Aboriginal Health and Wellbeing Services

Putting community-driven, strengths-based approaches into practice

Hannah Bulloch, William Fogarty and Kate Bellchambers

National Centre for Indigenous Studies
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About the authors

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Hannah is a social anthropologist who, over two decades, has researched topics including health systems, wellbeing, community development, livelihoods and changing gender roles. At the United Kingdom's Institute of Development Studies, Hannah helped to establish health systems and governance resource centres targeted at policy makers, practitioners and academics. For three years at the Royal Society Te Apārangi (formerly Royal Society of New Zealand) she worked in funding administration on a major government grants scheme. Hannah was awarded an Australian Research Council Discovery Early Career Researcher Award for her work on changing life trajectories of young women in the Philippines, and has authored a book about discourses of development and notions of the good life in the archipelago. She has worked in research and teaching capacities at Massey University, the University of Sussex, and the Australian National University's (ANU) Centre for Aboriginal Economic Policy Research, the School of Archaeology and Anthropology and the National Centre for Indigenous Studies (NCIS). At the NCIS, her work has focused on deficit discourse and community-driven approaches to health.

Dr Bill Fogarty

Bill is a Senior Research Fellow at the NCIS. He has a wealth of experience working on the development of Indigenous education programs, health discourse, Indigenous cultural and natural resource management, Indigenous sport, and Indigenous development policy across Australia. He has lived, worked and researched in remote Indigenous communities for more than 20 years and has conducted numerous research projects, consultancies and evaluations on various forms of development. Bill is engaged in several high-level research collaborations across Australia, as well as in Norway, Canada and New Zealand. He is also currently a Chief Investigator on the Australian Research Council grant 'Deficit Discourse and Indigenous Education', and the 'Indigenous Citizenship and Engagement' project through the Norwegian Research Council. Bill was a Chief Investigator and lead author on two previous Lowitja Institute-funded research projects in this series: *Deficit Discourse and Indigenous Health* and *Deficit Discourse and Strengths-based Approaches*.

Ms Kate Bellchambers

Kate has a Bachelor of Arts and a Bachelor of Science with Anthropology Honours from the ANU, with a thesis on 'Indigenous Education Through Numbers: A discourse analysis of NAPLAN'. She has been a Research Assistant at the NCIS, contributing to work exploring deficit discourse and strengths-based approaches in health and education. Before coming to the NCIS, Kate was employed by the Carpentaria Land Council Aboriginal Corporation (CLCAC) and worked with Traditional Owners in remote North-West Queensland to implement environmental and cultural heritage management programs. In this role she also contributed to CLCAC's program development, grant and consultancy management, funding and partnerships. Kate is now a doctoral scholar at the ANU, exploring discourses of development in Australia's Indigenous Ranger Programs.

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Finally, we wish to thank all the staff of the Lowitja Institute for their collaboration in developing this research, and the Institute for funding this project.

Acronyms

ACCHS	Aboriginal Community Controlled Health Service	LHAC	Laynhapuy Homelands Aboriginal Corporation
ANU	Australian National University	NCIS	National Centre for Indigenous Studies
CLCAC	Carpentaria Land Council Aboriginal Corporation	NDIS	National Disability Insurance Scheme
		NGO	non-government organisation
CPHC	comprehensive primary health care	NSW	New South Wales
GP	general practitioner	NT	Northern Territory
KPI	key performance indicator	PHC	primary health care

Executive Summary

This report explores strengths-based, bottom-up approaches to delivering Aboriginal health and wellbeing services.[1] It focuses on three case study organisations across two sites, all of which have reputations for maintaining highly positive relationships with their communities:

- Laynhapuy Health is an Aboriginal Community Controlled Health Service (ACCHS) operating in East Arnhem Land, Northern Territory (NT). It delivers comprehensive primary health care (CPHC) to Yolŋu people across the remote Laynhapuy Homelands (see **https://www.laynhapuy.com.au)**.

- Waminda is an ACCHS that provides a range of health and wellbeing services to Aboriginal women and their families in the Shoalhaven region of New South Wales (NSW) and beyond. This includes general practice, antenatal and postnatal care, lifestyle programs, justice support, social enterprise programs and more (see **www.waminda.org.au)**.

- Noah's is a community-based, not-for-profit organisation catering to children and young people with special needs and their families across the Shoalhaven. Their work includes National Disability Insurance Scheme (NDIS) services, childhood education, playgroups, and behaviour support. Noah's has several programs specifically for Aboriginal clients (see **https://noahs.org.au/)**.

Despite the substantial differences between the two field sites and the scope of the three organisations, there were strong commonalities between them in the approaches and challenges they raised. From the wide range of health and wellbeing practitioners we spoke to – which included nurses, midwives, Aboriginal health workers, therapists, caseworkers and more – there was clear sentiment that in a context of post-colonial power imbalance, Aboriginal people often experience inappropriate treatment in mainstream services. There was agreement that community-driven, holistic and person-centred approaches are key to delivering better services, yet, increasingly, restrictive and metrics-focus funding regimes constrain what works.

For all three organisations, strengths-based approaches are inseparable from their community-driven, holistic design. The linking elements are their understandings of power structures and neo-liberal trends in a cross-cultural context in the Australian health and wellbeing sector. This highlights that strengths always need to be understood in relation to constraints. For example, a narrow focus on strengths risks portraying individuals and communities as responsible for their situations, shading out wider relations of power and socio-economic inequality. We found that all three organisations strike an important balance between confidence in the strengths of the communities they serve and represent, and consciousness of the constraints on their (and their clients') room for manoeuvre in a post-colonial and increasingly neoliberal nation-state. In many ways large and small, the organisations keep working at pushing those boundaries a little further – creating more room for autonomy and for strengths.

This report explores these dynamics, and, in the process, details the three organisations' approaches and successes. This brings us back to many of the core issues that are well documented in relation to Aboriginal health and wellbeing, including the importance of community-driven design, holism, the social determinants of health, and person- and family-centred approaches. This allows us to celebrate the organisations' strengths and successes – highlighting 'beautiful, big, positive' stories, as one of our interviewees put it.

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1. Throughout this report we have followed the terminologies of our case study organisations, participants, and/or source materials in our use of the terms 'Aboriginal', 'Aboriginal and Torres Strait Islander' and 'Indigenous'.

The main section of the report details the organisations' understandings of effective approaches in the sector, as they have sought to implement them. Although there is much overlap, we have divided this into three areas of focus:

Under the section **What Works: Bottom-up approaches** we explore broad, organisational issues relating to governance, program design and staffing.

- Community-driven program design is fundamental to ensuring success. This requires building long-term relationships with communities that go well beyond superficial consultation.

- Relationship building goes hand-in-hand with long-term learning based on local histories, culture and socio-economic dynamics.

- From these relationships and learning, innovative place-based services that are responsive to community needs and aspirations can grow.

- Crucial to these processes is having staff who are part of the community, but drawing on expertise and support from staff with a diversity of backgrounds can also help build robust structures and services and provide clients with a wider choice.

Under the section **What Works: Holism and wellbeing** we then look at how the organisations think about health and wellbeing and what they incorporate within the scope of their work.

- Much of the health sector treats illness in Aboriginal people, rather than promoting health and wellbeing.

- Holistic health that addresses social determinants is preventative and protective. It can include supporting culture and language, connection to Country, spirituality, belonging and identity, strength of community and family, and empowerment and control.

- Holistic health may seem broad, and therefore difficult to implement. However, because the organisations are in tune with community needs and aspirations, it is often clear to them which health-promoting services are most relevant in their context. For example, for one health organisation, enabling people to live and thrive in remote homelands communities is at the core of their work, while another explicitly promotes fitness, nutrition and career pathways among other things.

Under the section **What Works: Delivering person- and community-centred care** we narrow to a focus on effective approaches at the 'clinical interface' of the organisations' work.

- Much top-down intervention in the health care sector and beyond relies on externally identifying and seeking to fix problems. Often systems operate based on practitioners' 'expert' values and terms.

- Person-centred care shifts the power balance and places clients' needs, desires, goals, values and circumstances at the centre of the care process.

- Related strengths-based approaches seek to shift the emphasis away from problems and negative labels through which a person's or community's identity can become defined, to instead recognising positive capabilities, goals and actions.

- All the case study organisations stressed the importance of their services being accessible on a regular and consistent basis. This was closely linked with making a long-term commitment to a place and a population, and building peoples' familiarity with the service and their trust over time.

- Consistency in service provision must be balanced with flexibility, adaptability and responsiveness based on community and client needs. In other words, consistently 'being there' for clients is important, but the form this takes need not be prescribed, rigid or unchanging.

- Brief consultation times, which are standard in the health care sector, are particularly sub-optimal in the context of Aboriginal health care for a range of reasons we detail. For example, building trust is essential,

particularly in light of traumatic histories with institutional services and the prevalence of negative experiences in the health and wellbeing sector. However, building trust and rapport takes time.

- All the case study organisations see brokering, advocacy and coordination of care as central to their work and success. This ranges from explaining to people the available services and talking them through what to expect, to (in the case of one organisation) escorting them on major hospital visits and translating between languages.

While many of these themes are well-established 'best practice' in the health and wellbeing sector, the organisations had remarkably similar **Challenges and Constraints** in marrying bottom-up, holistic and person-centred approaches with top-down funding regimes.

- Funding is typically for a specific purpose, falls within a siloed sector or assumes a certain set of realities. The purpose and scope of the funding is decided from the top down and it often assumes a compartmentalised approach to health and wellbeing.

- Project and programme grants are also often relatively short-term. But, as noted, genuine community relationships take time to build, and many programs that address the social determinants of health are unlikely to show results in such timeframes. Even initiatives with a strong and consistent record of positive results over the long term can be defunded at short notice with little or no explanation. This is a threat to the consistency and regularity of services (factors that our participants identified as being so important). It is also a threat to staffing in a context where the organisations have strived to build up Aboriginal staff capacity and cross-cultural understandings, as it can result in the loss of long-term institutional knowledge and produce employment precarity.

- The organisations are required to report on key performance indicators (KPIs). These are typically determined from the top down and are often strongly metrics-focused. There are frequent disconnects between what KPIs measure and what local organisations value, as well as frustrations that KPIs measure the 'wrong' things or fail to capture important successful activity. This is part of a broader international trend toward standardised statistical indicators, despite evidence that they often do not produce the desired outcomes.

Drawing on the findings throughout the report, we make a range of recommendations for ways forward. These are targeted at funders, policy makers and associated stakeholders seeking to enable non-government organisations (NGOs) in the Aboriginal health and wellbeing field to work more effectively.

Funding that embraces holism, innovation and responsiveness

- A prevalence of narrow, sector-specific funding may be impeding holistic health and wellbeing approaches, and those driven by community needs, values and aspirations. More funding streams that allow organisations to define and respond to holistic health and wellbeing in their context are needed.

- Designing bottom-up, holistic health and wellbeing services sometimes means innovating and taking risks. Funding streams that embrace innovation, but do not force it where it is unneeded, would benefit the sector.

Longer term funding cycles

The availability of more long-term funding options will better allow organisations to design projects and programs from the bottom up. This includes organisations' efforts to prioritise relationship building; to address the social determinants of health; to ensure there is leeway for strategies to be tried and, if necessary, amended; to provide consistency of presence over time; and to help build a more skilled and stable workforce that includes training, learning and career development opportunities for Aboriginal and non-Aboriginal staff.

Co-designed KPIs

- Funding providers should allow organisations the capacity to design or negotiate KPIs according to local realities and community-based aspirations, thereby allowing for greater local relevance, responsiveness and innovation.

- Co-design of KPIs should be an ongoing, reflexive process, allowing for the mitigation of unintended consequences.

Narrative-based reporting

- Reporting formats need to allow funding recipients the option and scope to detail progress, issues and outcomes in narrative/descriptive form. This may mean incorporating more open-ended questions in report templates.

- The capacity to integrate or attach multi-media (including videos, audio and photographs) is also merited.

- Public servants and program managers need professional development in valuing and using qualitative information, and in the dangers of privileging statistical information.

Reducing over-reporting

- It is incumbent on funding providers to ensure that reporting requirements and processes are efficient. This includes thinking carefully about how often reports fall due, how user-friendly the reporting templates are to complete, and whether the extent of what they ask applicants to produce is reasonable.

Relationship building between funders and recipients

- Policy makers and funders can gain a better understanding of the realities on the ground by talking directly to those implementing services in that sector. Staff at funding institutions should be encouraged to view the funding relationship as a partnership, rather than as a hierarchical relationship in which the funder holds the power. It is, after all, usually the service provider that best understands the realities, needs and aspirations of the communities with which they work.

- Organisations can feel that submitting reports on expended funding is like feeding information into a black hole; there is typically no engagement or feedback from the funding organisation and it is often unclear if or how the submitted information is (or might in future be) used. More transparency around the use of requested information is important, as is engagement with submitted reports.

Career public servants and time for learning

- The Australian Public Service encourages professional mobility among its staff, but understanding Aboriginal Affairs requires relationship building, substantial cross-cultural knowledge, and comprehension of a range of complex and interrelated historical, socio-economic and political issues. As such, there is strong merit in encouraging public servant stability and specialisation in Aboriginal Affairs.

- Because knowledge of best practice, and cross-cultural understanding, are central to effective Aboriginal health and wellbeing policy, public servants need time for learning. There is a vast amount of high-quality and accessible research and guidance material on these topics, as well as a plethora of other learning avenues such as courses and cultural immersions. It would be of enormous benefit for public servants to be encouraged to read such materials and to undertake learning opportunities on-the-job with allocated time to do so.

Introduction

This report investigates perceptions and practices of community-driven, strengths-based approaches to Aboriginal health and wellbeing services.[2] It particularly considers what success looks like to organisations providing these services, how they go about achieving it, and how policy environments (especially funding structures) can better enable their work.

The report is part of a series of three discussion papers examining strengths-based approaches and deficit discourse in the field of Aboriginal and Torres Strait Islander health and wellbeing. The first, entitled *Deficit Discourse and Indigenous Health* (Fogarty, Bulloch et al. 2018), explores the prevalence of 'deficit discourse' **(see page 17)** in a suite of high-level government policy and reporting texts. It found that deficit discourse is prevalent in both policy and research concerning Aboriginal and Torres Strait Islander health and wellbeing, but not uniformly so. There is, in fact, substantial diversity between policy documents, reflecting competing philosophies and values. There are, for example, active efforts in some branches of government to emphasise strengths, culture, Country, rights and partnerships.

The second report, *Deficit Discourse and Strengths-based Approaches* (Fogarty, Lovell et al. 2018), reviews a variety of strengths-based and related approaches. The team found considerable variation in the way the term 'strengths-based approaches' is used across the sector. The report argues that while strengths-based approaches show promise, there is also a risk that they can reproduce some of the same problems as deficit discourse if used uncritically.

This third report scales up 'voices from the ground' through case studies of three organisations – two Aboriginal community-controlled organisations, which constitute the heart of our study, and a third organisation that has been working for 20 years with Aboriginal communities. Each organisation delivers a range of health and wellbeing-related services. They vary in location, scope and context, but they share key elements, including that each pursues holistic health and wellbeing based in local strengths, and that the communities they serve and represent broadly recognise them as successful. Although not intended to be representative of the diversity of perspectives and issues affecting Aboriginal health and wellbeing services across Australia, this report privileges the voices of practitioners working at the coalface of service delivery.

Our conversations and interviews across the organisations began with a focus on the impacts of deficit discourse and on their strengths-based approaches. However, it quickly became apparent that, for the organisations, these are inseparable from their community-driven, holistic design. The linking elements are their understandings of power structures and neo-liberal trends in cross-cultural context within the Australian health and wellbeing sector. For example, when we asked one manager to tell us about strengths-based approaches, he immediately gave us a lesson on how the changes to funding based on episodes of care would impact their ability to pursue community-driven approaches. This accords with a key point in our earlier work on strengths-based approaches: that strengths always need to be understood in relation to constraints. Otherwise, a narrow focus on strengths risks portraying individuals and communities as responsible for their situations, shading out wider relations of power and socio-economic inequality.

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2   The research for this report is part of a larger project, entitled 'Discourse, Data and Deficit: Deconstructing the Indigenous Health Paradigm and its Effects on Aboriginal and Torres Strait Islander Peoples' – a collaboration between the NCIS and the ANU's National Centre for Epidemiology and Population Health. The qualitative strand of the project, on which this report is based, was carried out by the NCIS. The National Centre for Epidemiology and Population Health conducted a quantitative stand, which investigated how Aboriginal and Torres Strait Islander health and wellbeing can be positively framed through large-scale quantitative analysis. It explored what alternative statistical representations can reveal about the assumptions underlying, and the stories told through, the production of such metrics (Thurber, Thandrayan et al. under review).

We found that all three organisations strike an important balance between confidence in the strengths of the communities they serve and represent, and consciousness of the constraints on their (and their clients') room for manoeuvre in a post-colonial and increasingly neoliberal nation-state. In many ways, large and small, the organisations keep working at pushing those boundaries a little wider, thereby creating more room for autonomy and for strengths.

This report explores these dynamics and, in the process, details the organisations' approaches and successes. Doing so brings us back to many of the core issues that are well documented in relation to Aboriginal health and wellbeing, including the importance of community-driven design, holism, the social determinants of health, and person- and family-centred approaches. This allows us to celebrate the organisations' strengths and successes – highlighting 'beautiful, big, positive' stories, as one of our interviewees put it.

In the final sections, we shift to the policy–practice interface and detail what the organisations told us about some of the main top-down factors constraining their bottom-up approaches. We make practical recommendations for more enabling funding and reporting systems.

Research Methods

The project was carried out over 18 months and involved four phases. This builds on the desk-based studies from the first two reports in this series, and all phases incorporated relevant literature review and analysis.

The first phase involved discussing our proposed research with potential case study organisations and negotiating relationships. We opted to focus on East Arnhem Land in the NT and the Shoalhaven/Jervis Bay region of NSW, as we had existing connections in these areas and had been invited to conduct research on health in both places. In addition, the two sites would facilitate comparison of the issues between remote, urban and regional communities. In this scoping phase, we made one fieldtrip to East Arnhem Land and three to the Shoalhaven and Jervis Bay Territory (Nowra and the Wreck Bay Aboriginal Community). All the organisations we approached had a relationship with, or were well known to, one or more members of our research team; they also all have highly positive relationships with the communities with which they work. We negotiated partnerships with three organisations that were in a position to be part of the study and that saw the research as dovetailing with their own interests and concerns. As the research was inductive, we discussed its scope and adjusted our focus in response to this and to emergent findings.

The first phase included negotiating ethics approvals. A full human ethics application was approved through the ANU Human Research Ethics Committee. For Waminda, we also applied for, and were granted, ethics approval through its Research Committee and ascertained approval through its board. Regardless of the formal processes, the time spent negotiating mutually agreed parameters for the research proved invaluable. In each case, we endeavoured to ensure community interests were paramount and that we were transparent in the assumptions and purpose of the research design.

In the second phase, we returned to the field sites and conducted in-depth research. Our principal method was semi-structured interviews with a diversity of staff members across the three organisations, as well as with people working in the broader field of Aboriginal health and wellbeing. In this phase we made two fieldtrips to Arnhem Land, twice accompanying Laynha staff on multi-day visits to homeland communities, and two fieldtrips to the Shoalhaven, during which staff showed us the organisations' sites and outreach clinics and centres. We asked interviewees about their backgrounds, what Aboriginal health and wellbeing means to them, their perceptions and practices of strengths-based approaches, their experiences of deficit discourse, what approaches to Aboriginal health and wellbeing are working, and what challenges remain.[3] We interviewed 37 people in total, for about an hour each, and had many more conversations from which we took notes. Twenty-two of the interviewees were Aboriginal (predominantly identifying as Koori and Yolŋu). Of the non-Aboriginal interviewees, two were Indigenous from other backgrounds.

The third research phase involved data management and analysis, and drafting the findings. The interviews were fully transcribed and we coded them in the qualitative data management software NVivo. Through this, we identified more than 150 cross-cutting themes, which we organised into hierarchies. The dominant themes emerging from this exercise shaped this report.

In the final phase, we returned to the communities and reported back on our draft findings. This provided participants with an opportunity to reflect on, discuss, and again shape the emerging work.

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3   As will be clear from our approach, the study was not intended as a review or evaluation of the organisations. We did not interview clients of the organisations and did not observe clinical or therapeutic practice as this was beyond the scope of the research.

In this report, we have sought to foreground the voices of those we interviewed – the experts, working at the coalface, who entrusted us with their stories. We use initials when attributing quotes to participants, but to assist with anonymity these are not participants' real initials. Furthermore, when quoting or paraphrasing participants' comments we have often opted to avoid noting their ethnicity or profession unless it is particularly relevant. This is also because the themes and sentiments expressed across ethnic and professional subsets of the interviewees proved to be similar.

Case Study Organisations

The three case study organisations are all community-driven, share a focus on strengths-based approaches, and deliver an array of health and wellbeing services to Aboriginal and Torres Strait Islander people. However, each organisation is distinct in its operating context, the services it offers, its role in its local region, its staff composition, and its relationships with clients. Their similarities and differences have allowed us to compare their ways of using strengths as a cornerstone of local health care and wellbeing design. We were surprised by just how often similar approaches, visions and frustrations were raised across the different contexts – for example, many concerns about top-down policy were the same despite the vast differences between the urban/regional and remote areas that distinguished the organisations' operating contexts.

Figure 1: 'Word cloud', reflecting keyword frequency in interviews across the three organisations

Laynhapuy Health

Laynhapuy Health (colloquially called Laynha Health) is an ACCHS in East Arnhem Land, Northern Territory. It is the single provider of health services to Yolŋu people across 6,500 km² of remote country, including 20 Laynhapuy Homelands communities (LHAC 2017a).

Laynhapuy Health is part of the Laynhapuy Homelands Aboriginal Corporation (LHAC) and shares headquarters in Yirrkala with other LHAC services and enterprises including in housing, civil works and land and sea management. The Corporation seeks to 'maintain the vision of Yolŋu elders who initiated the Homelands Movement in the 1970s' (LHAC n.d.) and support Yolŋu people 'to maintain the land, the culture and the wäŋa (homeland centre) for future generations' (LHAI 2009:5). LHAC is governed by a board of Traditional Owners.

Laynhapuy Health delivers comprehensive primary health care through seven purpose-built clinics managed by local Aboriginal health workers and through outreach to smaller communities. During the week, Laynhapuy Health staff travel from Yirrkala to the homelands, with schedules determined according to set targets, patient and community needs. Laynhapuy clinical services are a 'nurse-led outreach service model' and include an offsite doctor providing advice, coordination and consultations via teleconference. Laynhapuy Health supports clients to access specialist and other services including clinics in Nhulunbuy, Gove Hospital, Royal Darwin Hospital and other major health care facilities as required.

Laynhapuy clinic at Wandawuy (photo by the authors)

Figure 2: Laynhapuy Homelands area, north-east Arnhem Land, NT[4]

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4   An earlier version of this map was created for Morphy and Morphy (2016:305) by the ANU's CartoGIS Services. The current
     version has been adapted by CartoGIS with the permission of Morphy and Morphy.

Waminda

Waminda – South Coast Women's Health and Welfare Aboriginal Corporation is an ACCHS that has been providing health and wellbeing services to Aboriginal women and their families in the Shoalhaven region of NSW, for 35 years. It offers a large (and growing) range of free services, with a focus on holistic and culturally safe strengths-based care. The organisation has grown substantially over the past decade, expanding from around 10 to 110 employees, 72 per cent of whom identify as Aboriginal and/or Torres Strait Islander descent (Waminda 2018a:50).

Waminda employs doctors, nurses, midwives and Aboriginal health workers who deliver primary health care, including general practice, chronic disease management, antenatal and postnatal care, and health promotion and education. It also employs a range of case workers, community and youth workers, counsellors, personal trainers, and community cultural mentors to provide a diversity of programs and services including **Balaang Healing** and **Dead or Deadly**. Waminda offers an intensive family support preservation and restoration program (Nabu), as well as justice support. The organisation now operates from six sites and undertakes outreach activities supporting women and their families from Coomaditchie in the north, down to Wallaga Lake and Bega/Eden in the south (see Figure 3).

Noah's Inclusion Services

Noah's Inclusion Services is a community-based, not-for-profit organisation straddling health and education as it caters to children and young people with special needs and their families across the Shoalhaven. Initially established as a toy library, the organisation has been operating for 33 years and now provides services to around 900 children annually through two locations and its outreach activities (Noah's Inclusion Services 2019).

Noah's offers NDIS services, early childhood education, playgroups, behaviour support, and coordination services. Around 20 per cent of its clients identify as Aboriginal or Torres Strait Islander or have an Aboriginal or Torres Strait Islander background, and over many years Noah's has provided several programs designed for Aboriginal children, families and communities. Noah's has a long-standing partnership with the Wreck Bay Aboriginal Community through the Koori Kids Together Program. Other current initiatives include the educational oral language program, Aboriginal Families as Teachers, and a playgroup, Young Yarns. Both programs build on family and community strengths and focus on linking families with early childhood education.

In the following sections, we focus predominantly on Laynha Health and Waminda, because of their larger Aboriginal programs and staff numbers (meaning we spent more time at these two organisations and interviewed many more people). However, as we found the approaches taken by Noah's and the issues arising from its work were similar, we regularly quote from interviews with Noah's staff in ways that resonate with the themes emerging from the ACCHSs.

Figure 3: Central and north Shoalhaven region (and beyond), NSW

Health Care Across Worlds

NGOs and ACCHSs play important roles in delivering health and wellbeing services for Aboriginal and Torres Strait Islander populations (Panaretto, Wenitong et al. 2014; Wood, Shilton et al. 2011). Panaretto et al. (2014:649), for example, find that 'ACCHSs have reduced unintentional racism, barriers to access to health care, and are progressively improving individual health outcomes for Aboriginal people'. They also point out that primary health care data show that ACCHSs perform better than mainstream general practice in a range of areas (Panaretto, Wenitong et al. 2014:649).

In this section, we consider what the case study organisations and their approaches are 'responding to'; that is, why they see it as necessary to have community-driven health and wellbeing services for Aboriginal people. Factors include histories of colonialism, cultural difference, and power and resource inequality; inappropriate or inadequate treatment in general services; and negative constructions of Aboriginality. (Throughout the report we also discuss additional factors, such as in the section **Seeing beyond the 'sickness model'**). This frames the subsequent three **What Works** sections, in which we explain how the organisations have been working to transform Aboriginal communities' experiences of, and engagement with, health and wellbeing services.

Power and difference

Guthrie and Walter (2013) point out that many health professionals occupy dominant positions in socioeconomic and racial hierarchies, 'while working directly with people who differ from them racially and culturally'. Within all societies, ethnocentrism (viewing the world by the standards of one's own culture) is common, but it can intensify and its effects can be greater when people are in positions of dominance. As such, it can be easy for health professionals to conflate what is 'normal' with what is 'natural' (Guthrie & Walter 2013).

These hierarchies are reproduced in conjunction with popular but academically discredited notions of 'progress', which assume that Anglo–American culture sits at the pinnacle of a supposedly social evolutionary ladder (Bulloch 2017). In myriad ways, such notions have unfortunately been fundamental to the dominant imaginings of the past, present and future of the Australian state. In the health field, the risk of misrecognising cultural and historical differences can be further exacerbated because it is a field that relies heavily on hierarchies of expertise. In addition, the 'technical' nature of much knowledge within the health field can make that knowledge erroneously appear culturally neutral in its origins and its effects.

One interviewee, NR, touched on these mentalities of cultural and professional dominance when he said that, 'It takes non-Indigenous people two years to know that they don't know'. He meant that when non-Indigenous people start working with, or living with, Yolŋu communities, their widespread belief that they have superior understandings fuels a 'fix it' mentality. 'If you can get rid of that stage of thinking you know, then maybe…'; he left the sentence hanging but the implication was that non-Indigenous people adopting greater humility would result in better relationships and improved outcomes.

Across both our field sites, interviewees often spoke of 'two worlds' to express differences between dominant culture and local Aboriginal cultures. The term 'two worlds' merits caution for a number of reasons: it simplifies differences between people even within a given Aboriginal group, such as Yolŋu or Koori; it similarly homogenises non-Aboriginal people who come from an array of cultural backgrounds; and it draws a seemingly sharp distinction between Aboriginal and non-Aboriginal worlds, which in reality are totally enmeshed. But it is clear that our research participants did not adopt this term out of naivety.

Rather, they use it to challenge assumptions that differences in culture and history are unimportant in the health context and beyond. The term 'two worlds' is a pushback against the idea that colonisation has made us all the same, or close enough.

Yolŋu have strenuously resisted assimilation, and their remoteness from urban centres has aided their resistance. People raised in the homelands do not speak English as a first language, although they may speak multiple Aboriginal languages. RT, a health worker of European descent who has worked for a decade with Yolŋu communities, explained the sometimes deep and underestimated nature of cultural difference:

I would love it if my clients and I could communicate in the same language, but I don't think that would necessarily lead to common understanding because we're coming from completely different world theories… [There are] little things like knowing what never to say in front of a male or never to discuss a pregnancy with a father… I think that for a Yolŋu person from Biritjimi, say, it's so inherent to them what they know, they don't know that I don't know it. We both don't know what the other doesn't know about the very basic things.

In the Shoalhaven, the present-day differences and divides between Aboriginal communities and the engulfing society may not be as stark, but colonisation has nonetheless wrought a legacy of structural inequality and intergenerational trauma. Although it may be easy for non-Indigenous people to dismiss colonisation and neo-colonialism as 'in the past', the reality for many Aboriginal people is very different. A Koori wellbeing worker, SN, spoke to us of 'not being able to express and practice what you've always grown up with'.

And to be told you don't do that, you're not allowed to do that, don't show that, don't talk your language… And I guess like [there's] a lot of shame and stuff too. Because some of the Elders, you know, wanted to hide it. They were Aboriginal and I guess if you were Aboriginal you weren't respected or you didn't get certain things or you weren't allowed to do this…

Even in the '70s we were told to run and hide when you're a kid. And it's like, why do we have to run and hide? You don't understand it, back in those days, but as you grow older and you learn… we need to do that. Mum and Dad protecting you and stopping you from getting taken away. Some of my cousins have been taken away.

Her colleague then spoke to us of the intergenerational trauma experienced by some of the clients she sees, and asked: 'How can it be any other way unless it's addressed and actually trodden down; unless it's made so safe and so caring and so non-judgmental?'

Inappropriate treatment from mainstream services

Most of the health workers we interviewed had previously worked in mainstream services, and almost all continued to liaise with such services. Unfortunately, when we asked them about these services, a picture of safe, caring environments did not immediately come to mind. They frequently spoke of Aboriginal patients experiencing inappropriate or disrespectful treatment, or receiving a different standard of care to non-Indigenous patients. This resonates with the wider research detailing negative experiences and inappropriate health care for Aboriginal and Torres Strait Islander people accessing mainstream health services (Aspin, Brown et al. 2012). Reasons cited in the literature for this include miscommunication, language barriers and differing world-views (Cass, Lowell et al. 2002), as well as feelings of shame by patients, systemic failings and racism (for example, Canuto, Wittert et al. 2018; Dunbar 2011; Worrall-Carter, Daws et al. 2016).

A midwife, SF, told us that while 'you get some really great places that are amazing', she sees a lot of women coming out of hospital 'feeling very disempowered, feeling traumatised from the birth experience… mostly because of racism. It's massive. People say, "What are you talking about racism for? It doesn't exist." Bullshit. It's massive.'

Originally from a large, multicultural city, SF has personally experienced racism in the local district health system. 'It was a shock to me and a shock to my kids,' she said. She and her colleagues gave a range of examples of inappropriate treatment, such as hospitals not facilitating collective visits from family, not facilitating ceremony, and new mothers waking up after giving birth not knowing where their babies were.

EW similarly told us that she was horrified at how Aboriginal people are being treated within mainstream systems.

> I've actually had to chase a client out of hospital to catch her before she threw herself of the cliff, from how someone spoke to her there. Literally had to pull her back off the cliff. So, you know, this is like a daily thing, it's not like a one-off thing. This isn't just me… this is constant and nothing is changing there.

EW went on to explain that workers in the mainstream system are often 'only seeing community when they're very unwell and so they're very judgmental'.

> It's like, do you have any idea what this person has just been through? And then they're treating them like a child.

> I've had one woman that when I went up there to support her, I was horrified. I went in. I can't even begin to tell you her story, but then I've come in and she's tiny, a really little lady, and she's got two big security guards holding her down on the bed, in emergency. And this is what the nurse said: 'You put yourself here, you should have thought about that before.' And she was there for a suicide attempt.

'This is what we put up with,' her colleague, SN, added.

'All she wanted to do was go and have a cigarette, calm her nerves a bit,' said EW.

In Arnhem Land, health workers we interviewed were similarly distressed by the treatment Aboriginal people received from mainstream services. One forwarded us an email that the local hospital sent to pilots contracted to transport people from Yolŋu homelands to hospital. The email read, 'Please do not wait for patients unless directed by the Gove Patient Travel Team. Do not even wait 15 minutes as previously instructed.' Yet the hospital often failed to inform clients of the expected landing time. Laynha Health would often only be given the landing schedule on the morning of the travel, with insufficient time to relay the message to clients. In some cases, the airstrip is a 10- or 15-minute walk from the settlement.

A nurse described it as 'absolutely ludicrous' that in mainstream services consultations often take place in English without language interpreters, even when the clients speak Yolŋu Matha and little English. 'I can feel like I've left someone with a common understanding,' she told us regarding such work, 'then I can see that same person the next day and realise that nothing has been communicated. Nothing. And I'm not terrible at communicating, but I'm communicating in the wrong language.'

Deficit discourse

'There's so much judgment put on our people,' says KT, a Koori woman and a manager at one of the case study organisations.

> So much judgment. No matter what we do, it's always negative. It's always: 'Well, they did this wrong,' 'They're an alcoholic,' 'They're a drug addict,' 'They're criminals,' 'They're this,' 'They're that'.
>
> It's like: well no, they're actually people.
>
> The only reason they have those stigmas is because of the impacts of colonisation. So how do you treat a woman when she comes through that front door? You have to be non-judgmental. It has to be about her.

Many non-Aboriginal staff members were similarly unsettled, and sometimes outraged, at the negative stereotyping of Aboriginal people they regularly encountered. One was disturbed by sympathy offered when strangers learn where she works. 'Oh god, that's so hard. Are you alright?' people ask her. But, she said of herself and another colleague, 'We're so proud to be here. We are so lucky. As non-Koori, we're walking in a space and a place where we are so lucky to be here, to be looked after and to feel included.' If you could 'flip' the discourse, she surmised, Aboriginal people would 'be able to stand up proud and just know that people are going to listen.' Instead of being 'surprised or sceptical or disbelieving', people would respond with, '"Wow, that's awesome, that's so amazing". If you could turn it,' she concludes, 'imagine what could happen?'

In Australia in recent years, the term 'deficit discourse' has come into increasing circulation to refer to the tendency to characterise Aboriginal and Torres Strait Islander people in terms of problems, absences and lack (Fforde, Bamblett et al. 2013; McCallum, Waller et al. 2019; Waller, McCallum et al. 2018). In our earlier work, we define deficit discourse as

> … disempowering patterns of thought, language and practice that represent people in terms of deficiencies and failures. It particularly refers to discourse that places responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded… [D]iscourses of deficit occur when discussion of Aboriginal and Torres Strait Islander affairs is reduced to a focus on failure and dysfunction, and Aboriginal and Torres Strait Islander identity becomes defined in negative terms, eclipsing the complex reasons for inequalities, and overlooking diversity, capability and strength. (Bulloch 2018:1)

One interviewee described deficit discourse as a subtle but pervasive form of racism (also see Paradies, Harris et al. 2008). You can dismiss racist people outright he said, but it is the ethnocentric fix-it mentality of some people in the health care sector and beyond – people who think they know what Aboriginal people need, while knowing little about Aboriginal history, culture and context – that does quiet harm.

Importantly, avoiding deficit discourse does not mean ignoring inequalities; discussion of socio-economic disadvantage, and ways to alleviate it, is important and necessary. However, it does mean keeping in perspective that inequalities are not problems that lie with disadvantaged groups; rather, inequalities concern *relationships* between groups, and are thus as much about the dominant groups. Power and resource differentials are inherent in these relationships, as are differentials in values. It also means being cognisant of the diversity of Aboriginal and Torres Strait Islander situations and experiences across Australia.

Our colleague, Scott Gorringe – a Murri man who has made deficit discourse a focus of his empowerment work – also points out that deficit discourse is not just something settler society 'does' to Aboriginal and Torres Strait Islander people. Deficit discourse is reproduced by Aboriginal and Torres Strait Islander people too. He writes:

> *Let's put the white opinion aside for a moment, and focus on the way Aboriginal people abuse and accuse our own mob in this space of identity construction and consider its association with deficit discourse. Aboriginal mob, mainstream Australians, politics, and media all currently play roles in constructing the Aboriginal identity... we are complicit and it leads to the same limiting outcomes for Aboriginal peoples* (Gorringe, in progress:8).

A fixation on problems can eclipse strengths and successes, large and small. This is a great loss, because just as negative stereotyping can become self-fulfilling, success can beget success. One interviewee, NH, expressed the importance of telling success stories:

> *You know, the money that [government] give us, it would be nice to actually see these beautiful, big, positive things out there in the media, instead of always negativity... Because when you go to conferences and government get up there, they present on all their statistics about where we're at – we're so low in this and so low in that.*

> *Look at what's out there and look at the deadly things that are happening out there and talk about them! You know, talk about them and come from that strength and look at that. Because then other people, who may not be doing things that way, can pick up on that, and they can go, 'Well yes, we can do that within our organisation'. Stop showing us what we already know. Let's look at all these positive things that are happening in communities and what is working. Because if it's working in one community, I'm sure it can work other communities.*

This report focuses largely on successes. Finding the positives has been effortless for us as researchers: the interview and ethnographic material we collected from the organisations exude strength and success.

Strong commonalities emerged from the three organisations regarding their understandings and experiences of what works in Aboriginal health and wellbeing services, which is explored in the following sections. The **What Works: Botton-up approaches** section covers broad, organisational issues relating to governance, program design and staffing. The section **What Works: Holism and wellbeing** looks at how the organisations think about health and wellbeing and what they incorporate within the scope of their work. The section, **What Works: Delivering person- and community-centred care**, focuses on effective approaches at the 'clinical interface' of the organisations' work. In practice, however, the various aspects of the organisations' philosophies and practices (from governance to the clinical interface) are inextricable, and key themes – such as the importance of relationships, culture and brokerage and much more – cut across all three sections.

What Works: Bottom-up approaches

Community-driven design

Employees at all the organisations emphasise that their fundamentally 'bottom-up' approaches are central to their success.[5] Both LHAC and Waminda are community-controlled organisations that explicitly place the values, needs and visions of those with whom they work at the centre of their practice – from governance, to one-on-one interactions with clients. In certain respects, it is a false binary to even separate their staff from the communities they serve, given that a large proportion of them are Aboriginal people from those communities (this is discussed further in the section **Aboriginal health and wellbeing professionals**). As Waminda employees are quick to point out, 'We *are* the community'.[6]

Non-Indigenous organisations also play important roles in community-driven health and wellbeing services. Bottom-up approaches exist to differing degrees, but rely on building trusting and respectful two-way relationships that go well beyond superficial consultation. Noah's is an example of an organisation that is not Aboriginal controlled, but has nonetheless managed to build strong, trusting relationships with the Wreck Bay Aboriginal Community, with whom it has been working for 20 years. A senior staff member describes the 'enormous strength in the community, the collective community, down here' and says that Noah's has 'a responsibility to try and push [community needs and desires] up the funding chain'.

Waminda was founded by local women. As NH explained, 'it was the strong people in our community, the Elders in our community, [who] said that there was a need for a health service for Aboriginal women and their families, that is culturally appropriate, that is meeting the health needs of our women and their children.' This original vision for Waminda still drives the service, and the importance of understanding and responding to community demand cross-cut the interviews. JS said that Waminda is the first place she has worked where 'every single person here is community first and not just talking about it, but actually doing it… It's just such a powerful space to be in.' Meanwhile, TR pointed out that

> It's always about what the community needs are first and foremost, it's never about what somebody else's expectations are of us. I know all that stuff happens, but it comes later. We mould it to the way that our community need it to be, not what anybody else needs it to be and I think that's probably one of the biggest successes of our organisation.

The Waminda Model of Care (Figure 4) represents an idealised way of imagining and guiding flows of power that reverses conventional organisational hierarchies and emphasises a cyclical nature of influence. Community, in different forms, appears at multiple points in the model including near the top, and at its heart.

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5   Although not commonly used by the interviewees per se, the term 'bottom-up' denotes approaches that seek (at least in part) to reverse conventional bureaucratic hierarchies. In these conventional hierarchies, channels of influence flow from policy makers or large funders 'down' to the upper echelons of organisations, such as non-government organisations, before affecting the lives of citizens or clients in ways the clients themselves may have little capacity to shape. The term 'bottom-up' draws on common conceptions of scale, which imagine governments and other large organisations sitting 'above' the myriad places and communities into which their processes extend. In this sense, scale – with government at the 'top' and communities 'on the ground' – is a metaphor for power. In reality, decision-makers in government or the upper echelons of organisations still exist in grounded localities, but have the power to influence the lives of others potentially far away and with no personal connection to them. The organisations we researched are at once subject to those flows of power (as we discuss), while also seeking to disrupt them.

6   The term 'community' has often been used uncritically, particularly in community development contexts (Guijt & Kaul Shah 1999, Walsh & High 1999). We are conscious that communities are never homogenous: they are cut through with differences in status, power and resources based on factors including age, gender and religion; they incorporate different values and aspirations; they are rarely bounded; and they can be variously delineated depending on one's viewpoint. Nonetheless, in this report we privilege our research participants' use of the term.

   In some cases, 'community' in this report refers to relatively well-defined populations, such as in the Laynhapuy Homelands context; in other cases, the boundaries of 'community' are less distinct, such as urban contexts. Each of the case study organisations has its own way of defining the people with and for whom it works. How they do that is beyond the scope of this report.
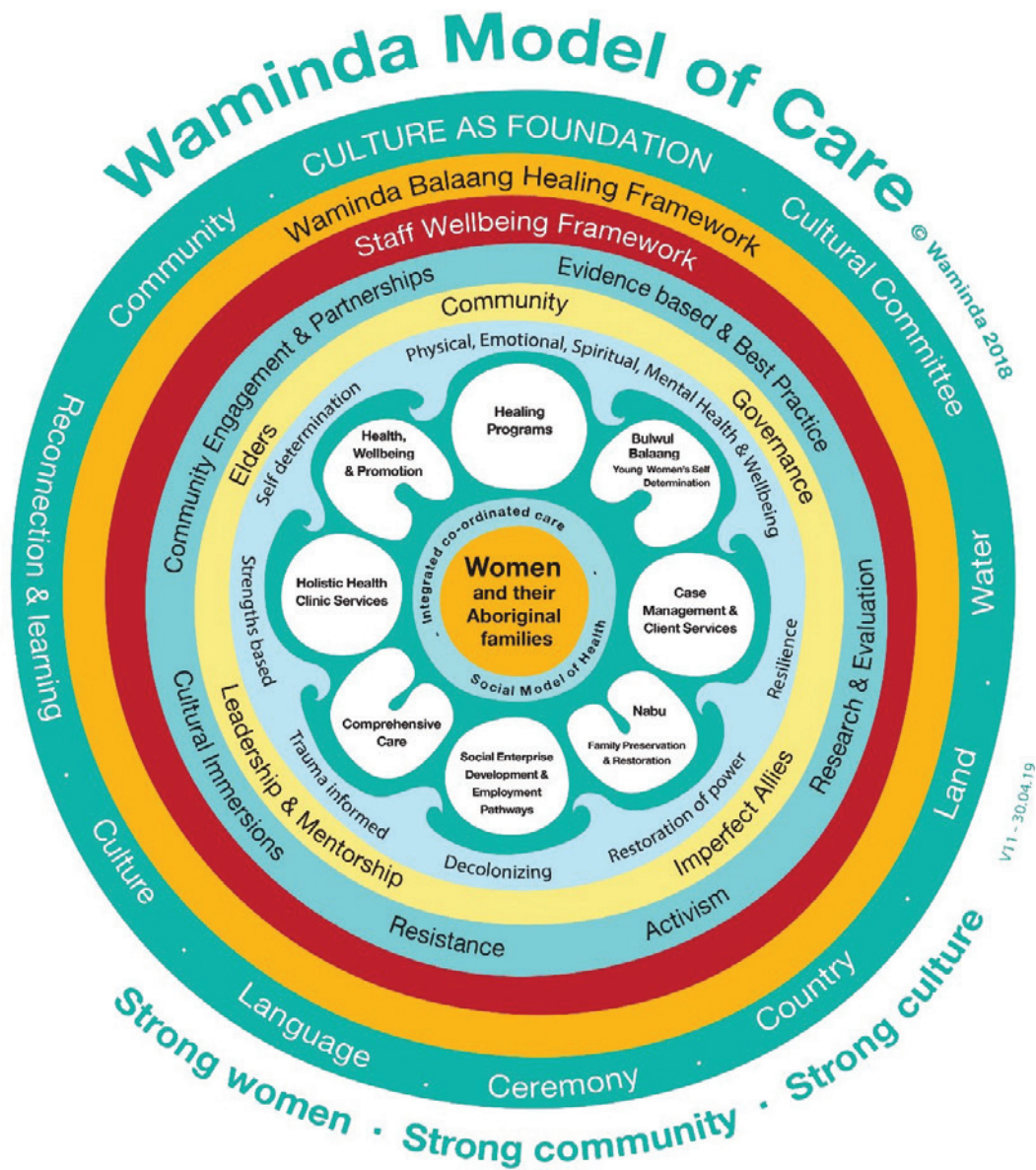
Figure 4: Waminda Model of Care (image courtesy of Waminda)

Waminda's governance model keeps it well connected to the community it serves. The organisation receives guidance from a board of seven respected female Aboriginal Elders. Waminda has 15 managers or coordinators, and while this may seem a lot for an organisation of around 100 staff, it affords decentralisation, representation from a range of key families in the region, and coverage across the organisation's range of services. In early 2017 Waminda established a Cultural Committee, which, among other things, advises the managers. Comprised of self-nominating Aboriginal staff members, the committee is designed to foster cultural knowledge and a strong Aboriginal identity so that Waminda stays 'grassroots'.

Balaang Healing

The history of Balaang Gunyah (Women's Place/Home) illustrates how Waminda has developed services in line with the needs of local Aboriginal communities. The Balaang Healing program at Balaang Gunyah provides short-term accommodation and round-the-clock care for women. It hosts an evolving range of activities including therapeutic services, cultural exchange, women's gatherings, an art group, and community drop-in.

Balaang Gunyah began as respite accommodation, funded through an 18-month innovation grant and auspiced by a local organisation. This initial short-term funding was challenging because it took a year just to get the premises ready (see the section **Short-term funding and underfunded services**). The funder also placed strict criteria on who could access the service and required clients to have specific diagnoses. As one staff member explained: 'The funding for that respite house was very mainstream, and it was so specific that community couldn't see themselves with it, and they couldn't access it because the criteria was too tight.' This did not fit with the vision of Elders who 'wanted to really open up the space for all women in community to come along'.

Over several years, Waminda reshaped the program in line with community needs. One interviewee referred to this as a process of 'constant consultation', which included community gatherings and yarning circles. As EW explains:

> It's always been led by community, and so it was always about creating a space and then seeing who comes, and then seeing: What do the women want to happen in that area? And through the yarning circles that we were having at the gatherings, we were really hearing: What was happening for community? What were they doing in the space of healing for themselves, for community?... What were the main issues that they were finding in community? And what were they doing in the space of culture?

These consultation processes elicited local priorities and allowed Waminda to identify gaps in mainstream services. From this, the vision of Balaang Gunyah formed. The early gatherings also promoted community ownership and a healing environment that remains central to Balaang Gunyah. EW highlighted the healing that clients experienced in yarning circles by 'feeling like they had a voice on issues that were important to them, and being heard and validated by the community that they live in'.

In 2016 the Balaang Healing Program was established in its current form, located at Balaang Gunyah, in its largest facility to date. The program has been on a journey from a respite house to a 24/7 facility that caters to clients, including women with complex needs, in a more flexible environment, however, remains largely unfunded. Elders have played a particularly influential role in the development of Balaang Gunyah, a role that was recently formalised through the establishment of an Elders Committee to provide on-going guidance in program development and to ensure the delivery of culturally informed healing (Waminda 2018a:12).

The Balaang Healing mat, created by the Balaang Healing team (photo by NEG photography, courtesy of Waminda)

Meanwhile, Laynhapuy Health and the broader Laynhapuy Homelands Aboriginal Corporation are structured and guided according to the 'Old People's Vision for the Yolngu of the Homelands': 'To determine our own future, to manage our own affairs, to become self-sufficient so the homeland mala [mob] can continue to live in peace and harmony' (LHAI 2009). The continuing resonance of this vision was clear in the words of one Laynha Aboriginal health worker, a senior woman who said, 'we like to stand strong as Yolŋu, not leaning to ŋäpaki [non-Indigenous people]'.

While Laynhapuy Health sits under the broader LHAC (see **Laynhapuy Health** above), its daily operations incorporate a great deal of flexibility and responsiveness to the needs of the specific homelands they service. At one level, the clinical governance of Laynha Health could be seen as nothing unusual, relying as it does on oversight of 'clinical competence, clinical audit, patient involvement, education and training, risk management, use of information, and staff management' (Health Outcomes International 2012:9). Similarly, the overarching governance of the LHAC – with its structured board, Chief Executive Officer, and program managers – might appear run of the mill. However, beneath these Westernised governance structures lies a uniquely Yolŋu form of governance.

Laynhapuy Homelands self-determination movement

Laynhapuy Health sits within a policy and social development space with an important history, and is part of an ongoing movement with its beginnings in a resistance to bauxite mining and the development of the town of Nhulunbuy on Yolŋu lands in the late 1950s. Yolŋu Elders contested the federal government's plans to establish a 99-year lease and a mine on their land, and in 1963 sent a bark petition to the Australian Parliament in protest. Yolŋu failed to stop the mining, but the petition brought political attention that helped lead to the establishment of the *1976 Aboriginal Land Rights Act*. The petition was also crucial in the High Court's Mabo decision of 1992, which overturned the notion of *terra nullius*.

The fight for land rights mobilised Yolŋu to return to their clan homelands, which they felt were under threat. This eventually became known as the 'homelands movement'.

The homelands movement predated the 'self-determination era' of policy led by the Whitlam Labor Government, which came to power in 1972 (Morphy 2008). However, the Whitlam Government provided small ($10,000) establishment infrastructure grants to people returning to their lands. Primary health and education delivery remained the responsibility of the states. Since the genesis of the homelands movement, successive NT governments have argued that the cost of providing outstation health is excessive and that the Australian federal government should bear much of the cost. The federal government has always maintained that primary health is a state/territory responsibility, and that such costs should therefore be covered by federal–state fiscal arrangements through the Commonwealth Grants Commission.

Support for homelands at a federal level has waxed and waned. For example, the Council of Australian Governments noted in 2008 that while they will recognise Aboriginal and Torres Strait Islander peoples' cultural connections to homelands, any policy relating to this will avoid 'expectations of major investment in service provision' (COAG 2008:A–1). Contestation over service provision has dominated policy discourse about homelands.

Despite the vagaries of policy under a federated system, the ethos of homelands has survived. The homelands movement has always been characterised by a rejection of assimilation and a broad recognition of Aboriginal land rights (Morphy 2008). The people of the homelands have maintained the goal of determining the nature and pace of development on their lands, including health service delivery. Simultaneously, homelands residents assert that a self-determined future entails the ability to live away from the destructive influences of alcohol and violence, which they see as characteristic of the larger townships (see **Connection to Country**).

From a service provider's viewpoint, challenges for planning and delivering a homeland's health program include population hyper-mobility, seasonal access problems, logistical expenses and cultural obligations that compete with mainstream notions of health. Despite these challenges, the health care model developed by Laynhapuy Health continues to represent a holistic and Yolŋu-led approach in a unique context.

Laynhapuy Health is responsive to a set of distinctly localised, Yolŋu ways of setting goals and priorities. The Traditional Owners, in combination with the local health workers, are effectively the 'bosses' of the Laynhapuy Health service. They make broad decisions about the nature and pace of health delivery, in keeping with the broader self-determined ethos of the homelands movement (see the section on **Laynhapuy Homelands self-determination movement**). The Aboriginal health workers, meanwhile, are responsible for the clinics in their communities (see the section **Aboriginal health and wellbeing professionals**). Difficult decisions about local health are made in the first instance through adherence to Yolŋu conventions of reciprocity, relational obligation, custodianship and clan-based understandings of the right way to do things.

In the second instance, decision making in Laynhapuy Health is intercultural. The Laynha Health manager (and a range of other staff) regularly meet with community leaders, health workers and a wide range of community members on routine community visits, and the communities are the manager's first point of contact for discussing new ideas or directions. This is not always an easy task as it relies on subtleties beyond formal governance. The community needs to trust that the staff and clinicians of Laynhapuy Health will respect and adhere to the decisions made at a homeland level. At the same time, the manager must ensure power in decision-making continues to reside with the Traditional Owners and the community, while also adhering to the clinical and bureaucratic conventions of biomedical systems. As we explore here, time, communication and trust are crucial elements in making this work. However, at the heart of Laynhapuy Health's model is a belief that the people of the homelands are best placed to make decisions about their own health care; in short, Yolŋu concepts of health create healthy Yolŋu.

Relationships with community

'Laynhapuy teaches you that the whole health service is about relationships,' DD told us. The importance of building and maintaining trusting, respectful, long-term relationships underlay almost all the major themes the interviewees explored with us. Various types of relationships were discussed – including those between organisations, and between funders and recipients – but the foundational relationships are those between the NGOs and the communities they work with and represent. It was recognised that in the health care sector generally – for reasons that include time pressures and traditional hierarchical divisions between health care workers and clients – if consultation with community members occurs at all, it is often superficial. This can lead to poor outcomes (Haynes, Marawili et al. 2019). As we will detail, our interviewees emphasised that relationship building takes time and goes hand in hand with learning about local place, culture and community dynamics (even for people who are already part of that community).

Although in the previous section we noted that organisations have formal mechanisms in place to liaise with communities, they also recognised that some of the best relationship building comes through informal contexts where power imbalances can be shifted. This was particularly important in relation to the homelands. DD, for example, noted that the power dynamics inherent in the health sector mean that Yolŋu people are 'not going to tell you that you're doing the wrong thing', although if they do not agree with your approach they 'may not do what you're suggesting'. She explains that 'stepping outside the clinic itself gives you another opportunity for people to actually tell you what they want from you or what will help them.'

> *Particularly when we stay in the homelands, you get the opportunity to actually take the other step and to learn and to be the student and tip that power balance a bit the other way and just to enjoy people. People are so incredibly warm and welcoming here and inclusive that it's a very special place to be.*

DD also mentioned that Laynha Health periodically holds 'women's days' in homelands communities. These generally involve health screenings, but at the request of women in one community they are now also developing an associated yarning group. DD explains: 'It's basically, "We bring the food, you do the yarning". So it's about relationship building… Basically it's about going in to listen and be taught, and for women to be able to say what they might want from me or a project that they want to develop together, that they might want some support with.' This relationship building also makes the women more comfortable with the subsequent screenings.

We see a similar approach at Waminda, where a senior staff member explained how central relationship building with community members has been to developing trust in her role:

> You know, I get phone calls almost every week from an Elder saying 'I need to come and see you and talk to you about something'. And that used to be to abuse me, to tell me what we were doing wrong. Or, why do you do this? And now, because I've always engaged in that conversation, it's not like that anymore. It's respectful conversations. Even with people who haven't had a lot of time for us. I've gone to people's homes where I don't know what's going to happen. But I've thought, well I've got to do it, so that we've got that face in community.

Another staff member at Waminda told us that while multiple organisations had tried to run a playgroup in a particular community, but had found that people did not turn up, members of that same community approached Waminda to set up a playgroup. 'I think it's just because we're there all the time,' QV surmises. 'We're not in their face. They just know that they can come down for a cuppa or do some art. Whatever they want to do. And, just building that trust.'

'Trust' is a term that came up often in the interviews – again, pertaining to different types of relationships – and it is a theme we pick up repeatedly throughout this report. A staff member at Laynha Health noted that Yolŋu 'will only trust people if they have a relationship with people… they don't know you, so they don't trust you'. He suggested that health care can only have limited success in the absence of trust, but building trusting relationships takes time. 'Relationships are so important,' says WG, but 'they take time to really strengthen and develop so that trust gets developed too.'

The importance of relationships is a theme that resonates throughout various sections of this report. We explore it further in the following section and, for example, under the sections **Accessibility, regularity and consistency of services** and **Brokering, advocacy, coordination and translation**.

Long-term learning

Relationship building goes hand-in-hand with learning about place, culture, history and community dynamics. It is this knowledge and experience that helps staff build services that are realistic, innovative and responsive to community needs. Indeed, as a Laynha Health staff member points out, 'Everywhere is different. Gurrumuru is different to Yilpara,' naming two homelands. 'I'm sure inner-city Sydney is different to here.'

There is great diversity among Aboriginal and Torres Strait Islander peoples, past and present. There are myriad languages and cultures, different lands, histories, economies, politics, infrastructure, and relationships with other groups. Health and wellbeing strengths, challenges and aspirations also vary considerably. As such, long-term commitment and program evolution based on the specificities of place, history and culture is crucial (Escobar 2001; Fogarty 2013).

Interviewees raised several facets of this learning, such as understanding local cultural protocol, the cultural significance of Country, the relationships between different people and groups (including any major fissures

within the community), and the day-to-day realities of peoples' lives. Many people we spoke to across all the case study organisations were also conscious that being Aboriginal is not, in itself, a substitute for long-term relationship building with local communities. Aboriginal staff members were often careful to point out if they were not from the local community, and that for them too it has taken time to learn about and connect with local contexts.

Local knowledge can inform major project design, as well as day-to-day interactions between workers and clients. One nurse in the NT said that she adapts her advice based on what she knows of people's living situations – for example, advice to sterilise a baby's bottle with boiling water after every use is unlikely to be adopted where the household lacks electricity.

Just as relationship-building takes time, so too does developing in-depth understandings of local contexts. A Laynha Health staff member spoke of how he has spent 13 years working with Yolŋu, and feels that ongoing learning, critical self-reflection and building relationships is central to his work. He explained that when he was a nurse at a hospital, it was easy to be relatively uncritical – to be ignorant of your ignorance. 'You don't know this stuff,' he says of the learning he has done since. 'You have no idea. And I can see it now – I was just as bad as everyone else when I worked there. You're just following whatever everyone else does.'

He spoke of being increasingly uncomfortable with the way things were done in the health field, of 'feeling, over the years, that something's not right'. It's hard to make sense of this feeling, he explains, 'because most people don't think something's not right.' The work can be 'really confusing and complex' and the learning 'takes a long time'.

> Now, I can handle things because I've got a position in this society, which [means], for me, I can do stuff. But for other people, it's really hard. You just learn as you go. No one has really taught me anything. I just learn by observation and experience, and you just sort of sit there thinking: Why did that happen?

Figuring out what works in a given place requires longevity of institutional knowledge, of individual staff learning, and of relationships. Unfortunately, short-term funding cycles often work against this, as we detail in the section **Short-term funding and underfunded services**.

Innovation and adaptability

Building effective programs also requires room for innovation (informed by long-term relationships and understandings of place, history, culture and socio-economic context). 'What's missing,' reflected one interviewee on the health sector broadly, 'is acknowledgement or encouragement for Aboriginal organisations to be innovative, to be community controlled… If we were really serious, if we got really serious and we said, "We're going to close the gap," then let Aboriginal health services do it. Stop stopping it.'

Being able to respond to community requests for services or ways of working is important to all the organisations. 'Much of what we do has to be flexible and responsive to what people are asking,' said JS. Meanwhile, HM explained that,

> when I say 'adaptable' – if the school or the early childhood centre or the community, or a parent, says to us, 'You know, what I really think would be good is this,' then we can think about it, and within a couple of months we can probably have that up and running. If you don't act right then, you lose that momentum.

Like several interviewees, she noted that working in an NGO can allow for more flexibility than in government health and wellbeing services. Innovation also means, however, that the organisations must take risks, and they were conscious that this makes them vulnerable to potential failures or scrutiny.

It is also seen as important that staff have flexibility in their work, particularly the freedom to try new approaches based on their grounded knowledge of needs and realities. Two staff members in different organisations specifically mentioned that they appreciate being given the opportunity to be 'creative', so they can respond to community need, but that they are always conscious of doing this within the strictures of funding guidelines. One interviewee talked about 'manoeuvring' within the funding guidelines. 'I've worked with a lot of mainstream or generalist organisations,' says JS, 'and there's their way of doing business that you have to try and meet.' But, she explained, you also have to try 'to do it the right way and the community way. So finding that balance can be quite tricky.'

She talked about the frustrations of seeing opportunities in other organisations but senior staff presenting her with barriers, such as lack of funding. In her current work under the NDIS at Waminda, 'those barriers aren't barriers':

We get to really be quite creative… obviously playing within the guidelines and doing it the way that they need it to be done. But we can do it really quite broadly, and meet the needs of our community and what people are asking for. It's really nice, it's finding that balance. But, it's really great, because it's a really creative, exciting kind of place. I mean, there's lots of hurdles, but when you can overcome those, then you can see some really exciting things happening for our people, and lots of opportunities.

We take up a number of these themes in the section **Flexibility and responsiveness to clients.**

When a program or project works well in one context, it can be tempting to ask how it can be scaled-up. While this an important question, and there often are lessons that are applicable across contexts, attention to the specificities of what makes something work *in place* is crucial. Wholesale replication of projects in a different context is risky. Flexibility, adaptability and responsiveness to local needs are crucial and this is detailed further from **page 51**.

Unfortunately, the process of marrying the evolving plans (that respond to community needs and visions) with top-down funding opportunities is often a major struggle. As a result, both Laynha Health and Waminda commonly run unfunded or underfunded programs until they can prove they work. Waminda has also declined substantial funding when it felt that it would compromise its accountability to communities. We explore these issues further in the section **Short-term funding and underfunded services**.

In the section on **What Works: Holism and wellbeing** we further explore the theme of innovation.

Aboriginal health and wellbeing professionals

All three organisations facilitate community control in part by actively recruiting Aboriginal staff, and providing them with training opportunities and employment pathways. For example, Waminda has a supported employment program that encourages Aboriginal women to enter the workforce. This includes entry-level positions for those who may not have been previously employed or had formal training. Waminda explicitly values life experience when considering candidates and encourages clients to apply for job openings, as GB explains: 'Being around strong Aboriginal women shows [clients] that they can be strong. And where else can you get that than a place like here?… So believing in the women that we work with and not privileging PhDs over their knowledge, their community knowledge, it shifts the game.'

The reception desk role has provided a soft entry for many staff members who then segue into diverse roles. Through monthly meetings with managers, employees at all levels are encouraged to upskill and are supported to undertake training. There are no restrictions on how long a staff member needs to be employed at Waminda before they can do some training, and almost all Waminda staff undergo some form of training in any given year. When new programs are set up, lower level staff members are mentored to manage the programs, and in time they, in turn, are expected to mentor other staff in program management.

Waminda's employment and training approach has been instrumental in its rapid expansion over the past decade to over 100 predominantly Aboriginal staff. It has moved from a system in which external, government-employed non-Indigenous nurses came in to see patients on screening days, with Aboriginal staff at Waminda treated as the nurses' low-skilled helpers and drivers, to a situation in which highly skilled Koori staff within Waminda deliver the screenings.

Waminda has a 94 per cent staff retention rate underpinned by a staff wellbeing program aimed at minimising 'burnout' and supporting career progression (Deroy & Schutze 2019). High retention is a deliberate strategy to provide consistency of personnel and approach, as GG notes: 'When we started employing women and young girls for small bits and pieces, rightly or wrongly we've sort of never let anyone go… So that's pretty exciting and that's always been a risk. But to me it's always more of a risk to let staff go and then have that chop/change.' As we point out in the section on **Short-term funding and underfunded services**, funding regimes pose a major challenge to this.

This non-traditional approach to recruitment and retention not only builds Waminda's capacity as a community-controlled and responsive organisation but, as GG explains, it also contributes to building the capacity and wellbeing of women in the community:

> *We got community women in, who may have never worked before or have worked elsewhere, who are traumatised because of what's gone on before. They have led really diverse and amazing lives. I really believe for women in particular having that sense of self and sense of value and purpose and ability to have your own money… So growing people here, developing up career paths, having really meaningful jobs. Not being the Aboriginal transport officer and sitting in the corner and waiting while the white therapist would do whatever and then go, 'Thanks so much for coming with me'.*

In the Laynhapuy Homelands context, Aboriginal health workers have a crucial role as primary health care providers, community representatives and cultural brokers. NR describes them as 'the keys to the community', referring to their pivotal work in bridging 'worlds'. This is supported by a wealth of previous research from across Australia demonstrating the importance of Aboriginal health workers in all aspects of health provision for Aboriginal people (for example, Cheng 2007; Davidson, MacIsaac et al. 2012). The employment of Aboriginal health workers in a suite of roles has a demonstrative effect on both clinical and pre- and after-care outcomes. For example, Taylor, Thompson et al. (2009) show that Aboriginal health workers had a significant positive impact on the health of cardiac in-patients. Similarly, Davidson, MacIsaac et al. (2012:640) found that Aboriginal health workers and liaison officers 'were pivotal to improving acute care management of people with cardio vascular disease'.

Laynha Aboriginal health workers live in the homelands and manage the seven purpose-built clinics. They regularly liaise – via phone, Internet and in-person – between the Laynha Health manager and nurses, and homelands residents. This includes liaison over day-to-day issues, such as advising on priority patients and actions, but they are also central to decision-making around health service delivery. The Aboriginal health workers undergo annual training in remote area first aid and primary healthcare, and are often a first point of contact for residents' healthcare treatments. This can include treatment for snakebites, fractures, cardiac

'Take my voice back and tell the government'

Mid-afternoon, we sit cross-legged under the high, galvanised steel roof of the community basketball court. BT is telling us about his life growing up here in the Laynhapuy Homelands and beyond, and how he became an Aboriginal health worker.

From a young age he wanted to become a health worker. 'It was my will,' he says. He was taught 'by all the Elder people' – women and men who took him on walkabouts through the bush, guiding him in collecting, processing and administering bush medicine. After finishing school, he also trained in health at the Batchelor Institute of Indigenous Tertiary Education, an Aboriginal-controlled higher education institution in the NT. He has worked in three Aboriginal health services in various communities over 25 years.

With his wife, daughters and sons, BT settled in the community where we now sit – a homeland his grandfather established. He saw it as a healthful place to raise children, away from the 'broken people' and 'ganja use' of some more populous places. BT is now passing his knowledge of Yolŋu and ŋäpaki health on to his daughter, hoping she will follow in his footsteps.

We ask him to tell us about Yolŋu ways of health.

'What we normally do is just to walk.' The exercise of hunting and fishing, he says, can help combat diabetes and kidney problems. 'We eat good foods that we find in the river, on the beach.' He adds too, 'We've got medicines under the water, on top of the tree, any site.'

'So when Yolŋu come to see you,' we ask, 'you've got Yolŋu health way, and ŋäpaki health training as well, right? Sometimes do you use both at once?'

'I use them both,' he replies.

He gives the example of a blocked nose, caused by a respiratory infection. To treat the condition, he usually goes to the billabong and cuts ŋämbarra, or paperbark, from the Melaleuca leucadendra tree. He crushes and boils it, then places it before the patient, allowing them to place a towel over their head and breathe in the vapour for approximately an hour. If that doesn't work, he explains, he puts Vicks VapoRub in hot water for the patient to inhale.

'Does everybody know some bush medicine?' we ask.

'Yeah. Even now, the school kids do.'

BT describes himself as 'in the middle' between ŋäpaki and Yolŋu health, mediating between the two.

'Is that hard sometimes?' we ask.

'No. It's manymak [fine]. It's easy for me, but hard for my community.' He explains that he can understand what ŋäpaki say, but many Yolŋu people are not fluent in English, and the systems and concepts are foreign. 'The Yolŋu side of health they get.'

We ask BT if there are any messages he would like us to take to the government when we travel home to Canberra.

He is worried about the health budget, he says. 'All the health workers in other homelands or communities or states – like in Alice Springs, Katherine – we work and we get just a little money.' He suggests that ŋäpaki and Yolŋu working together should receive equal pay.

'Take my voice back and then tell the government: we need more budget for homelands health workers.'

arrests, strokes, and diabetes-related complications. They also make arrangements when anyone needs to be medevac'd out. They have a considerable role liaising with external health care providers, arranging transport, escorting people to hospital and specialist clinics and acting as language translators. In addition, they dispense a range of basic medications and, through sharing knowledge, promote health education. We go into more detail about the vital clinical, patient-support and liaison roles of Aboriginal health workers in the section **Brokering, advocacy, coordination and translation**.

Workplace diversity, inclusivity and equality

Due to limited pools of available candidates, organisations can find it difficult to recruit Aboriginal people with the necessary training, skills and experience to fill all relevant specialist and management positions; for example, there is currently a shortage of Aboriginal doctors and nurses (Panaretto, Wenitong et al. 2014:651). Building the Aboriginal workforce through training and capacity development takes time. It is also important that people have choice – for example, some prefer *not* to see a doctor or caseworker from their own community.[7] Finally, staff who are not from local Aboriginal groups, but who are conversant in relevant cultural and professional realms, can provide another layer of brokering between 'worlds'. For these and other reasons, non-Aboriginal staff play important roles in all three organisations.

There are non-Indigenous managers in both the ACCHSs we researched. Yet, unprompted, staff emphatically endorsed these individuals, saying that they were approachable, inclusive in decision-making, respectful, provided room for personal initiative, and encouraged cultural safety. For example, KT at Waminda told us:

> In the last 11 years that [the CEO has] been here she's been amazing. And I mean it in the sense of – because she's not Aboriginal. She's very culturally safe in everything that she does, and she's always gone to community and asked specific Elders or leaders in the community, 'Am I doing the right thing?' You know, asks the staff members, she knows Aboriginal women, she always comes to us and seeks our advice. She's always pushing us to the forefront, because it has to be Aboriginal first and foremost, no matter what we do, but she's been a big part of why Waminda is where it is now. She's not one of those CEOs who sit in a room and you don't see them, or is unapproachable. She might be downstairs and she'll be washing up. She might be out the back taking rubbish out.

Indeed, all three organisations also strive for a relatively flat organisational structure, and approachable managers. DD at Laynha Health told us:

> I came here and by the end of the first week I said, 'This is where I'm staying.' And the reason for that is because straight away I was able to recognise a workplace with a great deal of respect and flat structure. And the kindness I think – the core of the work is about kindness and that was pretty special and it's not something that you find every day.

The Laynhapuy Homelands communities in East Arnhem Land are remote and culturally distinctive, which means that the non-Aboriginal Laynha Health manager has a crucial role as a cultural broker. With a mainstream health background, and a decade learning on the job about Yolŋu lifeways, he treats his role, in part, as that of an intermediary and facilitator in helping Yolŋu to lead their own wellbeing journeys.

Across all the organisations there were non-Aboriginal people who had deep, long-term connections and commitments with the communities they work. Many of these staff members had been instrumental in the successes of the organisations. A non-Indigenous staff member at Waminda spoke of the importance of balance and inclusivity in the workplace, but said that, at the end of the day, it is about ensuring that Aboriginal voices are prioritised: 'They have to be the leaders, they have to... And I think for non-Indigenous people, [our role is] finding where you can support that.'

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7   For this reason, in addition to Koori doctors, Waminda also has doctors from other cultural backgrounds. They undergo cultural immersion programs and are linked with a cultural buddy and an Elder.

What Works: Holism and wellbeing

Seeing beyond the 'sickness model'

Several people we interviewed drew an important distinction between promoting health and treating illness. 'We all see ourselves as being experts in Aboriginal health,' said RT, a nurse working in the Northern Territory, 'but we're not. We're experts in Aboriginal illness.'

Another nurse, DD, similarly suggested that 'health' may not be an appropriate term to describe the majority of work in the health care sector (particularly that carried out by doctors and nurses), given that the focus is on 'disease management' and 'disease modification'. She termed the prevailing paradigm the 'sickness model', while many other interviewees referred to it as the 'band-aid' approach.

Despite the enormous benefits biomedicine has brought to the world, there is now a general recognition in the literature that it has limitations (Wilkinson & Marmot 2003). One major limitation is biomedicine's focus on illness. Mackean (2009:522), for example, notes that 'within medical science, healing has specific meanings related to the pathophysiology of wound closure, organ repair and system function'. This is juxtaposed with Aboriginal and Torres Strait Islander understandings of health that go beyond 'treating the disease' to 'working towards reclaiming a sense of balance and harmony in the physical, psychological, social, cultural and spiritual lives of our people' (Mackean 2009:522).

NH, a caseworker in the Shoalhaven, said that mainstream medicine rarely views health holistically or probes the issues underlying people's health. In interactions with doctors, 'It's just, look at the symptom; why you presented. I presented with a headache; let's just fix the headache.' EW, a community development worker, expressed frustration that the government wants to 'close the gap' but are 'not actually looking at what is really happening… They're just trying to go, '"Well, you need to have more health checks, you need to do this". And so it's a band-aid.' NR in Arnhem Land points out that '57 blood pressure checks on one person in one year does nothing for their blood pressure'. The social determinants of health need to be addressed.

Specialisation is an essential element in many of the successes of biomedical systems, but specialisation can also result in compartmentalised approaches that screen off the wider causes and interactions that promote or hinder good health. Notably, the more biomedical training our interviewees had, the less they seemed to feel in a position to promote wellness. RT told us that while health care workers are aware of the social determinants of health, a tension exists between this knowledge and the relatively limited scope of the work they are trained and contracted to do.

> Everybody knows about social determinants of health. And I don't know whether we as health professionals just have to compartmentalise it because we don't see that as part of our role. We're just dealing with the recalls that are outstanding for that person – they need their annual health check. Their annual health check is not going to improve anything. It's the social determinants of health that are causing the illness. We're applying the band-aids. And I think we all know it on some level.

A skilled administrator in the health care sector similarly critiqued the compartmentalism of the 'medical model' (as she termed it) that screens out wider determinants of health and overlooks structural inequalities. She pointed out that there is a great emphasis in the Aboriginal and Torres Strait Islander health care sector at present on individual body parts – 'health workers for ears, health workers for eyes, health workers for rheumatic heart disease. And actually, when you think about those three things in particular, they are all

related to housing. So, I'd love to see at least one generation have great housing and see what difference that made.' When we asked her to elaborate on her views on the medical model she replied:

> It goes back to some of the key performance indicators,[8] for example, that are looking at the Medicare billing for certain items, like adult health checks and chronic disease management plans, GP management plans. The idea behind them is probably okay, but I haven't seen evidence that it actually improves any health. And then, when you're talking about health you just think, well, yeah, primary health care and hospitals do a little bit, but nothing's ever going to change if you don't change the social determinants, address the trauma, and just the sheer poverty, and just give people some control. Actually, not just some control – give people control on what we all want, and some of us enjoy more than others.

Holistic health and wellbeing

Holistic health looks beyond specific diseases and body parts, to broader interrelationships that impact on health and illness in complex ways. An influential definition was published in the 1948 World Health Organization statement on the concept of health: 'Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity' (WHO 1948:100).[9] The term 'holism' not only accords priority to the interconnections between branches of medicine, but also to factors outside of a traditional biomedical framework that act in a protective or preventative manner, or promote wellness, depending on the context. In relation to Aboriginal and Torres Strait Islander health, this includes:

- language, culture and spirituality
- connection to Country
- belonging and identity
- strength of community and family
- living conditions and lifestyle
- economy
- mental health, particularly in the context of intergenerational trauma
- empowerment and control.

A holistic approach to health takes into account the social determinants of health, which the WHO defines broadly as the 'conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life' (WHO 2017). Chenhall and Senior (2017:180) note that this understanding is premised on the interaction between 'various social factors (called determinants), such as income, class, occupation, education, nature of housing, and social cohesion, as well as a variety of early life exposures'. However, they, and others such as Boddington and Räisänen (2009), also argue that such definitions are restrictive and over-rely on metrics of disadvantage. Marmot (2011), for example, states that it is important to widen the frame of understanding to take a more comprehensive approach to social determinants that affect Indigenous peoples rather than simply focusing on poverty and historic influences.

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8   Key performance indicators are discussed in the section Metrics-based KPIs.

9   However, Boddington and Räisänen's (2009) work questions such definitions as being value laden and ultimately unhelpful insofar as they pertain to a field like Aboriginal health. 'A holistic approach is multidimensional,' they point out, 'there can be variation in how many, and which, dimensions are included. And holism is an organic notion, implying that the various dimensions act and mutually interact as a systematic whole' (Boddington & Räisänen 2009:51).

As this implies, holism is an expansive and often-used term in the health service and, inevitably, it means different things to different people. This can make practising holistic health care difficult. Yet, holistic approaches are at the heart of the case study organisations' work and are clearly fundamental to their success. Although the concept's broadness brings challenges (as we expand on in the section **Boxed funding**), in a sense the organisations are putting holism into practice with far less angst over what 'counts' as health and where they ought to place their energies than one might expect. This is in part due to their community-driven approaches – they are guided by what their communities know about their holistic health care priorities. This means that what holistic health care services actually look like in the two case study regions – the Shoalhaven and Arnhem Land – are very different, as we will detail throughout the sections that follow.

It is important to note that the organisations' holistic approaches to health do not compromise their delivery of specialist and clinical services. For example, both Laynha Health and Waminda provide consults with GPs and nurses, and facilitate access to specialists. But they also recognise that specialist services need to 'speak' to each other in ways that provide coordination and continuity of care, and that biomedical services are not enough to ensure wellness. As such, both organisations are involved in health-promoting services, including social enterprise, welfare and nutrition (Waminda), and food security and transport (Laynha Health).

Addressing the social determinants of health and providing a holistic approach to care are explicit elements of Waminda's vision and goals. As TR explains, 'we work on a social model of health and not a medical model of health. We do have GPs and we do have a whole clinical team but they're just a part of what we do; they're not the main be-all-and-end-all of what we do.' Waminda's Balaang Healing Framework draws on seven dimensions of social and emotional wellbeing, as illustrated in Figure 5.

Waminda staff members refer to their approach as 'wraparound' care, evoking both a sense of treating different aspects of a person and a sense of embracing the whole person. A client may initially come in to visit a GP, who may then refer her on to other internal services. Or a case plan may be drawn up to address different aspects of a woman or family's wellbeing in ways that integrate a range of Waminda services.

Staff at Laynha Health are also deeply conscious of the social determinants of health and that promoting wellbeing requires a holistic approach. They have adopted a comprehensive primary health care model. Bartlet and Boffa (2001:74) argue that, 'Aboriginal community controlled PHC services have led the way in Australia in developing a model of Primary Health Care service that is able to address social issues and the underlying determinants of health alongside high quality medical care'. In Laynha Health's case, the clinical practices of *primary* health care are augmented and informed by a *comprehensive* approach, involving responses to social determinants such as demographic or seasonal changes in the region or health-related community development aspirations. This includes an understanding that 'central to CPHC is community control, which is critical to the bottom up approach rather than the top down approach of selective PHC' (Bartlett & Boffa 2001:74).

In this, Laynha Health shares a common approach with Waminda, but the situation in Arnhem Land is very different to the Shoalhaven in a range of ways. One of these is that Laynha Health constitutes the *only* on-site access to biomedical care for most of the Laynhapuy Homelands communities, which means that clinical services constitute the core of its work. At the same time, in a context of much greater difference between the 'two worlds' (Yolŋu and non-Indigenous) discussed from **page 14**, staff are also conscious of the limits of their remit in Yolŋu society, and the importance of avoiding subtle forms of neo-imperialism. For example, it is clear that it is not Laynha Health's place to intervene in some broader realms of wellbeing unless invited to do so, particularly those concerning identity, culture and spirituality. Staff can respect and try to support these in certain discrete ways, but there are other systems and protocols in operation. DD touched on this when asked what the term 'Indigenous health' means to her:

Figure 5: Waminda Balaang Healing Framework (image courtesy of Waminda)

Dead or Deadly

An element in Waminda's holistic approach is Dead or Deadly – a set of lifestyle supports that include exercise opportunities, nutrition advice, smoking cessation guidance, chronic disease management, confidence building and goal setting (Fredericks, Longbottom et al. 2016). The main component is a 10-week guided health, happiness and fitness program for Aboriginal women.

Dead or Deadly started in 2009 as part of a ten-week pilot funded by a Tackling Indigenous Smoking grant. It was initially run out of a shed, and, despite discontinuity of funding, Waminda kept running the program due to resounding community demand. It now operates from a purpose-renovated gym in Nowra – a community space where women can also go just to have a yarn or share some healthy food. Through partnerships with various ACCHOs, the staff also undertake outreach in places including Coomaditchie, Jerrinja, Wreck Bay, Wallaga, Bega and Eden.

One goal of Dead or Deadly is to prevent and reduce women's need for biomedical intervention, such as prescription medications. Staff hope that the positive lifestyle changes will have a knock-on effect, that is, they will be passed on from women to their children, their families and the broader community. VN describes the program outcomes:

Through our journey together we've realised that it's possible to have someone in diabetes remission, for someone to have their K10s decrease, to have their mental wellness be better than what it's ever been, to have their confidence be better, and then filter it down through to their families as well... Taking [the focus] away from prescription medication, I'm looking at their wellness and not their illness.

Dead or Deadly staff at Waminda's Plunkett St gym (photo by NEG photography, courtesy of Waminda)

You say 'Indigenous health' and that immediately brings up that Indigenous picture of health that is widely touted around the place and involving whole spiritual and emotional and physical wellbeing… Indigenous health also conjures up in a Balanda (non-Indigenous) world of all the physical fallout from colonisation and invasion, whatever you want to call it – diabetes, kidney disease, infectious diseases, all of the long chronic health conditions that Aboriginal people have. So Indigenous health covers a lot of different things really. The things that we [as health professionals] deal with on a daily basis are that fallout from a physical sense more than an emotional wellbeing point of view, because the Yolŋu people are so good at emotional wellbeing and social wellbeing and spiritual wellbeing, they don't really need us for that particularly. So we're just part of that physical wellbeing part.

Laynha Health does, however, have a role in social and emotional wellbeing. Its homeland clinics enable people to stay on Country and, as we will describe in the following two sections, this facilitates not only residents' physical health but also their social, spiritual and emotional wellbeing.

The differences between Waminda and Laynha Health in their approach to the scope of health care illustrates the point we made earlier about the importance of local histories, cultures and contexts – an approach that works well in one place, may not be best suited to another. Having said this, Laynha Health staff unquestionably see their health services as inextricably dovetailing with their community development services, and we detail more about this approach in the sections that follow.

Culture, community and belonging

The themes of community, culture, language, identity, belonging and Country were central and inseparable to our interviewees' understandings of Aboriginal health. They were at the heart of conceptions of wellbeing, and sometimes indivisible from understandings of physical health. Indeed, when we asked CB, a Yolŋu health worker in the NT, what the term 'Indigenous health' means to her, she replied:

I think for people it's being strong in their identity. I think people – Yolŋu, non-Yolŋu, ŋäpaki – everywhere, everyone wants to belong and feel like they know who they are. And I think especially for Indigenous people, having that identity, knowing where they come from, that's a great step. That's huge.

Similar themes emerged from our interviews in NSW. JK told us that mental and physical health go hand in hand:

I think that if you are well connected with family and with community and with culture, then both your physical health and your wellbeing is going to be a whole lot better than if you're not connected to a family situation where they can support all those things.

Meanwhile, DH pointed out, the term 'social and emotional wellbeing' highlights that health encompasses not just physical health: 'it's mental health, it's emotional health, it's social health, it's being able to communicate with your mob and having a sense of belonging where you are'. These connections are also explicitly referenced in the goals of Waminda, which include to:

Promote pride in Aboriginal identity, culture and encourage self-determination, based on the belief that this is central to the health and well-being of women and their Aboriginal families. Waminda will reflect the caring and sharing nature of Aboriginal culture and create a sense of belonging and hope for the future, based on the belief that knowing who you are as an Aboriginal person is central to any positive life. (Waminda 2018b)

Welcome buŋgul (dance), Gäŋgan, Arnhem Land (photo by the authors)

Interviewees illuminated several aspects of community that are important in the health context, one of which concerns the importance of services 'engaging all of the community, not just individuals within the community'. It is imperative, said an interviewee at Noah's, that service providers 'understand the connections between families and within families', and 'how important it is to be looking at the whole community and to be open to everyone in that community.' This again takes us to the importance of services building long-term connections in communities.

Another crucial aspect is the social and economic support that community members provide one another through friendship, kinship and associated reciprocity. This has practical outcomes, allowing people to share burdens of labour such as child-care, to pool expenses such as to pay for medical costs, and to tap into wider networks of knowledge and expertise. Especially important – it reduces the burden of loneliness, depression and social anomie that impacts on mental wellbeing and physical health.

From community, too, people learn language, customs and other cultural practices. It is common in Australian society to hear references to 'culture' as if it is something held only by minority groups; as if Australians of European descent are culture-free. This is dangerous because it implies that the majority culture is both neutral and normal, and other cultures in the Australian context equate to hobbies that can be set aside and practised in one's spare time, or that are relics of a 'primitive' past. What this overlooks is that the majority culture dominates, often forcing out diversity. This in itself leads to a sense of dislocation and alienation. Strong Aboriginal communities enable the transfer of cultural knowledge and practice, and together community, culture and being on Country makes for a strong sense of identity and belonging. In the section **Connection to Country**, we discuss the importance of language, Country and culture for Yolŋu, who are living in a context where they have managed to defend these.

For Koori and other Aboriginal groups with whom Waminda works in the Shoalhaven, there is a strong focus on cultural revival. SN told us that it is a right 'to be able to practise your cultural beliefs and ways, and a lot of that was taken away… It's about reclaiming that and empowering that.'

'It's about creating that space for people to reconnect to the Country,' her colleague EW added. 'You know, reconnection to loss of identity, loss of culture, loss of language, loss of just I guess being cultural… that spirituality and reconnection to community and family. There's so much separation [due to the] stolen generations.'

EW also talked about people coming together to recognise existing cultural and healing practices:

> It was interesting because people were like, 'I don't know anything about culture. I don't practise culture. I don't do any healing things.' Well, when we actually sat and unpacked it, well this aunty actually goes out and makes herself teas from her yard and then this one did this, and then this one. And then as that conversation started to open up and it was kind of like, 'Oh well I do that. My grandma used to do that. We've always done that.'… Well that's your bush medicine. So it was like really about a lot of that stuff I suppose was hidden, but it was still taught and so people had never actually realised what they were being shown and what they'd learned.

In another interview, we asked JK if she would like to say anything further before we turned off the audio recorder. 'Only to say,' she replied 'that the more that I work around connecting kids back to culture, the more that impacts on their wellbeing and the better kids feel about themselves, then the better their health outcomes in many other areas are going to be'.

Connection to Country

'For Yolngu, the homelands are our flesh and our bones, the homes of our ancestors and where we will be laid to rest,' LHAC Chairman, Barayuwa Mununggurr, has written. 'Our homelands are a part of us, as we are a part of the homelands' (LHAC 2017b).

One of the key purposes of Laynha Health is to enable Yolŋu to live in homelands communities, on Country they have occupied since time immemorial, and to be healthy therein. For Yolŋu, living on Country and maintaining wellbeing are inextricably linked. The notion that the land looks after the people, and the people look after the land, has long been understood as central to Aboriginal worldviews (for example, Rose 1996; Stanner 1979; Sutton 1995; Yunupingu 1997). The immutable and multi-faceted nature of a concept of 'Country' is central to constructs of Yolŋu identity and cosmologies, as well as to the daily fabric of local socioeconomic orders. Through the lens of a homelands' resident, Country, people and health are an indivisible whole. The complex interaction between language, clan, ceremonial subsections and customary rights or obligations in Country are not static; they require constant negotiation and impact directly on how health is understood locally. For example, simply being off Country can be understood as 'ill health'.

We interviewed LB, an Aboriginal health worker, at the beach in a homeland community; it was quiet but for waves lapping the shore, the distant beat of clapsticks and nearby children laughing. We asked him what government, health workers and others need to understand about Yolŋu ways. 'What they have to understand,' he began,

> if we go back to, back to mainstream communities… there will be a lot of mess, lot of dying, suicide. In homeland, like here today, you can hear it's quiet. Good. Talking. You can watch the cloud drifting… No trucks driving in and out. All quiet. Peace… Business going on proper way. Not drunks coming in. All that.

This is what the government have to understand. Yolŋu – this is our homelands here. We were staying in mainstream before, in big communities, but there was a homeland there for us. So back in 1974, old people, they moved to their land. They were thinking, we have to go back to our homelands now. Take our kids so they will learn good way. Today, we are here now.

Like for myself there, when I'm in [a larger community], I don't feel good there. I just feel there's lot of things here. I have to go back to [my homeland]. More quiet…

When doctor comes to check up – now we got blood and we got heart problem or kidney not working properly, the doctor tells us you got a bad heart or something. In olden days, there were healthy people because they got food in their home. They have to go out to gather food – the bushmen have to go hunt for turtle, fish, stingray. Nowadays, we got lot of sugar and everything.

Balanda bought bad and good things. And now we are all sick people today. You know what I mean? Yo. But before, in the Yolŋu way, Yolŋu was clean because from bush food. Yo. They were clean. There was no heart problem, no kidney problem, no sugar, no dialysis, no anything, tumour or anything. But nowadays, we have all those sickness.

Everyone we interviewed in Arnhem Land agreed that the homelands provide a sanctum for Yolŋu away from the worse aspects of social dysfunction and anomie wrought by colonialism. For example, BH told us that he returned to the homelands to get away from 'sniffing, fighting, gambling, violence, suicides'. LM repeatedly referred to his homeland as 'our Promised Land'. The communities are alcohol free, and access to cigarettes, drugs and sugar is lower. Meanwhile, social cohesion is strong – people are close to family, have a deep sense of their place in the community and world, and spend more time building positive relationships. The transfer of Yolŋu matha and traditional knowledge takes precedence over foreign knowledge. The pace of life is different, with fewer stresses on mental health. Homelands residents spend much time hunting, fishing, gathering bush foods and maintaining Country, which means they eat a wide assortment of healthy foods, get exercise and transfer knowledge to the younger generations. In other words, Yolŋu are choosing to be on Country because they are building happier and healthier lives on Country.

The notion that it is more economically efficient for government if Aboriginal and Torres Strait Islander people move closer to centralised services is based on an equation that ignores a wide range of 'externalities' and may shift, rather than reduce, costs. For example, if investment in preventative medicine goes down, hospital costs rise.

Collecting fishing bait at Garrthalala

'Right way' mourning

There is a tidy sterility about the Laynha clinic. It sits on the edge of Yilpara, a homelands community about a four-hour drive on dirt roads from the larger Yolŋu settlement of Yirrkala. Like the other Laynha clinics we have visited, the floors are neatly swept, in cupboards pharmaceuticals sit in ordered rows, and the scent of antiseptic hangs in the air.

Outside the rhythmic beat of clapsticks echoes over a generator's thrum. Two dogs chase kangaroos across a dusty airstrip, their stride soon broken by bush that stretches into the vastness. In the village, visitors stir, preparing breakfast over open fires. An elderly lady, a long-time client of Laynha Health, has passed away, and her body is in wait to be buried. People are gathered to mourn, to perform ceremony.

We sit under the clinic awning with cups of tea and NR, a senior Laynha staff member and a former nurse, tells us that gathering for a funeral, doing ceremony the right way, is central to the social and emotional wellbeing of Yolŋu residents. 'We did nothing,' he says, 'and you couldn't get any better'. He's being modest though; Laynha Health paid $900 for the body to be brought from Nhulunbuy back to Yilpara.

'Ten years ago, it was awful,' NR tells us – the health service couldn't spend money on that kind of thing. 'But now it's getting a bit better. Imagine if you've got a community – 300 people waiting for a body to come up and no one can get it there. We've had examples from other communities where the coffin and the body sat at the airport for six hours while people desperately negotiated someone to pay for it.'

What does value look like when it comes to health and wellbeing, NR asks. He talks about the money spent on health education that overlooks the historical, cultural and economic reasons that things are as they are. Meanwhile, something that contributes to residents' livelihoods in a practical way – a fishing lure, a chainsaw, a car – is not usually recognised as contributing to health. But if people can fish, they're getting exercise, they're eating well, they're connected to Country; if people are in the homelands they're socially connected, alcohol free, and looking after the land; children are learning Yolŋu ways, speaking Yolŋu matha.

The best thing we can do for the health of people in the homelands, NR explains, is to help them stay on Country and stay healthy on Country. That's the point of the clinics:

Our vision for health services here is timely access to services that are safe and appropriate, in conjunction with working with the key issues, like food security – not in an educating way, but rather an access way. And then I reckon, if there's anything left, it should be used for strengths-based cultural support, connection to Country – just resourcing Aboriginal people to maintain themselves.

Promoting wellness through health-related services

As will by now be apparent, all three organisations have a range of non-clinical services that variously help prevent illness, promote wellbeing and support biomedical approaches. Laynha Health's services include improving food security in homelands communities through subsidised, community-run stores, providing jobs such as posts for Aboriginal health workers, supplying communication links in the form of satellite phone and Internet, enabling patient travel and emergency retrievals, transporting bodies to funerals (such as after an autopsy in Darwin), and generally assisting Yolŋu as they negotiate foreign systems in the Balanda world. In this section we stay with Laynha Health as an example, briefly expanding on some of these services to consider the crucial relationships between them and the organisation's core clinical work.

One of the vital services that Laynha Health provides is patient travel. As we described earlier, Laynhapuy Homelands communities are remote – for example, it takes at least three hours to drive one-way from Gängan to the regional centre of Nhulunbuy, and the road is impassable during some of the three to four months of the wettest season. The journeys from homelands communities to Nhulunbuy are along dirt roads with sections that may be corrugated, washed out or flooded. In addition, few people own cars, or if they do they may not always have the funds to maintain them. Meanwhile, the hospital is in Nhulunbuy and people must inevitably travel for other reasons such as to buy food, fuel or visit government departments. Homelands residents often rely on 'bush taxis' but as the companies are based in Nhulunbuy, residents must pay for two return trips (a return trip to collect them from their homeland, and a return trip at the end of the day to take them back to their homeland). As such, a round trip in a bush taxi from one of the more distant homelands, such as Gängan, costs about $1,300 (LHAC 2019:1). A single visit to town, perhaps for an NDIS consult, can consume a month's income.

A range of implications flow from this. People will understandably delay or avoid visits to town, which sometimes means they have little access to food or medical care beyond the services supplied at Laynha Health clinics. If they do visit town, they are likely to have little, if any, remaining funds for food, medical or other expenses. There is also the burden of long travel times that can mean children miss school and people cannot attend to other obligations; and there are risks of immersion in less functional communities, proximity to alcohol and of becoming stranded in town. As such, providing Yolŋu with transport to attend medical appointments in Nhulunbuy and beyond is an essential part of Laynha Health's work. It enables people to stay on Country, it opens the way for timely access to health care services, and it means Yolŋu have money left to pay for essential goods and services.

An important aspect of Laynha Health's transport role is emergency evacuations. These are not provided by the usual emergency services that other Australians can access when they call 000; when people in the homelands call 000 for a medical emergency, no ambulance or aeroplane is sent. Laynha Health fills this gap by arranging and funding chartered airlifts for people in emergency situations.

Although not a funded part of its work, Laynha Health also provides informal assistance to Yolŋu as they negotiate foreign systems in the Balanda world. This could be logistical help to apply for a driver's licence or pay a phone bill. NR explains that at first he was confused that people would visit them for such help, given that they are a health service, but he came to realise that this both reflects the trusting relationships between community members and Laynha Health, and builds on them further. Those trusting relationships, in turn, facilitate the organisation's delivery of health services. NR points out that in the homelands context, 'you need to be valuable first' to people in the community 'before you can work in any way that is health promoting'. That value includes assistance with transport, jobs and logistics.

Laynha Health does not receive specific government funding for much of this work, and the real costs of activities, such as patient travel and emergency retrievals, are not usually incorporated in funding calculations. Nonetheless, Laynha Health's added functions place it in a position of trust, reliability and accessibility for Yolŋu, which means that many of its funded health services are more successful than comparable organisations. According to NR, 'It's the value that we offer in these non-measured services that make our other services accessible and [that makes] people want them, or willing to comply with them.' As an example he adds, 'People are more likely to come to the clinic knowing that we're running and helping their shop. That's how it works.'

Laynha Homelands stores

Now that Laynha Health's clinical services are well established and highly functional, an important development in the organisation's work has been to facilitate homelands community stores so that residents have access to affordable and nutritious food. In 2017 a store was opened in Gängan, a second was opened a year later in Garrthalala, and a third is planned for Wandawuy.

Food security is a major issue for homelands communities. Private commercial ventures have been non-viable due to factors such as the high costs of distribution, the unreliability of the roads, and the lack of electricity for refrigeration. As a result, residents have to travel to Nhulunbuy to shop at the nearest supermarket. As noted, this can cost $1,300 for a return trip, during which a family may purchase $300 worth of food. These disproportionate costs further impoverish people whose budgets are already tight, and encourage them to rely on low-cost foods that can be purchased in bulk and do not easily spoil. As such, the store-bought component of residents' diets tends to be skewed toward foods with low nutritional value, such as white flour and sugar.

Poor nutrition has serious consequences for health, and is a major cause of some of the common health conditions among Yolŋu, including diabetes. As such, facilitating community-run stores has long been an aspiration for Laynha Health and is strongly supported by homelands residents.

Yolŋu residents run the stores, while Laynha Health staff provide training and facilitate provision of new stock. Decisions on stock are made collaboratively between the communities and the Laynha Health team, which includes a nutritionist. Cigarettes, soft drink, confectionery and fatty meat are not stocked; instead there is an emphasis on fresh foods. The stores are subsidised by LHAC, but are likely to pay for themselves in the longer term by reducing demand on clinical services.

The stores represent a cross-over between health and community development. Not only do they improve food security, provide access to a wider array of nutritious foods, save people money and allow people to spend more time on Country, but they also provide opportunities for employment, training, enterprise development and management.

Staff and customers at the Gängan store (photo by Rachel Godley, courtesy of Laynhapuy Health)

What Works: Delivering person- and community-centred care

In this section we focus on approaches underlying interactions between workers and clients. Again, this shows how the organisations value client strengths, seek to shift power balances, and build trust and understanding with clients and communities.

Person- and family-centred approaches

Across the three organisations, interviewees highlighted the place of 'person-centred' and 'family-centred' care in their daily work. Person-centred care is an approach:

> that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome (Health Innovation Network n.d.).[10]

We earlier noted that the 'sickness model' is oriented to medical diagnosis and formulaic 'corrective' treatments. Person-centred care, on the other hand, involves placing people's needs, desires, goals, values and circumstances at the centre of the care process, which can mean elevating these above the priorities of health care professionals.

Person-centred care is multifaceted and models vary, but it can include the following elements:

- building a relationship with the person as an individual
- recognising their expertise in their own health care
- handing over a degree of power and responsibility
- taking the time to understand and respect the client's background, values and needs
- providing emotional support and being aware of people's spiritual wellbeing
- ensuring effective communication and accessible and appropriate information
- putting in place services that are flexible and accessible
- coordinating care for people and ensuring continuity and integration of services
- involving family, friends and broader support networks.

The emphasis on person and family-centred care reflects and reinforces the diversity of professional backgrounds represented among the staff of all three organisations (including midwifery, child health, disability support, mental health and social work – areas in which person- and family-centred approaches tend to be prioritised). RT originally trained as a nurse and worked in a hospital setting. However, the sickness model unsettled her and she had the feeling that she was doing something wrong – that *she* was the problem.

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10 McMillan, Kampers et al. (2010:164) caution 'there is a need to raise a deeper level of awareness about some of the assumptions and, ultimately, the appropriateness of Westernized person-centred care approaches'. For example, uncritical notions of nuclear family or an overemphasis on individuality may be antithetical to Indigenous notions of personhood. That is, they may fail to account for extended kin networks, deeper connections to Country and collective or different understandings of wellbeing. Research by Davidson MacIsaac et al. (2012:640) admits that, despite aspirations to provide family- or person-centred care, 'it was commonly agreed that often in the busy culture of hospitals we don't take the time to stop, listen and act on individual's needs', let alone cater for more complex Aboriginal needs. In relation to our case study organisations, it is likely that the deep immersion of each in Aboriginal worldviews manifests in more culturally appropriate models of family- and person-centred care.

She went on to train in midwifery, but it was her subsequent tertiary training in child health that gradually, but dramatically, changed the way she thought about health care. Child health training emphasised supporting and encouraging the person, such as helping new parents to forge networks, integrate into the community, gain a greater sense of belonging and access services. That training made her realise, 'hang on, it wasn't me'. Rather, the problems lay in the mentalities and systems in which she had been schooled and embedded.

A mental health worker at Waminda told us that:

> *No one at Waminda ever dictates to a client or a patient, 'This is what you should be doing'. It's always, 'You know what? – If you'd like information on it, this is what I know about it. Do you need more information?' And we walk beside that person until they reach their goals, and we believe in every person. Every person's different. It's always completely individualised and it's person-centred but it's still holistic.*

Several Waminda staff members told us that their job is to 'walk alongside' clients. The implication here is that each client is on their own unique journey, so rather than paternalistically directing clients, Waminda staff members see themselves as there to help ease and facilitate that journey.

Staff members at Noah's particularly emphasised family-centred care. JT explained:

> *We take a really good look at the bigger picture for the child and what's happening for all the members because we realise that really affects [the child's] health and their wellbeing and their ability to make progress. If we work with a family – if the dad's unwell or ill or away, and mum's struggling, we look at different supports there so that if they're feeling calm and healthy then we know that's going to benefit the child just as much as us going in and doing an hour of therapy.*

Long-term relationship building can aid this through trust and through knowledge of the family and of the services with which the client has previously, or is currently, engaged. Sometimes Noah's conducts coaching and mentoring with the staff at local preschools and with families, so that approaches are backed up at school, home and in the community.

In the remainder of this section, we expand on several themes relating directly to person- and family-centred care. The first of these is client-focused, strengths-based approaches, which were often talked about in conjunction with person-centred care.

Strengths-based approaches

A staff member of one of the organisations described 'strengths-based' as 'meaning so many different things' in the context of her work, but at its heart being about 'working together to build hope; to empower people to reach positive goals'.

Strengths-based approaches are often talked about in the Aboriginal and Torres Strait Islander health and wellbeing field as a way to counter a pervasive deficit discourse, which we discussed from **page 17** and also explored in greater detail in our sister report, *Deficit Discourse and Indigenous Health* (Fogarty, Bulloch et al. 2018) (see also, Foley & Schubert 2013; Resiliency Initiatives 2013; Wolf 2016). Several cross-cutting themes emerged from our interviews about what strengths-based approaches entail, including:

- Much top-down intervention in the health care sector and beyond relies on externally identifying and seeking to fix problems.
- The basic concept of strengths-based approaches is to shift the emphasis away from problems and negative labels, through which a person's or community's identity can become defined, to recognising positive capabilities, goals and actions instead.

- Culture, language, family, community and connection to Country are core strengths.

- People already know what is best for them in a broad sense – their values ought to come first.

- People do not need to be 'fixed', patronised or re-educated – they need to be facilitated and supported to build on their strengths and to realise their goals.

Put another way, implicitly, most of the interviewees understand strengths-based approaches as having aspects that are internal and external to the professional (who may be a health care worker, manager, policy maker, etc.):

- The first aspect concerns *self-awareness*: recognising the strengths in the communities, families and individuals with and for whom one is working (and even recognising strengths in oneself). This can involve routinely questioning and challenging one's own biases.

- The second aspect involves *outreach*: guiding others to recognise their strengths and identify their own goals, especially in a context in which those strengths and goals may have been historically overlooked or even disparaged. This can range from collective strengths (such as community), to personal qualities (such as being kind or determined), to small daily 'wins' (such as getting out of bed in the midst of depression).

Strengths-based approaches and philosophies are embedded in the institutional culture of all three organisations. When we asked one senior Laynha Health staff member what gives him hope for the future, he answered emphatically: 'There is actually hope in strengths-based programs. I have no hope in problem fixing, I have no hope there. In strengths-based I have hope.' He later added:

> *The dominant culture want things for Yolŋu. But Yolŋu don't necessarily want those things. So I think, what we need to think about is just how your want for Yolŋu people may not be their want. And they've got a lot of things happening that are much better – their strengths, we talk about strengths. There are huge amounts of strengths that we don't have, or that we have let slip.*

Three staff at Laynha Health said deficit discourse is regularly and constructively challenged in team meetings, while another said that taking strengths-based approaches is something they 'naturally try to do'. Indeed, supporting strengths in connection to Country, community and culture is fundamental to Laynha's work.

Staff at Noah's told us strengths-based approaches are integral to their work and that they are strongly influenced by the disability field in this regard. Two staff members gave the example of an oral language and literacy program called Sounds, Words, Aboriginal Language and Yarning (SWAY), which they have been using in speech pathology work. Designed at the Royal Far West School, the program uses Aboriginal knowledge, culture and stories. 'They might use yarns or dreaming stories and through telling those stories we can get the children recounting the story through their words and adding different words so learning more about culture and tradition,' JT explained. They encourage families to bring their own stories to be turned into playgroup activities.

A number of workers at Waminda spoke at length about their roles in resisting negative labelling through which clients' identities can become defined. DH told us that, often in clinical settings, workers conflate the person with the problem:

> *You know – she's a woman whose been battered, she's a woman whose been a victim of sexual assault. They're far more than that, and that's why I was really interested in strength-based approaches because [it highlights] their values, their strengths. They're far more than just a problem coming and sitting in the room.*

SN told us that she likes to 'peel off labels'. This prompted her colleague EW to explain:

> *It's like reframing. Well, okay, this is what mainstream seem to think that is. But what did it look like traditionally? It's a different type of person... ADHD [Attention Deficit Hyperactivity Disorder] – well, you're a warrior. You're a hunter... Okay, autistic, like wow – you have this incredible focus in this area and what amazing things can you do with your life.*

> *So instead of separating – 'You're this and you're that. We have to fix that. We have to medicate that. We have to fix you.' – let's not look at trying to fix everybody and look at, 'Wow, what is your amazing gift that you're bringing? What is it that you're here to do?'*

Waminda uses strengths-based assessments in case management and therapeutic contexts. For example, when a case manager meets with a new client, they use a 'Family Strengths-Based Assessment' form as the basis for discussion and planning. The process is structured to help clients explore the issues, identify their strengths and resources, think about options and preferred outcomes, and identify steps to achieving their goals. Clients are encouraged to reflect on the skills, knowledge and activities that give them strength, and on the resources available to them – from family to external agencies. There is space to draw a family tree and a social connections map, and to describe their connection to community or culture.

As several interviewees explained, for many clients identifying strengths does not come naturally. NH told us that a client might come in to the centre ready to give up:

> *They say, 'Oh, I'm over it.' But when they're yarning to you, you can just see all their strengths, what they've done or how they've gone about doing it – supporting the kids, or making sure that the kids are safe, or making sure that the kids are going to school. You just see so much strength in them and sometimes they really, really struggle with seeing that within themselves.*

Elsewhere we have highlighted some of the pitfalls of using strengths-based approaches uncritically (Bulloch 2018; Fogarty, Lovell et al. 2018). In particular, by focusing on people's ability to 'help themselves', such approaches can shade out the structural socio-economic situations that can work against people's efforts to enact change. Two senior managers in Waminda were conscious of this danger and talked about how strengths-based approaches can be 'just thrown around'.

GB suggested that strengths-based approaches can be patronising if they focus overly on the individual and ignore the bigger picture of people's lives. People often think such approaches are just about 'focusing on the positives,' she said, 'and I think that puts us in a binary; it puts us in a binary of strengths and weaknesses.'

> *So I never get caught up in strength and weaknesses conversations with clients. I don't even use the word 'strengths'. Because then you get people in positions of power going, 'See how strong you are?' It's completely patronising and it's the end of a conversation. It's not the beginning of a conversation.*

'My experience of strengths-based approaches', GB went on, is that they 'are usually about the individual – looking at the individual through a positive.' But, she says, it ought to be 'a collective endeavour'. She suggests that focusing on individuals as atomised agents is 'the way government wants to view problems and issues... They try to understand what's going on without looking at the role that they play in it.'

GB then suggested something that was also raised by an employee of one of the other organisations – that taking strengths-based approaches concerns not just work with individual clients, it can also be about recognising and cooperatively building on strengths between a collective of organisations that are accountable to community. Through partnership rather than competition, organisations can, said

JK, 'capitalise on all the strengths of all the organisations' to 'offer families a much richer resource', and moreover to generate a 'collective ground swell'. As another manager pointed out:

> It's not just the fact that you've got strengths – no one just has strengths. It's that collective approach; it's you knowing that you've been backed by the community. The accountability to community. It's knowing that ultimately if we don't do things differently we're going to come up with the same outcomes.

Brokering, advocacy, coordination and translation

All three organisations play a key brokerage role between clients and external health, welfare and other service providers – work that includes cultural translation, advocacy and coordination of care. Facilitating access to services is part of this and can include guiding people on what services are available, organising appointments, arranging transport, and assisting with costs. HM at Noah's said that they are often trying to find out how to arrange for a family or individual to access a specific health service. 'That is not always easy,' she explains, as the services 'may not be easily accessible, either through distance, appointment bookings, cost, unfamiliarity.' As such, helping people access services often involves research, pre-existing knowledge, relationship building and advocacy.

Laynha Health now has strong relationships and established ways of liaising with a range of external services and specialist clinics, including Miwatj Health clinics, Gove Hospital and the Royal Darwin Hospital. In some cases, staff have negotiated generic appointment slots, in place of individual patient bookings, so they can then determine who will attend an appointment based on current medical priorities and their knowledge of factors such as the client's location and availability (Health Outcomes International 2012). Using satellite Internet they have set up in homelands, Laynha Health staff also organise videoconferences between families in the homelands and distant specialists; for example, one staff member described connecting a family in Yilpara with a surgeon in Darwin. Beforehand, staff helped the family determine questions to ask the surgeon during the teleconference. During the consultation, the surgeon was able to see the patient in the context of her family, and to begin building a relationship. Afterwards, staff discussed matters with the family, who then opted to proceed with the surgery.

Across the case study organisations, facilitating access to medical care overlaps with the advocacy role they play on behalf of their clients. On the client side, this includes navigating people through external health and welfare systems, such as detailing what they can expect in relation to the processes of a particular service, and helping people to understand their choices. In terms of the organisations' direct interactions with external agencies, it includes using contextual knowledge of families to support those families in interactions with agencies such as Family and Community Services, and pressing for increased responsibility and accountability from external providers to facilitate culturally safe, accessible and quality services for Aboriginal people.

In the context of a complex range of often-siloed services, the three organisations help to coordinate care for their clients, some of whom have multiple issues. In such cases, the organisations may conduct a range of internal and/or external referrals, such as to other health, welfare, medical and specialist services. With the client's permission, they can aid information sharing, such as case records, which can avoid individuals and families having to 'tell their story' repeatedly to different specialists. Liaison with non-health sectors can also reinforce a treatment approach, such as coordination between a specialist, the family and a school.

Laynha Health and Waminda also facilitate in-person support and cultural translation during appointments. Again, there are several aspects to this. Firstly, a familiar, trusted person accompanying a client to medical appointments can provide considerable emotional support, particularly in negotiating with and navigating what can be an impersonal, foreign and alienating system. Secondly, logistical help can also be crucial,

and we illustrate this in the following paragraphs in relation to Laynha Health. Thirdly, a support person can facilitate communication, such as between a specialist and the patient, by explaining questions that might be unclear or providing context, ensuring cultural appropriateness and, where necessary, providing language translation.

In a context where Aboriginal patients accessing specialist and hospital care often experience dislocation and distress (McGrath & Rawson 2013; Shahid, Finn et al. 2011; Worrall-Carter, Daws et al. 2016), Laynha Health's Aboriginal health workers are vital in mediating and easing the way. During both emergency and planned hospital and clinic visits, Aboriginal health workers arrange travel and escort the patient. In emergency situations after hours, the health workers liaise directly with the Gove Hospital or the district medical officer in Darwin to facilitate admission. During hospital visits, they often act as a language interpreter and cultural translator, assisting doctors, nurses and other health practitioners to understand 'Yolŋu way'. Similarly, they help navigate and explain Balanda medical systems to Yolŋu.

Yolŋu health worker, LB, described the process when he is alerted that someone is seriously ill:

Well [the family] come and talk to me first and explain he's very sick… He comes and talks to me, then I go and talk to the family members… And they make the decision. Family make the decisions. It's not me as health worker or the doctor – Balanda doctor. It's up to the family members to make the decision that he has to fly into Darwin or Adelaide for operation or anything.

LB also explained that:

If something serious happens in the homeland, like crocodile, shark, snake or car accident, we will know what to do. In olden days, something happens, it is very hard. There were no phones. There was only radio. They have two-ways for the plane. Maybe two, three hours. Hard. So nowadays, it's very easy. So when something happens here… I just call that through Laynha, talk to the nurses and doctors at Laynha. And after hours, something happens, I just call up to Darwin DMO [District Medical Officer], talk to them. Give their HRN [Health Record Number], date of birth and all that. They will look it on their computer. And this is what I do. Then they contact Gove for ambulance or plane. Plane comes in or the ambulance to pick up the person…

Fellow Aboriginal health worker, MG, explains how she organises bush taxi or chartered flight pick-ups for patients, and accompanies them to the hospital. Sometimes she even drives the patient and family herself. In Gove or Darwin hospital, LB continues, 'That's where they keep an eye on him. I look after him so he will be safe and come back to the community or the family.' He notes that 'for old people' language issues can be very hard. 'But as long as someone's there, like a Yolŋu interpreter… that's really important. It doesn't matter where you come from, you speak different language, we've got our interpreters there. That's helped the patient.'

At Laynha Health, the non-Yolŋu staff also play important advocacy roles, as explained by DD in relation to paediatric appointments:

Women particularly are grateful for us being with them during those appointments because they may know the people, or they may be different people on this occasion, and sometimes they're even men, which is super difficult… And so just being there and knowing what they're going through, and also knowing their story… Like a paediatric clinic – the paediatric registrars will ask all these questions, but they have no idea of the setting that people live in. So sometimes their questions are just not answerable, and the women haven't got the opportunity to tell their story. So you're almost like a translator… And also sometimes to be able to say, 'No, that's not appropriate'.

JS at Waminda touched on a range of related issues as she described supporting clients to access and navigate the NDIS. Firstly, she said, the clients need to know the scheme is there and is for them.

Then basically, your first point of contact is ringing a call centre, where you're going to get some random person who's asking quite personal information. So, there's no relationship. It's just quite confronting. A lot of people get put off because it's really disheartening… [Then], there's a lot of collecting reports, building evidence, and there's so much support that's really needed to help people in that. The next step then is around doing your preplanning, so that is about starting to think about okay, 'What is it there that I want? What is it that I need?'…

I've sat in meetings where people have basically been railroaded. Where questions aren't explained… Meeting somebody for the first time, you're expecting them to open up about all this really personal information… You need [someone] to be able to explain the questions, because… a lot of the questions are really ambiguous – they could be taken three, four, five different ways. It's only by sitting in and going through the meetings that you can know what they're actually asking.

Accessibility, regularity and consistency of services

All the case study organisations stressed the importance of their services being accessible, on a regular and consistent basis. This was closely linked with making a long-term commitment to a place and a population, and building peoples' familiarity with the service and their trust over time.

Transport difficulties (in addition to the expense of services, which can be prohibitive for some families) can inhibit people from accessing services. In some cases, people have neither their own transport nor easy access to public transport. One organisation pointed out that 'if we can't actually get to a family, then we see them pretty much drop away.'

All of the organisations work from multiple sites, and staff are mobile. This is particularly important in the Laynhapuy Homelands context where doctors, nurses and other staff regularly travel to the homelands clinics. In doing so, they have gradually built trust with communities by being visible, culturally appropriate and reliable. As a result, more and more residents have, over time, shown up for health checks when they see the LHAC four-wheel-drive pull up.

But service mobility is also important in the Shoalhaven. For example, Waminda achieves high rates of participation by Aboriginal women in cancer screening by going into the community with mobile, opportunistic screenings for which people need no appointment. Waminda also seeks to make their services more accessible and approachable by holding 'pamper days' – beauty therapy sessions that entice women to engage with the organisation in a way that is fun and non-threatening. The intention is for this to segue into women engaging with other Waminda services.

Meanwhile, personnel at Noah's stressed their need to provide regular services in the Wreck Bay Aboriginal community and to avoid long gaps between service provision. Staff understand relationship building as an ongoing endeavour, and a key part of this involves visibility and approachability in the community. HM pointed out that while health is 'output driven', such as the number of people who have visited a clinic, the process of building trust may mean continuing to send a staff member to an outreach clinic despite few clients turning up for the first few months, as trust is gradually forged. According to HM, what is ultimately needed to produce positive outcomes

is to have someone who can build relationships in the community and meet the needs, but also be there much more regularly, and just be *there. And, if no [client] turns up, it is the same person still there… And [clients] know they are coming next week, rather than next month…*

There are a lot of services in Nowra particularly. A lot of non-government organisations, and a lot of government services, but they don't always get accessed. I know that funding is a huge part of that because the funding that it takes to have somebody there – regularly week-in and week-out, no matter whether people come or not – to an accountant in Sydney in a government office, that is just not viable.

Flexibility and responsiveness to clients

While HM highlighted the importance of consistency in service provision, she stressed that this must be balanced with flexibility, adaptability and responsiveness based on community and client needs. In other words, consistently 'being there' for clients is important, but the form this takes need not be prescribed, rigid or unchanging over time. The role of adaptability, flexibility and responsiveness was a theme that emerged across our interviews, and was raised by a range of staff members in all the case study organisations. It can apply to various scales of operation, from innovation in organisational and program strategic planning to daily staff flexibility in interactions with clients. As such, it links in to our discussion of community-driven services and **Innovation and adaptability** above. Here we focus on the level of daily interactions with clients.

Interviewees stressed the importance of their services being flexible for clients and able to cater to individualised needs, even though this could make their own work (as staff members) more unpredictable. For this to happen, the organisations' policies and procedures need to allow for flexibility. For example, EW and SN talked about the range of restrictions applied to patients going into local mainstream sub-acute care (such as the type of diagnosis the patient must have and how long they must stay), and how such a restrictive system does not allow for differences between individuals. As SN commented, 'every person is different… there's no one size fits all. It's really important to meet that person where they're at and with no judgment.' QB also explained that part of Waminda's model of care is that 'everyone that walks in the door is entitled to a service… We're not like other services where it's like, "Oh, sorry, no. That's not in our KPIs. We can't do that. We don't offer that service. See you later"'.

Part of this flexibility, too, is being flexible and responsive to daily changes in plans and people's circumstances. Sometimes plans have to change at short notice, as JT at Noah's explained:

We might go to a centre with a plan – a written out plan – and then walk in, and I'll be able to go 'Yeah, that ain't going to work today'… We get good responses with that from the families by being able to go in and just go 'Hey, this is going on.' Because you don't know what's going to happen. Or you have a session planned for something; you might be in contact 20 minutes before and go 'Yep, we're alright', and then something could come up within 20 minutes and then the session's cancelled or they're not able to come or they've got to leave. It's just being very open-minded and non-judgmental and just going with the flow.

Flexibility and responsiveness were also talked about in relation to the timing, place and format of appointments. Waminda, for example, endeavours to provide people with services straight away. PK told us:

It's about being responsive straight away. It's not being: 'Okay, I'll book you into the in-take worker and you need to come back on Wednesday, and the week after that you need to come back on Wednesday'. It's not that at all. It's literally then and there. And you have to be responsive and you have to move on things immediately, whether it's just being able to, for the interim, give them a $100 food voucher to make sure they can get through the next days with baby formula and nappies and stuff like that, and then say, 'Okay, I'm going to check in with you tomorrow, and we can have a chat, and then I'm going to check in with you the next day'. It's actually not putting limitations on contact with families. It's meeting them where they're at. But also, it's giving families space when they want space.

Flexibility also extends to the location of appointments. Workers at Noah's explained that they try to meet people in spaces where the individual or family feel comfortable, which can mean going to people's homes or schools, to a playground or on Country. According to GB at Waminda:

Where we offer the therapy makes a difference to the experience. Like having a yarn down by the water, having a conversation in nature – it's such a sensory kind of experience. It addresses the power relationship. But it's also very different – you're sitting on the grass looking at the river, at the mountains and you're not in this traditional, professional clinical setting.

The organisations also allow for flexibility in the format of appointments, and one approach they have all taken up is group consults. At Waminda's **Dead or Deadly** program, for example, staff run weekly group sessions that include a GP and invited specialists. Each session focuses on a different topic, such as mental health or nutrition, and takes the form of a yarning circle. The women discuss their experiences and issues, raise questions and share what has worked for them. Several Waminda staff noted that the shared appointments have been highly successful in promoting social support and increasing health literary. As KG explained, the shared consults are 'a good way of identifying gaps':

Sometimes people are just too ashamed to talk about things. Or they didn't even realise that it's not normal. You know, they didn't realise that your blood sugar of 19 was that bad. So coming to the shared medical appointments, they can bounce off each other and they do learn a lot.

KT added:

I think when women are in that space together and they're talking, they're not on their own, so they realise another woman's actually going through the same thing. It's about that too – supporting each other through your healing journey.

Children and families in Noahs' Cullunghutti Playgroup raise the Aboriginal flag and acknowledge traditional custodians and Elders each week (photo by Melissa Harper, courtesy of Noah's)

Longer consultation times

In many mainstream services, consultation times are tightly constrained. Interviewees talked about the inadequacies of the brief appointment slots they were expected to adhere to in previous jobs, such as 15-minute consultations for GPs, 20-minute consultations for midwives, and hour-long casework sessions. In the context of Aboriginal health, these brief windows are sub-optimal for several reasons. Firstly, as we have discussed, building trust is essential – particularly in light of potentially traumatic histories with institutional services and the prevalence of negative experiences in the health and wellbeing sector – and it takes time. Secondly, in Aboriginal cultures communication tends toward a narrative, rather than direct question-answer, format. PY suggests that 'sitting around and yarning' is a culturally appropriate and productive approach in health care, yet, often, 'policy and procedures don't allow you that time to spend with that one client'. Thirdly, one interviewee in the Northern Territory noted that it is common for people with whom they work to have multiple health complications, which can interact, and complex case histories that take time to understand. Fourthly, family-centred care, for which a range of Aboriginal health organisations advocate, requires longer appointments; for example, one interviewee suggested hour-long GP meetings. Finally, there is the issue of cross-cultural communication, particularly in the homelands context, which means that translation to and from Yolŋu languages may be needed. Additionally, some concepts have no equivalent in the other language and culture, so even when a language and/or concepts are shared it can take extra time to ensure successful communication.

Waminda's standard GP consultations are 30 minutes but, prior to this, patients spend 20 minutes with a nurse or health worker as part of a triage and general check-up process. The health worker ascertains and records the patient's reason/s for presenting, conducts a set of general observations and routine health checks, then checks them in with the doctor. This process expedites the GP consultation, as the doctor can see someone's background and status before that patient enters the consulting room, thereby allowing them more time to discuss what's most important in that consultation.

Challenges and Constraints

In the previous sections, we have described the community-centred approaches being pursued by the three organisations. These approaches place local contexts and values at the heart of their work, and prioritise their core business while also recognising and responding to a range of wider social determinants of health. However, all three NGOs are dependent on external funding (predominantly from federal and state governments) and, as such, are subject to a range of associated enabling and constraining factors. These include pre-determined purposes for funding, funding timeframes and reporting requirements. In this section we explore some of the key top-down challenges and constraints that the interviewees raised. These particularly pertain to matching holistic, strengths-based, bottom-up models of health and wellbeing services, with narrower, more metrics-oriented top-down models.

Boxed funding

A challenge faced by all the organisations is that, while they seek to take holistic approaches tailored to the communities with which they work, funding is typically for a specific purpose, falls within a siloed sector or assumes a certain set of realities. The purpose and scope of the funding is decided from the top down and it often assumes a relatively compartmentalised approach to health and wellbeing.

In the Northern Territory, NR told us that in recent years he has become increasingly focused on and excited by funding opportunities that free-up capacity to provide strengths-based cultural support, on top of the team's core business. However, such funding is not easy to find. Meanwhile, funding is not always adaptable to the local context. For example, AG explained that funding restrictions at times overlook the realities of a remote area. Rules and expectations are 'suited to world where you can access things that are five minutes down the road or there's a taxi service or something available'. NR pointed out there is 'no recognition' that what is needed in the context of Laynhapuy Homelands are emergency evacuations and access to patient travel. Again, funding for these essential, context-dependent services is hard to obtain.

Meanwhile in New South Wales, HM at Noah's described engaging with community members who would like certain services, then developing a model of how those services would work. 'But getting that to the next stage is the bit I find difficult,' she said. She has approached government departments with a given proposal and, although the staff she speaks to there may think it is a good idea, 'it doesn't necessarily get anywhere… because it doesn't fit in the box, and it would take too long and take too many human resources to move to that. They will listen, but they have still got decisions from the top down'.

CH at Waminda described the same challenge in taking proposed holistic health programs to government: 'Could you imagine what's that like going to different departments of health trying to get funding? "Oh no, that needs to go to mental health." "Oh no, that needs to go to chronic disease." "Oh no, we've already got that program." What are you guys doing? This is the program.' GG agreed:

> There's the push definitely from government departments for us to articulate what we're doing and just do that. 'Okay, we'll just fund you just to do that.' And especially with the IAS [Indigenous Advancement Strategy] and with the Department of Federal Health and Department of Social Services, NDIA [National Disability Insurance Agency] – it's a frigging nightmare. And so we have to keep constantly looking at that and going: How do we hold onto our model of care and push back and say, 'No you mob have got to go and sort your stuff out and then come back to us'?

CH described exactly that kind of pushback:

> *We used to get funding and be told, 'This is how it is', and we used to fit between the little silos. We've got a pretty strong management team now, that will say, 'No, that's not right for our people. How do you get holistic health fitting in a box? So you guys sort out your box.'*

Short-term funding and underfunded services

Another major challenge is that project and program grants are often short-term – typically between six months and three years. Many programs addressing the social determinants of health are unlikely to show results in such timeframes. Furthermore, as will be apparent from the earlier **What Works: Bottom-up approaches** section, even establishing effective and appropriate community-driven services takes time. JT commented that funders do not always understand this:

> *Sometimes I think they will get an idea or they'll see something and they'll want it. 'Oh yeah, we're going to do this,' and 'Let's get this rolled out.' Or they get funding and it's got to be done in a certain amount of time, and you go, 'You know what? It doesn't work that way.'*

> *Say we've just been given funding for 12 months to set up some playgroups and to prove it's working. We can do that. But it's going to take time. You've got to build up. A lot goes through word of mouth too and if it's not done properly or appropriately or through protocol then it's not going to work.*

Even initiatives that are showing results – sometimes those with a strong and consistent record of positive results over the long-term – can be defunded at short notice with little or no explanation. This is a threat to the consistency and regularity of services that our participants identified as so important **(see page 50)**. It is also a threat to staffing in a context where the organisations have strived to build up their Aboriginal staffing capacity and cross-cultural understandings – it can result in employment precarity and the loss of long-term institutional knowledge.

When we asked EW how well a responsive approach to community fits with the government funding regimes that the organisation operates under, she replied, 'Often not very well.'

> *But it's our job to figure out how that works – we try not to let it affect community. Because so often what happens is people stop engaging because they're so fed up with coming along, getting their hopes up that something's really working, then government whips the money away, because 'Oh well, they're doing okay so we're going to put the money over here'. And then of course, that [program] goes downhill. Everything's taken away just when they were getting on their feet.*

Having many small and often short-term grants – such as local club grants – is a way for the three organisations to fund holistic health services. While such grants are useful and have their place, they also produce a heavy administrative load in designing and submitting applications, as well as managing and reporting on successful grants. KT at Waminda points out, 'we've got about 40 different funding streams to run the services that we do, and it is hard to manage. But in saying that, we need to, because we've got to provide all these different services and they all come from different areas.' Meanwhile, WW says: 'I'm forever trying to gather funding through the local council and networking with local builders and tradesmen to try and get something going for homeless young people. If there was a block of funding here right now it'd be amazing what we could do with the money'.

As available grants may not suit a specific bottom-up program, and because funding cycles are typically short, the case study organisations often run 'unfunded' and underfunded programs. Waminda's **Dead or Deadly** is an example. This now widely lauded program was piloted with funding from a small Tackling

Funding crisis

At 4pm on an early December afternoon, one of the organisation's CEOs received a call about a program they had been running for years. The program's funding was due to finish in just three weeks, but the program was highly successful, and the government had regularly reassured the CEO that funding would likely continue. Yet now a public servant passed on the news that funding would not be renewed.

The CEO was stunned. The program had met all its contractual agreements and exceeded its KPIs. It had been instigated at the request of the community, was now well established, and enjoyed immense community support. Without the funding, two full-time Aboriginal positions would be lost. There had been no community consultation about the decision.

The organisation marshalled support. Other community organisations quickly rallied to write letters, allies with political influence were mobilised and media outlets were contacted.

One week after the organisation was told the program would be defunded, Ministerial intervention saw the funding reinstated, but only for 12 months.

While this crisis was at least temporarily resolved, it illustrates the vagaries and precariousness of short-term government funding in the Aboriginal heath sector.

Indigenous Smoking grant. When the pilot ended, as noted, there was strong community support for it to continue, but no funding to do so. Nonetheless, Waminda kept the program going for five years with no or insufficient funding – staff at times volunteering their labour. As KT explained:

> *Dead or Deadly came from a community need, so we weren't going to get rid of it… But it's been those years of us going up into government and lobbying. It's amazing how many trips we've done to Canberra, and just sitting down and talking to ministers, talking to their secretaries, and just really saying, 'This is the community need, this is what they're telling us they need. We've got the outcomes, we've got the data'.*

Their efforts paid off, with Dead or Deadly currently fully funded on a three-year Indigenous Australian's Health Programme grant. (Waminda's **Balaang Healing**, meanwhile, had only just established its space and its operations at the close of its initial 18-month innovation grant, and has not received direct funding since then.) As this indicates, in some cases where organisations cannot tap funding specifically for a given holistic health service, they can support it through general funding, but this is far from ideal. That the organisations are willing to continue with programs and services without funding is testament to their profound commitment to meeting community needs and providing staff continuity.

There are advantages of sorts to running programs that are independent of a specific funding source. Without rules on how money can be spent, or rigid reporting requirements, the programs can be flexible, innovative and responsive to community needs as the driving force is from the bottom up rather than the top down. But running an unfunded program leaves the NGOs vulnerable; the sustainability of unfunded and underfunded programs is always under threat, and using general funding for a holistic health service can provoke anxiety over whether an auditor with a potentially narrow view of health deems this spending appropriate.

'At the end of the day,' CH said, 'we're experts in our field and we're getting outcomes with or without funding, which can be hard sometimes, but we do it anyway because it's our community.' JS said that at Waminda they are 'lucky' because both management and the organisation as a whole have an attitude of 'let's just provide the support because it's needed'. She continued:

I've seen that in lots of different programs since being with Waminda – where there is a community need and there's an absence of funding, then we are just really, really blessed to have such a fierce, courageous group of elders and women who are leading this team… So, to have the courage to go 'Okay, here's the need, we can see that there are gaps here, so we're going to step into this space, and take that calculated risk, but to do what we know is the right thing'.

While the organisations run unfunded programs, they have also turned down funding opportunities and partnerships that compromise their values. Waminda has even given money back. GG says that they stopped thinking that partner organisations knew better than them how a program should be run: 'We stopped thinking that we had to partner with people when it was painful, or not good for us.' The first grant they declined was for $20,000, but more recently they pulled out of a major government contract worth $1.7 million. After nine months of Waminda trying to make the program work, of negotiating with their partners, and of carefully weighing the risks and benefits, they concluded it was not culturally appropriate or flexible to change (Waminda & MacKillop Family Services 2017). As CH described it: 'We ended up going to the board meeting and discussing the pros and cons, but at the end of the day it wasn't right for our community so why would we expose our families to something that isn't right? At what cost are we going to make this work?'

Metrics-based KPIs

Just as the organisations have concerns about the nature and length of funding, so too they find reporting requirements can unnecessarily constrain their work. In particular, top-down key performance indicators, which they are required to work to, may detract from or even conflict with community-driven design.

KPIs are a management tool commonly used in the public sector. In the context of our case studies, they are sets of criteria through which funded organisations and individuals report on activity against expenditure. They can include measures such as number of immunisations, adult health checks or counselling sessions provided. Over the past 20 years, KPIs have become the pre-eminent way a host of activity across public policy is measured. This approach, however, is not without problems, nor is it value free. As van Thiel and Leeuw (2002) note, the use of KPIs can have unintended consequences, such as the performance paradox, tunnel vision and organisational paralysis. These can reduce the quality of the knowledge about actual levels of performance or even negatively affect performance, examples of which can be found in all policy sectors. Such unintended consequences were certainly a feature of discussion around KPIs in the context of this research.

Across the case study organisations, how KPIs are determined depends on the funder and the funding scheme. In some cases, the organisations have been able to propose their own targets in their initial funding applications. However, in one case, when an organisation did this, the government redefined the KPIs in a way that showed little understanding of their work and was unsuited to the local context. In other cases, KPIs were defined externally, but after considerable 'pushback' from the organisation there was later room for negotiation. Commonly, targets are defined from the top down and are non-negotiable, such as standardised state/territory and national KPIs. All three organisations are juggling multiple sets of KPIs and reporting requirements for numerous funders – federal, state and local. According to WG:

For a small grant you've got to do the same level of diligence around it and accountability as you do for a large grant, so it's constantly managing multiple relationships… Every single [grant] has its own

metrics that it's using and so then all of that stuff has to be translated into our systems here and so there's a huge amount of work into data collection.

Among those we interviewed, there was clear understanding that measurement and evaluation are important in guiding improvement in practice, as well as demonstrating success to outside funders. However, participants also identified a range of interlinked challenges with KPIs. These included concern over a lack of transparency of how particular KPIs were developed and by whom, that some do not appear to be evidence-based, that there is a disconnect between what KPIs measure and what the organisations value, and that they often measure the 'wrong' things or failed to capture important successful activity.

Foremost among the issues identified is that KPIs tend to be heavily metrics-focused. Many interviewees, like WG, felt that, increasingly, the success of services is being measured in statistical terms:

I know numbers have got a place. But... numbers don't really tell you very much. You can have a hundred people involved in something, but they're all having a pretty shitty time... It's so much more complex than that and I don't think governments know about complexity. They talk outcomes now, but really their outcomes are just more numbers mostly.

Another interviewee agreed, saying that numbers 'don't tell the story of the complexity of families or tell stories of what you're doing on the ground'. As such, a funder might think, 'we only had five families involved in that program – well that's not effective.' She went on to say that, 'they'll hand you these KPIs and you think, "Oh my God, these are so ridiculous". How are you going to get outcomes with this?'

The reliance on statistics and a focus on the 'sickness model' in reporting processes conspire to mean that clinical data are given prominence and even screen out much of the organisations' efforts towards preventative and holistic health. This is because clinical data are more easily quantified, appear value neutral and seem to be a straightforward way of making comparisons between organisations. Several interviewees at Waminda pointed out that this is a problem given they are working with a 'social model' of health rather than a 'medical model'. Another interviewee said that while the top-down KPIs require her to do ten one-on-one sessions with clients a week, this overlooks her work on community education, community consultation or with the Elders committee. NR explained the problem as follows:

What we have is Aboriginal community-controlled health services that are proven to be effective around the world **because** *they are Aboriginal community-controlled. And then we get this set of key performance indicators that you sign a contract and you measure, and it's the only measure you have, you're required to do... Then you have Aboriginal community-controlled health services that are mainly shaped and influenced by key performance indicators, not Aboriginal community control. That's the problem. What we've done is we've taken something that's proven to be effective and marginalised it.*

'There needs to be a balance,' he continued, 'but I don't think there is a balance. So for me, like all the things we've talked about' – he lists a range of health-promoting and supporting services – 'all those things that I think make us valuable, are Aboriginal community controlled, but none of it is reported. None of it is an indicator.'

Value and power

We live in an age of metric fixation. In his book *The Tyranny of Metrics,* Muller defines this as 'the seemingly irresistible pressure to measure performance, to publicize it, and to reward it, often in the face of evidence that this just doesn't work very well'. Standardised performance metrics have become inseparable from notions of accountability, transparency and effectiveness. Nowhere is this more evident than in the field of health care (Muller 2018:4).

Measurement has many virtues. It can allow us to see simple facts among messy histories of activity and to make comparisons. It can help individuals and organisations to assess their performance. But measurement 'can also distort, divert, displace, distract, and discourage' (Muller 2018:4). We all too often and easily slip from productive measurement into 'mismeasurement, over-measurement, misleading measurement, and counter-productive measurement' (Muller 2018:4). We conflate targets for effectiveness – confusing indicators with equations – and render literal the dictum that what is counted counts.

> But what can be measured may have no relationship to what we really want to know. The cost of measuring may be greater than the benefits. The things that get measured may draw effort away from the things we really care about. And measurement may provide us with distorted knowledge – knowledge that seems solid but is actually deceptive. **(Muller 2018:3)**

Indeed, numbers appeal to a Western self-image of rational bureaucracy because they appear objective. In fact, they are always imbued with value judgments, but the seeming solidity of numbers make those judgments (about goals, priorities and means to ends) appear technical and therefore neutral. Standardised performance metrics are part of a broader institutional technical discourse that acts as an 'anti-politics machine'[11] – depoliticising what are inherently political decisions and actions.

The case study organisations' KPIs are often informed by a governmental rationality that confers authority on biomedical expertise and prioritises quantity over quality. These are the 'authorised values' – official, codified and imbued with a looming but vague threat of consequences if they are not adopted. The value-laden nature of the performance metrics is plain to the health and wellbeing workers in our case studies, who are sandwiched between differing values. They are engaged in daily struggles to make visible the bottom-up values – devalued values – that normally lie in the shadows. The depoliticisation through 'rendering technical' (Li 2007) does not wash with these workers because they are in the thick of negotiating the resultant contending power relations.

Many of them are also cognisant of the surveillance roles of KPIs in a context where trust in Aboriginal and Torres Strait Islander governance models has been low. As such, 'governing through numbers' can be interpreted as a continuation of a mode of colonial and neo-colonial control. Alternatively (although the two viewpoints are not incompatible), looked at as part of a global neoliberal trend, the case studies show there are serious costs to be borne for replacing experience-based judgment and negotiations over expectations with standardised performance metrics.

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11   We borrow the term 'anti-politics machine' from Ferguson (1996 [1990]), who uses it to describe the way 'expert' technical discourse can depoliticise inherently political decisions about resource allocation.

In practice, the organisations at times pick which KPIs they will prioritise, based on what they think is actually important in their context. In other cases, they feel compelled to work toward KPIs they think are poor value. As WG points out, focusing on metrics-based KPIs can derail an organisation by imposing a focus on the wrong priorities:

I think we have a pretty good understanding of the impact we're having, but none of the data tells that story really. Because numbers don't say a lot… It can actually get you really off course. That's the worst scenario – you think this is where you want to go, but [the KPIs] not only constrain, but they can actually detour you altogether.

Where there is a mismatch between the organisation's own community-driven priorities and those entailed in the KPIs – as often appears to be the case – balancing the two becomes 'a massive juggle'.

Episodes of care

Two of the three case study organisations spontaneously raised serious concerns about impending changes in the delivery of government funding, to a model based partly on episodes of care. We describe this briefly here because it illustrates the implications of governing by numbers. An episode of care is 'is one or more contacts (with the same clinical reason) by a client with one or more health workers on the same calendar day' (Pen CS 2017). The organisations fear that this shift to a funding model based not on block grants, but tallied from numbers of episodes of care delivered, could compromise their place-based services models.

GG described the changes as 'massive': 'X amount of women come through and have a whole range of services based on our model of care. So she might come in and have 20 things happen while she's here. But under the new funding model, one person in: one episode of care.'

GG went on to explain that many clients come into the centre, with or without scheduled appointments, but might stay for most of the day engaging with a range of relevant services, from a GP to a counsellor to a caseworker, and having a cup of tea or two in between. That flexible approach is part of what makes the service effective and is embedded in their model of care. But under the new system, there will be a disincentive for health care staff to deliver multiple services to one client on the same day, because they will count as only one episode of care. Instead, the organisations will have a financial interest in making a client return for further services on another day. The client actually returning and receiving the follow-up service is then put at risk.

From **page 53** we touched on five reasons that longer consultation times are important in Aboriginal health and wellbeing services. For example, family-centred care simply does not fit in to a 15-minute GP-appointment model. Nonetheless, interviewees suggested that the new funding system will work best with (and is designed for) individuals attending 15-minute GP appointments. A 30-minute GP appointment (as is standard at Waminda) that allows more time for relationship-building and better captures complex case histories – and therefore can result in more effective and efficient health care delivery in the long run – garners no more funding than a 15-minute appointment. As such, our interviewees felt that Aboriginal health care organisations will be incentivised to focus on the volume of clients rather than the quality of care. One interviewee described this as 'absolutely mainstreaming Aboriginal services'.

'I strongly believe,' said GG, 'that at the Department of Federal Health, some of the bureaucrats don't understand what an episode of care is… or the impact. Because it's totally against Aboriginal health.'

Narrow reporting parameters

A related issue is narrow reporting perimeters. All three organisations have a strong focus on producing effective and efficient outcomes, and all think carefully about what constitutes success, how it can be achieved, measured and communicated. But in reporting outcomes to funders, the organisations are restricted by what is asked for in reporting templates. As one interviewee said, 'It's difficult to get that information through to [funders], because they don't ask for it'. Staff across all the organisations expressed frustration that (commensurate with performance indicators) reporting templates often focus on narrow, quantitative measures and are poorly suited to reporting on community-driven, strengths-based approaches. As another interviewee put it, 'Unfortunately, funding's always a numbers-based thing. What I meet in my funding requirements, doesn't show what I do in my work.'

While all our case study organisations see statistical measures as important, qualitative reporting captures certain complexities and results of their work in ways that statistics cannot. As a result, the organisations see both statistics and stories as needed – or as one interviewee put it, 'you can't have one without the other'. Qualitative reporting provides flexibility for organisations to detail the parameters of their work and allows them, and their clients, to define success in their own terms. One interviewee gave the example of adhering to cultural protocol; despite its importance in their work, she has never seen it asked for in reporting templates and it would be difficult to measure. Meanwhile, according to DH, Waminda uses stories to 'actually tell them what we think success is', rather than just reporting on the number of clients seen.

Within each of the organisations, the same three types of qualitative reporting were cited as more fully capturing their strengths-based work:

- Text-based exposition and/or case studies that explain the context, progress and outcomes of a program and/or the journeys of individual clients. Similarly, quotes from clients who have been impacted may be included. Sometimes results come from surveys with semi-structured or open-ended questions.

- Videos that, in ethical and appropriate ways, show the facilities and services and/or allow clients to speak directly about their needs and their engagements and experiences with a service or set of services.

- Site visits from funders through which they can see the context, facilities and work for themselves.

It was also clear from our conversations across the organisations that they were doing much work in building relationships with existing and potential funders to increase understanding of their community-driven approaches. This was usually at their own initiative and expense, including flights to Sydney and Canberra; funders rarely reciprocated with equal effort. It is not a given, however, that this should be the case. One of the authors of this report was formerly employed on a major overseas grants scheme in which funder visits to funding recipients throughout the country were built in to grant monitoring systems.

Finally, a number of interviewees, including WG, pointed out that they rarely receive feedback on submitted reports: 'We waste so much time reporting on stuff that – do they need to know about?... It doesn't come back. It doesn't come back in a useful way. So that accountability – we never get it back... I think they have to really review why they're wanting the level of data and types of data they're asking for.'

Dwyer, Boulton et al. (2014) argue that the constraints of new public management and neo-liberal approaches to funding are particularly detrimental when applied to Aboriginal controlled health organisations. 'Constraints of funding programmes,' they say, 'undermine responsiveness to communities and potentially threaten the sustainability of the Indigenous PHC sector' (Dwyer, Boulton et al. 2014:1093). Although they suggest there is some broad recognition of this in the Aboriginal health policy sector, they add that 'while a shift in accountability arrangements towards a more relational approach is an explicit intention, it is not yet possible to detect any general change in practice' (Dwyer, Boulton et al. 2014:1104).

Enabling What Works

Drawing on the findings throughout this report, in this section we recommend ways forward. These are targeted at funders, policy makers and associated stakeholders seeking to enable NGOs in the Aboriginal health and wellbeing field to work more effectively.

Funding that embraces holism, innovation and responsiveness

While 'holistic health and wellbeing' can seem dauntingly broad, organisations that are 'close to the ground' often understand the social determinants of health in their area, and know what kinds of health-promoting services are most needed or in demand. Yet a prevalence of narrow, sector-specific funding may be impeding holistic health and wellbeing approaches and those driven by community needs, values and aspirations.

Specific funding streams are needed that allow local organisations to define and respond to holistic health and wellbeing in their context.

Sometimes designing bottom-up, holistic health and wellbeing services means innovating and taking risks.

Funding streams that embrace innovation, but do not force it where it is not needed, would benefit the sector.

Longer term funding cycles

Regular competition through six-month to three-year funding cycles can help to ensure quality. Yet, as discussed throughout this report, long-term approaches are crucial for Aboriginal health and wellbeing as they can:

- better prioritise relationship-building and address social determinants of health
- allow for increased innovation by providing more leeway for strategies to be tried and, if necessary, amended
- help to ensure consistency of services over a time
- assist in building a more skilled and stable workforce that includes training, learning and career development opportunities for Aboriginal and non-Aboriginal staff.

The availability of more long-term funding options, to complement existing short- and medium-term cycles, will better allow organisations to design projects and programs from the bottom up.

Co-designed KPIs

KPIs are often determined from the top down. As discussed, this can cause major challenges for organisations seeking to build services from the bottom up. In particular, it can cause problems where top-down and bottom-up cross-cultural values mismatch, or where top-down standards or understandings overlook the on-the-ground realities of particular communities or places.

- **Funding providers should allow organisations the capacity to design or negotiate KPIs according to local realities and community-based aspirations, thereby allowing for greater local relevance, responsiveness and innovation.**

- **Co-design of KPIs should be an ongoing, reflexive process, allowing for the mitigation of unintended consequences.**

Narrative-based reporting

Although statistical measures of performance have their place, they can fail to capture complexity, non-quantifiable successes, 'promising' early results yet to manifest in the statistics, and/or diverse and cross-cultural notions of success.

- **Reporting formats need to allow funding recipients the option and scope to detail progress, issues and outcomes in narrative/descriptive form. This may mean incorporating more open-ended questions in report templates.**

- **There should be more capacity in reporting to integrate or attach multi-media (including videos, audio and photographs).**

- **Public servants and program managers need professional development in valuing and using qualitative information and in the dangers of privileging statistical information.**

Reducing over-reporting

Reporting on the outputs and outcomes of external funding is important and necessary. But where organisations are managing many often small and short-term grants, reporting requirements can become burdensome, draining resources from productive activities.

- **Funding providers need to ensure that reporting requirements and processes are efficient. This includes thinking carefully about how often reports fall due, how user-friendly reporting templates are to complete, and whether the extent of what they ask applicants to produce is reasonable.**

Building relationships between funders and recipients

While it is important that funding decisions are made on an objective basis, it is also crucial that staff have an excellent understanding of the sector.

- **Policy makers and funders can gain a better understanding of realities on the ground by talking directly to those implementing services in that sector.**

Once funding is allocated, stable relationships between funders and recipients will aid the smooth operation of funded projects and programs.

- **Staff at funding institutions should be encouraged to view the funding relationship as a partnership, rather than as a hierarchical relationship in which the funder holds the power. After all, it is usually the service provider that best understands the realities, needs and aspirations of the communities with which they work.**

Organisations can feel that submitting reports on expended funding is like feeding information into a black hole; there is typically no engagement or feedback from the funding organisation and it is often unclear if or how the submitted information is (or might in future be) used.

- **More transparency is merited around use of requested information.**

- **Similarly, sending a personalised message showing that a report has been read, engaged with and understood, can help build a better relationship and can be an avenue through which to seek clarification on any issues.**

Long-term learning for career public servants

While it was once common for public servants to work in a specific sector for their entire career, the Australian Public Service now encourages professional mobility among its staff. This includes movement within agencies, across agencies, and to and from the private sector. While mobility has a range of benefits – such as career development, networking, and knowledge exchange – it can also act against stability, long-term learning and relationship building.

Understanding the broad area of Indigenous Affairs requires substantial cross-cultural knowledge and comprehension of a range of complex and interrelated historical, socio-economic and political issues. As such, it is a field that requires long-term learning. Some NGOs feel frustrated that they build solid relationships with particular public servants, and invest in helping them to understand the sector and services, only to have them move on, forcing the NGOs to start over again with someone new.

- **There is strong merit in encouraging staff stability and specialisation in Indigenous Affairs. Among other factors, it would reduce the chances of regular recycling of previous failed policies that has particularly characterised the last 15 years.**

- **Because knowledge of best practice, and cross-cultural understanding, is central to effective Aboriginal health and wellbeing policy, public servants need time for learning. There is a vast amount of high-quality and accessible research and guidance material on the topic, as well as a plethora of other learning avenues such as courses and cultural immersions. It would be of enormous benefit for public servants to be encouraged to read such materials and undertake learning opportunities on-the-job – and to be allocated time to do so.**

Final Words

In researching and writing this report, we were guided by several related goals. We wanted to understand if or how deficit discourses were affecting the three case study organisations, and how their staff think about and employ strengths-based approaches. While maintaining these strands throughout the interviews, we also gave participants the leeway to talk more broadly about what is important to them in their work, what success looks like to them, how they go about achieving it, and what challenges they face.

This 'zooming out' proved important because it became apparent that participants' understandings of deficit discourse and strengths-based approaches were often inseparable from their efforts towards community-driven, holistic design. As noted, strengths always need to be understood in relation to constraints. Thus, the organisations are constantly negotiating a balance between championing the strengths of the communities they serve and represent, and operating within the constraints on their (and their clients') ability to manoeuvre in a post-colonial and increasingly neoliberal nation-state.

From this flowed our third and fourth goals – to highlight strengths of the organisations themselves and recommend how government and funding environments can better enable their work. There is so much to celebrate about the work of all three organisations, that this proved straightforward, the inevitable pros and cons of any approach notwithstanding. We, as sceptical researchers, were consistently impressed. Furthermore, despite the distinct differences between the organisations, many of their key challenges were cross-cutting.

Perhaps more than anything, what impressed us in talking to people across all three organisations was the hope, resilience and perseverance that shone through. When we asked SN what gives her hope in her work with women, she told us that she turns up each day for every woman who has been part of her life. Then she told us this story:

> I recently had to sing for a healing group, and I'm not a great singer. But we had to perform at the NAIDOC day at the showground, in front of all these people. I thought I'd be really nervous. But when I got on there, I had this little girl in front of me: that was me when I was little.
>
> I was singing for her. I was singing for my mum. I was singing for my grandmothers. I was singing for all my aunties.
>
> I don't have a great voice, but I do it to have a voice. Yes, I do it to have a voice. Because you've been told to shut up for so long. No – I'm standing tall and proud. I'm going to have a voice.
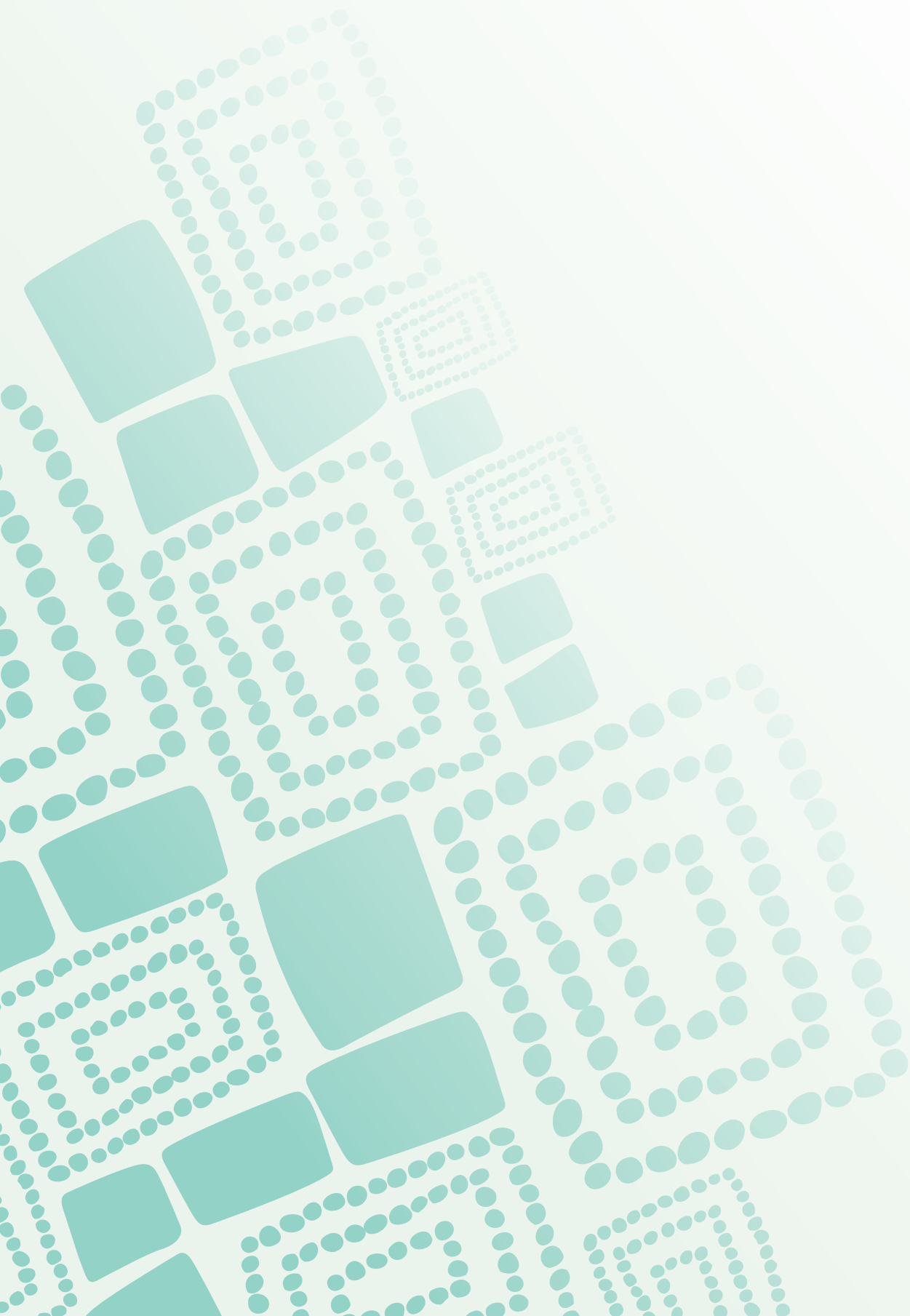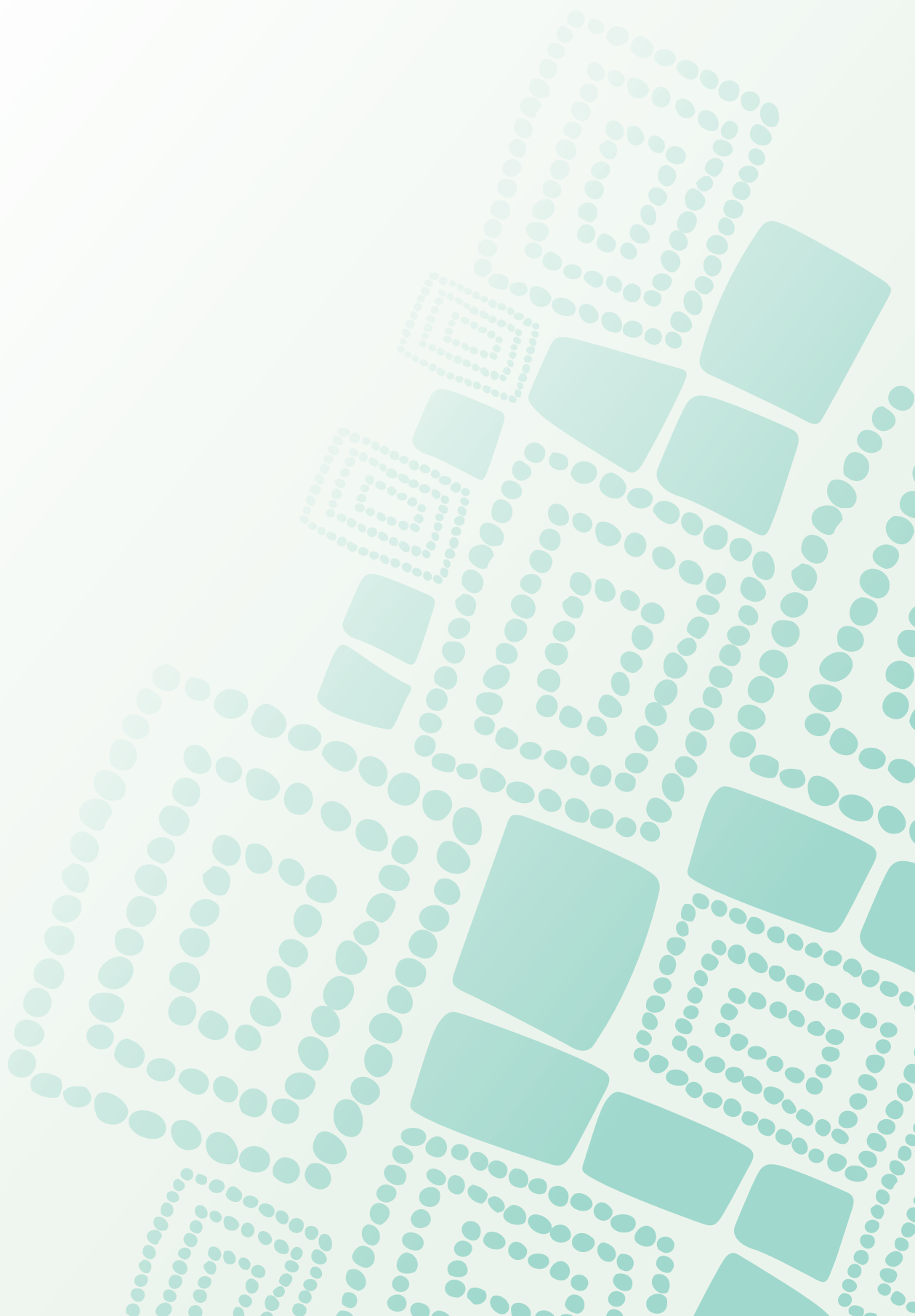
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