Collaborationwith**impact**

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Mick Gooda – Collaboration and impact in Indigenous Research

Please allow me to acknowledge the traditional owners on the land in which we sit today and thank them for allowing us to do so. I would also like to acknowledge the Elders with us here today and those who have passed.

Can I also acknowledge the Australasian Research Management Society for the invitation to speak here today and to give the issue I will address the prominence I think is warranted.

Given the current environment in which we find ourselves, I can't think of a more appropriate time to talk about collaboration and impact of the research that we are all doing in the area of Indigenous health. There has never been a more crucial time when we should be presenting the way forward based around the best evidence available rather than on anecdotes aiming for the quick fix. Our mob out there deserves better from all of us whether we are in government, in the Indigenous health sector or in the community sector.

A little about us. The CRC Program has the aim of putting researchers and the users of research together with an aim of undertaking research that will make a difference rather than the clichéd reports sitting on the shelf gathering dust.

The Cooperative Research Centre for Aboriginal Health is in its second iteration. In our first, we were the CRC for Aboriginal and Tropical Health and concentrated our work in the top end of Australia, particularly the NT.

July 2003 marked the start of our second life when we took a national focus on Indigenous health generally.

We have 12 partners, 5 of whom are universities, 3 others are major research institutions, 2 are Government Departments and last but not least 2 community controlled health organisations.

Whilst we are not community controlled according to the usual definitions we nonetheless consider ourselves Indigenous controlled as our centre agreement stipulates that there must be a majority of Indigenous Board Members with an Indigenous Chairperson who must be elected unanimously by the Partners.

We have a simple but challenging vision of:

Sustained improvement in Aboriginal health through strategic research and development.

We aim to ensure the highest quality research is carried out with greatest impact on Aboriginal health outcomes through improved partnerships, greater Aboriginal participation and control, and better ethical practices. We do this by

carrying out research that Aboriginal People and Health Services need

Making research meaningful to our people by transferring into it practical change

Ensuring specific plans are made and acted upon to promote the transfer of findings into policy and practice including:

- Designing projects so they are most likely to have an impact
- the application of research findings,
- and addressing barriers to uptake,

We also advocate change which will enable the use of research findings in policy development and service provision

These are the words that you will find in all of our documentation and on our website, but for us involved in the CRCAH, be it Board Members or staff, they are more than nice words, they are the values that underwrite all of our endeavours. They are the standards to which we aspire and against which our efforts will eventually be judged.

Those who wish to collaborate with us also need to subscribe to these values. This is one of the non-negotiables. But I will come back to this point later.

Two weeks after I began with the CRC there was a Board meeting which was due to sign off on several research projects. To get to this point there had been a call for expressions of interest which resulted in the receipt of 34 project outlines. These were then shortlisted down to 14 – to be developed into full proposals. At the Board meeting just 3 of the original 34 proposals were endorsed for funding.

It seemed to me there was some dissatisfaction amongst the Board with this process, and I was asked for my opinion.

I made the following observations:

The process had been extremely resource intensive, with a lot of wasted effort by those who submitted proposals that did not eventually get approved.

The competitive process pitted researcher against researcher and institution against institution. But our organisation was supposed to be the **Cooperative** research centre

And finally, the Board felt they were presented with a fait accompli with the chance for little or no input to the process to make sure that the projects would be addressing what they saw as the most important issues – from the right perspective.

Before I arrived at the CRC the Board had decided to implement what we call the Programmatic Approach to set our research agenda. There are several layers to this approach….and the process I've just described above provided an impetus to bring about even greater change in the way the CRC would develop and fund research.

First, the Board had recognised that in trying to address ALL Aboriginal health concerns at once, the CRC ran the risk of succeeding in none. So our efforts were focussed down into 5 Programs. These are:

- Primary Health Care, Health Systems and Workforce;
- Chronic Conditions;
- Healthy Skin;
- The Social Determinants of Aboriginal Health; and
- Aboriginal Social and Emotional Wellbeing.

Within each Program there are specific goals – endorsed by the Board – to focus the activity of the program itself – and particularly, where the CRC will direct its funds.

Secondly, the organisation was restructured. Previously the CRCATH had separate sections dealing with Research Transfer, Capacity Development, and Knowledge Brokering. Now the Board wanted to ensure that these elements were combined within each program…and indeed within each PROJECT.

The Programmatic Approach now sees these elements are considered jointly when projects are developed and implemented. Whist this seems almost a procedural change the effect has been dramatic. By insisting research transfer issues are considered when designing the project can have significant implications for the methodology. Similarly, thinking about capacity development opportunities is likely to radically affect the design of a project. We will not accept the employment of a trainee researcher almost as an afterthought to ensure a box is ticked as a legitimate capacity development strategy.

These changes set the parameters and framework around which our research would be prioritised and developed, and then promoted change.

We then had to fill in the framework and make it all work. We had to develop systems that took Program goals and turned them into viable research projects that addressed all of the above elements.

First and foremost, the CRC is committed to the proper engagement with the Indigenous health sector in all of this process. We are also committed to ensure our research makes a difference.

The first step is stakeholder consultations in the form of Industry Roundtables. These are usually attended by members of the Indigenous health sector and relevant Government agencies and it is at these where the germination of the research projects occur. Our industry stakeholders very quickly identify what they see as the crucial questions to which they would like answers. These are not long, convoluted processes – they are current and relevant.

These priorities from the Roundtable are then written up into research outlines that will flesh out the issues and consider what the research question might look like.

The outlines are then presented to the Board which further prioritises them to ensure the CRC's efforts are directed to where we can make the greatest impact.

The priorities are then developed into full proposals using a collaborative approach that has researchers, the Indigenous health sector and Government coming together around a particular priority.

Importantly, we resource the development of our research proposals both with money and effort. A crucial part of this structure are our Program Managers, the cocktail waitresses Geoff Garret mentioned in his presentation, who coordinate the development process for each program…and mediate between the industry and research players to ensure that Aboriginal and other stakeholder voices are heard strongly throughout the process.

The final step in project development before the research actually begins is what we call our quality assurance process. Quality Assurance is our form of peer review. The CRC had been concerned for some time that the traditional peer review process was not particularly constructive in our context. We followed our own advice and carried out some research to look into the issue. What we have ended up with is quite different. We identify reviewers from relevant scientific expertise, and also from community and government perspectives. They then come together with the project team to workshop the proposal and ensure it is of the highest possible quality.

This way we ensure the research is scientifically sound, that the planning and design are likely to be effective and that the project team has the capacity to carry out the project. The QA criteria include:

The quality of the proposal (including soundness of methodology and appropriateness of approach).
The feasibility of the proposal and its prospects for successful outcome.
The track record of proponents in research, research outcomes, and collaborative work with Aboriginal people.
The clarity of timeframes and milestones.

Interestingly, but not surprisingly, we often find the community input into the design and review of proposals adds considerably to the effectiveness and feasibility of the project.

The research can then begin.

We know our process is … like traditional competitive research grant processes…resource intensive. But we believe that we are more likely to produce good returns for our investment in the resulting research – bigger bangs for bucks if you like.

A common theme running through all of this is the involvement of the users of research in every step in every process. As I said before these are more than mere words, they reflect our values and drive the way in which we work.

I will not stand here in front of you today and say this has all been plain sailing. There have been some robust discussions with researchers and the Indigenous health sector in the early days. Some researchers had their pet projects they wanted to pursue and came to the CRC for funds, some had difficulty with community members assisting the development of the project or casting a critical eye over a project in the QA process because they were not qualified.

Some of those in the Indigenous sector, both individually and organisationally, viewed us with the suspicion they do all researchers and as such were reluctant to fully engage at first.

Let me address the Indigenous side first. There is an entrenched view that Aboriginal people in Australia are the most researched people in the world and that while researchers got their PhDs and built reputations around that research, there was little or no benefit to the research subjects. We start from the perspective of building proper and appropriate relationships with the community sector.

But saying it and doing it are 2 different things. The most essential ingredient to the proper engagement is the building of respectful relationships based on mutual trust.

> Trust that as Indigenous people we will be in a safe environment around research
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> Trust that they will be listened to and
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> Trust that they and their knowledge will be valued

I would like to stop at this point and let your hear from the people who have been involved in our processes. I have a brief video here that presents comments from people involved in our priority setting processes – roundtables – and our quality assurance processes.

I will let them speak for themselves.

PLAY VIDEO

What you've heard there is shows a big turnaround in the attitudes of many Aboriginal people towards research. Increasingly, we are seeing the Aboriginal health sector embrace research and the use of hard data as ways of improving the services they provide to our mob.

But as anyone who's involved in Aboriginal research or Aboriginal services knows…there is a huge gap between the resources available and what needs to be done. So for our industry collaborators in the Aboriginal health sector, we need to resource the involvement of Indigenous people. If you're an Aboriginal health worker, your attendance at a meeting about research may mean someone misses out on getting treatment, unless there is support to cover your participations. This is a cost the CRC is prepared to bear because we are so sure the proper involvement will produce much better research outcomes. I have been asked about this engagement by researchers across the country and internationally and my advice is the same as I will tell you.

If you are going to engage, engage properly and appropriately, and resource that engagement.

There are two costs, money and time. We can always go about getting more money but there are only 24 hours in each day and sometimes that cost means extending the timeframe... We certainly do that and while a process can't go on forever a balance has to found between the need for a timely conclusion of a process and the proper engagement of the right people. This balance is more easily found if there is a relationship of mutual trust established….and the engagement is resourced with money, people and time.

After nearly three years of doing this, we're confident our approach is worthwhile. But it's a very different world for researchers….So what do they get out of it?

When we embarked on a process that would produce a user driven research agenda we knew we would ruffle a few feathers within the research community.

Some fully embraced the concept, while others dipped a testing toe in the water… and there were a minority who were down right cynical.

So like our approach with the community sector we went about building meaningful relationships with researchers.

As I said earlier we aim to:

'ensure highest quality research is carried out with greatest impact on Aboriginal health outcomes'

To carry out the highest quality research we need the highest quality researchers…and indeed our processes have reaffirmed the important role that researchers play in the process of finding answers to complex problems.

In 2006, Dr Alice Rumbold from the Menzies School of Health Research, one of our Partners, conducted a project called:

Exploring the characteristics of the research workforce in Aboriginal and Torres Strait Islander health.

The project arose from discussions about building capacity in Aboriginal health research between our partners at Menzies involved in the CIPHER program; which is a program funded under the NHMRC's Population Health Capacity Building Program, and the first program funded that had a focus on Indigenous health. These discussions identified a need to better understand the career paths of current and past researchers, to identify the positive and negative factors that may influence people's decisions about working in Aboriginal health research.

One thing that became quite clear was how little we know about the current research workforce in Aboriginal health.

The project surveyed nearly 400 people who had published in Aboriginal health research in the past ten years. Of these 32 identified as Aboriginal and/or Torres Strait Islander, 80% were currently active in research but only 38% considered Indigenous health as their primary area of research. This identifies the "core" Aboriginal health research workforce as a very small group – with a big responsibility on its shoulders. It may also reflect the multidisciplinary nature of Aboriginal health research, or indeed indicate that some researchers become involved in research in this field, but based on their experiences or other reasons, choose not to continue.

This project found that of those involved in Aboriginal health research, the most important factors that drew them towards carrying out this research were:

Its importance as a national priority

The opportunity to make a difference

And the opportunity to contribute to social justice

On the other hand, some of the most unattractive factors included:

Politics and their potential to derail or bog down a project

Lack of institutional support to carry out the work required

Not enough mentors

Time and effort required to undertake community consultation/participation

Furthermore, close to 60% of individuals surveyed did not feel that their education and training as a whole, prepared them to work in Aboriginal health research.

Many respondents identified the need for strategies that increase institutional support for the research processes in Indigenous health, as well as access to mentoring and professional networking.

While the implementation of the CRC's new processes preceded Dr Rumbold's study, these findings indicate the significant barriers to Indigenous health research, and reflect the responses we have had to our approach.

When faced with the research priorities set by the CRCAH Board…based on the needs identified by the Aboriginal health sector…some researchers commented that the questions were "not very exciting" (in a researchers' way of looking at the world.) Interestingly, that same researcher nonetheless went ahead and worked with the CRC to develop a proposal that met those priorities.

Another researcher commented that while the process was confronting and demanding,…."it was a great opportunity to work on something that I know the Aboriginal health sector wants and wants to use."

At this stage, we are only able to assess the outcomes of the research projects that we've developed using this process from feedback from stakeholders and through the impacts we can trace as the projects are actually underway.

However, we are strongly encouraged by things like…

> Presenting our body of work around the Primary Health Care and Health Services area to senior managers involved in the CW dept of health and ageing…and finding a huge congruence between the priorities and program directions of that department's office of Aboriginal and Torres Strait Islander Health, and our own research priorities.
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> Overwhelming responses from Aboriginal health services and governments to take part in projects looking at the use of quality standards to bring about cultural appropriateness and quality services in both mainstream and Aboriginal-run services, ranging from small remote clinics to large, internationally renowned hospitals.
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> Increasing interest amongst both Aboriginal health services and government agencies to know about what we are doing and how research and evidence can be used to help improve how we tackle the immense challenges we face in Aboriginal health.

Sadly, there remain substantial areas of resistance. I have personally been deeply distressed by the complete lack of any evidence base in the recent Commonwealth intervention in the Northern Territory….and indeed the determined rejection of evidence based policy by those who initiated the intervention. I am however heartened that in the face of that determined ignorance, the Commonwealth Dept of Health and Ageing have continued to support the evidence and there is now a maturity around the Aboriginal health sector to question itself and work constantly to improve itself.

I can not finish my talk to you today without also talking about the CRCAH's capacity development program.

I mentioned that we have embedded capacity development in our research – and require projects to address capacity development at an individual, organisational or system level.

And I am not just talking about Indigenous capacity to do research. Working in the way we require demands a great deal of any researcher, whether Indigenous or not. It may require non-Indigenous researchers to rethink many of the assumptions and practices they have been brought up on. It also stretches the existing capacity of sciences – in many of our projects, multi-disciplinary research or new adaptations of methods are needed to be able to even begin to address the questions. Finally, it will require support from institutions (academic and funding) engagement in our research approach; which as Dr Rumbold's work suggests, has been less than optimal to date, as many individuals surveyed highlighted a lack of institutional support as a significant barrier to undertaking research in Aboriginal health.

However there are some important things we've learnt from the almost ten years life of the two CRC's for Aboriginal health.

The first CRC recognised that…despite the presence of many exceptionally talented Aboriginal thinkers and academics ….the impact of poor education outcomes for Aboriginal people meant that as a CRC, we could not just rely on PhDs to build the Aboriginal health research workforce. So that CRC offered a whole range of educational opportunities, from traineeships, cadetships, honours, masters and PhD Scholarships.

The traineeship program – while small – was extraordinarily successful. A recent survey of former CRCATH trainees showed all were still employed in the health or health research sectors, and many have gone on to higher degrees. One is doing his PhD…from starting as a lab assistant. One is my PA….and taking a strong leadership role in encouraging young Aboriginal people to think about their potential as future leaders in Aboriginal health.

In 2005 we carried out a review of our education and training programs, and refocussed our efforts towards what we hope will bring about lasting changes instead of just supporting individuals. The support of individuals is vital…but unless we have changed systems, when this CRC winds up in 2010, that support will probably wither and die.

We identified a number of crucial areas of action, where people such as you, in big and small ways, can help to build a stronger Aboriginal research workforce.

One important finding was that Aboriginal researchers are a very valuable commodity. The lower levels of Aboriginal education achievement – combined with the recognition that Aboriginal involvement is crucial to ensuring good outcomes in both research and service provision – means that there is a very competitive market for skilled and qualified Aboriginal people. An Aboriginal person with an undergraduate degree can attract a substantive salary in government, way beyond what they can earn in research. Aboriginal research students are also likely to be mature aged, have family and cultural responsibilities, and be unable to survive on traditional PhD stipends. We believe that if we truly wish to encourage Aboriginal people to become researchers – or even to work in research for periods of time, moving back and forth between research and other areas of employment – we must find ways to provide realistic stipends to compete for talented Aboriginal students to gain the qualifications and expertise needed. One of the ways we have addressed this is to encourage the inclusion of PhD students as fully funded project officers in research projects…

One particularly important point – and one rarely supported by funding agencies – is at the Honours Level. We found that if we are able to hold people on through an honours year, they are highly likely to go on to higher studies and research careers. We have identified scholarships for Honours research degrees as one of our most effective investments in capacity development.

I do not have time to address all the other components of our capacity development strategy, but if you are interested in finding out more our website includes the entire strategy and stories that illustrate the ways we have put it into practice. We also have a number of CRC publications in the foyer at lunchtime.

Finally I remember being at an international conference a couple of years ago when a Maori man made the same comment. But he went onto to say that he thought there could never be too much research because he saw the way forward for his people was through a well developed base of evidence.

What he did concede was that a terrific amount of research done in the past was not ‘good research’ in that Maori people were not involved in any way other than to be subjects that were measured, poked and probed. He said he was committed to the

“good way” of doing research where there is involvement of Maori at every stage of the research process.

This is simply the view we take at the CRC. Doing ‘good research’ - in the way he described.