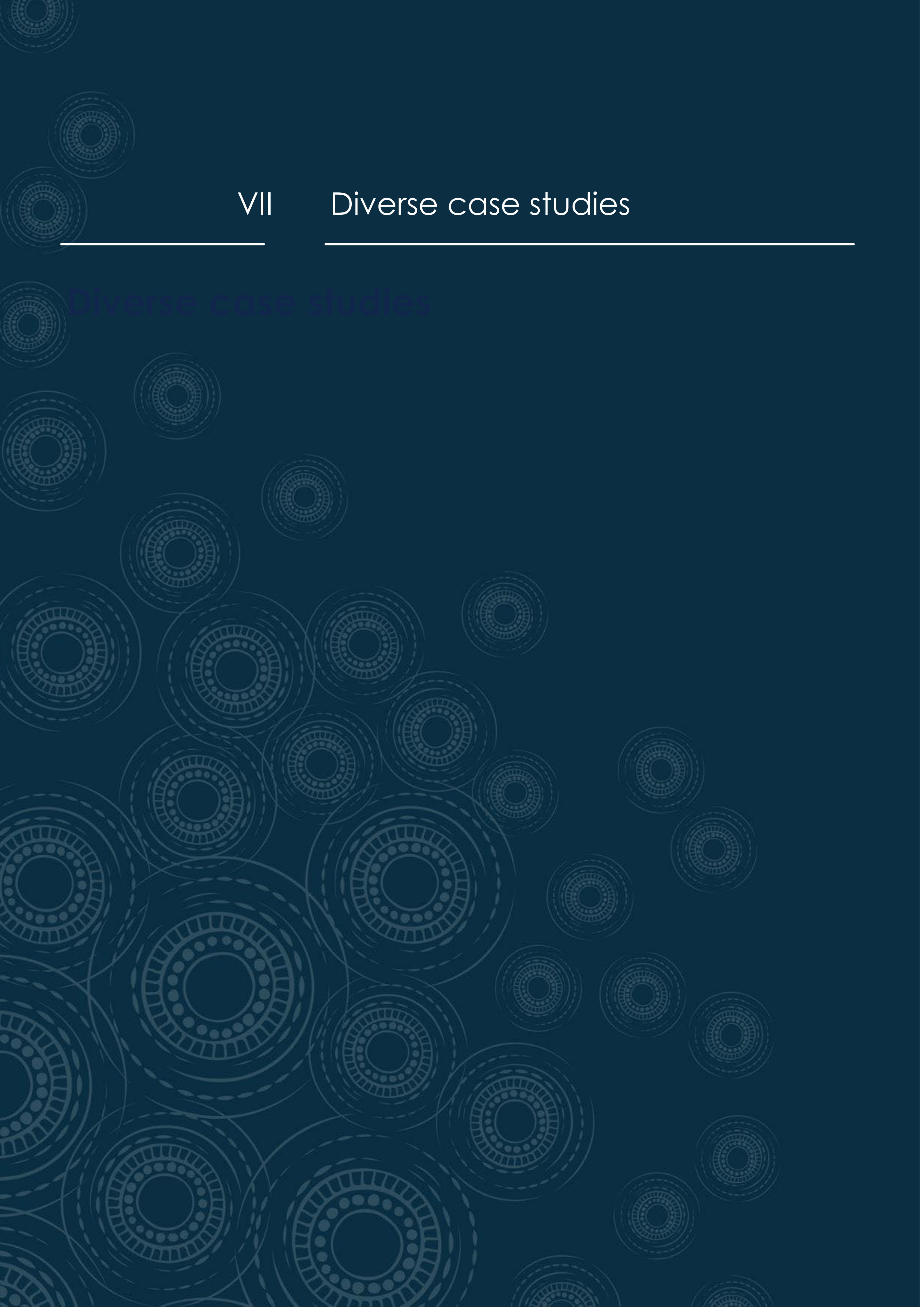
- developing an effective partnership takes time, trust and personal relationship – for most Aboriginal Australians, who you are is more important than what you are
- having regard for Aboriginal protocols in community contexts is essential – often a process of vouching is required, in which one or some of the community members will attest to the person wishing to enter the community
- working in collaboration with cultural consultants strengthens projects and organisations; they will advise about cultural matters, provide guidance in appropriate behaviour, and mediate between the practitioner and the family/carer and community (Dudgeon et al., 2014).

Implications of this chapter

This chapter shows the effort Aboriginal and Torres Strait Islander people and organisations have put into explaining their cultures, principles, practices and ways of working to mainstream organisations.

It also highlights the diversity of approaches.

Mainstream mental health services wishing to partner with Aboriginal and Torres Strait Islander need to do the work to grasp generalities about working with Aboriginal and Torres Strait Islander people and organisations, then about the particular group with which they wish to work.



VII Diverse case studies

Diverse case studies

Looking Forward and Looking Forward Moving Forward

The *Looking Forward* (2011-2015) project was the result of cooperation between the Nyoongar people of south-eastern Perth, an Aboriginal-led project team, and with mental health and drug and alcohol service providers, in an effort to change the way services are provided there. It took place on the lands of the Wadjuk clan of the Nyoongar nation. It is, in some ways, a research project about establishing a partnership and the framework within which that partnership will operate.

The *Looking Forward Moving Forward* project (2017-2021) is the story of how Nyoongar Elders, the project team and mainstream service providers and peak bodies took what they had learned from *Looking Forward* and built on it to influence government and community sector mental health and drug and alcohol services to Aboriginal people throughout Western Australia.

Looking Forward (2011-2015)

The *Looking Forward* project began in 2011 after Dr Michael Wright, a Yuat Nyoongar man who had worked as a hospital-based social worker and as a mental health manager with an Aboriginal Community Controlled Health Organisation, completed his PhD in 2010.

His PhD investigated the caregiving experiences of Aboriginal people affected by mental illness, and the Aboriginal participants in the study had told him that interactions with mental health providers were often 'very debilitating, disempowering and traumatic' and that any future research should focus on changing the way the mental health system engaged Aboriginal people.

He sought to do this by forming a cross-cultural multidisciplinary project team managed from Curtin University, with the ongoing support of participants from the study. The participants also assisted Dr Wright by providing support and advice for his National Health and Medical Research Council (NHMRC) post-doctoral award and for the project funding provided by Lotterywest.

The *Looking Forward* project team said their approach was:

> *informed by an Indigenous research framework, motivated and inspired by Indigenous colleagues, personal experiences and writings by Indigenous scholars (Tuhiwai-Smith, 2003; Rigney, 1997; Moreton-Robinson, 2000; Wright, 2011) and by contributors to the literature on participatory action research (Stringer, 1996; Wallerstein, 1999; Pyett, 2002; Fine and Weis, 2005), emancipatory research (Lather, 1991; Friere, 1983; Wallerstein & Sanchez-Merki, 1994) and critical community development (Kelly, 1991; Kretzmann & McKnight, 1993; Holland & Blackburn, 1998; Ife & Tesoriero, 2006).* (Wright et al., 2013, p. 8)

Following is a summary of the process followed to develop the partnership.

Engaging the community (2011-2012)

The project team attended Aboriginal community events and mental health awareness events, meeting people, sharing ideas, and developing relationships, familiarity and trust. The project team then formally met with 14 community-based non-government organisations, largely mental health and drug and alcohol service providers, to introduce themselves and the project

and seek commitment to take part. The project team also held 11 community forums and 10 smaller community focus group discussions and did a survey about experiences and impacts of racism.

The project team originally intended to develop a process for putting mainstream service providers in touch with Aboriginal community members so as to inform changes within the services. But they paused the process, as initial consultations revealed a high degree of distrust among Aboriginal community members towards service providers. The project team decided to work more closely with a small cohort of Elders, community members and Aboriginal health workers. The group formed from community members had initially participated in the community forums and self-selected to take part in a series of focus group discussions and activities to develop a culturally safe model of care for Aboriginal families.

The community focus group members directed the project team to seek endorsement from local Elders of the model. A large meeting was held to present the model to the Elders. After discussions between the project team and Nyoongar Elders, the Elders were invited to become cultural consultants by the mental health and drug and alcohol service providers. They were seen as cultural custodians, teachers of Nyoongar culture, and experts about service delivery for local Aboriginal people. Before agreeing, the Elders made one non-negotiable condition. They said they would only participate if it were boordiya with boordiya (boss with boss) – Elders talking to CEOs rather than to managers or junior staff. They maintained that this arrangement was in keeping with cultural protocols, for it gave recognition to their legitimate status as cultural leaders in their community.

Preparing the 'working together' space (2012-2013)

The project team took some time to prepare a 'working together' process and a safe space for Elders and service providers to establish trust and build relationships. It was to be a space in which world views could be discussed and assumptions challenged.

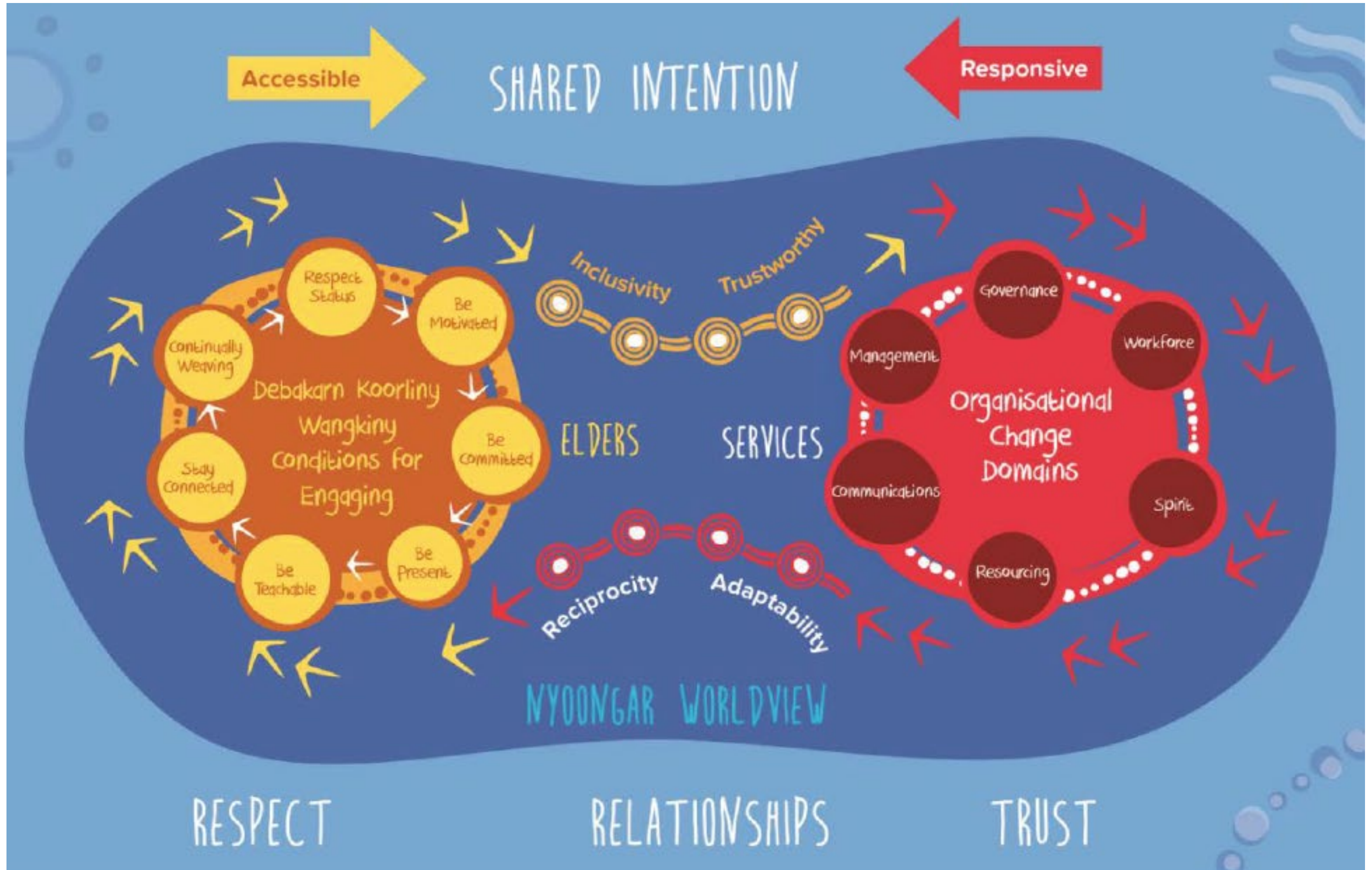
A series of meetings between Elders and service provider leaders were held through 2012 and 2013, but project team staff came to think of them as cumbersome and slow. On reflection, the project team thought smaller meetings would have allowed for more meaningful discussions and ways of creating deeper relationships.

An important part of the process of meetings, and of reflection, was asking Nyoongar Elders to tell their stories about their lives. Service provider leaders reciprocated by telling their stories as a way to connect as people beyond their roles and job titles. The project team thought service providers might be more encouraged to shift their thinking about Aboriginal people and mental health issues once they understood personal perspectives, and their emotions were engaged.

The project team and the Nyoongar Elders developed a handbook called *Open hearts, open hands: A spiritual journey of change*. This provided cultural and technical direction for service providers, and allowed them to navigate the professional practice and service delivery changes they were seeking to make in partnership with the Elders. They did this by engaging first with the Elders, building trust by sharing stories and histories and then by meeting regularly over an extended period of time.

The project team and the Nyoongar Elders also developed the *Minditj Kaart-Moorditj Kaart* framework (meaning sick head – good head), which is shown in Figure 8. This is based on Nyoongar world view, and shows the domains in which organisations needed to bring about change – governance, workforce, spirit, resourcing, communications and management.

Figure 8: *Minditj Kaart-Moorditj Kaart*: A comprehensive framework for systems change in service delivery



Source: Wright et al., 2017b, p. 11

The key principles were to adjust power imbalances by privileging a Nyoongar worldview, to establish trust, and to foster reciprocal relationships between service provider leaders and the Elders. The Elders were a proxy for their community, and so where relationships developed with service provider leaders, there appeared greater acceptance of the service within the community. Likewise, professionals and people using services and their families would also have greater trust and respect for one another.

> *Unless there is trust, any initiative undertaken with Aboriginal people will fail. (Wright et al., 2015b, p. 32)*

Working together (2014-2015)

Service providers and Elders began regular meetings, guided by the *Minditj Kaart-Moorditj Kaart* framework. They also participated in Aboriginal cultural activities together such as walking on Country, gathering bush foods, preparing and sharing food and yarning.

Elders and service providers also swapped stories about their lives, experiences and communities in formal meetings, and informally too. This sharing was new to service providers, for whom revealing personal stories, or even their personality, is seen as unprofessional. Some service providers found it confronting and difficult. As this executive manager explains:

> *I'll be honest; there have been times when it's been incredibly uncomfortable just because I've never sat around the table with Aboriginal Elders before. My sense is that – or my feeling is that if*

*you put me in a room leading a meeting amongst service providers or with other staff, I know the unwritten ground rules and I know how things work and how things operate but if you put me in a group… any meeting with Aboriginal Elders, I don't know what the unwritten ground rules are and I'm learning very slowly. They've been very welcoming and very approachable but just from myself, I just think having a complete lack of confidence in myself to know what is appropriate (*Wright, O'Connell, Jones, Walley and Roarty 2015*, p. 61).*

Deepening relationships (2016-2017)

There was a gap in project funding in 2016-17, due to an earlier application submitted to the NHMRC not being successful. During this time the Elders and service providers continued to meet and deepen their relationships. The project team kept in touch with both groups and re-applied for more funding, and were successful in the following year with an NHMRC partnership grant.

Looking Forward Moving Forward (2017-2021)

In 2017, with NHMRC funding for five years a new project commenced, called *Looking Forward Moving Forward*. It is essentially a large-scale, complex evaluation to assess the impact of the *Minditj Kaart-Moorditj Kaart* framework.

Our Vision

We see a future where Aboriginal people feel confident they can access any mental health or drug and alcohol service in Western Australia knowing they will receive culturally secure and responsive care.

Statement of intent (2017)

Most of the service providers continued from the previous *Looking Forward* cycle. Some new service providers joined. These service providers formulated and signed up to 'working together' intentions, which is a commitment about how they would operate. See Appendix 3.

A co-designed, large-scale evaluation

The multi-layered evaluation was co-designed by Elders and service providers and included some 40 semi-structured interviews and service data (conducted and collected over two time points), a survey of service providers about culturally safe work practice (conducted 2018 and 2020) and a three-way client/worker/supporter service experience survey (a pilot undertaken with four service providers).

Each stage of data collection informed the next stages, with co-researchers provided with feedback to inform these next steps.

Data collection enabled the project team to:

- measure change within each service provider across time, at three points – baseline, mid and end – over the five years of the project; how each and collectively organisations implemented *Minditj Kaart-Moorditj Kaart* and whether this was having a positive impact for Aboriginal clients
- assess the alignment on where individual service providers are at in their change process, and if it is the same for the Elders, and how the change process is of benefit to service users and the community

- record and share these insights to support a sector-wide strategy for reform in terms of planning, policy, practice and service procurement.

Baseline data collection from service providers and Elders (2017)

Most of the service providers had been involved since 2013, and had made considerable changes in their mental health models of care, work practices, venue and staff training, due to their engagement with Elders. The project team conducted a series of semi-structured interviews with each of the Elders and the service provider staff with whom they worked. Service data such as number of Aboriginal clients, Reconciliation Action Plan documents, annual reports and so on were also collected from each of the services.

The project team, with Elders and service provider leaders, analysed interview data and identified themes. These were discussed and fed back individually to each service provider to support their learning and change processes. Some interview themes showed alignment between Elders and services providers, including that:

- service providers expressed deep respect for Elders, and Elders felt that respect, and both groups acknowledged that
- both groups were concerned about sustainability – what would happen when CEOs changed, and when Elders aged?

Embedding Elders (2017-2018)

Those service providers new to the project were paired with two Elders. The project team members initially facilitated these engagements until the relationship between the Elders and service provider leaders was well-established.

"The Elders have taught me that the relationship is not just Boordiya to Boordiya, it's personal"

- Service leader, 2017

Setting up co-design (2018)

With the key themes derived from the baseline data analysis, the project team convened a meeting with service providers and the Elders group to determine the next steps that would shape the co-design of a service evaluation. The evaluation would assess the impact of the Elders on the level of cultural security the services offered to ensure they could appropriately support Aboriginal families.

It was decided that three working groups would be convened to develop a set of actions and strategies in response to the key themes derived from the baseline data. The themes were governance, workforce and cultural security. Each working group was co-chaired by an Aboriginal and a non-Aboriginal service provider staff member. Two Elders were present at each meeting. By early 2019, a set of strategies and actions were developed and presented to the Elders group and service providers as a whole by the working group chairpersons.

Co-design and evaluation (2019-2020)

Co-design workshops were held with Elders, Aboriginal staff and executive staff from the service providers, and the project team. They co-designed instruments, including a survey, to measure the impact on service provider change and its benefits to Aboriginal service users and their families. At one co-design workshop, participants were asked to vote on their priorities – service provider staff's votes were worth one point, and Elders' votes were worth two.

The evaluation is ongoing and will assess and measure the impact of 'culturally secure' work practices through the lens of client, family member and worker perceptions and experiences of the service. The surveys designed includes questions about:

- the strong connections an individual has to their community and culture as a large part of their social and emotional wellbeing
- support from family members, relatives or friends, who are asked to reflect on quality of the relationship of their loved ones to service providers' staff
- different perspectives:
    - the client's service experience
    - the worker's perceptions of how the client benefits from the service provided
    - the level of community acceptability of the service/worker in relation to the client, as perceived by the family member or friend.

Report on, share and translate the findings (2020-2021)

Some service providers and external organisations formed a dedicated 'translation group', with members especially committed to leading sector-wide change. Their vision is to improve client outcomes across mainstream mental health and drug and alcohol services in Western Australia. This group is focused on the translation of research findings from *Looking Forward* and *Looking Forward Moving Forward* into broader mainstream practice and policy settings.

As well as Nyoongar Elders, the translation group is led by:

- Mental Health Commission
- Western Australian Association for Mental Health Services
- Western Australian Council of Social Services
- Western Australian Network of Alcohol and Drug Agencies.

The translation group aims to bring about changes to:

- key performance indicators for all organisations funded through the Mental Health Commission Western Australia
- professional development initiatives across health and community service sectors
- accreditation and evaluation indicators

Outcomes to date

The project team has reported in a series of publications how the two projects have had a significant influence on the way mental health and drug and alcohol services think about Aboriginal and Torres Strait Islander people, whether as clients or as family members of clients. Following is a brief summary.

Governance

Most of the Elders feel listened to, respected and empowered in their work with service providers (Wright et al., 2017). Many of the Elder co-researchers are working with other organisations external to the project to offer cultural leadership and guidance to executive staff. So too, other community Elders outside of the Elder co-researcher group have been approached by service organisations to work with them in a number of their service sites.

Executive staff across most service providers continue to meet with the Elders and in some cases have increased their engagements to include other Elders, in particular in other service sites.

Program funding specific to supporting Aboriginal clients has increased where partner organisations can demonstrate their direct engagement with Elders and Aboriginal community members to form local partnerships. There are a number of examples where service providers have extended their reach into new areas where large Aboriginal populations exist.

Elders have become embedded in some services to now hold executive or board member positions. Likewise other Aboriginal community leaders have taken up these roles, including younger professionals.

Workforce

Service providers have developed recruitment and retention strategies to improve career pathways for Aboriginal staff, including into senior positions across the services, and in both operational and financial areas.

In most cases there has been a notable increase in the number of Aboriginal staff employed across the service providers.

Sector survey results show that service staff value training and development about Aboriginal culture and history and have selected at least one and in some cases between two and four training options to develop their cultural awareness. This correlates with an increased level of confidence in providing a culturally safe service to Aboriginal clients.

Cultural security

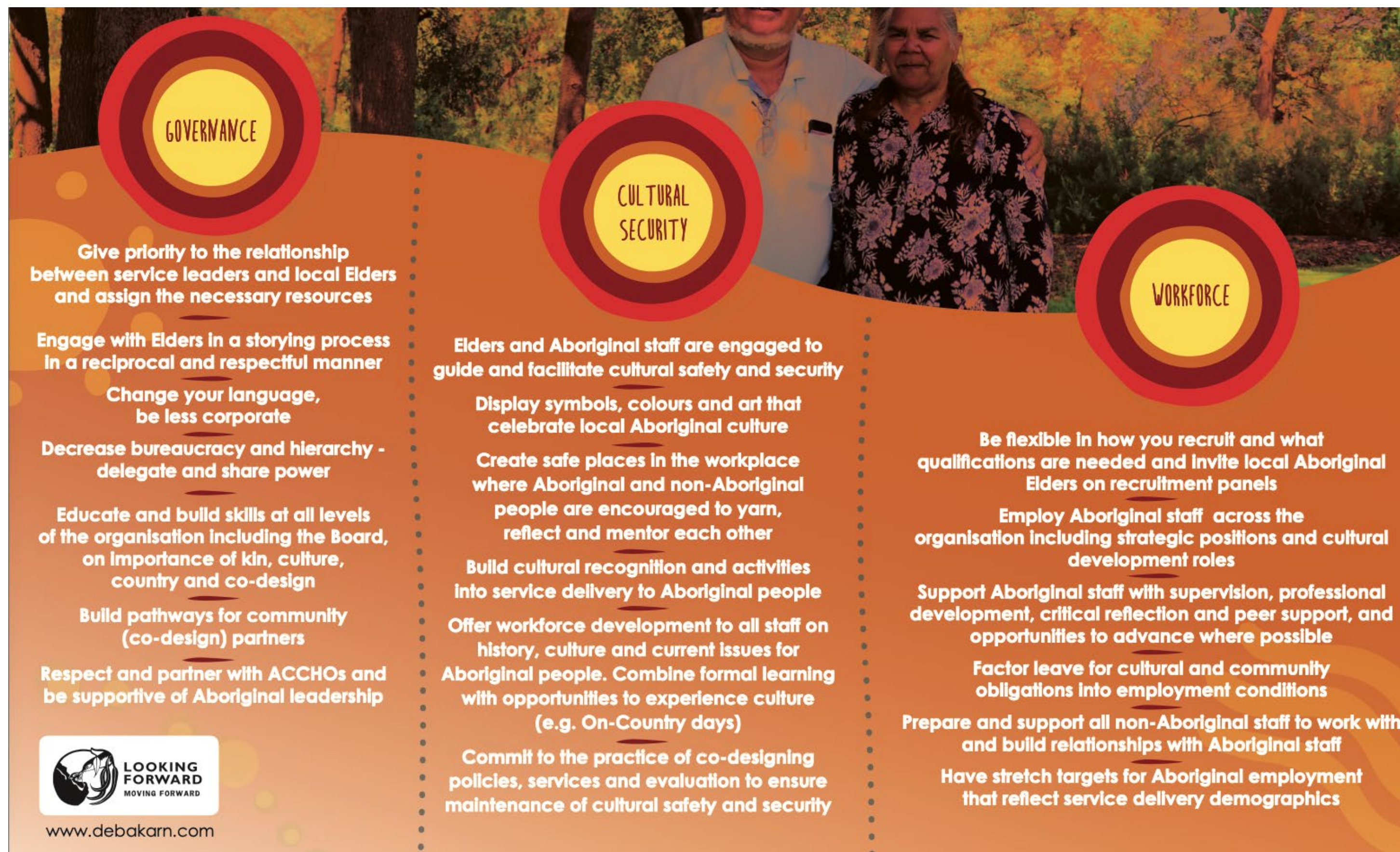
A number of service providers have seen a steady increase in the number of Aboriginal clients. Aboriginal clients are often aware that Elders are working with the service provider, and in some cases the Elders work alongside health workers to support Aboriginal clients. Early survey results report increased visibility of service providers in the community, including at local events and co-locating with other community organisations to collaboratively support families in the area.

Early analysis also shows a connection between the presence of Elders within an organisation and the sense of cultural safety experienced by Aboriginal clients. These data will be released in more detail following the project's conclusion in 2022.

Process

The process itself is a key outcome. The relationships developed are facilitated through the shared storying process (Wright et al., 2019b) and involve on-Country experiences that enable non-Aboriginal service staff to not only understand Nyoongar people's strong connection to Country and culture, but also to recognise their own connection to the place in which they live and work.

Figure 9: Advice from the Looking Forward, Moving Forward project



Source: debakarn.com.au

Insights

According to the project team, the most important feature is the centrality of the relationship between Elders and the mainstream organisational partner CEOs.

> *The Elders felt it was crucial to pair boordiya with boordiya (bosses with bosses) to maximise the impact of any changes on the organisation. They guide and mentor the leadership of each service to gain a deeper appreciation of Aboriginal culture and to better understand the impact of colonisation on individuals, families and communities. Service leaders develop a decolonising practice by building their capacity to work with Aboriginal people in a more culturally secure and safe way.*
>
> *A sustained and transparent relationship between the service leaders and local Elders (in addition to cultural consultants or senior Aboriginal staff) is crucial. Transparency in a relationship recognises the authority of the Elders in their community, and the legitimacy through which they provide cultural advice. Their knowledge of local kinship connections and their ability to vouch for the service within the community is both unique and critical to the success of the partnership.* (Wright et al., 2018, p. 13)

Other important lessons for partnerships between mainstream mental health services and Aboriginal Elders, community members and organisations are:

- ongoing commitment is required, in the short, medium and long term, because this change is generational and the experiences transformative
- any research needs to focus on relationships in the partnerships and their impact on process and trust (Wright et al., 2013)
- that systems change is a process of decolonisation, and that efforts are focused on process as an outcome in itself (Wright et al., 2013)
- any research and evaluation must be transparent and supportive of the long-term interests of the partnership between organisations and the wider community (Wright et al., 2013)
- mainstream organisations need to listen to, understand and be accepting of worldviews of Aboriginal community members – in this case, the Nyoongar people (Wright et al., 2013)
- four key attributes for partnerships are trustworthiness, inclusivity, reciprocity and adaptability (Wright et al, 2015b)
- humility, inquisitiveness and openness are key attributes for meaningful engagement with Nyoongar people (Wright et al., 2016).

What's next?

At the time of writing, the project team have been funded nationally and at a state level for two other projects based on their learnings from *Looking Forward* and *Looking Forward Moving Forward*. They are exploring how much of the success of the work with Noongar Elders can be shared with and is useful for other Aboriginal communities in Western Australia and including Aboriginal and Torres Strait Islander young people as additional co-researchers.

Interestingly, one of the sites for further research is headspace Broome – see below.

For more information, see the Looking Forward Moving Forward project.

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[3] All images in this case study are sourced from www.debakarn.com

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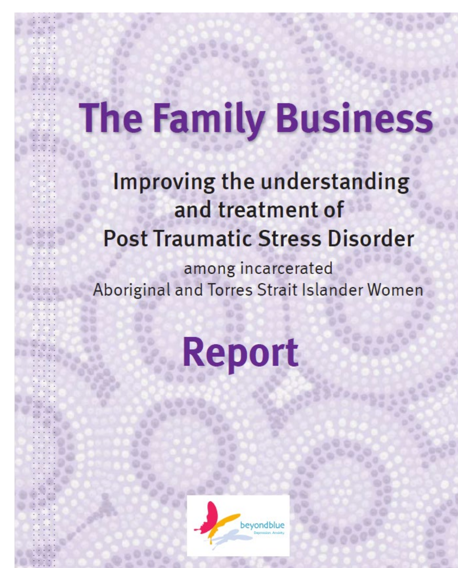
Indigenous Mental Health Intervention Program[4]

The Indigenous Mental Health Intervention Program (IMHIP) is Australia's first Aboriginal and Torres Strait Islander-led multidisciplinary social and emotional wellbeing service for Aboriginal and Torres Strait Islander people who are incarcerated in and transitioning from Queensland prisons. IMHIP was developed by the Queensland Forensic Mental Health Service (QFMHS), with leadership by its Aboriginal and Torres Strait Islander clinical staff in partnership with other clinical staff, supported by Aboriginal and Torres Strait Islander staff from other government departments, Aboriginal and Torres Strait Islander and other researchers, Aboriginal and Torres Strait Islander community sector health professionals, and Aboriginal and Torres Strait Islander organisations including the Institute for Urban Indigenous Health (IUIH).

Strong partnered research background

IMHIP began with research into the mental health needs of Aboriginal and Torres Strait Islander men and women in prison – the *Inside Out* project (Heffernan, Andersen, & Dev, 2009). This research had Aboriginal and Torres Strait Islander leadership, and governance by Aboriginal and Torres Strait Islander people. *Inside Out* found that:

- assessment tools were not appropriate for Aboriginal and Torres Strait Islander people and were not culturally informed
- needs for support, treatment and referral were not being met
- services provided were not culturally safe
- recruitment and retention of Aboriginal and Torres Strait Islander staff were lacking.



[4] Declaration of interest: Megan Williams participated in an advisory committee of the Queensland Forensic Mental Health Service for *Inside Out*, and is Chief Investigator B of the IMHIP-Youth project supported by the Medical Research Futures Fund.

Further research – *The Family Business* – occurred, with a particular focus on post-traumatic stress disorder among Aboriginal and Torres Strait Islander women in Queensland prisons. This was also led by Aboriginal and Torres Strait Islander clinicians in partnership with others and included governance by Aboriginal and Torres Strait Islander people. *The Family Business* showed an extremely high rate of post-traumatic stress disorder experienced by Aboriginal and Torres Strait Islander women in prison, but very few had received any treatment or support (Heffernan et al., 2015).

Successful pilot and embedding

The QFMHS, which sits within Queensland Health, sought and received funding to trial a 'culturally capable' mental health service that was designed by, led by and staffed by Aboriginal and Torres Strait Islander people (Heffernan, Andersen, & Kinner, p. 4).

This resulted in IMHIP, which was successfully piloted at the Brisbane Correctional Centre among Aboriginal and Torres Strait Islander women. IMHIP is now a multi-million-dollar program operating also at the Southern Queensland Correctional centre for Aboriginal and Torres Strait Islander women, and the Woodford Correctional Centre among Aboriginal and Torres Strait Islander men. The project won the Connecting Healthcare Category at the 2018 Queensland Health Awards for Excellence. The partnerships which have supported IMHIP for adults have been continued over a decade to now inform the funded action research project that is piloting and evaluating the IMHIP-Youth service, described further below.

IMHIP partnerships

IMHIP is comprised of health workers specialising in mental health and social and emotional wellbeing, social workers, psychologists, psychiatrists and project managers. It is led by an Aboriginal mental health clinician based at QFMHS, and all health worker and clinician positions have Aboriginal and Torres Strait Islander staff.

IMHIP has separate formal arrangements in each prison, and each involves:

- Queensland Corrective Services, which manages the prisons
- Queensland Health Prison Mental Health Services, which provides mental health services to people in custody
- Queensland Health Offender Health Services, which provides physical health care to people in custody.

IMHIP has a formal arrangement with the Institute for Urban Indigenous Health (IUIH), an Aboriginal and Torres Strait Islander community-controlled health service in south-east Queensland with five member services. It has comprehensive primary health care and care coordination services, including transitional care for people leaving prison. Gallang Place, a holistic Aboriginal and Torres Strait Islander counselling service, had previously contributed to transitional care with IMHIP.

IMHIP model

IMHIP is available to all Aboriginal and Torres Strait Islander people incarcerated in one of the participating prisons, regardless of whether they are on remand or have been sentenced. Participation in IMHIP is voluntary.

The in-custody IMHIP provides:

- early identification of mental health and social and emotional wellbeing needs through assessments and support by Aboriginal and Torres Strait Islander mental health professionals
- assessments that have been validated for use among Aboriginal and Torres Strait Islander people
- culturally capable care in custody, including:
  - trauma-informed care
  - strengths-based strategies centring Aboriginal and Torres Strait Islander people and culture in health and wellbeing
  - support and interventions that strengthen Aboriginal and Torres Strait Islander people's cultural identity, connect people to culture and community, and healing processes
  - supporting people to identify and understand impacts of incarceration and institutionalisation
  - goal setting, health education and support to enhance decision-making, coping strategies and resilience.

IMHIP staff and Prison Mental Health Services cooperate to support the mental health and wellbeing of all Aboriginal and Torres Strait Islander people incarcerated in Queensland. They share best practices in culturally safe care, cultural knowledge with non-Indigenous staff at Prison Mental Health Services. Shared care arrangements can be made.

Although QFMHS is a government mental health service, it can offer much more through partnerships, including trauma-informed counselling and support with accommodation, income and financial management, employment, education and training, health, disability care, child welfare, legal representation, transport and everyday living.

IUIH provide the transitional support begins about six weeks before Aboriginal and Torres Strait Islander people are due to be released from prison. Staff meet and make support plans with Aboriginal and Torres Strait Islander people in custody, and continue to provide support for up to six months post-prison release. As part of IMHIP, IUIH provides direct support and coordinates support by other services including for trauma-informed counselling, accommodation, income and financial management, employment, education and training, health, disability care, child welfare, legal representation, transport and everyday living. IUIH also supports Aboriginal and Torres Strait Islander people to meet probation and parole requirements and any other legal orders, and payment of fines.

Outcomes and expansion

IMHIP initially had short-term funding from the Queensland Government, and moved to recurrent funding as part of standard care in the three correctional centres it is offered in. The strategies to gather evidence about IMHIP, based on experience and some of the relationships developed through *Inside Out* and *The Family Business* research, continue to be used. These show that IMHIP benefits include continuity of culturally informed mental health support in custody and during transition from prison, with associated reductions in morbidity, mortality, relapse and return to custody risks. IMHIP leaders continue to request funds for its expansion to all adult correctional centres in Queensland.

Based on the success of IMHIP as a partnership project and achieving outcomes for individual Aboriginal and Torres Strait Islander people, an IMHIP-Youth version was proposed for youth detention centres in south-east Queensland. A new research collaboration was developed including QFMHS, with Queensland Health's Child and Youth Mental Health Service, Aboriginal

and Torres Strait Islander clinicians, Aboriginal and Torres Strait Islander and other researchers including some *Inside Out* and *The Family Business* contributors, and IUIH.

IMHIP-Youth is still in development by the partners, informed by a longitudinal action research project supported by a Medical Research Futures Fund grant and multi-disciplinary Evaluation Working Group (IMHIP-Youth, 2022).

Insights

Interestingly, the multi-pronged IMHIP and now IMHIP-Youth has as one of its foundations research about the needs of Aboriginal and Torres Strait Islander people in selected Queensland correctional centres. This developed an evidence base on which to design and advocate for the funding of a program, as well as develop tools better suited to understanding the mental health and wellbeing of Aboriginal and Torres Strait Islander people. The research also highlighted how essential it is to respect and centre Aboriginal and Torres Strait Islander cultures, as a source of healing and wellbeing, particularly because mainstream mental health instruments and programs are biased to the general population, often not validated for use among Aboriginal and Torres Strait Islander people, risking being alienating and damaging.

IMHIP shows that mental health service delivery and research can co-occur successfully, and that this is important to better develop an evidence base; mental health services need not be separate from research. Partnerships can and do help successfully bridge the clinical practice and research divide. This is essential for Aboriginal and Torres Strait Islander people about whom the mental health evidence base has long been lacking.

Partnerships, particularly across cultures, require clear governance and strategies for reflexivity and critical self-reflection by those involved. Reflexivity and critical self-reflection can be learned and supported by partnerships, as an enjoyable and valuable addition to partnership meetings, that can result in strengthening relationships.

Openness about 'many ways capacity-building' is a critical success factor – that each contributor to the partnership both contributes important expertise, and needs support to develop understandings and skills in other areas outside their expertise. Aboriginal and Torres Strait Islander leadership and governance are skilled at sharing cultural processes for reflection and relationship development, agreement making, and intergenerational caregiving, with a vision for Aboriginal and Torres Strait Islander people in the criminal justice system contributing to family, home, and community life and for Country, in a holistic and circular way to strengthen mental health and wellbeing.

In the context of IMHIP, the clinical and research relationships among partners now extend beyond a decade and are set to continue with the collaborative commitment to IMHIP-Youth.

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headspace Broome

This case study occurs on the lands of the Yawuru nation in coastal Western Australia.

The Kimberley Aboriginal Medical Services (KAMS) has been the lead agency for headspace Broome since the service opened in 2008. In effect headspace Broome is a partnership between KAMS and headspace National, with funding provided and managed by the Australian Government and its agencies.

As with all headspace centres, the services of headspace Broome are available to Aboriginal and Torres Strait Islander people and people of all other cultures aged 12-25. It provides information, support and counselling in person, online and by phone.

headspace Broome operates from a building which looks like it could be any other headspace centre around Australia. On its web, it looks like any other headspace. But people who enter the building see a higher proportion of Aboriginal and Torres Strait Islander staff than in many other mental health services. headspace Broome reports that it has implemented strategies to show respect to the Yawuru nation, such as use of Yawuru language in the naming rooms, provision of on-Country social and emotional wellbeing groups for young people, and a recent partnership with Yawuru Elders as co-researchers with young people, led by Curtin University to support co-design for service improvements.

headspace Broome staff use the *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing 2017-2023* (Commonwealth of Australia, 2017) and the SEWB service model developed by AHCWA (2021). These both draw on the earlier work of the *Working Together* (2014) book edited by Aboriginal and Torres Strait Islander mental health professionals and the work of SEWB models and workforce models of Gee et al. (2014).

This positions headspace Broome to have a holistic focus, providing care for the individual person and their family within the context of the community and with consideration to political and historical impacts on a person's wellbeing. This sets headspace Broome up to move beyond a focus on mental health symptoms to individual experiences. Overall, headspace

Broome relies on strong feedback from the community to ensure its approach is fit for *all* members of the community, and achieves this through Aboriginal community control governance structures, engagement of young people and family and friends in the governance structures of the service (consortium and youth advisory committee), and partnership with youth and Yawuru Elders in co-design of service improvements through the Our Journey Our Story partnership project, which is following on from the Looking Forward Moving Forward project (see above).

KAMS provides management, staff, information and services, and ensures linkages with other local and regional services that could support those using headspace Broome. headspace National collects headspace Broome data and provides national data and systems support.

The partnership offers two-way learning between KAMS and headspace National staff members. It also offers headspace National's non-Indigenous executive team more knowledge and experience working with Aboriginal and Torres Strait Islander people.

headspace National has an Aboriginal and Torres Strait Islander Youth Reference Group and a National Aboriginal and Torres Strait Islander Advisory Group. It offers information and programs for Aboriginal and Torres Strait Islander young people that draw significantly on *Working Together* and the SEWB description of Gee et al (2014). headspace National is committed to funding more ACCHOs to run headspace centres.

Insights

headspace Broome has managed to create a culturally appropriate service within the bounds of a national mainstream service and government funding.

Sources for this case study

Interviews with headspace Broome staff

headspace Inala[5]

headspace Inala (QLD) is located in a region with a significantly large and culturally strong Aboriginal and Torres Strait Islander community. There is strong local leadership within the community from the Inala Elders, which became an incorporated organisation in 2000. For more than two decades they have provided a range of structured programs as well as yarning place and support for community members.

Accoras, an NGO in southern Queensland and northern NSW, won the contract to establish a headspace in 2011. As with other headspace centres, it is effectively a partnership between the lead agency, in this case Accoras, and headspace National, with funding provided by the Australian Government and its agencies.

To ensure its accessibility to Aboriginal and Torres Strait Islander young people, it developed a partnership approach with local Aboriginal and Torres Strait Islander communities, including through the Inala Elders. They collaborated to develop an Indigenous governance mechanism. Taking such a governance approach is thought to have increased the commitment from the local Aboriginal and Torres Strait Islander community to the headspace partnership project.

The relationship has been described as being based on mutual respect, and being mutually beneficial, with a broad understanding that Inala Elders will provide guidance to Accoras, and

[5] Awaiting final approval from headspace Inala

Accoras will provide support. Interviewees for this report said outcomes include better access for community members to headspace, better quality care at headspace, and a better understanding of community needs for headspace.

Members of Inala Elders are involved in a range of committees and advisory groups at Accoras, and are paid as consultants. Both at headspace and across the organisation, they have provided guidance on how to conceive of and design the physical space when headspace moved offices, and how to develop a reconciliation action plan.

Accoras provides support for Inala Elders' activities through setting up, cleaning up and washing up, and through providing access to care at any time when a member of Inala Elders walks through the door with a community member. They attend fundraising events such as art exhibitions, and buy artworks. They support holiday programs and suicide prevention activities. New staff at Accoras receive induction about the partnership very early.

The two organisations are located near each other, and both parties say there is a lot of to and fro most days. They also have good relationships with the Inala Indigenous Health Service, which is a primary care and research service backed by the Queensland Government.

There is a service level agreement, which they see as important in case of changes of staff and membership, but both parties say the relational element is more important.

Insights

This partnership depends on informal ways of working together based on trust and relationships, rather than formal service agreements about how care is delivered. It is quite different to the headspace partnership in Broome.

Sources for this case study

Interviews with Inala Elders, headspace Inala staff, Accoras staff

Winnunga Nimmityjah Primary Healthcare

Winnunga Nimmityjah Aboriginal Health and Community Services is an ACCHO that supports Aboriginal and Torres Strait Islander people in the ACT region and beyond.

In 2017, Winnunga expressed its concerns over the Primary Mental Healthcare Minimum Dataset (PMHC-MDS), which is a reporting requirement of the Department of Health primary health network (PHN) primary mental health care funding pool. The PMHC-MDS requires reporting of highly detailed individual client personal mental health information to primary health networks. Client information is 'de-identified' but date of birth, Indigenous identification and detailed health care provider information is required.

In small communities, this level of detail could identify individuals. Requesting that Aboriginal and Torres Strait Islander people provide their fully informed consent to report their mental health information is necessary, but the ACCHO thought this could jeopardise the relationship of trust between it and its clients. The use of particular screening tools was also mandated by the PHN. Winnunga thought this would infringe on the ACCHO's right to assess clients how it saw fit, in culturally appropriate ways.

In a submission to the Productivity Inquiry into Mental Health, NACCHO outlined how Winnunga declined funding from the PHN because the reporting requirements were unacceptable for

them as an ACCHO and for the Aboriginal and Torres Strait Islander people they serve. This resulted in money intended for Indigenous mental health care going instead to a mainstream organisation, which was known in the community to not have the same reach or capacity to address issues in the ACT.

Examples like this highlight the need for funding for Aboriginal and Torres Strait Islander mental health services in ways that respect Aboriginal and Torres Strait Islander community governance and their decision making and reporting.

NACCHO says it is a national issue that ACCHOs have to decline funding of mental health services by PHNs is 'due to the imposition of inappropriate and unacceptable reporting requirements'. It argues that ACCHOs must be funded holistically to allow for holistic service provision, rather than funding in silos.

Insights

Primary health networks are a common source of some funding for ACCHOs, and PHNs sometimes term funding arrangement as partnerships. In this case, Winnunga Nimmityjah Aboriginal Health and Community Services declined the opportunity of funding and partnership due to concerns over the appropriateness of data collection and assessment tools. Funding and commissioning bodies wishing to work with Aboriginal and Torres Strait Islander organisations should be aware that a respectful dialogue about how the funding and commissioning works is essential.

Sources for this case study

Adapted with permission from NACCHO. (2019). Submission – Productivity Commission inquiry into mental health. https://nacchocommunique.com/wp-content/uploads/2019/10/naccho-mental-health-submission-.pdf

Wadamba Wilam

Wadamba Wilam means 'renew shelter' in the Woiwurrung language of the Wurundjeri people. The Wadamba Wilam intensive support service is in Melbourne's northern suburbs and supports Aboriginal and Torres Strait Islander people who experience mental illness and homelessness. Their clients are described as having 'many physical and mental health needs, complex histories of trauma and neglect, and a mistrust of services that have been historically difficult to overcome by a disjointed and discriminatory service system' (Chiera et al., 2021, p. 3).

Wadamba Wilam is an interagency team, being a partnership between:

- Victorian Aboriginal Health Service, which provides an Aboriginal SEWB worker
- Neami National, a community-based organisation (and lead agency) provides a service manager as well as mental health and wellbeing support workers
- Uniting Care ReGen Alcohol and Other Drug Service, which provides a senior AOD clinician
- Northern Area Mental Health Service, a Victorian government organisation which provides a consultant psychiatrist (one session per week).

Funding for the Wadamba Wilam partnership and services is from the Victorian Government. Neami National holds the funds and pays the wages of other team members. Team members have access to all the other skills and knowledge within the four services.

Wadamba Wilam is a small service, working with 30-35 consumers at a time. It offers:

- holistic mental health treatment and psychosocial support with a focus on trauma recovery and improving social and emotional wellbeing
- specialist alcohol and other drug treatment and support
- case management and care coordination, which involves supporting engagement with social services and community resources such as cultural groups and camps
- advocacy and support to navigate the myriad systems involved in a consumer's life, including housing
- supporting engagement in activity that consumers identify as meaningful
- liaison, education and involvement with the identified family to support and empower the consumer. (Chiera et al., 2021)

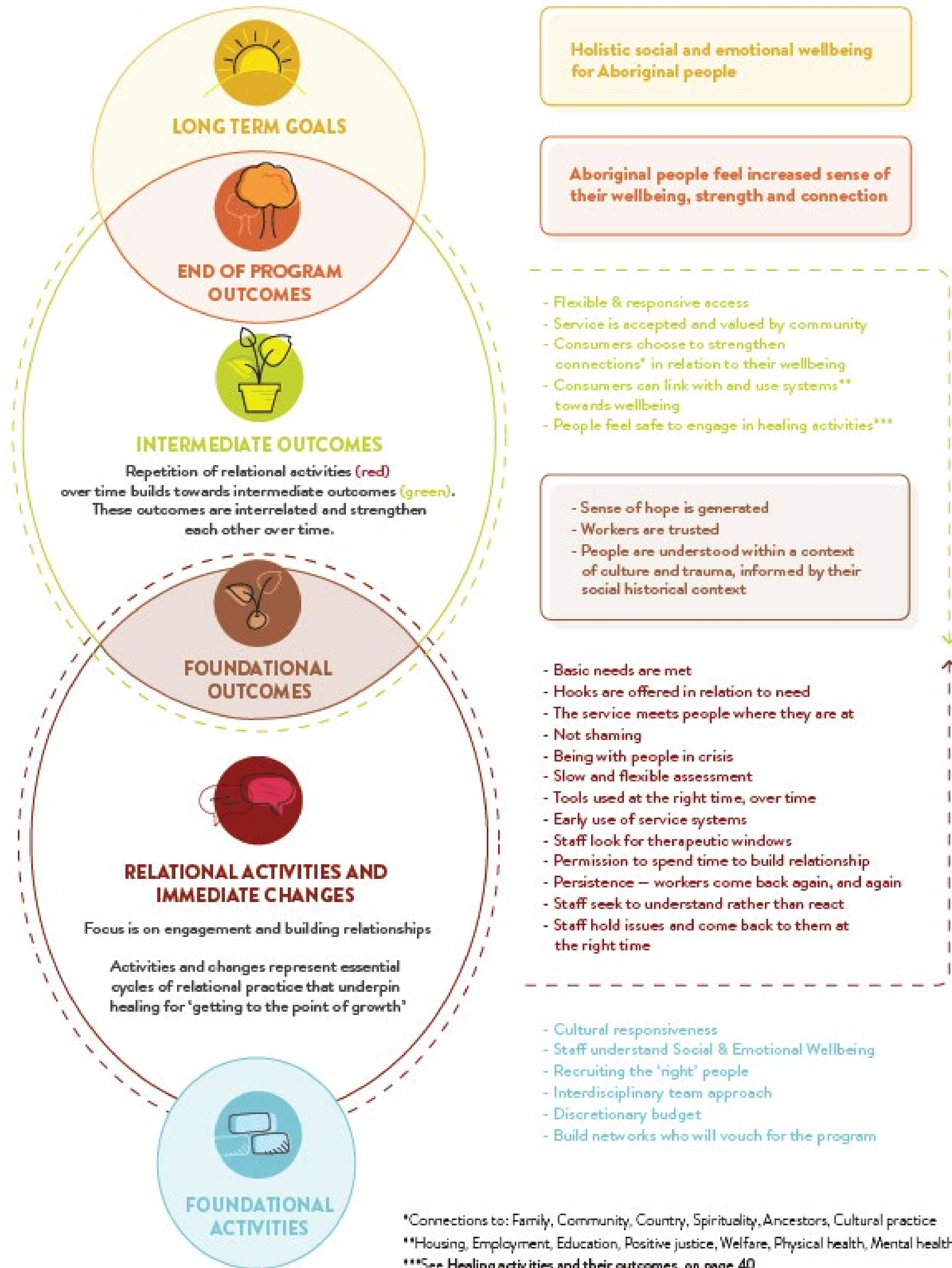
Wadamba Wilam's engagement with consumers is long-term – some people have been receiving support from Wadamba Wilam for six to eight years.

Wadamba Wilam's practice approach has been developed over eight years. It describes three phases as follows.

- Phase 1 focuses on ensuring the individual's safety, reducing symptoms, and increasing important emotional, social and psychological competencies.
- Phase 2 focuses on processing the unresolved aspects of the individual's memories of traumatic experiences. This phase emphasises the review and re-appraisal of traumatic memories so that they are integrated into an adaptive representation of self, relationships and the world.
- Phase 3 involves consolidation of treatment gains to facilitate the transition from the end of the treatment to greater engagement in relationships, work or education, and community life.

The Wadamba Wilam service uses a range of assessment tools, including the International Trauma Questionnaire (Cloitre et al, 2018), which has been validated among Indigenous people, and the Aboriginal Resilience and Recovery Questionnaire developed by Aboriginal mental health professionals (Gee, 2016). These assessments are carried out slowly by the Wadamba Wilam team across phase 1, rather than occurring at a single intake interview. The assessments are repeated across other phases of Widamba Wilam care, as staff and clients agree are appropriate.

Figure 10: Wadamba Wilam's theory of change



Source: Chiera et al, 2021, p19

Team members are flexible, working with consumers expressed needs and wishes. Some of the practical activities used are described in Table 7.

Table 7: Wadamba Wilam's healing activities and their outcomes

Connection to	Activities	Outcomes
Land	Support access to attend cultural comps Support people to be on Country Facilitate conversations with Elders Conversations with Elders	Strengthened cultural connections Respectful connections with Elders established Increased agency and sense of personal capacity/responsibility for own health and wellbeing Strengthened connection to Country which underpins identity and strengthens a sense of belonging
Spirituality/ancestors	Facilitate cleansing ceremonies/house smoking, etc. Curiosity around expressions of distress and cultural solutions Invite conversations regarding spirituality Support access to cultural camps Visit gravesites	Misinterpretation of cultural experiences are avoided Spiritual healing and spiritual connection are strengthened which helps provide a sense of purpose and meaning
Physical wellbeing	Hep C program Link with ACCHO Link with GP Dental program Support health system navigation Practical support and skill building	Individuals cured of Hep C Regular nutrition Decreased emergency department use Decreased hospital admissions/bed days Stable housing Increased overall physical health, increased ability to participate as fully as possible in life
Mental and emotional wellbeing	Timely response to triggers/distress System buffering Support mental health system navigation Support change of diagnosis to complex trauma and offer appropriate therapies Assess and sit with risk Use of culturally appropriate tools, for example, the Aboriginal Resilience and Recovery Questionnaire	Decreased self-harm Increased self-soothing Acceptance of medications and therapeutic interventions Decreased mental health hospital admissions/bed days Decreased suicidal ideation Re-traumatisation avoided Decreased isolation Access to services as needed Willingness to re-engage Positive justice system outcomes Bans from services are avoided

Connection to	Activities	Outcomes
Family/kinship	Work with kin Open supports to family members Support kinship care Support around death and loss	Increase social connection Family actively seeks support from service Decreased unnecessary child protection notifications Increased connection to family Decreased family justice issues
Community	Take people to funerals Support around death and loss Work with communities Spend time in community Invest in community relationships	Community trust in service Increased involvement in community groups Self-referrals from community Engagement in meaningful activities, for example work, education, gym
Culture	Support people to be on Country Facilitate conversations with Elders Conversations with Elders Offer cultural approach to symptoms Attend cultural events	Representing self/culture/organisation, for example speaking at conferences, involved on job interview panels Increased connection to culture creates a sense of continuity with the past which helps underpin a strong identity and strengthens social and emotional wellbeing

Source: Chiera, J., Burns, A., Lovatt, M., Kennedy, A., Raudys, J. & Waring, J. (2021) *Wadamba Wilam: Practice approach*. Neami National, 40-41

Reporting

A feature of Wadamba Wilam is that it spends less time collecting data that is not meaningful to its clients than do many other services. Partly, that is because its initial funding was to Neami National, a non-Indigenous organisation, and as such, it did not have the onerous requirements that ACCHOs face (see above).

As well, Wadamba Wilam has put a substantial effort into working with Neami National's research team to understand the program logic and to tease out what works. It also gathered and reported meaningful data (see Outcomes), such as that concerned with SEWB and with complex trauma, and ensured that decision-makers in government knew of it.

Outcomes

Over eight years of operation from 2013, Wadamba Wilam reports:

- an increase in self-referrals and referrals from community, with a corresponding decrease in referrals from other services
- a 61% decrease in hospital admission for clients
- a decrease in the proportion of clients with an involuntary treatment order from 20% to 6%
- an increase from 12.5% to 69% of clients who are having their medical needs met
- a reduction in offending in 52% of clients
- 81% of clients in sustainable tenancies

- reduction in clients engaging on survival activities only from 73% to 13%
- a decrease in use of alcohol and other drugs for most clients.

Staff at Wadamba Wilam believe that the keys to its success lie in:

- that the service is outreach – seeing people where they are, rather than expecting them to come to somewhere they are not comfortable with
- the intense engagement – visits usually last two hours or more, and can be daily in the early stages and in any acute phases, moving to once every 1-2 weeks over time
- the focus on time, trust and relationships – staff know it can take a year or two of regular visits before enough of a relationship has developed to make much progress
- the involvement of family as appropriate, and Elders as appropriate, to build support and resilience
- the awareness that needs fluctuate over time independent of symptoms – for example, needs escalate when housing is achieved due to new complexities to be managed, even if symptoms remain stable
- the service's ability to learn over time what the customers want and need, and to adapt the model of care along the way, which they say has taken eight years to develop, and may still be revised
- the preparedness to operationalise SEWB
- the willingness of team members to give up 'expert' status and see themselves as supporters of people who are the experts of their own lives.

They also recommend that long-term funding is implemented wherever possible – annual funding cycles undermine the ability of services to make commitments to their clients.

Insights

Wadamba Wilam has built slowly. It started with an idea of how the service would operate, but learned what consumers needed from those consumers, and adapted over time. Its theory of change, and the service model that reflects it, centre the importance of relationships. Its healing activities reflect an understanding of the culture of its consumers, and are based on the SEWB model of Gee et al. (2014).

Sources for this case study

Interviews with Wadamba Wilam staff

Chiera, J., Burns, A., Lovatt, M., Kennedy, A., Raudys, J. & Waring, J. (2021) *Wadamba Wilam: Practice approach*. Neami National.

Wiyiliin ta[6]

Wyiliin ta is part of the Child and Adolescent Mental Health Service (CAMHS) in Hunter New England Local Health District (LHD). It aims to provide culturally appropriate care to Aboriginal children and young people aged 2-18 with existing cultural connections.

[6] Awaiting final approval from Wyiliin ta

Wyiliin ta is one of five units within CAMHS. The other four are generalist – three in the community and one inpatient – and accept Aboriginal and Torres Strait Islander children and young people. Wyiliin ta is offered as a specialist service for suitable Aboriginal and Torres Strait Islander children, young people and families with strong cultural connections who enter CAMHS.

Who Wyiliin ta works with

Wyiliin ta works with children and young people and their families with severe and complex mental health problems with:

- risk of harm to self and others
- multiple co-morbidities
- high levels of distress and acute emotional disturbance
- multiple risk factors including trauma
- significant impairment in functioning and conditioning.

The model of assessment, stabilisation and treatment assumes a level of cultural connectedness and involves sharing of cultural strengths, beliefs, connection and world view.

Wyiliin ta offers service at three locations:

- four days a week at the LHD (James Fletcher Hospital Psychiatric Rehabilitation Service, Newcastle)
- one day a week at Awakabal Primary Health Care Service (an ACCHO), Hamilton
- one day a week at Mindaribba Local Aboriginal Land Council, Metford, which is a non-health service

In some circumstances, Wyiliin ta provides clinical services at other CAMHS community and inpatient services; at primary and secondary schools; at community organisations and at other Hunter New England LHD sites.

Workforce and workforce support

Wyiliin ta has three Aboriginal clinicians, two non-Aboriginal clinicians with extensive experience working with Aboriginal communities, an administrative officer, and a trainee. Under the model of care, clients are supported by two clinicians working together. At least one of these clinicians must be Aboriginal, and an Aboriginal clinician must be involved in all aspects of the care. If possible, one of the two clinicians will be male and one will be female.

Psychiatry services are available part-time.

Staff are generally senior and experienced, given the complexity of the work.

Clinicians generally have a caseload of 25-30 clients/families in which they are the lead, and they may be the secondary clinician on another 15 or so clients/families.

Capacity-building partnerships

Wyiliin ta has a number of capacity-building partnerships, which allows for the management of complex issues, such as child protection, within the context of community and cultural obligations. It provides specialist allied health support for allied health clinicians working in Aboriginal primary care services such as Awabakal Primary Health Care Service, to Mindaribba Local Aboriginal Land Council, to out of home care providers and to a range of other NGOs.

The Awabakal Primary Health Care Service now offers mental health care, along with medical and SEWB care.

Respectful transfer of knowledge

Its staff have a significant capacity-building/education role that continues across health and professional networks, offering joint clinical review to other teams within and outside the LHD, and providing expertise to the University of Newcastle.

Wyiliin ta contributes to the development of social and emotional wellbeing policies and processes across Hunter New England LHD and those that relate to NSW Health, and to special projects in the area of Aboriginal social and emotional wellbeing, such as ibobbly and the LifeSpan Aboriginal suicide prevention group.

It is a specialist clinical resource that is often drawn on by internal and external services for clinical advice in areas such as culturally appropriate psychometrics and assessment processes.

Future possibilities

Wyiliin ta would like to:

- increase the age range up to 25, in line with current evidence and best practice
- would like to offer an assessment to all who seek support – a true 'no wrong door policy'
- would like to have an occupational therapist as part of the team, along with a nurse and a dietitian.

Insights

Wyiliin ta began as part of a mainstream government community mental health service, but changed over time as it gained more Aboriginal and Torres Strait Islander staff, and now partners with an ACCHO in a capacity-building manner. It may change again.

Sources for this case study

Interviews with Wyiliin ta staff

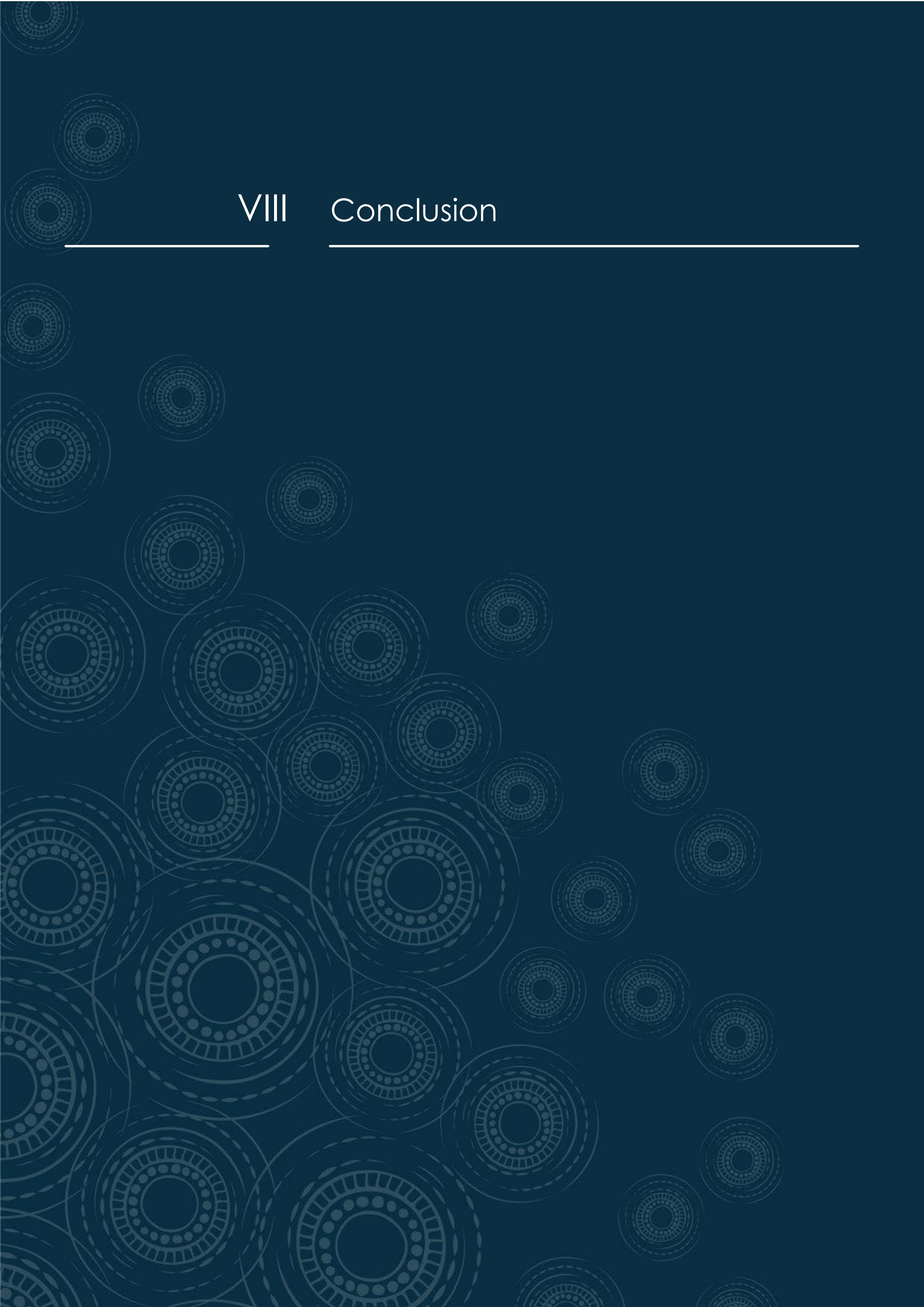
Wyiliin ta (n.d.). Providing culturally appropriate care to Aboriginal children and young people (unpublished)

Implications of this chapter

The diversity of case studies highlights that there is no one approach – these partnerships have grown in response to local need and to the local environment. And they have grown in different ways, and changed over time.

The two headspace examples show that even within one mainstream mental health service, it is possible to have two different approaches to partnership that reflect local needs and local institutions.

The implication of these case studies is that mainstream mental health services wishing to work with Aboriginal and Torres Strait Islander organisations need to prepare themselves, as described elsewhere in this report, and be willing to learn in the local context.



VIII Conclusion

Conclusion

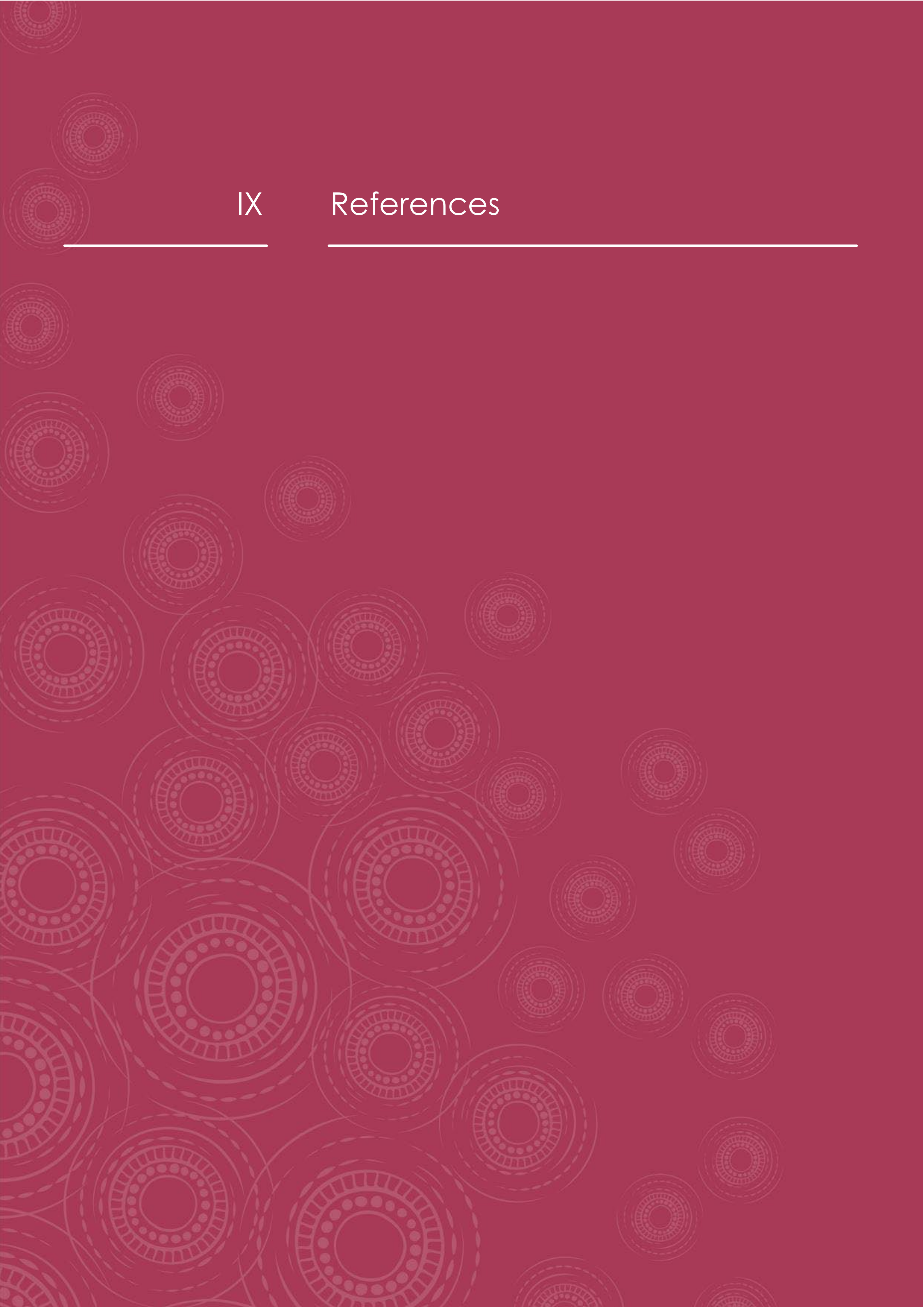
Aboriginal and Torres Strait Islander peoples and communities are diverse, with different histories and different cultures. Aboriginal and Torres Strait Islander organisations reflect the cultures and communities they arise from, rather than reflecting a central body.

Aboriginal and Torres Strait Islander people and communities have clear protocols about how health services should operate, and many have communicated that to governments and mainstream services repeatedly. The protocols and approaches listed in chapter 5 are but a sample.

The experiences and expectations of the Aboriginal and Torres Strait Islander organisations we have sampled, and the case studies we have highlighted, show that there is no one way to form a partnership. They highlight common elements – time, trust and relationships among others. They highlight the need for power to be shared, or to sit with the Aboriginal and Torres Strait Islander organisations, to support the right to self-determination and to respect local expertise.

They also show that partnerships can bring considerable benefits to mainstream organisations and communities, and to Aboriginal and Torres Strait Islander organisations and communities.

But mainstream organisations need to build their own capacity first. They need to do the work to prepare themselves to work with Aboriginal and Torres Strait Islander organisations and communities. They need to show respect for cultures that have survived for 60,000 years, despite the atrocities of the past 250 years.



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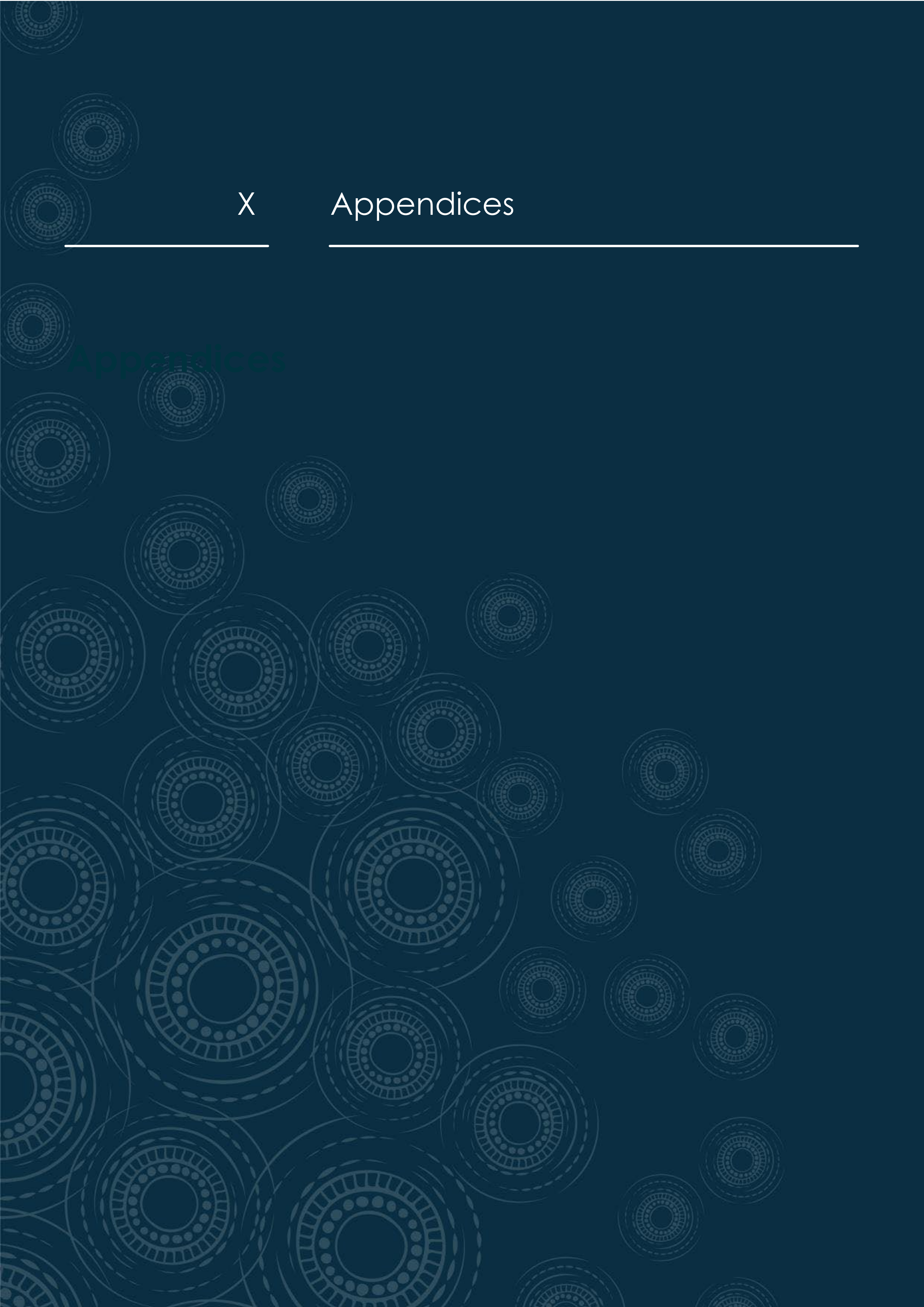

X Appendices

Appendices

1. Acknowledgments

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2. SNAICC's draft Statement of commitment

SNAICC recommends that non-Indigenous organisations wishing to work in partnership with Aboriginal and Torres Strait Islander organisations make special commitments that, if kept, will enable a stronger partnership. It has published the following draft text for organisations to consider using, directly quoted below (SNAICC, 2014, pp. 13-14)

Our commitment to genuine partnership with Aboriginal and Torres Strait Islander communities and their organisations

This statement describes the principles and actions that reflect our commitment to work in partnership with Aboriginal and Torres Strait Islander communities and their organisations to support wellbeing for children and families.

While genuine partnerships require shared responsibility and joint action, there is a special obligation on non-Indigenous people and organisations working in partnership with Aboriginal and Torres Strait Islander communities. This special obligation arises from the unique rights, history and cultures of Australia's First Peoples and the priority to redress the historical and continuing injustice and discrimination that they experience.

At the core of this commitment is our recognition and respect for: the right of Aboriginal and Torres Strait Islander peoples to self-determination; and the strengths and value of Aboriginal and Torres Strait Islander cultures to care for children and support families.

In all of our work with Aboriginal and Torres Strait Islander children, families, and communities, we undertake to:

1. Develop the cultural competence of our organisation and all of our staff.

LEARN about and respect local Aboriginal and Torres Strait Islander cultures

We will ensure cultural education for our staff is provided by local community organisations and Elders, as well as seeking cultural advice to inform our day-to-day practice working with children and families. We will adequately compensate people and organisations for cultural knowledge and expertise they share.

VALUE Aboriginal and Torres Strait Islander cultural knowledge in our practice

We will work to ensure Aboriginal and Torres Strait Islander cultural perspectives influence mainstream service delivery frameworks. We are committed to practice that reflects the best of non-Indigenous evidence, and Aboriginal and Torres Strait Islander cultural strengths in supporting children and families.

EMBED cultural competence throughout our organisation

We will work to develop organisational Aboriginal and Torres Strait Islander cultural competence that is embedded in all of our processes, practices, relationships, and staff training and support.

2. Build respectful relationships with Aboriginal and Torres Strait Islander people and communities.

CONNECT with local Aboriginal and Torres Strait Islander people

We will take the time to get to know people within the Aboriginal and Torres Strait Islander community, to understand community leadership structures and the role of community organisations, and to listen to Elders.

LISTEN to Aboriginal and Torres Strait Islander communities

We will consult with the local Aboriginal and Torres Strait Islander community through their own representative organisations and leadership structures. We will listen to the needs that they identify and respond by working with them to provide supports that they request.

TAKE a stake in the long-term wellbeing of children, families and community

We won't work with an Aboriginal and Torres Strait Islander community unless we are prepared to stick around while the community wants and needs our support for families or for community development. We will work with the community to secure funding for local needs beyond limitations of government contracts.

3. Support capacity for local Aboriginal and Torres Strait Islander community-led responses to child and family needs.

ASSESS existing community strengths and needs

We will identify existing child and family support strengths and needs in the Aboriginal and Torres Strait Islander community before we start any work, and ensure that we do not duplicate or compete.

ENABLE capacity growth for community controlled organisations

We will work with Aboriginal and Torres Strait Islander community controlled organisations to support their growth in line with their identified needs and priorities. We will not compete for service funding where there is existing capacity in these organisations to deliver services for their community.

TRANSFER service delivery to community controlled organisations

We will negotiate plans for the supported transfer of service delivery roles and resources in line with capacity growth. Capacity-building plans will include realistic timeframes and specific targets to ensure growth objectives are met, and decision-making roles and resources are transferred without unnecessary delay.

DEVELOP local skills and employment opportunities

We will prioritise and support training and employment opportunities for local Aboriginal and Torres Strait Islander people. We will collaborate with community controlled organisations to create local workforce development plans and seek to limit competition with them for Aboriginal and Torres Strait Islander staff.

4. Establish the processes, governance structures and accountability required for effective and sustainable partnerships.

NEGOTIATE agreements with community controlled organisations

We will seek to establish memoranda of understanding with Aboriginal and Torres Strait Islander organisations that reflect these commitments, and our shared objectives to improve outcomes

for Aboriginal and Torres Strait Islander children and families. Our agreements will direct resources to partnership development by establishing mechanisms to drive and oversee the partnership.

EVALUATE partnership work

We will establish joint processes for monitoring and evaluating our partnerships. We will ensure that Aboriginal and Torres Strait Islander organisations and communities participate to ensure culturally appropriate evaluation design, conduct, and interpretation of evaluation outcomes.

3: Looking Forward Moving Forward's statement of intent

30 June 2017 to December 2021

This statement is an affirmation of the partners' five-year commitment to working actively together to enhance and build meaningful relationships to improve the health and wellbeing of Aboriginal people living in Western Australia.

Chief Investigator, Dr Michael Wright, on behalf of the Looking Forward Moving Forward project team, commits to this statement in collaboration with the senior leaders of the following service partners:

- Hope Community Services
- MercyCare
- Palmerston Association
- Richmond Wellbeing
- Ruah Community Services
- St John of God Health Care Midland
- Western Australian Association for Mental Health Services
- Western Australian Council of Social Services
- Western Australian Network of Alcohol and Drug Agencies
- Western Australian Mental Health Commission.

Working together objectives

Service partners and researchers will work together to effect changes that will have both a positive and sustained impact that improves the health and wellbeing of Aboriginal people. Working together strategies will impact on three levels:

- Shared learning and mutual support between partner organisations
- Shared experiential learning that will be integrated across each organisation
- Using their collective expertise and authority to translate the findings of the project to the broader sector.

Working together intentions

Together, the partner organisations will:

- Commit to the Working together objectives by being prepared to:
    - engage in experiential learning and for these learnings to be integrated across each organisation;
    - share ideas and provide support to each other;
    - identify strategies (including mapping spheres of influence) for wider impact.
- Acknowledge that as service partners their relationship with Aboriginal people has not been working, and a change is needed.

- Acknowledge that as service partners the key to building trust with Aboriginal people is to gain respect and establish meaningful relationships.
- Expect that all members of the group are here because they care and are committed to working for change.
- Keep the focus of the work on having a tangible impact at the grass-roots level.
- Commit to staying with the process over the time of the project.
- Commit to taking responsibility to ensure the membership of the group remains consistent (i.e. being proactive about succession planning within each organisation).
- Respect confidentiality of issues that arise within the group.
- Listen deeply, explore others' viewpoints, and be prepared to compromise to accommodate the views of others and note that all viewpoints matter.
- Accept that group decisions may not be universal, but that dissenting or alternative views will still be included in the record of the meeting.
- Bring service delivery issues and feedback to the group for discussion, and take insights and recommendations from the group back to their respective service for integration and implementation.

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