Growing an Evidence Base for an Indigenous Australian Model of Social Health Care

Thesis submitted by

Jacqueline Maree STEWART

BBus, GradDipPubPol, DIndStud, PGCertIndStud

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Abstract

To create a future characterised by improved, sustained social and emotional wellbeing for Aboriginal and Torres Strait Islander Australians practitioners and policy makers require evidence – evidence of how programmes work (or do not work), for whom they work and in what circumstance this is the case. This thesis tells the story of a research study undertaken in partnership with an Aboriginal and Torres Strait Islander community controlled health organisation, namely the Wuchopperen Health Service, to grow such an evidence base for their social health programmes. The study is a direct response to a need for research as identified by representatives of Wuchopperen. Its significance also stems from the paucity of systematic research that explores what works to address the disparities in the social and health status between Aboriginal and Torres Strait Islander Australians and the rest of the Australian population.

Informed by the principles of theory-based evaluation, the study investigated the conceptualisation and design of Wuchopperen's social health programmes. The qualitative investigation proceeded in three phases. In phase one document analysis, interviews and field research were completed in order to gather rich descriptions of the history and current day operations of the programmes. A preliminary analysis of these descriptions revealed a rudimentary outline of the key activities implemented across all programmes to achieve desired results. In phase two a workshop was organised to augment this basic plan. It focused not only on what was done, but also on how these activities or strategies were perceived by the programme staff as positively contributing to intended results. A thematic analysis of the entire data corpus was carried out to pinpoint prevalent patterns in beliefs or assumptions about how and why programmes functioned as they do. The results of this analysis were assembled into a model that reveals the approach to social health care as specific to Wuchopperen. In phase three, this model of social health care was assessed in light of existing evidence and documented practice experience on what works to enhance the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples.

Wuchopperen's model of social health care incorporates a complex interplay of factors. At its core is the primary goal of promoting coping and resilience. To accomplish this goal, the team simultaneously implements five key strategies: personalising support, responding to community priorities, integrating culture into programme delivery, advocating for system level change and exercising professionalism. All of these strategies are executed within an operational environment that presents both constraints and opportunities.

Strong support for Wuchopperen's model of social health care was found in existing research as well as in documented practice experience. In keeping with Wuchopperen's experience, many writers reinforced the worth of care that is tailored according to the unique needs and circumstances of Aboriginal and Torres Strait Islander Australians. Similarly, authors backed the significance that the Wuchopperen team places on integrating Aboriginal and Torres Strait Islander culture into programme delivery. For all this support there were also areas where Wuchopperen's approach extended current thinking. An emerging theme in the literature relates to the need for service providers to heighten their advocacy work given the many structural barriers to wellbeing. The Social Health experience provides insight into how this can be done. Furthermore, the model provided a unique opportunity to grant a voice to Aboriginal

and Torres Strait Islander practitioners regarding the principles and practices that represent professional conduct in social health care.

This study contributes to the evidence base on effective social health care for both Wuchopperen and the broader health care profession. By undertaking this study Wuchopperen has increased their understanding of the capacity of their model of social health to deliver desired results for Aboriginal and Torres Strait Islander individuals, families and communities. Equally, in committing the documentation and critical analysis of this model Wuchopperen have provided a framework that other practitioners and researchers can draw on when considering how and why to deliver social health care with and for Aboriginal and Torres Strait Islander Australians.

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List of Abbreviations and Acronyms

ANTaR	Australians for Native Title and Reconciliation
CCRE	Centre for Clinical Research Excellence
CRRMHQ	Centre for Rural and Remote Mental Health
CSO	Child Safety Officer
FaHCSIA	Department of Family Housing Community Services and Indigenous Affairs
IA	Investigation and Assessment
JCU	James Cook University
NHMRC	National Health and Medical Research Council
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
SEWB	Social and Emotional Wellbeing
SCAN	Suspected Child Abuse and Neglect
UQ	University of Queensland

Chapter 1 Introducing the Study

Wuchopperen is derived from the Wikmungkan Aboriginal language of the central western coast of Cape York, Far North Queensland Australia,
WUCH meaning house or place
OPARRA refers to traditional medicines and practices
(Wuchopperen Health Service, unknown-b)

1.1 Introduction

The Wuchopperen Health Service is one of the largest Aboriginal and Torres Strait Islander community controlled health organisations in Far North Queensland, Australia. Aboriginal and Torres Strait Islander community controlled health organisations are initiated and managed by local Aboriginal and Torres Strait Islander communities to deliver holistic and culturally appropriate health care to people within their community (National Aboriginal Community Controlled Health Organisation, 2006). The Wuchopperen Health Service has been providing such care for 30 years. Operating from permanent bases in Cairns and Atherton, the organisation delivers a comprehensive suite of primary health care services and social and emotional wellbeing programmes. Examples of its primary health care services include general medical and oral health clinics, population health services such as immunisations and specialist programmes such as chronic disease management. The organisation's social and emotional wellbeing programmes focus on the prevention and management of social conditions that can negatively impact on wellbeing, conditions like stress and lack of social support (The Commission on Social Determinants of Health, 2008). Its programmes include counselling and support, substance misuse prevention and early intervention, and family violence prevention.

This thesis tells the story of a systematic investigation into the conceptualisation and design of the Wuchopperen Health Service's social and emotional wellbeing programmes. Social Health, the unit responsible for the design and delivery of these programmes, initiated the research to grow the evidence base for their work. They sought to do so both to validate their approach and to highlight possible areas for enhancement.

This introductory chapter locates the research by providing a synopsis of the development of the study. It charts how and why the research came to exist in its present form, introduces the methodological approach and outlines the aims and objectives of the study. The chapter also considers the significance of the research. It concludes by outlining the content of the other thesis chapters.

1.2 Arriving at the study

Social Health programme staff initiated the research. First, they approached associates at the Centre for Rural and Remote Mental Health (CRRMHQ) for advice on what might be involved in setting up a research project. The CRRMHQ is an entity that amongst other things forges working relationships between organisations undertaking rural and remote mental health promotion, prevention and care. In the beginning, the two groups discussed analysing service utilisation data and client satisfaction surveys collected by the Social and Emotional Wellbeing (SEWB) Clinic. The SEWB Clinic operates under the banner of the Social Health's Counselling and Support programme. It performs mental health assessments, prescribes medications (as appropriate) and provides ongoing support to individuals dealing with mental and behaviour conditions such as depressive episodes (World Health Organisation, 2007). Social Health programme staff wanted an analysis of the data to grow an evidence base around what works (or perhaps does not work) with regards to how the clinic supports people with

mental health concerns. The organisation planned to draw on this evidence base to foster ongoing development and management of the clinic.

Discussions about how to realise a research study concerning the SEWB Clinic expanded to include other parties. Along with the Wuchopperen Health Service, the CRRMHQ has a number of other participant organisations that collaborate on projects and initiatives relating to mental health service provision. In this case, the CRRMHQ invited representatives from the University of Queensland (UQ) and James Cook University (JCU) to discuss the Social Health team's research ideas. Over the course of several meetings the discussants agreed that a research study about the SEWB Clinic could reasonably be undertaken by a Masters student supported by JCU.

Around the time of these discussions I (the principal researcher) was in the final phases of a Postgraduate Certificate of Indigenous Studies at JCU. A Postgraduate Liaison Officer with the School of Indigenous Australian Studies at JCU approached me to see if I might be interested in the research study. The study appealed to me immediately. It represented an opportunity to extend the research skills I had gained through my postgraduate studies (completed at the end of 2006). I was also excited about the prospect of working with a community controlled health organisation. In 2003-2004 I had been fortunate enough to volunteer with a non-government organisation in Quetta, Pakistan. My experience had revealed how 'grass-root' initiatives can achieve improved health, education and employment related outcomes for individuals, families and communities. I wanted to expand my knowledge of how such initiatives operated with and for Aboriginal and Torres Strait Islander Australians.

A research proposal was prepared and submitted in December 2006 to the Centre for Clinical Research Excellence (CCRE) in Circulatory and Associated

Conditions in Urban Indigenous Peoples[1] to secure funding. Contributors to the proposal included members of the Wuchopperen team, JCU academics and myself. Representatives of Wuchopperen and JCU pooled their expertise to provide details of the research aims together with a proposed methodology. I outlined my background and interest in the project. The proposal was submitted in December 2006. The funding was provided in August 2007 and the study was officially commenced the following month.

Given the eight month interval between seeking the funding and its provision, the study commenced with a review to establish the Social Health team's immediate research priorities. This review involved representatives from Social Health, the CRRMHQ and JCU (with the JCU participants including the principal research and members of her supervisory team). Even though the SEWB Clinic had been the focus of the initial proposal it was only mentioned in passing during these sessions. Instead the Social Health team spoke more broadly about the questions that they wanted answered concerning their programmes. One of the participants from Social Health commented "we instinctively do what is right for our mob" and revealed an interest in finding out whether these instincts were substantiated by other research or 'best' practice examples (former manager 1, F: 24/10/2007) (see the introduction of Chapter 4 for referencing of research data). Their comments succinctly captured the essence of the questions raised by their colleagues – Is our approach to social health care supported by evidence?

[1] The Centre for Clinical Research Excellence (CCRE) in Circulatory and Associated Conditions in Urban Indigenous Peoples is a business unit of the Queensland Aboriginal and Islander Health Council (QAIHC). The CCRE in Circulatory and Associated Conditions in Urban Indigenous Peoples conduct research focussed on improving health outcomes for Aboriginal and Torres Strait Islander people.

1.3 Research design and focus

To answer the team's overriding question the research focus became the design of the social health programmes. Specifically, the study examined the plan or blueprint underpinning how the social health programmes are supposed to work (Rossi, Freeman and Lipsey, 2004). Undertaking such an examination dictated the consideration of an evaluation approach known of as theory-based evaluation (Birckmayer and Weiss, 2000) (also referred to as theory-driven evaluation (Chen, 1990) or "program theory evaluation" (Rossi et al., 2004)). Theory-based evaluations take for granted that a social programme is based on an explicit or implicit theory about how and why the programme should conduct its business in order to attain its goals (Rossi et al., 2004; Weiss, 1998). The evaluation process involves assessing this theory, or more particularly the expectations concerning the relationship between the strategies that the programme has adopted and the social benefits it is expected to produce (Rossi et al., 2004). This evaluation approach ultimately came to inform the research design.

The prevailing research aim was to determine:

- Whether, and how, the approach to social health care adopted by the Wuchopperen Health Service is supported by existing research evidence and documented practice experience.

Following on from this research aim, a number of objectives were explored. The research objectives were to:

- Identify the strategies that all social health programmes routinely adopt to enhance the social and emotional wellbeing of their target audiences
- Ascertain the assumptions and expectations held by programme staff as to how the adopted strategies enhance wellbeing

- Determine whether the presumed links between the adopted strategies and desired outcomes are congruent with existing research evidence and documented practice experience
- Discuss how the adopted strategies support chronic disease management and prevention (of interest to the CCRE – the scholarship provider).

Informed by the principles of theory-based evaluation, a three-phased research approach was adopted to address the research aim and the resulting objectives. Phase one entailed a review of the five social health programmes. Specifically the goals, objectives and activities of each social health programme were identified. Three research methods were implemented to reveal these details: an analysis of existing programme documentation, interviews with representatives of each programme, and field research, which encompassed participant observation and informal discussions with programme staff about their daily practice. A key output from phase one was a preliminary model of key strategies that cut across all social health programmes.

Phase two was devised as a way of validating the preliminary model and enriching the data corpus. It involved a workshop with programme staff engaged in counselling and support related activities. These staff members were nominated because of their role as the first point of contact for most of the visitors[2] to the Social Health unit. They are seen by senior management as essential to setting the standards or benchmarks on how all programmes should conduct their business. The workshop had three main aims: 1) examine the social outcomes or benefits that the programmes are expected to produce, 2) review the strategies or tactics adopted to attain these outcomes (with particular reference to the model prepared in phase one), and 3) collect

[2] '*Visitors*' is the term preferred by members of the Social Health team to describe the individuals who approach the unit for support and assistance.

case studies illustrative of how adopted strategies produced desired outcomes in the past.

The final phase drew conclusions about the validity of the logic (as perceived by programme staff) that connects the adopted programme strategies to the intended wellbeing related outcomes. Insights were obtained from the data and external evidence, namely existing research and documented practice experience. The research data revealed anecdotal accounts from programme staff about how particular approaches or techniques contributed to positive life changes for their visitors. Existing research and practice experience exposed empirical evidence supportive of the perceived relationship between the strategies the social health programmes commonly adopted and the social benefits they were expected to produce.

1.4 Significance of the research

Several factors are offered in support of the significance of the research study. The factors fall into two categories. First, there are those that relate to the Social Health unit. They address the question as to why the research is of consequence to the unit. The other factors relate to the relevance of the study to the consequent, broader research agenda for Aboriginal and Torres Strait Islander peoples.

The fact that the study addresses a need for research as expressed by Social Health makes this research worthwhile. Like other Aboriginal and Torres Strait Islander community controlled health organisations (National Aboriginal and Torres Strait Islander Health Council, 2003), a high ongoing demand for programmes coupled with limited resources required Social Health to prioritise service delivery over research and evaluation related activities. The absence of a well designed research study has made it difficult for programme staff to develop an evidence base for their work. This research

contributes to an evidence base that Social Health can draw on to inform programme design and delivery decisions and to guide future evaluation initiatives.

The research findings are also of value to Social Health in other ways. The findings represent useful material for induction resources designed to help new recruits understand how and why programmes function as they do. Similarly, given the Wuchopperen Health Service's commitment to supporting the effective operation of other agencies, the findings provide a means for advising other organisations as to how they should go about working for Aboriginal and Torres Strait Islander individuals, families and communities.

The significance of the study lies also in the selection of a research design that integrates the Social Health unit's expertise with the best available external research evidence and documented practice experience. As Sackett (1997) suggests the expertise of Social Health incorporates the proficiency and judgment that programme staff have acquired through experience and practice. This study acknowledges and privileges this expertise, providing Social Health with a permanent record of their particular approach to social health care. Because the study compares Social Health's approach to existing research and practice literature this research also provides the team with an opportunity to reflect on how and where programme strategies may be enhanced.

Outside the context of Wuchopperen's Social Health unit the study is important because of the paucity of research that explores 'what works' to address the health disparities experienced by Aboriginal and Torres Strait Islander peoples. In 2001-2003 only 35 studies across Australia, New Zealand, Canada and the United States tested the effectiveness of clinical or public health interventions for Indigenous people (Sanson-Fisher, Campbell, Perkins, Blunden and Davis, 2006). Findings like this one

have resulted in increased calls, not only for more research, but for research addressing particular issues in relation to health care (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Dwyer, Silburn and Wilson, 2004; Murray et al., 2002; National Health and Medical Research Council, 2002; National Public Health Partnership, 2006; Sanson-Fisher et al., 2006).

One type of 'in demand' research relates to how organisations and practitioners go about delivering programmes and services for Aboriginal and Torres Strait Islander peoples. The National Health and Medical Research Council (NHMRC) Road Map specifically calls for "a focus on health services research which describes the optimum means of delivering preventive, diagnostic and treatment based health services and interventions to Aboriginal and Torres Strait Islander peoples" (National Health and Medical Research Council, 2002, p. 3). The NHMRC Road Map identifies that while knowledge of this kind exists it is generally either inaccessible or has not been translated into strategies that are practical. As more and more service providers, like Social Health, take up the challenge to make their models of care both accessible and practical, the opportunity to achieve substantial health gains for Aboriginal and Torres Strait Islander peoples becomes more of a reality.

Finally, the significance of the study lies in its efforts to navigate tensions that exist around the conduct and dissemination of research for Aboriginal and Torres Strait Islander peoples. The historical reasons for these tensions are manifold. Some researchers have framed their research in ways that "assume the locus of a particular research problem lies with the indigenous individual or community" (Tuhiwai Smith, 1999, p. 92). Such research has not only blamed communities for the problems they are experiencing but puts forward the idea that these communities are bereft of solutions (Tuhiwai Smith, 1999). Research of this nature fails to put Aboriginal and

Torres Strait Islander peoples' interests, experiences and knowledges at the centre of research methodologies and the construction of knowledge about them (Irabinna Rigney, 1999). It is neither culturally respectful nor culturally safe (K Martin, 2003). Such research has understandably depleted the confidence Aboriginal and Torres Strait Islander peoples have in the value of research.

Additionally, tensions around the conduct of evaluation research have grown out of the lack of a real commitment to this endeavour and/or idealistic expectations about what can be measured within programme funding cycles. For many programmes there is no clear link between continued funding and demonstrable results. Consequently there is little incentive for rigorous evaluations, particularly in light of the resource constraints experienced by many service providers (National Aboriginal and Torres Strait Islander Health Council, 2003; Shannon, Wakerman, Hill, Barnes and Griew, 2002). Moreover, even when policy makers and/or project sponsors require, and appropriately resource, evaluations short project funding cycles (typically three years) mean that meaningful analysis of outcomes resulting from health and wellbeing initiatives is difficult. Many programmes depend on longer-term change and/or were influenced by multiple factors to which the project components may have contributed. These external, and essentially uncontrollable, 'confounders' make it difficult for evaluators to interpret findings about a programme within the narrow cause and effect framework expected by many policy makers and/or project sponsors (Legge, 1999; Shannon et al., 2002; Tsey and Every, 2000). The end result is a lack of evaluation data on 'what works' to enhance the social and emotional wellbeing of Aboriginal and Torres Strait Islander Australians.

While this study does not pretend to hold all the answers on how to address or counteract the identified research related tensions it does offer valuable insights into the components that underpin ethical research with Aboriginal and Torres Strait Islander peoples (see Australian Institute of Aboriginal and Torres Strait Islander Studies, 2002; Lee, 2007; Letiecq and Bailey, 2004; Scougall, 2006; Taylor, 2003). With more detail to follow in chapter three, key components have included partnering with programme staff to set the research agenda and negotiate a mutually beneficial agreement for the publication of findings, advocated as critical to cross–cultural evaluation research by Lee (2007), Letiecq and Bailey (2004) and Taylor (2003). My on-site placement facilitated a skills transfer to programme staff in aspects of the research process (advanced as important by Letiecq and Bailey (2004) and Taylor (2003)). The research findings privilege the stories of programme staff to validate their experiences and contribution to the research and provide a permanent record that can be used by the team for ventures such as education and promotion (endorsed by Lee, (2007) and Scougall (2006)). Finally, the research design does not attempt to narrowly define 'evidence' in a quantifiable cause-effect manner (cautioned against by Legge (1999), Shannon et al. (2002), Scougall (2006) and Tsey and Every (2000)). Rather, it focuses on producing findings that demonstrate the richness and complexity of the Social Health experiences in working with their visitors to enhance wellbeing.

1.5 Thesis structure

The thesis consists of seven chapters. Chapter one explores the development of the study. It also presents the research aim and objectives and addresses the significance of the study.

Chapter two sets the context for the research. It charts the evolution of the Wuchopperen Health Service and describes the organisation's current operations, with a particular focus on the Social Health unit as the central area of investigation. The chapter reveals the important role played by Wuchopperen, along with other Aboriginal and Torres Strait Islander community health services, in addressing issues of accessibility, acceptability and appropriateness for Aboriginal and Torres Strait Islander peoples seeking health care.

Chapter three examines issues that relate to the methodology for the research. It considers the reasoning behind the choice of a qualitative approach informed by the principles of theory-based evaluation. The chapter also examines how the application of three research methods (document analysis, interviewing and field research) allowed me to capture thick descriptions about the operation of the Social Health programmes and describes the processes that were adopted to analyse and interpret the data.

Chapters four and five present the study findings as a model representative of how Social Health delivers social health care. The model consists of three key components: the desired outcome that Social Health is working towards, the strategies adopted by the team to realise this outcome and the context within which the model operates.

Chapter six positions the model in relation to relevant literature. The identified literature considers existing interpretations of practices or initiatives that work to enhance the social and emotional wellbeing of Australian Aboriginal and Torres Strait Islander peoples. The chapter draws comparisons between the research findings and this literature to determine the degree of congruence.

The final chapter, chapter 7, reflects on the research endeavour and considers the implications of the research. It revisits the research aim, objectives and significance of the study and contemplates the limitations of the research. The chapter also presents ideas for future research at Wuchopperen.

Chapter 2 Setting the Context

2.1 Introduction

Compared to the rest of the Australian population, Aboriginal and Torres Strait Islander peoples experience the lowest standard of health. Large disparities exist across a range of health indicators (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008). The gap between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians life expectancy is 11.5 years for males and 9.7 years for females (Australian Bureau of Statistics, 2010). Around 65 per cent of the Aboriginal and Torres Strait Islander population suffer at least one chronic health condition (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008). Hospitalisation rates are significantly higher for Aboriginal and Torres Strait Islander people. For diagnoses like respiratory disease and mental illness Aboriginal and Torres Strait Islander peoples are hospitalised two to five times the rate of other Australians (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008). Aboriginal and Torres Strait Islander Australians are also twice as likely as non-Indigenous Australians to report high to very high levels of psychological distress. (See Appendix A – The Health Status of Aboriginal and Torres Strait Islander Australians for more details.)

Moreover, Aboriginal and Torres Strait Islander Australians experience substantial disadvantage in other key social outcomes. Educational outcomes are typically poorer.

Between 2000 and 2006 the proportion of Aboriginal and Torres Strait Islander 15 year olds who attained the national proficiency level for reading literacy was substantially less than non-Indigenous 15 year olds (33.5 per cent compared to 66.5 per cent) (Steering Committee for the Review of Government Service Provision, 2009). Rates of employment are lower as are median household incomes. A 24 per cent gap in employment rates between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians was recorded in 2006. Also, in 2006, the median incomes of Aboriginal and Torres Strait Islander households were 65 per cent of those of non-Indigenous households (Steering Committee for the Review of Government Service Provision, 2009). Finally, exposure to life stressors is higher. Aboriginal and Torres Strait Islander adults were three-and-a half times as likely as non-Indigenous adults to have been affected by abuse / violent crime and/or alcohol / drug related problems (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008).

Many causes underlie the poor health and social outcomes experienced by the Aboriginal and Torres Strait Islander peoples. From a historical perspective, generations of Aboriginal and Torres Strait Islander Australians have experienced trauma in relation to dispossession and to the disruption of culture, family and community. This trauma has contributed to ongoing problems in emotional, spiritual, cultural and social well-being for many Aboriginal and Torres Strait Islander individuals, families and communities (National Aboriginal and Torres Strait Islander Health Council, 2003; Swan and Raphael, 1995). In the present day overcrowded, poorly maintained houses – which lack basic amenities like access to safe water and sewerage – play a large part in the burden of ill health among Aboriginal and Torres Strait Islander peoples (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; National Aboriginal and Torres Strait Islander Health Council, 2003). Equally, Aboriginal and Torres Strait Islander peoples experiences of prejudice

and discrimination negatively impact on their wellbeing (Gallaher et al., 2009; Paradies, Harris and Anderson, 2008), as does inadequate service provision (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Murray et al., 2002; National Aboriginal Community Controlled Health Organisation and Oxfam Australia, 2007).

One response to this disadvantage and its causes has been a focus, at a government and community level, on self-management and self-determination for Aboriginal and Torres Strait Islander peoples. This strategic direction has been expressed in various ways including the development of community-controlled health services, the formulation of Aboriginal and Torres Strait Islander specific health policies and programmes and increasing participation of Aboriginal and Torres Strait Islander people within the health professions (Shannon and Longbottom, 2004). All of these strategies play an essential role in addressing the poor health and social outcomes highlighted directly above. In short, they ensure the delivery of services capable of addressing the specific needs and circumstances of Aboriginal and Torres Strait Islander peoples (Dwyer et al., 2004).

Of these strategies this chapter explores the emergence of the Aboriginal and Torres Strait Islander community controlled health sector, with a particular focus on the Wuchopperen Health Service. It aims to set the scene for the research. While not designed to provide a complete history of community controlled health organisations, the chapter does address how and why such services were established. It also introduces the Wuchopperen Health Service. This introduction is designed both as a case study of how community controlled health organisations operate and as an initiation to the study's central character. The chapter concludes with some reflections on the evidence base underpinning community controlled health organisations.

2.2 What are community controlled health organisations?

Aboriginal and Torres Strait Islander community controlled health organisations are instigated and operated by local communities. They are set up to deliver holistic, comprehensive and culturally appropriate health care (National Aboriginal and Torres Strait Islander Health Council, 2003; National Aboriginal Community Controlled Health Organisation, 2006). All services operate within a framework of local accountability. Accountability is achieved through a Board of Directors (elected from the local community), annual General Meetings and annual reports (Larkins, Geia and Panaretto, 2006; National Aboriginal and Torres Strait Islander Health Council, 2003).

The first Aboriginal and Torres Strait Islander community controlled health organisation was established by the Redfern Aboriginal community in Sydney in 1971. The community set up the Redfern Aboriginal Medical Service to address the ill health and premature deaths of Aboriginal people, the barriers inhibiting Aboriginal access to primary health care services and the need for a culturally appropriate health service (Bartlett and Boffa, 2005; Briscoe, 1974; National Aboriginal and Torres Strait Islander Health Council, 2003). Its opening was inspirational to many Aboriginal communities and similar services were established in the following years. In 1973 alone the Victorian Aboriginal Health Service, the Aboriginal and Torres Strait Islander Community Health Service Brisbane and the Derbarl Yerrigan Health Service Incorporated (Perth) were all opened. These and other services were initially started with either no government funding or small seed grants (Bartlett and Boffa, 2005). Consequently, the services offered each other support and assistance where possible. For example, the Redfern Aboriginal Medical Service sent and paid for a doctor to work at the clinic shopfront commenced by Wuchopperen in 1981. This history shows the remarkable advocacy and agency exercised by Aboriginal and Torres Strait Islander individuals and communities to enhance the health and wellbeing of local communities.

There are now over 130 community-controlled health services in urban, rural and remote communities across Australia (National Aboriginal Community Controlled Health Organisation, 2006). Twenty one of these services operate in Queensland, the Australian state in which the Wuchopperen Health service is located (Queensland Aboriginal and Islander Health Council, 2008-2010).

The programmes and services that are offered vary in line with community needs and available resources. Most commonly, community controlled health organisations diagnose and treat illness, provide referral pathways to specialists, conduct population health programmes, deliver social and emotional wellbeing services (like counselling) and fulfil advocacy and community support roles (Queensland Aboriginal and Islander Health Council, 2008-2010). They can also provide basic training of health professionals, facilitate research and promote the development of new approaches to Aboriginal and Torres Strait Islander health care as well as supporting other providers in identifying culturally appropriate service responses (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Couzos and Murray, 2003; Dwyer et al., 2004; Shannon and Longbottom, 2004).

2.3 Why are these services important?

The first and subsequent Aboriginal and Torres Strait Islander community controlled health organisations came about in large part due to the inadequacy of non-Indigenous specific (or 'mainstream') services for Aboriginal and Torres Strait Islander individuals, families and communities. Non-Indigenous specific services have failed (and sometimes continue to fail) in the areas of accessibility, acceptability and/or appropriateness.

2.3.1 Accessibility

Accessible health services fulfil four overlapping dimensions. They are non-discriminatory, physically accessible and affordable. Furthermore they seek to receive and impart information in an accessible (or understandable) manner. Despite ongoing attempts by Federal, State and Territory Governments to remove barriers to accessibility, many non-Indigenous specific health providers do not deliver on these dimensions for Aboriginal and Torres Strait Islander peoples (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Scrimgeour and Scrimgeour, 2007).

Non-discriminatory

Under law, health facilities, goods and services must be accessible to all without discrimination. Yet many non-Indigenous specific health services fail in this regard (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005). Only four decades ago Aboriginal patients were denied care or were separated from non-Indigenous patients at select hospitals (Skellett, 2007). In the current day Aboriginal and Torres Strait Islander peoples are around one-third less likely than non-Indigenous patients to receive appropriate primary health care from non-Indigenous specific providers across all health conditions (Paradies et al., 2008).

Community controlled health services provide health care to Aboriginal and Torres Strait Islander peoples on a fair and equitable basis. Practically speaking non-discriminatory care may mean having interpreters on hand to ensure people who speak English as their second, third or even fourth language fully understand medical procedures or health related information. At Wuchopperen an Aboriginal and Torres Strait Islander case worker explained how they had attended a healthy living workshop to “provide extra explanations in language [that is, the participants’ first language], when required” (case worker 1, F: 22/10/2008). Non-discriminatory care could also be

about supporting the right of an Aboriginal and Torres Strait Islander person to be part of a non-Indigenous specific programme. As one counsellor at Wuchopperen explained:

> A lot of the time we get really inappropriate referrals from other agencies and it seems to be oh this person's Indigenous so we'll flick ‘em to you. There's no understanding that maybe they actually are the most appropriate service to deal with that regardless of whether the client is Indigenous or not. (Counsellor 1, I: 584-587)

Physically accessible

Physical accessibility implies that health services are within safe physical reach for all sections of a population. The Wuchopperen experience provides examples of how physical accessibility can be achieved by community controlled health organisations. From its beginnings until the present day Wuchopperen has run a bus to take people to and from its Cairns based facilities. Currently the bus operates five days a week, providing pickup and drop offs to Cairns and surrounding areas as far as Edmonton and Smithfield (around 15 to 20 kilometres from Wuchopperen’s base in Cairns). Additionally, over time Wuchopperen has increased the number of areas or regions it services. Depending on the programme, Wuchopperen’s operating radius can extend 100 kilometres outside of Cairns (see figure 2.1). Given that lack of access to private transport or the financial means to utilise public transportation represents a major barrier to physical accessibility for many Aboriginal and Torres Strait Islander peoples, measures such as these are highly significant (Gallaher et al., 2009; Scrimgeour and Scrimgeour, 2007).

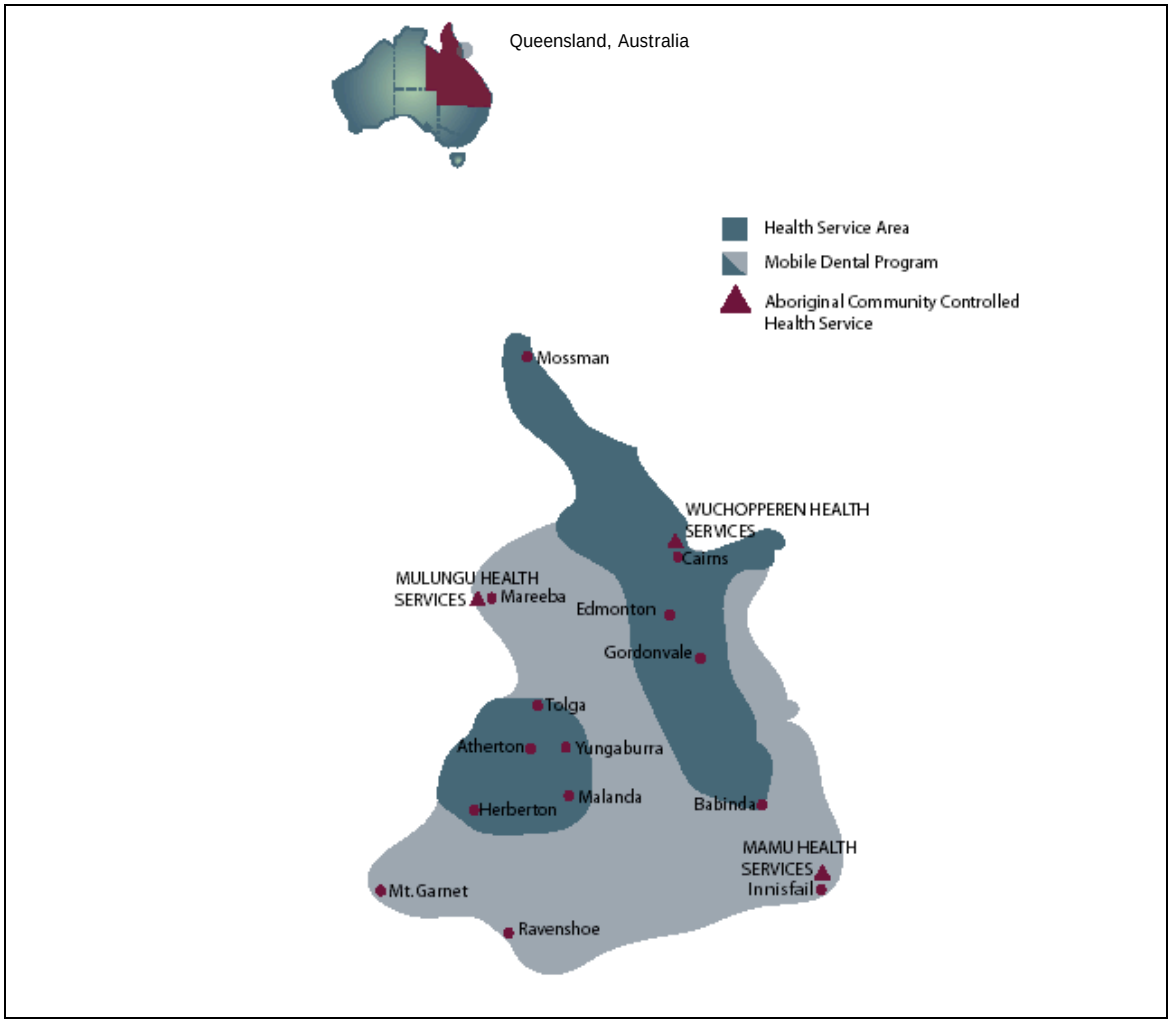

Figure 2.1 Wuchopperen's geographic coverage as of 2008-9

Affordable

Affordability is another dimension that can work to promote or inhibit access to health care. Community controlled health services can work at a number of levels to promote affordability. At a grassroots level programmes and services are provided free of charge. At a policy level community controlled services lobby for reduced health care costs. For example, the National Aboriginal Community Controlled Health Organisation (a peak body) lobbied the Federal Government for changes to the way the Pharmaceutical Benefits Scheme (PBS) operates[3] in order to reduce the cost of

[3] The Pharmaceutical Benefits Scheme (PBS) regulates the provision and cost of medication. For many Aboriginal and Torres Strait Islander people the cost of medication represents a significant financial burden. PBS reforms (introduced in the late 1990s) enable eligible and

medicine for urban Aboriginal and Torres Strait Islander peoples (Scrimgeour and Scrimgeour, 2007). These efforts are important because upfront fees for services and medications represent a major impediment to optimal health care for many Aboriginal and Torres Strait Islander peoples (National Aboriginal and Torres Strait Islander Health Council, 2003; Scrimgeour and Scrimgeour, 2007).

Information accessibility

Information accessibility relates to the way information is sought, received and imparted by health providers. Again the Wuchopperen experience illustrates how information accessibility can be achieved. A visit to this organisation's waiting rooms and resource library reveals posters, fact sheets and brochures specifically designed for Aboriginal and Torres Strait Islander peoples. Design features include concise and straightforward explanations and culturally relevant images (like a picture of an Aboriginal baby rather than a non-Indigenous baby). Wuchopperen also seeks to impart their knowledge of how to effectively communicate with Aboriginal and Torres Strait Islander peoples through formal and informal channels. Informally such information may be shared between Aboriginal and Torres Strait Islander workers and their non-Indigenous colleagues. A non-Indigenous counsellor shared how they had learnt in-house that "authenticity is important, not acting professional [and] using the right language so not to shame people" (counsellor 2, F: 19/02/2009). Wuchopperen staff members have also joined government and non-government forums to discuss, amongst other things, effective communication with Aboriginal and Torres Strait Islander peoples. As one manager said:

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approved rural and remote Aboriginal and Torres Strait Islander community controlled health organisations to supply PBS medicines to their patients without co-payment. In urban areas, Aboriginal and Torres Strait Islander peoples still need to present their prescription to a pharmacist and hand over the co-payment. The National Aboriginal Community Controlled Health Organisation (NACCHO) has lobbied the Federal Government to improve access to medications for urban Aboriginal and Torres Strait Islander people (Scrimgeour & Scrimgeour, 2007).

> It's me raising when they talk about legislation and policies and procedures wherever I can comment in relation to how does this affect or work or not work for Indigenous children and their families on the ground in practice. (Manager 3, I: 140-143)

Since many Aboriginal and Torres Strait Islander peoples report difficulties in understanding or being understood by non-Indigenous specific health providers (National Aboriginal Community Controlled Health Organisation and Oxfam Australia, 2007; Scrimgeour and Scrimgeour, 2007) the value of these efforts is that they aid effective communication about health related matters.

2.3.2 Acceptability

Even though the accessibility of health is clearly important, it is arguable that '*acceptability*' is a more important determinant of Aboriginal and Torres Strait Islander peoples' utilisation of health care services. The acceptability of health care services to Aboriginal and Torres Strait Islander peoples relates to the notion of cultural respect (Scrimgeour and Scrimgeour, 2007). Cultural respect is achieved when health providers deliver a safe environment for Aboriginal and Torres Strait Islander peoples through respect and practical recognition of cultural differences (Australian Health Ministers' Advisory Council: Standing Committee on Aboriginal and Torres Strait Islander Health Working Party, 2004).

Cultural respect remains a fundamental principle underpinning the operation of Aboriginal and Torres Strait Islander community controlled health organisations (Scrimgeour and Scrimgeour, 2007). One way that these organisations demonstrate cultural respect is through the recognition of Aboriginal and Torres Strait Islander concepts of health and wellbeing (Aboriginal and Torres Strait Islander Healing Foundation Development Team, 2009; National Aboriginal and Torres Strait Islander

Health Council, 2003; National Aboriginal Community Controlled Health Organisation, 2006).

Aboriginal and Torres Strait Islander peoples recognise that health and wellbeing is a multi-dimensional concept that embraces all aspects of living (Grieves, 2009; Swan and Raphael, 1995). When translated into health policy their understanding of wellbeing has been described as follows:

> Not the physical well being of the individual; but the social cultural well being of the whole community. This is a whole of life view and it includes a cyclical concept of life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and thus bring about the total well being of their community…
> (National Aboriginal Health Strategy Working Group, 1989).

Aboriginal and Torres Strait Islander community controlled health organisations recognise that health initiatives must be based upon this worldview, not non–Indigenous ('western') health understandings alone (Aboriginal and Torres Strait Islander Healing Foundation Development Team, 2009). They seek to design programmes that support a healing journey which acknowledges cultural values and ways of being and doing identified by Aboriginal and Torres Strait Islander peoples as critical to enhanced and sustained wellbeing (Aboriginal and Torres Strait Islander Healing Foundation Development Team, 2009; Grieves, 2009).

The Wuchopperen Health Service provides an example of how to acknowledge and practically demonstrate respect for Aboriginal and Torres Strait Islander worldviews. The organisation defines health as the "physical, social, emotional and cultural wellbeing of the individual, family and whole community" (Wuchopperen Health

Service, unknown-b). In keeping with the National Aboriginal Health Strategy's definition (see directly above), the organisation's adoption of this philosophy means that its programmes and services seek to address all aspects of health – that is, the physical, social, emotional and cultural aspects of wellbeing. It also implies a population health approach, which means the organisation's operational focus is deliberately on whole communities as well as individuals.

Conversely, many non-Indigenous specific health providers face difficulties in providing acceptable health care to Aboriginal and Torres Strait Islander peoples. Often these difficulties stem from a limited knowledge or awareness of Aboriginal and Torres Strait Islander worldviews (Aboriginal and Torres Strait Islander Healing Foundation Development Team, 2009). Many social and emotional wellbeing programs are based on non–Indigenous understandings of mental health, which can limit their effectiveness (Aboriginal and Torres Strait Islander Healing Foundation Development Team, 2009). The difficulties that some services face in, at the very least, integrating the two differing worldviews is in large part due to a "workforce that is largely non-Indigenous and not trained in the issues relevant to Aboriginal and Torres Strait Islander individuals, families and communities" (National Aboriginal and Torres Strait Islander Health Council, 2004).

Non-Indigenous specific health care providers can be supported to develop culturally acceptable health care practices. The supports that are needed include enhanced training in Aboriginal and Torres Strait Islander health for non-Indigenous health professionals and increased numbers of Aboriginal and Torres Strait Islander health care workers throughout the system (Scrimgeour and Scrimgeour, 2007). It also demands a commitment from non–Indigenous health professionals to acknowledge cultural difference and reflect on how it will impact on their work with people of a

different cultural background (Grieves, 2009). Even though such measures and practices are underway in many States and Territories (Aboriginal and Torres Strait Islander Healing Foundation Development Team, 2009; Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005), concerns exist within the health care sector around how far-reaching they will be. Aboriginal and Torres Strait Islander populations constitute a small proportion of the total health care sector in many parts of Australia. Consequently, this group's power to stimulate non-Indigenous specific health providers to deliver acceptable health care is severely limited (Dwyer et al., 2004). For this reason, the ongoing necessity of Aboriginal and Torres Strait Islander community controlled health organisations seems assured not only because of their ability to deliver acceptable health care but also because of their willingness to do so.

2.3.3 Appropriateness

Limited availability of '*appropriate*' health care is another key barrier faced by many Aboriginal and Torres Strait Islander peoples. Appropriate health care fully meets the health needs of its consumers (Scrimgeour and Scrimgeour, 2007). It is particularly important for Aboriginal and Torres Strait Islander peoples given their distinct health needs (Dwyer et al., 2004). Aboriginal and Torres Strait Islander peoples experience higher incidences of chronic diseases such as heart / circulatory diseases and diabetes (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008; Dwyer et al., 2004). They often need to manage these conditions in conjunction with comorbid conditions such as substance use disorders or depression (R. J. Anderson, Freedland, Clouse and Lustman, 2001; Hall, Lynskey and Teeson, 2001; Wilson, 2001). Additionally, Aboriginal and Torres Strait Islander peoples face disadvantage across a range of socioeconomic indicators including education, employment, income and housing (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008). People of low socioeconomic status have higher levels of ill health

because they typically lack the finance, knowledge and skills to acquire the essential prerequisites of good health (The Commission on Social Determinants of Health, 2008).

Combined, these factors dictate the necessity of health services that appropriately meet the health needs of Aboriginal and Torres Strait Islander peoples. Dwyer et al. (2004) describes such services as multifaceted, ongoing interventions delivered by a skilled multidisciplinary workforce able to sustain effective long-term treating relationships and links with other providers. To illustrate such an intervention, the Wuchopperen Health Service draws on its multidisciplinary team of General Practitioners, Nurses, Aboriginal and Torres Strait Islander Health Workers and a Health Promotion Officer to run the Healthy Heart Programme for people with heart / circulatory diseases. This programme incorporates a weekly exercise group, regular information sessions about medications, stress management and good nutrition and routine medical checkups. Each programme component works at a different level to prevent and manage the chronic illness. As required, the team collaborates with other professionals (either within or external to the organisation) to ensure individuals receive appropriate care. For example, someone suffering from depression could be referred to Wuchopperen's Counselling and Support programme. A person with addictions may be referred to a drug and alcohol rehabilitation centre – one of the many external agencies with which Wuchopperen has contact. Following rehabilitation, a case worker from Wuchopperen may offer assistance to address environment factors, like inadequate housing, that are impacting on the person's health.

Research indicates that non-Indigenous specific health providers are sometimes ill-equipped to provide a similar type of care to Aboriginal and Torres Strait Islander peoples (Dwyer et al., 2004; Larkins et al., 2006; Scrimgeour and Scrimgeour, 2007).

No single reason exists for this failure. Some providers lack the infrastructure required to deliver multifaceted, ongoing interventions. Others may lack the capacity to maintain sustained treatment relationships or to collaborate and coordinate with other health professionals to ensure continuity of care (Dwyer et al., 2004; Larkins et al., 2006). System restrictions also play a part. A lot of non-Indigenous specific providers adopt a fee-for-service or bulk billing system. These systems can limit the amount of time spent with patients (Scrimgeour and Scrimgeour, 2007). Consequently mainstream health providers are often unable to address comorbid conditions within a single consultation (Larkins et al., 2006).

Recognising the pressing need for appropriate health care, community controlled health organisations have sought to fill the gaps in the broader health care system. Depending on the scope of their operations (which vary), Aboriginal and Torres Strait Islander community controlled health organisations may provide multi-faceted ongoing interventions, such as the one described at the Wuchopperen Health Service. Additionally, many community controlled health organisations employ salaried General Practitioners. The choice not to run a fee-for-service or bulk billing system generally speaking means that General Practitioners get to spend more time with patients, which boosts the number of health concerns addressed per consultation (Larkins et al., 2006). Whatever measures are adopted they all add up to contribute to appropriate health services for Aboriginal and Torres Strait Islander individuals, families and communities.

2.4 More about Wuchopperen

The exploration of the role that community controlled health organisations play in delivering accessible, acceptable and appropriate health care for Aboriginal and Torres Strait Islander peoples has provided some insights about Wuchopperen. As the central figure in this research, however, further consideration of Wuchopperen's inner workings is required. The following account outlines the organisation's early beginnings. It aims to create a picture of where Wuchopperen has come from and where it has ended up. Special attention is paid to Wuchopperen's Social Health unit – the initiator of the study.

2.4.1 Wuchopperen's early history

The impetus for Wuchopperen grew from within the Aboriginal and Torres Strait Islander communities of Far North Queensland. In 1978 these communities elected a council to investigate means for addressing the poor health status experienced by many community members. With support from the Far North Queensland Land Council, the council organised a survey of Aboriginal and Torres Strait Islander peoples in Cairns and surrounding districts to determine the exact nature of existing health and wellbeing concerns. The council presented the survey results to a number of agencies to secure funds to establish a medical clinic in Cairns. Other Aboriginal Medical Services, including the Redfern Aboriginal Medical Service, also supported staff to run the clinic. A more detailed account of these facts – as relayed by Mrs. Eslyn Wargent, an Aboriginal Health Worker with over 28 years of service to Wuchopperen – is provided with her permission below.

In 1978, the Aboriginal community of Far North Queensland elected within itself a council for the purposes of dealing with its [sic] appalling health conditions of our Indigenous communities.

Much of the ground work had been done by the Far North Queensland Land Council ... [A] submission [sic] had been made to the Federal Government for financial assistance to conduct a survey to support the applications to launch the Health Service but they were rejected. Finally after 4 years of negotiations, funds were granted in June 1979 to conduct a needs assessment into Aboriginal Health in FNQ [Far North Queensland] (which was done by myself, three males, in which we went door to door, south to Murray Upper, north west to Georgetown down through the Tablelands, north to Mossman and Cairns and surrounding districts).

When the results were collated, the Federal Govt. [sic] was approached for funds again and still not too eager to fund a service ...

So strong was our commitment and dedication to see our dream a reality that we approached other agencies such as the New South Wales Teacher's Federation, The Christian Medical Council in Geneva and our North Queensland Land Council.

These organisations provided enough financial assistance to open a clinic. With these funds Wuchopperen was able to rent a base clinic [sic], purchase an 8-seater bus, purchase basic medical equipment and supplies and employ an Aboriginal Nurse. The Doctor was sent from Redfern and paid by Redfern [sic]. This was the basic team and equipment.

Wuchopperen Health Service opened on July 10th 1981 – NAIDOC [National Aboriginal and Islander Day Observance Committee].

(Source: Extract from a brief letter by Mrs. Eslyn Wargent about the early history of the Wuchopperen Health Service)

Figure 2.2 Recollections of Wuchopperen's early beginnings

The first clinic represented the start of many primary health care related services. In 1983 Wuchopperen established a dental clinic along with outreach medical services in Innisfail. By 1990 their outreach services extended to the Cairns Watch House and Mareeba. By this time a Health Worker had also been supporting communities in and around Kuranda for about a year. Furthermore, a number of other programmes were being implemented to promote good health and to support people to manage their wellbeing. Examples include:

- Murries Don't Need Durries (1992) – a programme designed to increase awareness about the health risks associated with smoking cigarettes (colloquially known by the local Aboriginal and Torres Strait Islander populations as durries)
- Jalbu (1995) – a Women's Health programme
- Failure to Thrive (1995) – a programme designed to support expectant and new mothers
- Hearing Heath programme (1997)
- Sexual Health programme (1998)
- Eye Health programme (1999).

Up until the mid 1990s the majority of Wuchopperen's work focused on the primary health care needs of local Aboriginal and Torres Strait Islander individuals, families and communities. Then in 1994 the organisation investigated the feasibility of setting up a Social Health unit. As a present day counsellor explained it was "identified that there needed to be more social supports for clients and it wasn't enough just to meet their primary health need, so that's when Social Health became established" (counsellor 1, I: 30-32).

The Social Health unit became a reality in 1996. Initially it offered counselling and support services. Over time the unit expanded to include the following programmes and services:

- Tableland Drug and Alcohol service (1999)
- Stolen Generations Counselling (1999) – providing specialist counselling and support to individuals and families traumatised by past governments forcible removal of Aboriginal children from their families, communities and Country
- Project 300 (1999) – supporting people with a psychiatric disability to live in their communities
- Intensive Family Support programme (2002) – working to enhance the parenting skills of Aboriginal and Torres Strait Islander participants
- Healthy Happy Families programme (2003) – assisting individuals and families at risk of or experiencing family or domestic violence
- Recognised Entity services (2004) – providing cultural and family advice in Aboriginal and Torres Strait Islander child protection programmes (that is, matters involving the possible or actual harm or neglect of a minor).

On top of delivering an array of primary health care and social and emotional wellbeing services, Wuchopperen sought to give back to the communities in which it worked and the industry of which it was a part. Capacity building initiatives represented a key way to achieve this aim. The team contributed to the development of professional training materials including an Aboriginal and Islander Health Worker Education programme (1983) and an Aboriginal health curriculum (1993). Representatives of the organisation joined working parties and forged coalitions, such as the National Health Strategy Working Party (1989) and the Northern Aboriginal Health Alliance. They sought to promote good industry practice and lobby for changes in Aboriginal and

Torres Strait Islander health care. Organisational support was also provided to the Innisfail and Mareeba communities to help them initiate their own Aboriginal Medical Services.

2.4.2 Wuchopperen 30 years on

These early beginnings continue to shape how the organisation operates in the present day. Currently Wuchopperen delivers a comprehensive suite of primary health care and social and emotional wellbeing services from permanent bases in Cairns and Atherton (Wuchopperen Health Service, 2006a, 2006b). Two operational units deliver these services: Primary Health Care Services and Social Health (see figure 2.3). Primary Health Care Services operates from Cairns and Atherton. The unit's services include general medical and oral health clinics, population health services (such as immunisations) and specialist programmes (such as ear and hearing health). The Social Health unit works, depending on the programme, in Cairns, Atherton, Yarrabah, Mossman and Kuranda. Examples of the Social Health unit's services include general and specialist counselling, child protection services and family violence prevention.

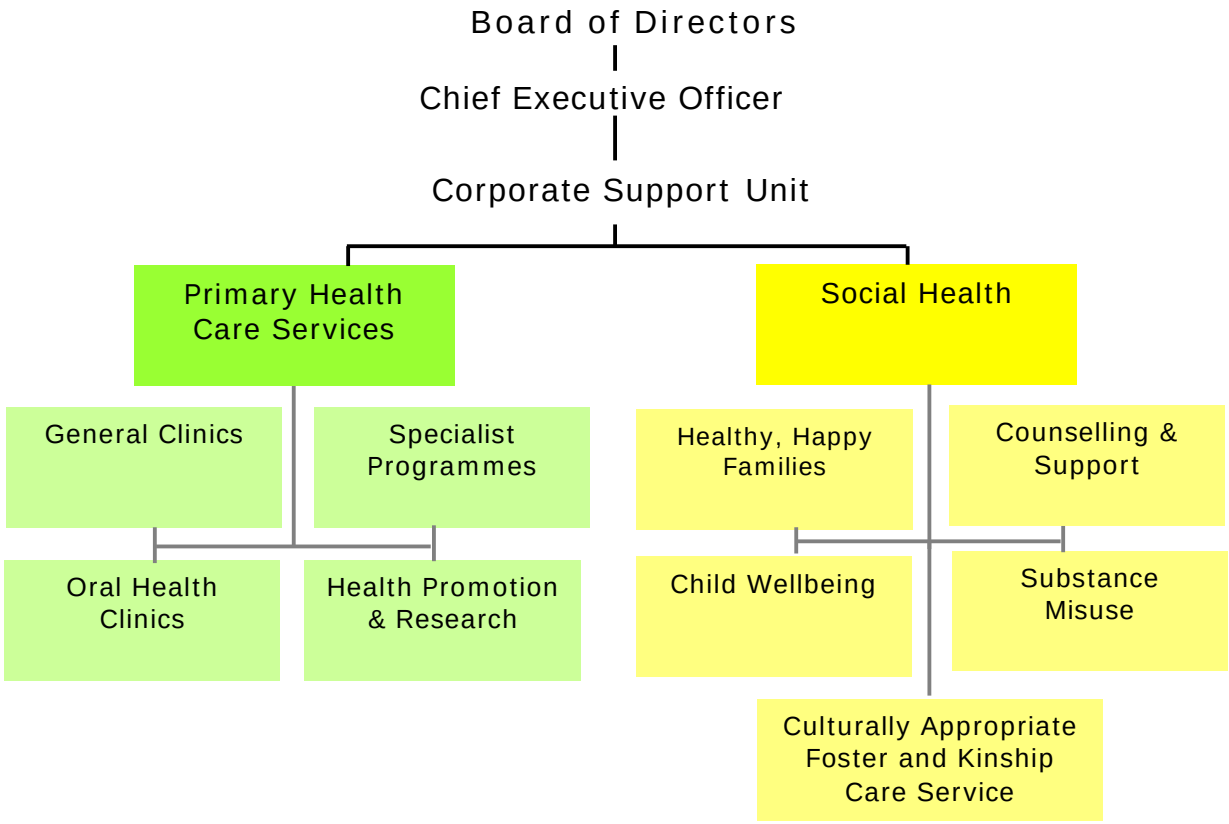

Figure 2.3 Wuchopperen's organisational structure as of 2008[4]

A team of around 130 people deliver the programmes and services that fall under the banner of either Primary Health Care Services or Social Health. Seventy five percent of these workers are Aboriginal and Torres Strait Islander (Wuchopperen Health Service, 2006b). People are employed in a range of health and management related disciplines. Job roles include general practitioners, dental officers, Aboriginal and Torres Strait Islander health workers, nurses, counsellors, programme coordinators and administrative support officers.

[4] In 2009 the Social Health unit commenced a new programme called the Australian Nurse Family Partnership. This programme works to improve pregnancy outcomes, support parents to develop a vision for their own future and enhance child health and development. The programme commenced after the completion of the data collection phase for this research study. Therefore, Australian Nurse Family Partnership is not included in the organisational structure or in any subsequent discussions.

The workforce is highly committed to meeting the needs of the individuals, families and communities they work for and with. Many personnel choose extended careers with Wuchopperen despite opportunities to earn better money outside of the community controlled health sector. Mrs. Eslyn Wargent (whose account of the early history of Wuchopperen was highlighted in figure 2.2) has defied career trends staying at the organisation she loves for over a quarter of a century (Wuchopperen Health Service, 2006b).

Aboriginal and Torres Strait Islander individuals, families and communities in Cairns and surrounding districts are the target audience for Wuchopperen's programme and services. As of June 2006, the estimated resident Aboriginal and Torres Strait Islander population in and around Cairns was 18,267 (9.1% of the total population in the region) (Australian Bureau of Statistics, 2007). Of this population Wuchopperen has 3,000 individuals registered in their 'client'[5] database.

2.4.3 Social Health

As the name suggests the Social Health unit (or Social Health) strives to enhance the social and emotional wellbeing of Aboriginal and Torres Strait Islander individuals, families and communities. Their vision is:

> that our mobs enjoy supportive and loving family and community environments in which we can all happily and safely live our lives, and strive to fulfill our life goals (Wuchopperen Health Service, unknown-a).

The vision acknowledges and demonstrates respect for Aboriginal and Torres Strait Islander worldviews. For Aboriginal and Torres Strait Islander peoples, health incorporates not only the physical wellbeing of an individual but also the social,

[5] Typically the Wuchopperen Health Service's workforce prefers not to use the terms client, consumer or patient. To demonstrate respect and promote equality, preferred terminology includes people who visit with the centre (or visitors) or people seeking support or assistance.

emotional and cultural wellbeing of the whole community (Swan and Raphael, 1995). Consequently, Social Health recognises that factors such as family and community are important in order to optimise health and wellbeing.

The work of Social Health also aligns with Aboriginal and Torres Strait Islander health reform agendas advanced by the government sector. In the last two decades social and emotional wellbeing has emerged as a key priority for policy makers. National, State and Territory policy frameworks have consistently called for action against the high incidence of social and emotional wellbeing problems and mental ill health among many Aboriginal and Torres Strait Islander people (Centre for Rural and Remote Mental Health Queensland, 2009; Cooperative Research Centre for Aboriginal Health, 2006; Henderson et al., 2007). These reports include the *National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health, 'Ways Forward', (1995)*, the *Queensland Aboriginal and Torres Strait Islander Mental Health Policy (1996)*, the national *Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan (1996–2000)*, the *Social and Emotional Wellbeing Framework: A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing (2004-2009),* the *Queensland Plan for Mental Health (2007-2012)* and the *National Mental Health Policy (2008)* (Centre for Rural and Remote Mental Health Queensland, 2009; Commonwealth Department of Health and Ageing, 2004; Cooperative Research Centre for Aboriginal Health, 2006). Social Health represents the front line of these frameworks, delivering accessible, acceptable and appropriate care to Aboriginal and Torres Strait Islander individuals, families and communities.

Social Health programmes

Social Health delivers five distinct programmes. The term programme is used here to refer to:

> ... a coherent series of activities, which together make up one strategy or more than one strategy, carried out with a group of participants for the purpose of improving the health status of the target group. This can be individual behavioural change, or environmental, legislative or other change ... (Hawe, Degeling and Hall, 1990).

Figure 2.4 summaries the key role of these programmes. See Appendix B for further details of specific programme activities.

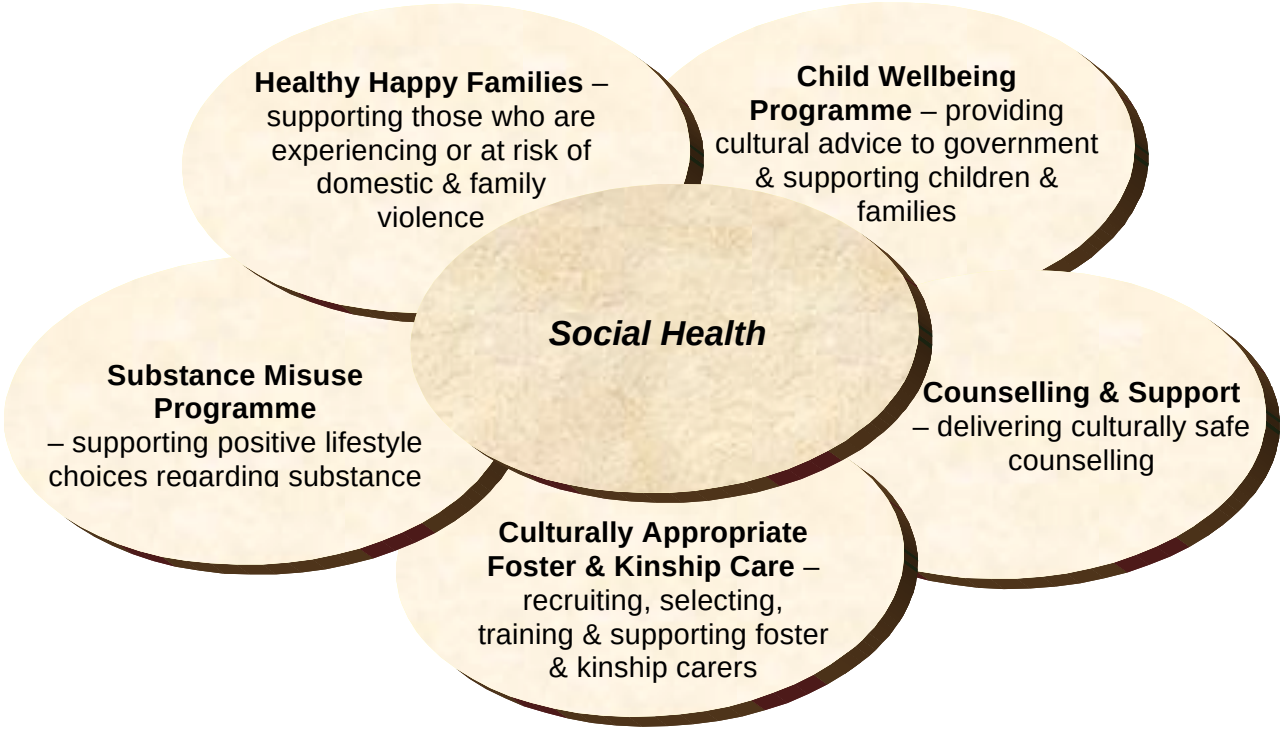

Figure 2.4 Overview of the Social Health programmes

Up to 52 people (assuming no positions are vacant) work together to deliver the social health programmes. Table 2.1 provides a breakdown of the different roles within each programme. As appropriate, specific details of a particular job role are provided to help clarify what they are responsible for.

Table 2.1: Job roles within the Social Health programmes

Programmes	**Job roles**	**Explanatory Notes**
Counselling and Support	Manager Generalist male and female counsellors (x6) Bringing Them Home Counsellor Support Workers (x 5) Project Support Officers (x2)	The Bringing Them Home Counsellor works with individuals and families affected by past government policies to remove Aboriginal and Torres Strait Islander children from their families, culture and Country. The support workers typically work on sub-programmes, like Project 300. Project 300 is a Queensland Government initiative designed to help Aboriginal and Torres Strait Islander persons with a physical disability and/or psychiatric condition to live independently in the community (rather than in an institution).

Programmes	Job roles	Explanatory Notes
Healthy Happy Families	Manager Men's Programmes Coordinator Female Programmes Coordinator Youth Programmes Coordinator Family Support Workers (x 2.5) Project Support Officer (0.5)	One team member undertakes duties relating to family support and project administration (hence the idea that two job roles are part-time (or 0.5)).
Substance Misuse	Manager Health Promotion Officer Substance Misuse Counsellor Case Worker Support Worker Youth Programmes Worker	The Substance Misuse Programme budget has been used to employ a Health Promotion Officer. However, the Health Promotion Officer does not work exclusively for this programme. Instead their skills are utilised across the organisation (that is, the Primary Health Care Services and Social Health units).
Child Wellbeing	Manager Investigation and Assessment (IA) officers (x 3) Case Workers (x3) IA / Case Work Officer* (x2) Court Officer Suspected Child Abuse and Neglect (SCAN) Coordinator	The Child Wellbeing programme operates from bases both in Cairns and Atherton. In accordance with a need as expressed by the local community, the Atherton team has combined some job roles. For example, in Atherton one person is responsible for investigations and assessments and ongoing case work; whereas, in Cairns these

Programmes	Job roles	Explanatory Notes
	SCAN / Court Coordinator* Family Intervention Support Worker Project Support Officer (x2) *Based in Atherton	duties are performed by two separate people.
Culturally Appropriate Foster and Kinship Care	Manager Project Officer Training Officer (x1) Care Workers (x 5)	The Project Officer role was set up to be a non-ongoing contract position. This person was primarily responsible for helping the team apply for a license from the Queensland Department of Child Safety to take on foster and kinship care support work.

A distinct advantage of this multi-disciplinary team is the diverse expertise they bring to Social Health. To ensure this expertise is shared across programmes, the team works within a coordinated case management type framework. For instance, the Substance Misuse Counsellor (part of the Substance Misuse programme) often provides advice and assistance to other personnel seeking to support people with an addiction such as smoking. Similarly, the Family Intervention Service Support Worker (part of Child Wellbeing programme) may approach the Youth Worker (with the Healthy, Happy Families programme) to explore support options for a child they are working with. Interactions like these also occur since visitors to Social Health may participate in more than one social health programme. Consequently, staff work together to ensure they are not doubling up on any of their supportive efforts (such as writing “20 letters from Wuchopperen for housing” (counsellor 1, I: 444)). As long as

prior consent of a visitor has been obtained, the team also comes together to discuss what is working (or perhaps not working) in the care of that particular person.

2.5 Growing an evidence base

Social Health initiated a research study to grow an evidence base for their work. They are not alone in wanting to know what contribution community controlled health organisations make towards the sustainable achievement of greater wellbeing of Aboriginal and Torres Strait Islander peoples. Increasingly policy makers, researchers and practitioners are seeking evidence of both the impacts and outcomes achieved by community controlled health organisations and the processes adopted to facilitate these results (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Department of Health and Ageing, 2004; Dwyer et al., 2004; Larkins et al., 2006; National Aboriginal and Torres Strait Islander Health Council, 2003; National Public Health Partnership, 2006).

With regard to the above-mentioned impacts and outcomes, there is now a small but growing evidence base. Dwyer et al. (2004) highlight the evidence of achievements by community controlled health organisations in some key areas. Examples include improved child and maternal health outcomes, early detection and reduced complications of mental illnesses and improved treatment of communicable diseases (Dwyer et al., 2004). Similar examples are cited in reports by Shannon, Wakerman, Hill, Barnes and Griew (2002) and the Australians for Native Title and Reconciliation (ANTaR) (2007).

Another vital component of this evidence base is an increased understanding of how impacts and outcomes are achieved. While evaluations are beginning to take place, there is a general lack of information on what did or did not work in terms of

processes, practices and strategies (Department of Health and Ageing, 2004; National Health and Medical Research Council, 2002; Shannon et al., 2002). The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2004-2009 recommended further research into the promising or good practices that underpin service delivery (Department of Health and Ageing, 2004). Similarly, the NHMRC Road Map highlights the need for research that describes the optimum means of delivering health care to Aboriginal and Torres Strait Islander peoples (National Health and Medical Research Council, 2002).

Both of these research priorities were of import to Social Health. The team was interested in knowing about the impacts and outcomes achieved and the efficacy of their processes in contributing to desired results. Through careful planning, a research agenda was devised that focused on the Social Health approach. It was a matter of starting at the beginning of an evaluation journey, using the research as a means to articulate the approach and determine what evidence (if any) underpins how the team goes about working with visitors to enhance their social and emotional wellbeing. Future research may then go on to grow the evidence base around achieved impacts and outcomes.

2.6 Summary

The Wuchopperen Health Service is one of around 130 community controlled health organisations fulfilling a need for accessible, acceptable and appropriate health care for Aboriginal and Torres Strait Islander individuals, families and communities. Over the last 30 years the service has grown substantially. From its early beginnings as a medical clinic, the organisation currently delivers a suite of primary health care and social and emotional wellbeing programmes and services. Social Health, the focus of the research study, delivers five programmes. They encompass a diverse range of

activities including counselling and support, drug and alcohol education, child protection, foster and kinship care support and early intervention and prevention of domestic and family violence.

This study is primarily concerned with growing an evidence base of how Social Health delivers these programmes. Social Health is not alone in seeking such evidence. Policy makers, practitioners and researchers have all pointed to the need for enhanced knowledge pertaining to which strategies, practices and initiatives work (or perhaps do not work) to enhance the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. Given the substantial disparities that exist between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians across a range of health indicators, the expansion of the evidence base around the strategies and approaches that community controlled health organisations utilise to address the health needs of those they work with and for represents an urgent priority.

It is against this backdrop that a research study into the operation of the Social Health was conceived. The following chapter examines the conduct of the research. Specifically, it looks at issues relating to the research methodology.

Chapter 3 Methodology

3.1 Introduction

This chapter examines the reasoning that informed the design and conduct of the study. It presents the rationale for implementing a qualitative approach informed by the principles of theory-based evaluation. The chapter examines how this approach enabled me to illuminate the key research question. It also explores how my adopted qualitative methods – document analysis, participant observation and interviewing – lead to rich, detailed descriptions about the operation of the five social health programmes. It reviews how thematic analysis was applied to the entire data corpus to identify common patterns in the beliefs or assumptions underpinning how and why programme staff do what they do. Finally, the chapter considers my response to the ethical dilemmas that arose during the study.

3.2 Determining a methodology

When senior staff in Social Health first proposed a research study they envisioned some type of programme evaluation. As Patton (2008) suggests the staff saw evaluation research as a way to collect and synthesise evidence that culminates in conclusions about the state of affairs, value, merit, worth, significance, or quality of the programme/s. The absence of well designed evaluation research made it hard for Social Health to develop an evidence base for their work. Anecdotal accounts from the unit's visitors suggested a high level of consumer satisfaction with the unit's operations. However, staff members were aware that evaluation research would enable assessments to be made about their programmes effectiveness and would also reveal information useful to future programming decisions (Patton, 2002).

I undertook a series of brief literature reviews to help me make informed decisions about where to focus an evaluation in light of the priorities identified by Social Health. Key topics included the different types of evaluations and the community controlled health sector. The review of evaluation types considered the five programme domains typically considered during an assessment. These domains are: 1) the need for a programme, 2) the design of the programme, 3) programme implementation and service delivery, 4) programme impact or outcomes, and 5) programme efficiency (Rossi et al., 2004). Information gained from this review helped me to advise the Social Health team about how a particular evaluation approach may (or may not) answer the questions they had about their programmes. A subsequent review of reports and studies about the community controlled health sector provided insights into existing understandings about how organisations within the sector operate. This information assisted me to understand the backdrop for the study. Also, since Social Health had expressed an interest in learning about how their operations compared with those of similar organisations, the review provided me with a sense of how existing research and practice related documentation about the community controlled health sector might be utilised to scrutinise the operations at Wuchopperen.

Drawing on knowledge gained from the literature reviews and planning sessions with Social Health, key representatives from the team and I elected to make programme design the focus of the study. This focus represented the best fit with the information needs expressed by the team. Their questions invariably related to their particular approach to social health care. In short, the programme staff had explained that their programmes were often conceived on the basis of experience, practical knowledge and intuition (a common phenomenon (Weiss, 1997)). While they expressed a level of confidence in the operation of programmes, the staff wondered

what evidence (if any) existed to support how programmes set out to achieve desired outcomes.

The decision to focus on programme design led me to explore an evaluation approach known of as theory-based evaluation. Theory-based evaluations are premised on the idea that all programmes have some plan (or theory) of what must be done to ameliorate social problems or bring about intended social benefits. A theory-based evaluation establishes this plan and examines how reasonable, feasible and otherwise appropriate it is (Rossi et al., 2004).

Informed by this approach, I worked with Social Health to devise the pivotal research aim. Our aim was to determine:

- Whether, and how, the approach to social health care adopted by the Wuchopperen Health Service is supported by existing research evidence and documented practice experience.

To address this aim I needed to understand how and why members of the different programmes do what they do. Specifically, I required a methodology that would enable me to unpack the team's beliefs and assumptions around how and why their adopted strategies were assumed to enhance the social and emotional wellbeing of their target audiences.

Due in part to this information need I conceptualised the research as a qualitative study. Quantitative data, like the number of times a particular tactic was employed, was not alone going to provide insight into how this tactic was perceived by programme staff as positively contributing to a person's wellbeing. Instead the study needed to produce rich, accessible narratives around the way programmes function or operate. As Patton (2002, p. 5) prescribes such narratives are the "fruit of qualitative inquiry".

Equally influential to my choice were the approaches adopted in earlier research conducted with and for Indigenous populations. Other researchers revealed to me how qualitative methods – including document analysis, interviews and focus groups – could be employed to obtain comprehensive information about the development and operation of health and wellbeing interventions (see Charteris, 2001; Kowanko, de Crespigny and Murray, 2003; Pipi et al. 2004; Scougall, 2006; Willis, Pearce and Jenkin, 2005). Through my reviews of this work I came to appreciate the value of collecting narratives from the Social Health team regarding their experiences of designing and delivering social health care programmes.

The design and delivery of the Social Health programmes also signalled the suitability of a qualitative study. Social Health delivers a complex intervention, complex in the sense that it encompasses five programmes with multiple interconnecting activities. Campbell et al. (2000) advocate that an evaluation of a complex intervention commence with a qualitative study that defines individual components and describes how the overall intervention is perceived to work. The authors maintain that this information improves the understanding of the inner workings of a complex intervention and informs future evaluation activities (Campbell et al., 2000). The authors' experience validated the legitimacy of a qualitative approach for describing and analysing the complex approach to social health care adopted by Wuchopperen. It also reinforced that the notion that Social Health would end up with information that would prove invaluable to subsequent evaluations (which were outside the scope of this study).

Moreover, a qualitative approach complimented the theoretical perspectives that guided the study. I was informed by the principles of interpretivism. As an interpretive researcher I sought to understand and describe meaningful social action (Neuman,

2006). I adopted a constructionist epistemology that focused on building knowledge and meaning in partnership between subject and object (Crotty, 1998). A qualitative inquiry provided me with the means to become highly involved in the actual experiences of programme staff and to develop in-depth understandings about their work practices (Creswell, 2003; Scougall, 2006). Through ongoing processes of communication and negotiation (Neuman, 2006; Taylor, 2003), I worked with programme staff to construct understandings around how and why different strategies were applied in programmes with a view to positively contributing to the wellbeing of visitors to Social Health.

It is important at this point to draw attention to the fact that the study only privileges the voices of the Social Health team. A decision not to engage with visitors to (or clients of) the unit was driven in large part by the study's timeframe. Following the example of Pawson et al. (2005), I needed to acknowledge that there was only so much territory I could cover during the study. Furthermore, in terms of where to focus our evaluation energies it seemed appropriate to start with the perspectives of the Social Health team. Prior to this study there was minimal documentation around how or why Social Health operated the way it does. Therefore, this study represented a starting point. It captured the blueprint around how Social Health is supposed to work. Putting this plan in place gives the team a resource around which other research studies – ideally involving the unit's visitors – can be built.

3.3 Building relationships

Strong working relationships with the Social Health team represented the key to my successful implementation of this methodological framework and ethical cross–cultural research. I built these relationships in a number of ways. First, they were established through the engagement of a cultural mentor (Letiecq and Bailey, 2004; Scougall, 2006; Taylor 2003). My mentor, Ms. Valda Wallace, provided advice about whom from Social Health to invite to the initial planning sessions and how to go about extending those invitations. Her suggestion to invite Social Health programme staff in a position to become champions for the research within the organisation proved invaluable. My early work with these 'champions' facilitated my later acceptance by the broader team. My cultural mentor's attendance at some of these planning sessions also helped, as other researchers have described (see Fasoli and Ranu, 2007; Hodge and Lester, 2006), to position me as someone who could be spoken with.

Furthermore, the advice provided by my cultural mentor to work on-site for one day each week proved critical. My physical presence in the Social Health offices showed how genuine I was to learn about what the team did on a daily basis. It also afforded me the opportunity to become actively involved in activities, like community events or even the occasional stint on reception. These experiences further established my commitment to work together with the team and to take every opportunity to increase my knowledge of their operations.

I found that openly demonstrating my desire to work in a respectful and approachable manner was very important. The Social Health team and I worked together to negotiate a research agreement (see Appendix C). The agreement confirmed, in a formal sense, my respect for the rights of the organisation in relation to issues like confidentiality, intellectual property and authorship of papers (Taylor, 2003).

I provided ongoing communications about key happenings and decision points within the research process. A poster (see Appendix D) was prepared to provide a snapshot of when key research tasks, like data collection and analysis were scheduled. Monthly newsletters (see Appendix E) were then produced to communicate progress towards these tasks. Invitations were extended to the Chair of Wuchopperen's Board and the Social Health team to participate in any public forum, like the university driven confirmation and pre-completion seminars, in which the research was discussed.

Equally significant to the strong working relationships I developed were my efforts to work in a reciprocal way (Taylor, 2003). As I learnt about the activities different staff undertook I asked where and how I might offer some contribution to their work. Many staff requested that I pass on details of relevant research that could enhance their understanding of how other organisations implemented similar projects. Understanding how important it was for the team to share details of their work and obtain feedback, staff members and I also wrote and co-presented three conference papers.

3.4 Collecting data

Three data collection methods were employed: document analysis, field research and interviews (one-on-one and group). Other researchers' positive experiences (see Birckmayer and Weiss, 2000; Carvalho and White, 2004; Rossi et al., 2004; Weiss, 1998) in applying these methods to reveal information about the design of programmes guided my choice. Similar to the identified researchers I found that each method revealed important clues about the beliefs and assumptions underpinning the operation of the social health programmes. My failure to adopt anyone of these methods would have resulted in an incomplete picture of how and why the social health programmes operate in the way they do.

3.4.1 Document analysis

With the assistance of the Social Health team I collected all available documentation for each programme. This documentation had been written within the last five years either by, or for, various programme sponsors. The materials written by sponsors dictated things like programme objectives, geographic service areas or staffing levels. The documents written for sponsors typically revealed quantitative data such as the number of people attending counselling or the number of health promotion campaigns delivered.

The documentation provided me with limited insight into the operation of individual programmes. While my preparatory reading about theory-based evaluation alerted me to the idea that documentation rarely explicitly articulates the assumptions underlying programme design (Rossi et al., 2004), I had imagined that my detailed analysis would provide some revelations. Instead after reading each document my journal was full of highly factual information such as the duration of funding agreements (generally speaking between one to three years), the name of the funding body (typically a State or Federal Government department) and the reporting requirements (most often quarterly). Apart from a list of programme activities (like counselling, referrals, case management and interagency partnerships) I found nothing substantial around how the programmes conducted their business in order to attain desired goals.

The true value of this documentation to the research process did not reveal itself to me until after I had finished the document analysis. I came to appreciate the worth of reviewing the documentation during my first round of one-on-one interviews with representatives from each social health programme. Prior knowledge of the documentation enabled me to demonstrate to interview participants that I was interested in what they did and that I respected their time enough not to waste it on

questions about elementary programme details. Much later, during data analysis, I also realised how much of the credit for the design and operation of programmes rested with the Social Health team. Given that service agreements from funding bodies typically did little more than to list desired objectives or key programme activities, the team was largely responsible for dictating the choice of programme strategies and tactics. This realisation helped me to stay focused on looking for the unique knowledge and skill set that enables programme staff to set up programmes with and for Aboriginal and Torres Strait Islander peoples. It also reinforced the importance for building an evidence base for the work. The team were working solo in a sense and the members involved were keen for evidence that either validated their approaches or pointed to areas for possible enhancement.

3.4.2 Field research

My field research entailed direct observation of interactions between the members of the Social Heath unit in Cairns and informal chats with the programme staff about their work. Most of my direct observations occurred as a consequence of the desk I occupied one day a week when working on-site at Rainforest House – a building occupied by the Social Health unit in Cairns. A senior manager had wisely suggested I sit at a desk neighbouring the unit's administrative hub. Since I was situated directly behind the main reception area I was able to observe and interact with the Cairns–based staff members who regularly visited this hub to collect mail and print-outs, sign in and out of the office and collect mobile phones and car keys. These staff members included Managers, counsellors, Support Workers, Program Coordinators, Case Workers and Project Support Officers from all five social health programmes. Close proximity to this often intense area of activity meant that I was privy to many discussions about people's daily activities. I heard staff from all programmes talk about the challenges of working with different agencies and of the joys in supporting

someone to achieve a goal. Similarly, I listened as programme staff sought advice from each other about how to best support someone with a particular social and emotional wellbeing related concern. I was however also able to directly observe all programme staff in comparatively more formal settings. These settings included team meetings and Open Days organised to celebrate events like NAIDOC[6] or to promote awareness about issues like family and domestic violence.

Informal interviews with programme staff were initially conducted on an impromptu basis in order to extend my knowledge of the Social Health unit's work and later became premeditated attempts to corroborate findings emerging from data analysis. When I first started working on-site I constantly sought opportunities to learn about the nature and scope of the social health programmes. Upon initially meeting all Cairns–based programme staff I would ask about what they did and how they individually fitted into the team as a whole. Additionally, if I overheard someone discussing their day I would approach them for a chat about their activities. Once I commenced data analysis (after I had completed document analysis and one-on-one interviews with programme representatives) I relied less and less on spur-of-the-moment chats. Instead I deliberately approached people from all programmes to clarify my understanding of the collected data or to review the significance of early themes or patterns arising from the data corpus.

The spontaneous nature of my field research did pose challenges. I needed to regularly negotiate my position as an independent observer (Neuman, 2006). When I was new to the organisation it was natural that I had to explain over and over the intent of my field research and obtain oral consent to incorporate observations and notes

[6] Every July NAIDOC Week celebrations are held across Australia. The celebrations rejoice in the culture, history and achievements of Aboriginal and Torres Strait Islander peoples. The name NAIDOC came from the acronym for the National Aborigines and Islander Day Observance Committee. This committee was once responsible for organising national activities during NAIDOC week (Australian Government, 2010).

from informal chats into the research findings. As I became a familiar face around the organisation I was confronted with the dilemma of having to remind programme staff that their words and actions may become part of the research findings. During an intimate disclosure, for instance, it felt awkward interrupting someone with a reminder about my role as researcher. Instead I elected to re-visit programme staff after the event to describe how what they did or said was pertinent to the research and to seek their oral consent to use my analysis and interpretation of observations or discussions in the final write up.

It was the informal nature of my field research that promoted me to obtain oral consent. My process involved going over key text from the informed consent forms I had designed for the one–on–one interviews. Specifically, I would review the research aims with programme staff and emphasise that their participation in the study was voluntary. I would explain my commitment to keep their information confidential by excluding all names and other personal information from the research findings. Furthermore, I would describe how the research findings would be published in a thesis and possibly other materials, such as journal articles.

Undertaking field research enriched my understanding of activities carried out by programme staff. As Spradley (1980) suggests participant observations enhanced my appreciation of the significance of key behaviours. For instance, during our formal one-on-one interviews programme staff spoke about the importance of building relationships with visitors to the unit. However, it was only when I witnessed programme staff greeting their visitors that I fully comprehended how an established rapport facilitated open disclosures. In the same way informal chats with programme staff helped me to delve deeper into the motives for their actions. Since the formal interviews sometimes occurred out of context programme staff struggled to fully explain

the rationale for particular activities. However chatting informally with programme staff when they were immersed in their working day often led to rich, detailed descriptions of exactly how and why certain tasks were perceived to enhance the social and emotional wellbeing of the individuals, families and communities seeking support from Social Health.

Direct observation and informal chats also helped me to develop a holistic view of the unit's operations. Patton (1980a) argues that a holistic outlook comes from researchers drawing on the results of field research to move beyond the selective perceptions of research participants. In my experience I was the one with the selective perceptions. Following document analysis and formal one-on-one interviews, I had almost an entrenched view of Social Health as an assortment of discrete programmes. Through field research I came to appreciate the collective nature of the Social Health unit's operations. My observations and informal chats regularly presented me with evidence of a variety of programmes that applied common strategies and tactics to assist individuals, families and communities. Over time I came to understand that the various programs were, by and large, bound together rather than existing as separate entities. Insights such as this one contributed to a major breakthrough in my data analysis. I was able to see past the minute detail of how and why individual programmes functioned and was consequently able to gain a broader perspective of the workings of an integrated Social Health unit.

In spite of the benefits that my field research yielded the process nevertheless required constant attention and reflection. Initially I struggled to maintain my enthusiasm for the detailed field notes recommended by other researchers (see Neuman, 2006; Patton, 1980a; Spradley, 1980) (see Appendix F for a sample of the notes taken). It seemed like a lot of effort with no guarantee of a return, particularly in

the early days when I was working with the Social Health unit to refine the research aims. I constantly questioned myself about taking time to record observations and conversations that may later prove irrelevant to the stated aims. It was only when I commenced data analysis that these doubts receded. At this point the themes emerging from the data became clearer to me and consequently I gained a greater understanding of what needed to be recorded in the field in order to validate findings.

3.4.3 Formal interviews

One-on-one interviews

I conducted one-on-one interviews with representatives of the five social health programmes. Drawing on the experiences of other researchers (Kowanko, de Crespigny and Murray, 2003; Pipi et al., 2004), I recognised that interviews represented a key means of collecting information about the development and current operations of the Social Health programmes. Furthermore, I understood the significance of meeting programme personnel face-to-face in an interview setting. The interviews provided a forum for staff to get to know me better as 'the researcher' and for me to acknowledge and demonstrate respect for the practice knowledge and experiences of programme personnel (Kennedy and Cram, 2010).

The timing of these interviews proved important. I conducted them about two months after I had started working on-site one day a week. The value of allowing this time to elapse was that programme staff were now getting to know me and appeared to be more comfortable in my presence, freely disclosing details of their work in the tea room or corridor. As Scougall (2006, p.52) explains in his discussion of cross–cultural evaluations, 'it is best practice for researchers in Indigenous contexts to slowly build some social connection before commencing data collection'. I certainly found this principle to be true.

I collaborated with a senior manager to identify who might participate in these interviews. This collaboration was one way I attempted to ensure my Aboriginal and Torres Strait Islander research partners were 'involved in and consulted as legitimate participants' (Taylor, 2003, p.47). Together the senior manager and I nominated personnel who held unique insights into the design and delivery of programmes, either because of their length of service or the particular position they held, an approach advocated by Rossi et al. (2004). Six candidates were nominated. All but two participants represented different programmes. Two candidates were selected from the same programme since they had experience of implementing the same programme in different locations.

Initially I made interview requests via email, thinking candidates may prefer to indicate non-participation in writing. Around a week after sending the emails I approached people on a one-to-one basis (either in person or over the phone) to discuss the interview process. This follow up procedure proved to be very important. Some people were uncertain about the prospect of being interviewed. They therefore appreciated being able to talk about the interview schedule (see Appendix G) and discuss further how data from the interviews would be used. Other people did not responded to emails (which I came to discover was not unusual given heavy workloads). Thus a face-to-face discussion was necessary to confirm their participation.

When conducting the interviews I reflected on my practice to identify positives and/or areas for possible improvement. I discovered that preparing and distributing an interview schedule ahead of each interview put people at ease because they had an idea of what to expect. Working from a pre-prepared interview schedule also assisted me in obtaining consistent information across programme areas. Typing up transcripts

within a week of the interview provided me with an early indication of key themes prevalent in the data (Braun and Clarke, 2006; Tuckett, 2005) and assisted review and enhancement of my interview technique. With regard to technique, I realised that parts of the first two interviews were like “conversational partnerships” (see Rubin and Rubin, 2004), with me offering positive opinions about the quality of the programmes as described by interviewees. In subsequent interviews however I refrained from this practice aware that it may discourage people from sharing challenges or programme shortcomings to prevent ‘tarnishing’ my good opinion.

My review of the transcripts also highlighted missed opportunities to confirm my understanding of interviewees’ comments. For example, one interviewee talked about the importance of a holistic approach and I failed to follow up on what such an approach represented for them. To ensure that I gained fully rounded descriptions of ideas and concepts during the interview, I took to asking myself two questions: What is the central idea that is being conveyed at the moment? and Do I fully understand what the interviewee means? (Travers, 2006, p. 98). By engaging in this internal dialogue my ability to prompt for extra clarifying information on the spot improved (Travers, 2006). Preparing the transcripts during the interview process also revealed that my interest in anything and everything meant that I often allowed, and even encouraged, interviewees to explore experiences not directly relevant to topics in the interview schedule. With practice I became better at maintaining ‘control’ through gentle interruptions designed to bring the conversation back on track (Patton, 1980b). Moreover, my cultural mentor’s advice that Aboriginal and Torres Strait Islander interviewees may purposely pursue peripheral conversations if they are reluctant to answer questions made me aware of the importance of either rephrasing questions or postponing discussions until a time when people felt more comfortable sharing certain details with me.

Group workshop

I conducted a group workshop about three months after the completion of the six one-on-one interviews to deepen my understanding of the operation of the social health programmes. While the one-on-one interviews produced useful background information about the function and key activities of each programme, I needed data that explicitly identified the assumptions and expectations held by programme staff about how programmes should conduct their business in order to attain desired outcomes.

My choice of a group workshop to obtain this data was informed by the experiences of other researchers working within Aboriginal and Torres Strait Islander contexts. Based on the positive experiences of Kowanko, de Crespigny and Murray (2003) and Willis, Pearce and Jenkin (2005) I recognised that a workshop would enable me to gather a range of viewpoints and thus go some way to overcoming the risk of presenting a homogenous perspective of why programmes operate as they do. Equally, I understood that from a cultural perspective preserving a group focus would allow for a form of collective control over the information shared, with participants able to reflect on and confirm or further explore each other's experiences of implementing programmes (Willis, Pearce and Jenkin, 2005).

Senior programme staff and I identified members of the Counselling and Support and Substance Misuse programmes as the most suitable candidates to participate in the workshop. At one level the decision to hold a workshop with members of only two out of five programmes represents a limitation of the study. However, senior Social Health staff and I reached this decision in order afford me the best prospect of collecting and presenting meaningful findings within the study's timeframe. Furthermore, the senior staff and I gave considerable thought as to why

representatives of these programmes were the most appropriate prospective participants. Ultimately, our decision was driven by the knowledge that counselling (an activity delivered by each of the specified programmes) is the main gateway to other programmes. Most people who approach Social Health for assistance first meet with a counsellor. Consequently, counsellors set the tone of someone's Social Health experience and are expected to embody the very essence of what Social Health is all about; setting standards or benchmarks regarding how all programmes should conduct their business to enhance the social and emotional wellbeing of visitors to the unit.

Planning for the workshop entailed discussion and negotiation between me and representatives of the Social Health unit (subsequently referred to as my co-planners). As highlighted previously, our joint decision making represented at important way of ensuring the Social Health team exercised ownership and control over aspects of the study (Scougall, 2006; Taylor, 2003). Furthermore, given their insider knowledge of people's work experience it made sense that my co-planners were best placed to nominate exactly which individuals from the Counselling and Support and Substance Misuse programmes participated in the workshop. My only input was in relation to the group size. I suggested that between six to ten participants would be ideal (Morgan, 1997). In the end my co-planners identified nine people (with one later pulling out due to work commitments). Regarding the duration of the workshop I proposed two hours based upon the reported experiences of other researchers (see Krueger and Casey, 2000; Rossi et al., 2004). Given heavy workloads I was prepared to negotiate on how this time might be allocated (for example, two sessions of one hour). However, my co-planners scheduled a two-hour block off site to avoid interruptions. An invitation to the workshop was sent by a manager since participants needed to know they had approval to be absent from work. I had ethical concerns that participants may feel compelled to attend upon receiving an invitation from someone relatively senior in the organisation.

To counter this possibility I obtained the manger's consent to follow up individually with invitees to confirm they understood participation was voluntary.

The design of the workshop structure and content rested solely with me. I turned to Patton (2008) and Rossi et al. (2004) for ideas on what information was critical to understand the assumptions or beliefs underpinning the operation of the programmes. Insights from these authors prompted me to prepare three exercises. These exercises explored: (1) the desired outcomes sought with and for people attending counselling; (2) the strategies or tactics employed to ideally bring about these outcomes, and; (3) case studies or examples that demonstrated how programme activities had lead to outcomes in practice (see Appendix H for the run sheet). To ensure group discussion was not stifled by a rigid agenda I prepared the exercises using the "funnel approach" (Morgan, 1997). In keeping with this approach I started with less structured exercises to promote free, open discussion. For example, participants were initially asked to brainstorm desired outcomes. The next exercise (around utilised strategies) was slightly more structured. I presented participants with a mind map that displayed my early impressions of key tactics commonly employed by programme staff (this mind map was the result of a preliminary analysis of the one-on-one interview transcripts). Participants were then asked to add to or change this mind map during their discussion. The concluding exercise was comparatively more guided with participants asked to think of real life case studies that encapsulated particular conditions such as the management of comorbid conditions (namely depression and high blood pressure).

During the actual conduct of the workshop I learnt three valuable lessons in relation to personal disclosure, time management and group dynamics. Acting on the advice of my supervisory team I started the workshop with a short story about myself, to show respect for the principle of reciprocity (National Health and Medical Research

Council, 2003). While I felt intensely uncomfortable about being under the spot light, the value of my introduction became immediately apparent as I witnessed participants visibly relax and become more attentive. This powerful lesson of giving in order to receive will be everlasting. Not so everlasting were my memories of how important time management was when working with the Social Health team. Through past experience I knew that people often run late for appointments (typically because of other pressing work commitments). I also knew that agreed meeting durations can change in an instant (either because people need to get to another meeting or they become so engaged in a discussion they spend more time with you than originally anticipated). In spite of this knowledge I failed to fully document in my run sheet how I would shorten group exercises in the event of us running over time. My failure ended up as major distraction. I needed to split my brain between actively listening to participants and re-calculating how long we could spend on our next discussion point. In the end I was very thankful that the group consented to an audio-recording of collective discussions so I could go back to the recordings to catch points I had missed. I was also thankful that my on-the-run efforts to revise the schedule resulted in us finishing on time. The lesson I learnt regarding group dynamics relates to my earlier stated assumption that the workshop would create a form of collective control over the validity of information shared (a belief borne of my reading of Willis, Pearce and Jenkin (2005)). While I never gained the sense that individuals censored themselves, it did sometimes appear that group members would defer to the views of others (typically the most senior representatives of Social Health) before sharing their insights. This occurrence did not cause me concern rather I understood it as the group's way of ensuring I received the most accurate description possible of how and why the Social Health programmes operate as they do.

3.5 Analysing data

I analysed a data corpus that consisted of four distinct data sets. The hand written notes that grew from my analysis of programme documentation represented one data set. The transcripts I had generated from the audio-recordings of the one-on-one interviews and group discussions from the workshop were another two data sets. Finally, there were my typically hand-written field notes.

A general inductive approach was adopted to analyse the extensive and varied qualitative data. As described by Thomas (2003) the approach involves three phases: (1) condense raw data into a brief, summary format; (2) establish clear links between the research objectives and the summary findings derived from the data, and; (3) develop a model regarding the underlying structure of experiences or processes which are evident in the data.

Phase one entailed repeated close readings of the data to condense the qualitative text into conceptual themes or categories. I began with an open coding process (Neuman, 2006) in which I assigned highly descriptive codes (or labels) to chunks of text. The aim was to capture in a few simple words the central message conveyed by the data. Examples of the preliminary codes I identified included (staff) supporting each other, responding to client need, working with other agencies and developing understandings of the clients' situations. To condense the many, varied descriptive codes I subsequently switched to axial coding. Through the application of axial coding I connected themes and moved from descriptive to analytic categories (Neuman, 2006). I ended up highlighting six key themes: multi-faceted support services, collaborative working style, strong advocacy related focus, person / client focused approach, decision making through experiential knowledge and building productive relationships.

Having summarised the raw data I worked deductively in order to determine whether the research objectives were reflected in the condensed version of the qualitative text. I found that some objectives were well represented and others were not. My initial round of coding had provided me with valuable insights into the strategies that all social health programmes routinely adopt to enhance the social and emotional wellbeing of their target audiences (a key objective). These strategies included multifaceted support services and a person / client focused approach (as noted above). However, I had been less successful in pinpointing the assumptions and expectations held by programme staff as to how the adopted strategies enhanced wellbeing. I realised that my analysis described what the Social Health unit did without providing genuine insights into how or why its activities are believed to support Aboriginal and Torres Strait Islander individuals, families and communities with social and emotional wellbeing concerns. Consequently, I re-visited the raw data selectively seeking evidence of the programme staff's beliefs about how the programme strategies linked to desired outcomes. This approach enabled me to recognise what a large part cultural knowledge and understanding played in the support provided to visitors to Social Health. One research participant, for instance, attributed a positive wellbeing outcome for an Aboriginal male visitor to their counsellor's ability to support them in reconnecting with their cultural and spiritual self. Equally, I uncovered many examples concerning the role that relationships played in the realisation of a visitor's desired wellbeing related outcomes. In essence the Social Health team maintained that the nature of their commitment to building responsive, empowering and ethical relations with others played a large part in the fulfilment of desired results.

In the final phase of my data analysis I fashioned a model of the Social Health team's approach to social health care. There were a few iterations. In an early version my model existed in a vacuum because I had failed to describe the context in which

Social Health operates. Unlike the previous stage of data analysis it was not that I had missed particular insights in the data. Rather I had become so close to the data that I began to assume knowledge or take for granted what others, unfamiliar with the Social Health unit, needed to know in order to gain a complete picture of the team's approach. Working with my supervisors helped me to re-claim a perspective as an outside observer of the organisation.

To validate my data analysis I presented the findings to the Social Health unit. Following the advice of Lee (2007) and Taylor (2003), I recognised that the presentation represented a critical means of respecting the Social Health team's absolute right to authenticate my interpretation of Aboriginal and Torres Strait Islander practice knowledge and experience. The presentation was scheduled at lunchtime. An open invitation was extended to any Wuchopperen staff interested in attending. Approximately half of the Social Health team were able to come and two to three members of the Primary Health Care Services unit were also able to attend. I received very positive feedback from the group. People commented that they felt the model accurately reflected what and how Social Health did what they did. I was also encouraged when staff from different Social Health programmes started to share stories of how they had utilised a particular strategy from the model. Their comments confirmed the findings.

3.6 Ethical considerations

Ethical clearance for the research was obtained from the James Cook University (JCU) Human Ethics Sub-Committee. The ethics approval number is H 2951 (see Appendix I). In accordance with the National Health and Medical Research Council's *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* document, my application set out rigorous standards of

ethical conduct for the study. For example, informed consent was obtained at both an organisational and an individual level. The Wuchopperen Board of Directors were presented with and signed off on a research proposal before I gained entry to the field. Each research participant also received and signed an informed consent form in order to ensure that they understood what it meant to be involved in the project.

Protection of the participants' individual and collective intellectual property rights represented a major ethical concern. To ensure that these rights were appropriately addressed my supervisory team and I wrote a research agreement (see Appendix C), covering issues like authorship and publication of the research findings. My contribution to and signature on this document demonstrated to the organisation that none of their intellectual property would be appropriated for academic and/or commercial purposes without their prior knowledge, understanding and informed consent.

3.7 Summary

This chapter revealed how a qualitative research approach, informed by the principles of theory-based evaluation, enabled me to gain access into the world of Social Health with a view to identifying how their programmes operate. I examined how my selected data collection methods (document analysis, field research, one-on-one interviews and a group workshop) were utilised to generate empirical data. My methods of data analysis and key ethical considerations were also considered.

The next two chapters explore the results of my data analysis in more detail. Specifically they examine the model I created to reveal the Social Health team's particular approach to social health care.

Chapter 4 Wuchopperen's Model of Social Health Care Part 1

4.1 Introduction

This chapter and the next present my findings on how the social health programmes delivered by the Wuchopperen Health Service function. The data analysis I undertook to reach an understanding of the organisation's approach to social health care revealed an interplay of factors, all of which influenced how and why the unit operates in the way it does. Thus I collated the research findings into a model that details the social health care approach specific to Wuchopperen.

The model reveals that three key components underpin Wuchopperen's approach of social health care. At its core is the unit's principal goal of promoting coping and resilience (component one). To realise this goal the unit adopts five key strategies: personalising support, responding to community priorities, integrating culture into programme delivery, advocating for system level change and exercising professionalism. Together these strategies are the second key element of the model. The final component is the broader operational environment in which each of these strategies is implemented. The model is presented visually in figure 4.1.

Figure 4.1 Wuchopperen's Model of Social Health Care

Chapter four considers two elements of the model. It commences with an examination of the operational environment, the context in which Social Health delivers their programmes. Following this review, the unit's principal goal is revealed in further detail.

Throughout this and the subsequent chapter, data collected from the Social Health team (through field research, one-on-one interviews and a group workshop) are used as supporting evidence for the model. I combine the words and experiences of the Social Health team and the notes taken during field work with my description of the model to substantiate it.

The evidence interspersed through the narrative is referenced using three elements. The first element is a job title (excluded if the evidence stems from my observations or recollection of a conversation). To protect confidentiality the job title broadly describes the study participant's primary role (for instance, manager). As some study participants fall into the same generic category I randomly assigned a number to each person (for example, manager 1). The aim was to give readers a sense of the diversity of views represented in the study. The second component is an alphabetic character (I, W or F). The alphabetic character reveals the source of the evidence. 'I' denotes evidence originating from a scheduled one-on-one interview. 'W' indicates evidence from the planned group workshop and 'F' signifies evidence from field notes (typically hand written in journal). The third and final component points to the location of the data. As the one-on-one interviews and a group workshop were recorded and later transcribed, references to data from these sources include the line numbers from the transcript, for example, manager 5, I: 45-58. References from field notes include the date on which I recorded the observation, for example, F: 22/02/09.

4.2 The operational environment

The Social Health unit's approach to social health care is shaped by forces in the broader operational environment. These forces fall into two groups: those relating to the resources required to run programmes and those relating to the life circumstances of the individuals, families and communities that approach Social Health for assistance. With regard to resources, external funding and personnel were identified as critical to the functioning of Social Health. These resources can constrain and enable the unit's operations. Falling into the other category are the stressful living situations confronted by many people and communities along with the suffering experienced as a consequence of traumatic events and the lack of accessible services to address social

and emotional wellbeing concerns. These three factors determine (in large part) the type of programmes and programme activities delivered by Social Health.

4.2.1 Funding challenges

The operation of each social health programme is reliant on external sources of funding. Funding providers are typically Federal or State Government departments or agencies. Examples include the Office of Aboriginal and Torres Strait Islander Health (or OATSIH, a Federal Government agency), the Commonwealth Department of Health and Ageing and the Queensland Department of Child Safety and Disability Services.

The Social Health unit's funding arrangements with these bodies can work to impede or assist the implementation of their programmes. Short-term (one year) agreements and shifting funding priorities represent two significant constraints on programme functioning and longevity. Similarly, strict guidelines around the type of activities that are funded inhibit the unit's ability to grow supporting infrastructure for programmes. Conversely, long-term (up to three years) funding agreements present opportunities for the unit to deliver programmes in keeping with the needs and priorities of local communities.

In the Social Health unit's experience short-term funding agreements present challenges relating to staff retention and programme planning. To illustrate this challenge, the Healthy Happy Families programme originally received funding to cover operations for one year at a time only. A manager attributed past high staff turnover to the short-term funding contracts. I recorded the following comment in my field journal following our discussion:

> Such funding did not offer staff long-term job security and as a result there was regular staff turnover, resulting in Wuchopperen needing to re-establish / re-train teams at the beginning of each year. (F: 14/01/08)

Short-term funding arrangements can also pose difficulties in regard to design and scheduling of programme activities into the future. One manager, whose programme was recently awarded triennial funding, spoke of what the switch to a longer-term funding arrangement would mean for the team:

> Basically had a thing where they had annually recurrent funding. We have now triennial, I suppose, funding and that will help us as far as being able to plan in advance of what we're going to do ... the triennial funding I think that it will give us a lot more room to move as far as the programmes and service delivery to clients. (Manager 2, I: 27-32)

Even after funding is secured shifting government directives can threaten a programme's longevity. A manager illustrated through the use of an example how shifting government priorities contributed to the conclusion of a parenting programme. I recorded their example as follows in my field notes:

> [Name of Social Health team member] also spoke of how changes at a government level can impact on budgets. The example provided related to a parenting programme. Originally funding came from the Department of Health and Ageing. When the government revisited funding priorities the Health Department determined that the parenting programme didn't deliver health outcomes as such. The suggestion was made that Wuchopperen contact the Department of Family Housing Community Services and Indigenous Affairs (FaHCSIA). They were told that FaHCSIA had guaranteed funding set aside.

> Despite submitting an application this funding was never forthcoming. (F: 14/01/08)

Financial support is however not only required for the day-to-day running for programme activities. Additionally, the Social Health unit needs funds to establish and maintain supporting infrastructure like buildings or computer systems. Often this funding is difficult to come by with many government agencies directing available resources to measurable programme activities such as counselling sessions or health promotion campaigns (Wuchopperen Health Service, 2009). A lack of backing for infrastructure projects makes it particularly difficult for Social Health to deliver Information Communications Technology that keeps pace with their ever expanding operations (Wuchopperen Health Service, 2009). As a manager highlighted:

> Our database [patient information system] was originally set up when there were eight staff and two funding streams. Now Social Health has 52 staff and 12 funding streams. It is becoming harder and harder for the Access database to fulfill all reporting needs. (Manager 1, F: 13/08/08)

For all the funding challenges that can work to constrain the operation of the Social Health unit, occasionally opportunities arise to secure flexible, recurrent financial support. This type of support opens up programme delivery possibilities. One of the organisation's largest sources of triennial funding comes from OATSIH. A manager explained that this funding must be split between "primary health care (predominantly dental health), mental health and substance misuse related programmes" (manager 1, F: 18/06/08). Apart from this requirement comparatively few guidelines exist to inform what programme activities this funding must be used for. A former programme staff member stated that the flexibility inherent in this arrangement has enabled

Wuchopperen to “successfully combine primary and social health care without ever being funded for this specific purpose” (former programme coordinator 1, F: 24/10/07).

Social Health’s reliance on external sources of funding directly affects its ability to operate. Flexible, long-term funding arrangements have afforded the unit the opportunity to retain staff, build necessary infrastructure and deliver programmes in keeping with the unique needs and circumstances of their visitors.

4.2.2 Staffing challenges

Another factor impacting the ability of Social Health to deliver programmes is the availability of suitability qualified and experienced staff. The demand for workers in the community controlled health sector generally exceeds the supply. Consequently, Social Health struggle at times to fill job vacancies. A worker with knowledge of the Child Wellbeing programme simply stated “we’re struggling to attract and retain kids” (manager 3, I: 157-158). A counsellor explained that “it’s hard to find suitably experienced and qualified Indigenous candidates” (counsellor 1, F: 30/06/2008). Consequently, the counsellor lamented that the Counselling and Support programme “is short three positions at the moment [August 2008]” (counsellor 1, I: 14).

Lack of staff can constrain the operation of social health programmes. Unfilled positions often result in the temporary postponement of planned programme activities. In the Counselling and Support programme some outreach services have yet to be established:

> There is provision for us to offer outreach in homes around Cairns but we just don't have the man power to do that at the moment or women power, person power (laugh). So it can be a bit difficult. (Counsellor 1, I: 310-313)

Outreach services are on hold in the Healthy Happy Families programme as well:

> We were supposed to have two workers in Atherton that were meant to service all Cape area and we [Cairns based team] do all Cairns, Innisfail – or maybe not Innisfail – but Cairns, Yarrabah over to the other side to Mossman up to Mareeba as the furtherest but because we haven't got the two workers in Atherton we've been unable to do that. (Group facilitator 1, I: 60-64)

In light of the challenges entailed in recruiting staff, Social Health sometimes hire people with a view to providing them with opportunities to gain the necessary skills (through training and on-the-job experience). Often this strategy produces positive results. A counsellor talked about how their colleague "lacked formal training but is an absolute natural; he'll sit in the bush, use metaphors, get straight to where a person is at" (counsellor 2, F: 19/02/09). Similarly, the Substance Misuse programme employed a worker with limited existing experience in supporting people with addictions. This individual explained to me:

> I've never been involved in the intervention side before. In my previous work, like with [name of organisation], I might have identified substance users, assisted in the assessment process but a third party intervened for rehab. (Case worker 1, F: 10/09/08)

As I noted in my field journal "with the support of Social Health, [name of Social Health team member] has been attending relevant training and working with their colleagues to intervene with people using cannabis" (F: 10/09/08).

For these success stories, there are occasions when Social Health does not see a return for the time and energy spent training up staff. As I noted in my field journal:

> [Name of Social Health team member] mentioned it would be interesting to get a print out of all staff with start and finish dates. They were curious about how long staff members stayed with the organisation after receiving training. They seemed to suggest that a lot of training goes into staff and then they leave. (F: 13/08/08)

Also it may happen that despite all the training a new employee is not up to the job at hand. A manager spoke about the need to sometimes let people go. My corresponding field entry reads as follows:

> [Name of Social Health team member] talked about the tough decision they've made re: needing to let people go. They said it helps to remember it's all about the people coming in for help and ensuring the right staff are there to offer that help. (F: 16/09/08)

The Social Health unit's answer to ongoing staffing challenges is a testimony to their ability to positively respond to challenges in their operational environment. They transform the problematic issue of staff shortages into a skill development opportunity for new recruits without compromising on the high performance standards expected of all staff.

4.2.3 Stressful living situations

Individuals and families in the communities in which Social Health works face a range of adverse social situations. Programme staff highlighted inadequate housing, unemployment, violence and substance abuse as endemic community problems:

> Housing is always a problem and that's just from lack of housing. Employment is always a problem; so ... not being able to get employment. (Counsellor 1, I: 579-583)

> Indigenous clients, community, individuals were actually affected by I suppose what you call a trifecta and it was really the alcohol, the domestic violence and then you know like I suppose the disintegration of family units mainly attributed to addictions and drugs and alcohol. (Manager 2, I: 42-45)

The social circumstances in which people live have serious, negative impacts on their health and wellbeing. A counsellor revealed “a lot our clients, counselling clients, have got depression” (counsellor 1, I: 98-100). Many individuals experience feelings of low self-worth or self-respect. “The self-esteem around not being able to get employment, especially for our men, that’s really hard” a counsellor explained (counsellor 1, I: 581-2). Victims of domestic and family violence were identified as experiencing low self-esteem too. A group facilitator said “their self-esteem is that low into the ground they can't even pick [a positive quality or strength inherent to them]” (group facilitator 1, I: 704-705). These feelings of despair and hopelessness can directly harm a person’s physical health. In the workshop counsellors highlighted how often it is important to “explain [to their visitors] that their sadness can actually impact on conditions like high blood pressure” (counsellors [participating in group discussion], W: 15-16).

The problems apparent in community life and the evidence of their negative impact on people’s health and wellbeing dictate the need for multi-faceted support for Aboriginal and Torres Strait Islander peoples. Multi-faceted support simultaneously seeks to address the different social conditions and wellbeing concerns faced by different audience groups, like children, parents, couples or community groups.

Typically the social health programmes provide multi-faceted support by targeting different categories of people touched by a community issue or problem and by

addressing all forms of that issue. For example, the Healthy Happy Families programme supports women, men and children experiencing (or at risk of) domestic and family violence. A group facilitator described the programme components:

> We run Women's Group for women who are affected by domestic and family violence, as well as younger girls, ages from about eight up. We also do [the] Healthy Relationships Programmes within schools. That's done in collaboration with the Men's Group which is [names of two Social Health team members]. They run the Men's Yarn Up ... [name of Social Health team member] runs the Youth Programme ... He deals with all the youth so about 17 and under. Eighteen and over is [name of Social Health team member] ... Our focus is domestic and family violence, building healthy, happy and stronger families. (Group facilitator 1, I: 7-19)

Together these components work to support both perpetrators and victims of violence. Additionally the components tackle different types of violence. The Women and Men's Group "deals specifically with the domestic violence issues" (group facilitator 1, I: 264-5). When working with children (most particularly in schools) the focus shifts to bullying and building healthy relationships with peers. As a group facilitator noted "realistically domestic violence when it comes into school arena is bullying within the school" (group facilitator 1, I: 87-8).

Social Health's provision of multi-faceted support is a direct response to the life circumstances of their visitors. It reflects the team's commitment to build needs based programmes that holistically address the various stressors that can negatively impact on their visitors' wellbeing.

4.2.4 Traumatic events

Compounding the life stressors are visitors knowledge and/or direct experience of traumatic events. Programme staff identified child removal policies, separation from land, culture and family, deaths in custody and racial discrimination as events associated with severe stress, feelings of mistrust or wariness toward institutions and concerns about cultural identity.

Past experiences of child removal policies created apprehension within communities about the possibility of future generations facing a similar ordeal. One manager recalled how communities remain ever concerned about ensuring future generations know their place:

> We'd like to see is that children aren't gunna be one of these Stolen Generations again. They know who they are. They know where their place is, in the family, to do with their siblings, to do with their Country, their culture. (Manager 3, I: 412-415)

Their colleague concurred noting that communities were adamant about protecting cultural identity, most particularly when an Aboriginal and Torres Strait Islander child is placed into out of home care:

> We go back to things like the Stolen Generations, and a lot of the activities of previous Governments about moving people around, so the identity thing is really, really big for us. One of the first things we really need to happen is that particular culture that their parents raised them in is maintained when they come into care. (Manager 4, I: 256-258)

Even with the presence of such strong community sentiments, some Aboriginal and Torres Strait Islander people feel powerless and despondent as a result of child removal policies. These feelings can leave people unable or reluctant to act when child protection agencies investigate the welfare of their children. A manager indicated that some parents chose not to contest a decision by the Queensland Department of Child Safety to place their children in out of home care. They noted:

> Parents weren't even showing up [at court] ... It was pretty much – **and this is because of the history** – Ah Child Safety is involved, that's it we've lost our kids, there's no point. So [parents] wouldn't get legal representation because they either felt that hopelessness or they didn't know how to or they didn't know they had a right to [my emphasis]. (Manager 3, I: 599-603)

Aboriginal and Torres Strait Islander people have also experienced trauma as a result of deaths in custody. Programme staff linked knowledge and/or familial experience of deaths in custody with Aboriginal and Torres Strait Islander peoples fear or mistrust of interacting with law enforcement agencies. A manager shared an example of one man's reluctance to turn himself into police:

> We have people, I've got one this Tuesday actually who skipped bail in [name of place], he's come up here. He's gone to his local job network agency that I work closely with, one of 'em, and she's rung me and she said he wants to hand himself in [to police] but he's too frightened to go alone. (Manager 3, I: 238-241)

Equally, past discriminatory treatment by service providers is related with Aboriginal and Torres Strait Islander peoples' hesitancy in seeking assistance from non-Indigenous specific services. After listening to an Aboriginal Health Worker talk about this situation I recorded the following notes in my field journal:

> Aunty explained that when Wuchopperen was first established [1979] three people went door to door asking Aboriginal and Torres Strait Islander people in and around Cairns about the health situation in the region. Many people indicated they didn't feel comfortable going to Cairns Base [a public hospital] because they'd felt misunderstood or had been discriminated against. (F: 15/07/2009)

A consequence of these traumatic experiences is the lasting influence it brings to bear on Aboriginal and Torres Strait Islander people's decisions on where they will go for assistance. Many Aboriginal and Torres Strait Islander people feel most comfortable interacting with agencies that practically demonstrate an awareness of their history and current day life circumstances. They may also need specialist services to address wellbeing concerns unique to their past or present. This situation presents an opportunity for organisations, like the Wuchopperen Health Service, to deliver programmes specifically designed around the unique needs of Aboriginal and Torres Strait Islander peoples.

Social Health responds to this opening in a number of ways. First, through considered recruitment strategies, the unit has established a workforce that allows visitors choice on who they work with to address their social and emotional wellbeing concerns. As one manager explained:

> ... some people seeking help will prefer someone from their own cultural group and gender. We attempt to offer this, and with the diversity of staff we have, this is still possible. (Manager 1, F: 26/02/2009)

Within the team there is also specialist staff to offer assistance with wellbeing concerns borne from the life experiences of Aboriginal and Torres Strait Islander peoples. One

such role is the Bringing Them Home Counsellor. A generalist counsellor described their colleague's role as follows:

> Bringing Them Home that is a very specialist area for a counsellor to work in ... You have to have someone that has a good understanding of the issues and can work effectively around that and there's also inter-agency, a lot of inter-agency work, a lot of travelling around ... they work a lot with Link Up to hopefully reunite families as part of their role as well. (Counsellor 1, I: 199-207)

Furthermore, Social Health delivers programmes that proactively seek to prevent a repeat of past policy failures. Programmes like Child Wellbeing and the Culturally Appropriate Foster and Kinship Care Service seek, in the words of one manager, to "prevent Stolen Generations" (manager 3, I: 371). This manager emphasised:

> At the end of the day children do have absolutely a right for safety and wellbeing, utmost number one, but not at a cost, and that's why it's so hard, at the cost of loss of cultural identity. (Manager 3, I: 414-417)

The Social Health team demonstrates a solid understanding of the trauma experienced by many of their visitors. They apply this knowledge to deliver programmes and activities that are sensitive to the unique circumstances of their visitors.

4.2.5 Lack of services

Lack of accessible, acceptable and/or appropriate services is a pressing concern for many Aboriginal and Torres Strait Islander peoples. An example came from a group facilitator who highlighted the limited support (in and around Cairns) for Aboriginal and

Torres Strait Islander men with anger management issues or a history of violent behaviour. They maintained:

> ... to have a support system ... especially for men is important because men don't have a support service. We've got Women's Groups, we've Women's Shelters but we've got nothing for men. (Group facilitator 1, I: 771-774)

Another example was presented by a manager familiar with the history behind the recruitment, selection and training of Aboriginal and Torres Strait Islander foster and kinship carers. They explained how, for about the last eight years, Indigenous communities have been without a service that facilitates their direct input into the selection of Aboriginal and Torres Strait Islander carers and the eventual placement of children with those carers:

> ... wind right back to the early 2000s, perhaps even late '90s, where the old Aboriginal and Islander Child Care Agencies were established. There was one particular service in [name of place] that was called [name of organisation] and they had some other organisational issues and were actually de-funded. So, the service itself was absorbed by the Zone, the Far Northern Zone, and it was then known as the Aboriginal and Torres Strait Islander Carer and Placement Support Service. ATSICAPS is the acronym. And that sat within the zonal office here in [location] [under the control of the Department of Child Safety]. That went on for some time and the Department's spiel was that they always intended for it to go back out into the community, they saw that as where it belonged. And I think it was some five odd years, six odd years that it actually sat there yeah. So we're talking up until January this year [2008] that the funding was actually released for it to come out [into community]. (Manager 4, I: 16-26)

Lack of services can inhibit individual and community development. One Social Health team member spoke of how limited support for people caught in a cycle of violence sees them “just breaching orders [like a Domestic Violence Protection Order] up to 20 something times and ending up back in [jail], where they started, and not getting any supports” (group facilitator 1, I: 31-32). Another manager identified a lack of services as resulting in “people end[ing] up in a turnstile and that’s what I don’t want ... I want us to have a healthy community and healthy I suppose mind set” (manager 2, I: 475-476).

For Social Health a lack of services can be constraining. The unit is sometimes flooded with requests for assistance and support even though they are not necessarily the most appropriate service provider to assist with a particular issue or problem. One manager stated “we found a lot of people were trying to use us as a dumping ground, this is too hard for us, we’ll just give it to them” (manager 5, I: 56-57). This same manager expressed concern about how to help such people when they possibly had nowhere else to go. They gave the example of working with members of the Stolen Generations:

> Now Stolen Gens is actually a whole different programme within the Social Health unit. We don't have one here. It's actually linked up in Cairns. However, we do get them here [a regional town in which Social Health delivers services]. And a lot of the Stolen Generations stuff that we're doing here is not so much about the counselling for the Stolen Generation. They might come and lay off all their problems and we do counselling in that area but a lot of it is to help them go through this re-dress stuff for the government and whilst I know we're not supposed to be paper fillers and you know do that sort of thing at the end of the day where to they go? (Manager 5, I: 210-216)

Social Health can face the equivalent of a juggling act, trying to support all visitors to the service without placing undue pressure on available resources.

While a lack of services poses challenges for the unit, the processes adopted by Social Health to address this issue have at least one positive spin-off. In working with communities to identify required services Social Health facilitates local autonomy. As a manager explained:

> We do not subscribe to the view that because we are black people that we are knowledgeable about all things black, and know instinctively what every black person might be needing and that we therefore are always the best people for the job. What we, and (I think) our visitors do believe though is that we are part of the same community; we share similar highs and lows; this commonality brings us together. This **collective sense of taking power back and doing for ourselves** provides the basis for the community controlled factor in our health service [my emphasis]. (Manager 1, F: 26/07/2009)

Ultimately, the operational pressure of responding to gaps in service provision for Aboriginal and Torres Strait Islander peoples is both constraining and enabling. It places real pressure on the Social Health team to carefully manage their resources to ensure those in need receive appropriate support and assistance. Conversely, working with communities to address gaps in service provision can prove to be an empowering experience for all concerned.

4.3 Promoting coping and resilience

Juxtaposed against the environmental forces that require reactions or responses from Social Health is the alternate story of the unit's deliberate attempts to support individuals, families and communities to take control and change their life or

circumstances. While Social Health acknowledges the life stressors and hardships that many individuals and communities face, the team also recognises that it is possible to overcome difficulties and forge new ways of living. To facilitate such a change the unit's central goal is to promote coping and resilience.

For Social Health the notion of coping refers to peoples' and communities' capability to effectively deal with situations, especially ones that present difficulty. Specifically, counsellors described an individual's coping capability as the "confidence to be able to deal with their issues" and "the ability to cope with life's stressors" (counsellors, W: 15-16 and 39). A manager added that coping is also about knowing where to go for extra help when needed:

> Our primary focus is to get 'em to a point where they're self-reliant, able to manage on their own, but if they get into trouble to pick up the phone. (Manager 5, I: 439-440)

At a community level, coping can be thought of as a process that the collective goes through to gain the information and resources needed to constructively manage a situation. A manager illustrated how this process can work using two examples:

> [Name of Social Health team member] spoke about setting up a forum in Yarrie[7], at the invitation of the community, so community members could talk through a safety plan for the kids at risk of maltreatment. The community sought to address questions like: So where can they [children] go to feel safe? What is appropriate or inappropriate behaviour for adults to exhibit around kids?

[7] Members of the Social Health team use the term Yarrie to refer to an Aboriginal community called Yarrabah. Yarrabah is located about 60 kilometers south of Cairns in Far North Queensland.

> They also spoke about going up to Kuranda[8], again at the community's request, following the abuse of a very young child ... counsellors ... were available to work with individuals, but also talked at community forums and addressed community concerns around issues like what people might be feeling (normalising behaviour like anger or distress), how to keep safe and how to remain calm. (F: 22/04/2009)

Resilience extends on the notion of coping. It is about an individual's or group's ability to successfully adapt despite adversity; the capacity to not only cope with hardships but to even thrive in harsh conditions (Clark, 2009; Punamaki, 2009). Social Health works with individuals to help them adapt and prosper in spite of adversity because they recognise that hardships will inevitably arise. A group facilitator described this concept as follows:

> If they walk away with feeling proud and confident, mainly confidence, and just knowing that yeah we get a lot of hurdles in life but you know get over that hurdle and you're very proud because you built yourself up to that level. And I say to them: look you will fall down on your bottom a few times; you'll get up that ladder, think you're going well and then boom something will happen that will throw you straight back to the ground. And I say: What you going to do? I said: You going to sit there and cry about it? I said: Yeah you'll cry. I said: But **then you'll get back up and you'll keep going** [my emphasis]. (Group facilitator 1, I: 366-373)

This ability to keep going in spite of adversity was also described as important at a community level. A manager spoke of working to grow flourishing communities where its members demonstrate resilience in the face of endemic social problems:

[8] Kuranda is a township around 20 kilometers north west of Cairns.

> We're driven by trying to get the outcomes and the outcomes I believe is trying to get healthy, happy and productive communities where people aren't being affected as much by the things that you know the social problems and also the alcohol and all the other factors that are negatively impacting on them. (Manager 2, I: 423-427)

4.4 Summary

The purpose of this chapter has been to present the foundations or underpinnings of Wuchopperen's model of social health care. The chapter examined the environment or context in which the model operates and the model's central goal or purpose.

Chapter five represents a continuation of the research findings. Its focus is on the specific strategies adopted by Social Health to realise their principal goal of promoting coping and resilience.

Chapter 5 Wuchopperen's Model of Social Health Care Part 2

5.1 Introduction

This chapter continues the exploration of the model I developed, as a result of my data analysis, to portray Wuchopperen's particular approach to social health care. With the model's context and principal goal addressed in chapter four, this chapter examines the five key strategies adopted by Social Health to promote coping and resilience. These strategies are personalising support, responding to community priorities, integrating culture into programme delivery, advocating for system level change and exercising professionalism (see figure 4.1). Individually, each strategy makes a contribution to the ability of people and groups to deal effectively with life events and even to blossom in the face of difficulties. Collectively the strategies create a platform or basis from which visitors are afforded the best possible support and assistance to take control and change their lives.

As with chapter four, substantial evidence for the findings is provided. This evidence includes the words and experiences of the Social Health team (obtained from recorded interviews, informal chats and the group workshop) and the notations of observed daily practice from my field journal. The introduction to chapter four presents full details of how this data is referenced.

5.2 Personalising support

Personalising support speaks to the unit's efforts to respond directly to the needs, goals and life circumstances of their visitors. One manager summed this concept up as the equivalent of wrapping care around a person. They said:

> Just say there's a thing where the person who comes into counselling is admitting DV [domestic violence] issues and stuff like that and the counsellor and the case worker get together and basically develop a thing of, a case plan of how they're going to address the, you know, the DV that's happening in the family, the possible overcrowding and things like that. The case worker will, the counsellor will do a case plan. The case plan will ensure that it is basically **developed individually around that person and wrapped around 'em**. And then the support worker comes in and does the leg work [my emphasis]. (Manager 2, I: 260-266)

5.2.1 How personalised support is delivered

In the first instance personalised care entails collaborating with visitors to identify their exact circumstances and requirements. Counsellors gather this information through what they described as an "assessment process" (counsellors, W: 25). One counsellor spoke of:

> ... collecting information about family, growing up, schooling level, places they've settled or moved from, employment, close friends, good relationships, intimate relationships and general story information. (Counsellor 3, F: 23/02/09)

This information helps counsellors to learn about "how a person is coping and how they are dealing with it, what's happening and what's happened" (counsellor 3, F: 23/02/09).

Other programme staff however adopted different methods. Group facilitators with the Healthy Happy Families programme conduct pre group interviews:

> We call it, like for the Men's Group, it's Men's Yarn'n and for the women it's the Women's Yarning group. The reason why we call it a yarning group is that it's informal. It's just sitting around and dealing with issues. So, before they start we do what we call a pre-group interview. And in that interview we pretty much ask

> them stuff like: What do you want to get out of the programme? How do you think you will have grown from the programme? (Group facilitator 1, I: 285-290)

In the Child Wellbeing programme team members often organise home visits to learn more about people's situation and needs. For example, a support worker with the programme visits parents in their home to both hear about and observe their parenting experiences (F: 5/11/2008). In essence programme staff utilise the assessment methods most appropriate to their work and their visitors' circumstances.

As well as collaborating with their visitors, staff members draw on their experiential knowledge of what has worked in the past to offer appropriate personalised support in the present. The counsellors' past experience of group counselling sessions, for instance, prompt them to offer alternate solutions to visitors. As one counsellor explained:

> We do offer family counselling. We don't get a great deal of that cause usually the tensions are too high to have that ... I've had a few sessions with mums and daughters but it doesn't work as a rule because they're coming because everything is really pear shaped and there's a lot of resentment so it just doesn't work. And later on it's a lot better. And we try to keep it as separate as we can, so each has a space to vent, yep, before we get 'em in a room together because that doesn't work a lot of the time. (Counsellor 1, I: 149-162)

Counsellors also know that challenges can arise when a number of agencies (in addition to Wuchopperen) are involved in supporting an individual. For instance, it is possible for the care professionals to assume that someone else is ensuring case plans are implemented or followed up on. For this reason Social Health typically recommend that a particular provider or case manager assume overall responsibility for the care provided. As one counsellor said:

> What we found is that people would slip through the cracks. Oh well I'm closing shop now. See you tomorrow morning or Monday. Who would the lead provider or case manager be to prevent the client from slipping through the cracks? That's really important! (Counsellor 2, W: 144-148)

Other social health programmes have even put in place permanent support systems for individuals and families given their awareness of the challenges and difficulties they may confront. Workers in the Culturally Appropriate Foster and Kinship Care programme have expertise in the types of demands the child protection system can place on carers. Consequently the team put in place a carer support system to ensure ongoing personalised support. A senior member of the team described the system:

> We've actually put our carers into three different categories. One of those, the higher one, is very experienced and we'll make contact with them via phone once a fortnight and home visits once a month. Then you come down to the second one, so they're intermediate. They've got a little bit of experience but they're not so experienced ... so we might contact them once a fortnight as well as home visits somewhere in between. And then the early days they're once a week. So we've got someone who's brand new, just finished their training, all of a sudden got a placement ... so every week we'll be on the phone with them saying: Everything ok? Is there something we can help you out with? And the next week certainly a home visit. (Manager 4, I: 449-458)

Social Health combines two powerful sources of knowledge to deliver personalised support. The team collaborates with their visitors to learn about their requirements and draws on their ever evolving experiential knowledge of what worked in the past to provide appropriate (or needs based) support in the present.

5.2.2 What personalised support entails

The nature of the support provided to visitors varies according to their unique needs and circumstances. As one counsellor emphasised it is about “offering them, you know, what they need” (counsellor 4, W: 27-28). It could be that a visitor is looking for Social Health to advocate on their behalf with other agencies. Examples of the Counselling and Support programme’s advocacy work was provided by a counsellor:

> I know that there's been a case recently where a client was having mental health issues but also was having issues in society basically because of lack of identification and things like that. So ILS [Independent Living Skills – a sub-programme in Counselling and Support] actually supported her in getting her Birth Certificate and just really practical stuff. And it might even be stuff as simple as making sure I do a letter for housing for them to take, assisting with letters for court, you know going along with them to housing interviews. (Counsellor 1, I: 118-124)

Alternatively it may that a person needs support to deal with a traumatic event that has occurred in their life. A manager relayed details of woman who had been sexually abused. They indicated that:

> One of the strategies was for me to put the support worker with her three times a week or if she wanted it more she just picked up the phone called and we'd find somebody available to be with her, somebody female. She could not walk outside the front door. And we just got her to a spot – I used to pick her up myself a couple of times a week and we'd go to lunch – and it was, the idea was, to get her out into the community again. (Manager 5, I: 524-529)

A lot of the personalised support that Social Health delivers revolves around the provision of knowledge and skills to visitors. Based on the issues or life events someone is facing the team tailors know-how designed to help an individual or family take control of the situation and make a change. For example, Healthy Happy Families provides information about domestic violence with a view to helping people understand and address this issue. A group facilitator explained:

> ... you want to talk about ... the power and control wheel, the equality of the relationship and the power and control wheel. So, it makes them realise, hang on a minute my man does that to me or my man does that to me. Well it isn't ok! You need to talk to your partner. Hey let's make it even. Why can't we have a relationship where we value each other rather that argue with each other? (Group facilitator 1, I: 309-313)

Furthermore, because of the pre group interview conducted prior to the commencement of the Yarning Groups, the Facilitators can customise the content according to the specific requirements of the participants. As a Facilitator said:

> So if I do a pre-group interview you get a fair idea of what's going on through their head. And then that way I can put the programme [the yarning group] around the pre group interviews. (Group facilitator 1, I: 297-298)

The Child Wellbeing programme also focuses on the provision of specialist knowledge and skills to their participants. A support worker was described as:

> ... building capacity with our parents in relation to their parenting with that and to support them so that down the track their learning skills that they're not going to sort of slip into that child protection system again. (Manager 3, I: 367-369)

In the same way, counsellors sometimes offer parents information about how to approach meetings with the Queensland Department of Child Safety. One counsellor said:

> We teach a lot of our clients how to work with them [the Department] effectively. And how to ensure things go well for them because if they get upset or angry in the middle of a meeting Child Safety don't understand that. (Counsellor 1, I: 650-653)

Social Health seeks to deliver personalised support with a view to empowering people to achieve the change they are seeking in their life. A counsellor explained that the idea is to "build on people's strengths basically, and most of it's about empowerment – working through their goals" (counsellor 1, 166-168). They said visitors are supported to answer questions like: "What areas are you excelling in? What areas do you need to work on?" (counsellor 1, I: 175-177). A group facilitator provided an example of how visitors might be encouraged to answer these questions:

> I'll give 'em [participants of a Yarning Group] a group of cards. And when they start reading it's got words like – I'm honest, I'm caring, I'm loving, I'm supportive, I'm a good mother ... (Group facilitator 1, I: 702-705)

They also detailed how they might work with someone initially unable to identify their strengths:

> I said why didn't you pick anything, like curious. She said cause I don't feel like that about myself. And I said ghee that's a real shame. I said do you have sisters or brothers? She goes yeah. I said do you run around for your sisters? She goes me always run around for my family. So I said you're reliable. And she like looked at me and I said well if you're there for your family then

> obviously you’re someone they know they can turn to for help which makes you a reliable person. She goes yeah.... (Group facilitator 1, I: 714-721)

The facilitator revealed that with this type of gentle, ongoing encouragement it eventually got to the point where the woman no longer “hid herself in the dark” (group facilitator 1, I: 737). Instead she was “sitting up ... talk’n up to these women saying we can make changes, oh I made this and I’m that” (group facilitator 1, I: 738-739).

While positive outcomes are achieved, Social Health recognises the need to constantly reflect on whether adopted processes are empowering their visitors. Not all team members adopt an empowering approach all of the time. A counsellor said:

> you've got to be careful as well that people don't rescue, run in and try to do everything for them [a visitor] and that sometimes you need to reign that in a little bit. Some people might work differently to what we [Counselling and Support] do and you might need to say no, no, no part of the case plan for counselling is that this person does this. You don't do that for them and that sort of stuff. (Counsellor 1, I: 447-451)

So, it is through constant review, discussion and negotiation that the team ultimately makes empowerment a mainstay of their practice.

Personalised support varies according to the needs and circumstances of an individual or family. Commonly it involves the team delivering practical day-to-day living support and the passing on of knowledge and skills that promote positive life choices. Whatever the nature of the support provided, it is always driven by the team’s commitment to empower their visitors.

5.3 Responding to community priorities

Social Health engages with communities as well as working directly with individuals and families. Communities are consulted to identify their needs, circumstances and requirements. Information of this kind enables Social Health to identify community priorities and to develop programme responses accordingly. Counsellors described the role of community consultations as follows:

> ... getting the feedback from our people, so, because Wuchopperen is you know controlled by the community, getting their feedback. What's useful? What programmes are useful for them? Rather than us going off developing stuff that's not actually useful for our people. (Counsellors, W: 29-32)

Community consultations can take place at a number of points during the life cycle of a programme. Sometimes it is the feedback from a community that actually prompts the inception of a programme. For example, the Child Wellbeing programme was initiated, in large part, because it was identified as an important service by the community. A manager said:

> Because that [the Recognised Entity function] was regarded by Wuchopperen and the community generally that that's a very important piece of work to do and the mere fact that the local service that was here was de-funded back in 2001 and there's been no service since then the concern was well who's going to do it? (Manager 3, I: 250-253)

Likewise, it was a call from community representatives that resulted in the Counselling and Support programme commencing operations up in Yarrabah (an Aboriginal community approximately 60 kilometres south of Cairns). The counsellor described the programme's outreach work as follows:

> It comes as a community response. Yarrabah was actually particularly strong. We were asked to go over. Council wanted us there. The Health Service wanted us there. So, we went basically. We've just maintained it since then. (Counsellor 1, I: 316-319)

Once programmes are up and running the Social Health unit continues to seek community feedback about their appropriateness. This feedback can be used to check that structure or day-to-day operations of the programmes meet community expectations and requirements. This situation occurred when representatives of the Child Wellbeing programme consulted with members of the Atherton Aboriginal and Torres Strait Islander community to discover how they wanted the local Recognised Entity to function. A manager stated:

> Wuchopperen, together with Child Safety, went out to consult with the Indigenous community up there and put together what did they want to see in a model of the new triennial long-term service. They preferred that it's one worker who covers the geographic area and does both lots of work [investigations and ongoing case work]. So, that's the way the team looks which is specific to what they [the community] are again defining as their needs. (Manager 3, I: 79-84)

Alternately community consultation may be undertaken to shape the content of ongoing programme activities. For example, a member of the Substance Misuse programme regularly goes into the community to see what is happening. A manager said:

> we have outreach programmes where – or not outreach programme – ...we have a person, we have component of outreach programme that goes out to the camps and just sort of keeps tabs of what is happening, what is being drank and all that stuff. (Manager 2, I: 189-191)

Based on the information gathered the need for a specialist programme response may be identified. The same manager gave the following example:

> It might be over-proof rum – or it could be whatever that particular thing that's problematic rather than just alcohol per se, it could be um it could be a whole range of things but if you single out with over-proof rum or you had something where they're all drinking – then we'd have the case worker supporting the counsellor and also the support worker racing around working with the individuals and the family. And then we'd have the Health Promotions Officer basically coming and going out to the community and running educational programmes and prevention programmes to stop that. (Manager 2, I: 159-165)

Finally, community consultations may herald the need to discontinue a programme. Much of the outreach work conducted by Counselling and Support is based on the understanding that as soon as a community is ready to take over the service themselves then Wuchopperen will exit. A counsellor explained:

> [Name of Social Health team member] has done his programme [a boys group at a local residential college] in a way that the actual ownership [rests with] the school. The school will take it and run with it later. And that's the same, Yarrabah is the same. They're supposed to, the Health Service there is trying to recruit counsellors. So, as soon as counsellors are recruited there we will leave and yeah Kuranda is again is the same. We're hoping to help them get counsellors and then exit. (Counsellor 1, I: 373-376)

Despite all the benefits that community consultations can produce in relation to programme design and planning, it does not always proceed smoothly. Two staff members spoke to me, on the proviso they would not be identified, about their attempts at community consultation (F: 5/9/2008 and 22/10/2008). They felt Wuchopperen's

upper management often stifled their efforts because of their insistence on micro managing all community collaborations. For one of these people this tension eased when they started working with a new manager. They explained that “they’ve become our manager and [name of manager] [has] been excellent, you know, like they pretty, they don’t give me free reign as such but they’ve been very clear with me about exactly what my role is which is what I didn’t have before” (F: 22/10/2008). This person’s experience suggests that some of the tension around community consultations can be relieved with more open feedback between managers and their direct reports around job roles and responsibilities.

Social Health’s approach to community consultations is dynamic. Community input is sought at various stages throughout the lifespan of a programme. While some challenges exist in how community consultations take place, experience within the team reveals that issues can be addressed with robust discussion.

5.4 Integrating culture into programme delivery

The Social Health unit actively incorporates knowledge of Aboriginal and Torres Strait Islander culture into their day to day practice. This integration is most evident around the areas of place, people and approach. The team carefully considers how their places of practice, the people engaged in that practice and the actual approaches to practice recognise and respect the worldviews, knowledge and values of Aboriginal and Torres Strait Islander peoples.

5.4.1 Place

Social Health recognises the central importance of place to wellbeing. As such the team supports individuals and groups to connect with places of significance to them as a way of promoting coping and resilience. Sometimes this connection happens outside

of official programme activities. For example, in the workshop counsellors shared a story about a man who had identified a safety plan for himself prior to commencing counselling sessions. They said:

> So he'd already like identified a help, like a um with, working up a safety plan for himself i.e. around talking with Elders, cultural pursuits like he was doing fishing and whatever, hunting on Country. (Counsellors, W: 88-90)

Recognising the high value this person placed on cultural pursuits on Country, their counsellor worked with them to help them "transport those skills [gained on Country] back to life here in Cairns" (counsellors, W: 91).

Alternatively it could be that when a person commences working with Social Health they express a preference around where they would like to work. As one manager stated:

> I visit in-home or in-office or wherever people would like to meet. Some people believe it or not like to have counselling in the park and that's not a bad. I don't have a problem with that. (Manager 5, I: 30-32)

Their colleague reinforced the idea of respecting and supporting a visitor's choice on places of practice. They explained "being in a natural setting can make it more relaxed" and the "more relaxed people are the more it [counselling] works" (counsellor 2, F: 19/02/2009).

Programme staff may also nominate particular places based on their experience of environments that have worked in the past to promote healing. The Healthy Happy Families programme incorporates visits to the beach into their Women's Yarning Group. A group facilitator explains the visit to their participants as follows:

> we're gunna go out the beaches and we're going to collect shells, we're gunna collect beads, we're gunna go hunting and gathering – you know what we used to do in the old days, the gathering side, the men did the hunting, and yeah so that'll be and when we do that that's part of our relaxation. (Group facilitator 1, I: 534-537)

They said “the group is still doin’ the same thing [yarning about domestic violence] but out in the fresh air, it’s more laid back and more casual” (group facilitator 1, I: 538-539). After the visit the Facilitator works on helping participants to make connections between their time away and the potential benefits for their wellbeing. They said:

> It's a matter of coming back before we drop ‘em all or in the car as we're driving back to say, how did youse feel? How did that make you feel? Is it something that you think that you'd take on personally? Can you imagine? You know, it becomes a yarn, like a talk. Oh yeah, like we used to do this when we was younger and it was deadly. Well why can't you do that now, you know? ... Take your family out. Oh yeah, I suppose, you know. I suppose you know (laugh), a little bit of a growl on you know. And it ends up, we laugh, and it ends up being real casual but their still getting a lot out of it. (Group facilitator 1, I: 537-547)

Sometimes it is not always easy to find the right environment in which to work. The same group facilitator identified such a scenario:

> ... at the moment we’ve been meeting at the church but the concern we have is it’s a holy place. And when it comes to DV – domestic violence issues – you know some [participants] swear and they don’t feel comfortable and to me if they can’t express themselves then that defeats the purpose of the programme because it’s about letting go and getting it all out in the open. So we’re trying to

> change it from there [the church] to go somewhere else. (Group facilitator 1, I: 664-669)

So, finding the 'right' place, most particularly when it comes to outreach work, can represent a challenge for the team.

Finally, not all interactions with Social Health visitors occur off site. The vast majority of visitors attend offices in Cairns and surrounding areas. Consequently, programme staff take responsibility of creating a therapeutic environment on-site. Waiting areas typically include Aboriginal and Torres Strait Islander posters, drawings and pictures. Additionally, Aboriginal and Torres Strait Islander flags are often displayed in both waiting rooms and offices. Essentially it is about using symbols and/or artefacts that help to reinforce feelings of belonging.

Whatever the location, the Social Health team is open to finding places or creating environments in which their visitors feel culturally safe and respected. The team recognises the fact that these feelings can promote or enhance wellbeing.

5.4.2 People

Social Health is committed to engaging the people most able or equipped to support their Aboriginal and Torres Strait Islander visitors. Often this commitment means that the unit employs people from the same culture as their visitors. I captured a manager's description of the unit's recruitment process as follows:

> Through osmosis Social Health has been able to build the right mix of people. And now when it comes to recruitment they might actually say – ok in this area we already have an Aboriginal male and female. Therefore, when we fill this vacant position perhaps we look for someone from the Torres Strait. (F: 25/02/2009)

The unit seeks Aboriginal and Torres Strait Islander employees because of their ability to integrate cultural knowledge and understandings into their practice. Programme staff presented numerous examples of how a blend of cultural experiences and professional practice is achieved. Workers in the Child Wellbeing team utilise their know-how of community engagement protocols to ensure Aboriginal and Torres Strait Islander participation in child protection related matters. A manager explained:

> ... when I recruit they need to be Indigenous, all the team are Indigenous. They need to know fairly solidly who they are, rather than the issue of identity crisis. Because the very stuff that Child Safety rely on us for is about using our understanding and protocols of working with the Indigenous community, using our networks to know who in the community to actually draw in the appropriate people significant to that child to be involved with decision making. (Manager 3, I: 181-187)

Youth Workers with Healthy Happy Families carry out cultural pursuits with children who may lack role models at home to teach them about these activities:

> The Youth Programme because they're dealing with youths that have high behavioural um, they're trying to, [name of Social Health team member] is more or less like a role model sort of thing for a lot of the boys that attend. A lot of them don't have fathers so to see someone there every Friday afternoon they're really excited about it. [Team member's name] does, they do a lot of cultural stuff with 'em like the painting, the beading, they do dance, they go out and do activities with 'em. And then they also talk to them one-on-one about issues that they might want. (Group facilitator 1, I: 176-184)

Counsellors support individuals and families to draw strength from their culture during times of hardship. In the workshop counsellors explained how a past visitor spent time on Country – yarning with Elders and undertaking cultural pursuits – as part of a safety

plan to break their addictions and control violent behaviour. One workshop participant reflected:

> I guess if [name of Social Health team member] hadn't been open to the importance of those cultural connections or spiritual reconnections and didn't have a belief in the true story of Aboriginal men[9] then maybe that [life change] couldn't have been maintained. You don't know. (Manager 1, W: 105-108)

The networks that Aboriginal and Torres Strait Islander workers have in the community also enable them to bring other people in to support visitors. These people could be holders of specialist cultural knowledge, like Traditional Healers. A manager explained:

> There are times when we are also required to seek a Traditional Healer for someone who believes they have been 'caught'[10]. We do not have a list of people who do this; this would not be appropriate anyway. We put out feelers and source someone who might be in the vicinity at the time. This of course must come from the person's cultural group, unless they are prepared to accept someone else. There is total acceptance on the part of staff that this is what we must do if our visitor requires it. This has been the only way forward for some people in the past. White researchers might label this a placebo effect, but we know it works. (Manager 1, F: 26/02/2009)

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[9] After the workshop I asked a participant to talk with me about the "true story of Aboriginal men" (manager 1, W: 106). Following our discussion I recorded the following notes:

> [Name of Social Health team member] said that since the Little Children are Sacred report a misconception had grown that if you were black and male then you abused children. [Team member's name] said that research shows that in any colonised nation there is evidence that those colonised lost coping skills (or they are "beaten out of them"). But she emphasised that it is not the norm to hurt children. So, as a counsellor you need to believe that people can make changes ("if not why do it, it's like pushing sh*# uphill"). So you start from that viewpoint that change is possible and from the belief that black men can form fantastic relationships with the children and women. (F: 25/2/2009)

[10] The notion of being 'caught' can stem from "a strong belief in spirits of those who have passed, and in those who have the power to do mischief and worse" (manager 1, F: 26/02/2009).

Moreover, it could be people who have shared similar life experiences to the visitors. For example, due to the strong relationships he had formed with the Social Health team a former visitor attended Wuchopperen forums about family and domestic violence. He participated to show other people that it is possible to confront and change destructive behaviours. A counsellor recalled:

> Because he really started trusting Wuchopperen; and he came to the Men's Group [part of Healthy Happy Families] and went to the RE [Recognised Entity] forum, yeah, came when they had that Domestic Violence Day, came and stood up in front of everyone, put on one of them ribbons, yeah no, good, what a change. (Counsellor 5, W: 117-121)

While Aboriginal and Torres Strait Islander staff are highly valued for their cultural knowledge, the Social Health unit's commitment to grow a competent workforce is not only about employing people who share the same culture as their visitors. First, this employment strategy would not always be feasible given ongoing staffing challenges (see section 4.2.2 for more information). Furthermore, as one manager put it "you don't have to be black to work for a Murri organisation, it's not absolutely necessary" (manager 5, I: 636-637). What is absolutely necessary, however, is for non-Indigenous personnel to demonstrate recognition of and respect for Aboriginal and Torres Strait Islander worldviews, knowledge and values.

Examples of the unit's non-Indigenous workforce's ability to act in a culturally sensitive manner were evident. One non-Indigenous counsellor acknowledged the important role that family connections plays in the wellbeing of the Aboriginal and Torres Strait Islander visitors. Consequently, this counsellor shares information about their background and seeks to establish a relationship with a visitor's family. They said:

> personalise, self disclosure ... when I start off because I'm [nationality of counsellor], I'm not Australian, and because also I'm non-Indigenous, for me developing that relationship, I can talk to people about, obviously I don't sound Australian, I'm [nationality of counsellor], and I talk to them about the fact that I've got ... kids and my photos sit on my desk. So it helps sort of, oh gosh she's you know human and sort of gives us a starting point. Um building a rapport with family as well is you know really important. (Counsellor 4, W: 16-24)

The same counsellor also accepted that not all Aboriginal and Torres Strait Islander visitors will want to work with a non-Indigenous health professional. Therefore, they encourage discussion around who is the right person to offer support and assistance:

> ... working out to begin with who is the right person or the right cultural person to work with the client and letting that be the client's choice. (Counsellor 5, W: 25-28)

Equally, another counsellor accepted it is “a big thing seeing someone not from community” (counsellor 2, F: 19/02/2009). So, they worked with their colleagues to identify the best way to introduce themselves to new visitors. They explained that:

> [Names of two Social Health team members] will go for the first visit, I won’t attend, and they vouch[11] for me, vouching is really important. (Counsellor 2, F: 19/02/2009)

It is this combination, namely the non-Indigenous workers respect for culture and a willingness to seek assistance from their Aboriginal and Torres Strait Islander colleagues that facilitates their ability to support visitors in an appropriate way.

[11] Westerman (2004) describes vouching as members of an Indigenous community conveying information about a health professional to potential consumers.

Skilled and qualified staff – Aboriginal and Torres Strait Islander or non-Indigenous – are critical to the successful implementation of Social Health programmes. Aboriginal and Torres Strait Islander culture informs the work of all staff. Aboriginal and Torres Strait Islander workers incorporate cultural knowledge into their day-to-day practice and reach out to other holders of cultural knowledge for extra assistance, as required. Non-Indigenous workers partner with their Aboriginal and Torres Strait Islander colleagues to ensure a culturally sensitive approach.

5.4.3 Approach

The unit adopts a holistic approach to social health care. This approach is based on the philosophy that sustained enhancements in coping and resilience are achieved by caring for all aspects of health. For Aboriginal and Torres Strait Islander peoples health is seen as "encompassing mental, physical, social, cultural and spiritual health" (Swan and Raphael, 1995). Therefore, the team's holistic approach entails supporting individuals, families and communities to take care of all of these aspects wherever needed.

Evidence of a holistic approach is apparent in the expansion of unit's programmes over a period of time. Wuchopperen's history reveals concerted efforts to establish a continuum of care, that is, a range of programmes designed to address the variety of needs of individuals and communities throughout their life spans. Counselling and Support was the first programme to be set up under the banner of Social Health. A counsellor described the rationale behind its commencement:

> I don't know dates or anything but I do know that Primary Health opened up in '79 and a few years after that, and that could be up to 10, 15 years (laugh), afterwards it was identified that there needed to be more social supports for clients and it wasn't enough just to meet their primary health needs so that's

> when Social Health became established. And we were actually in medical [Primary Health Care Service] originally and slowly we came over here. So counselling was offered over there. Um I think counselling was the first part of that, you know that sort of slowly expanded. (Counsellor 1, I: 28-34)

Later the Substance Misuse and Healthy Happy Families programmes were established to extend the type of the support available to individuals, families and communities dealing with specific problems like addictions or domestic violence:

> I think at least for the last um probably ten years but before that they actually had a focus because Indigenous clients, community, individuals were actually affected by I suppose what you call a trifecta – and it was really the alcohol, the domestic violence and then you know like I suppose the disintegration of family units mainly attributed to addictions and drugs and alcohol. So ... that's always been a factor which has been looked at by Wuchopperen. (Manager 2 discussing how the Substance Misuse programme came to be, I: 41-46)

> Healthy, Happy Families was actually, it's been within Wuchopperen for I think about three or four years now give or take. I'm not really sure. But see what I do know is that the need was always there and it was just a matter I think of getting the funding to get, well a lot of the clients that were coming here were seeing counsellors were affected by DV [domestic violence]. So ... I mean to have a support system like this ... in order for them to build happy, healthy families. (Group facilitator 1, I: 766-774)

Additionally, the Child Wellbeing programme and Culturally Appropriate Foster and Kinship Care Service were set up to afford Aboriginal and Torres Strait Islanders input into government responses to child protection related matters (often arising because of

adverse social conditions like addictions and violence). The establishment of Culturally Appropriate Foster and Kinship Care Service was explained as follows:

> Wuchopperen also saw that they you know needed probably to expand as far as their Social Health was concerned so we're talking about in particular child protection. It sits well with the organisation's activities under the Recognised Entity umbrella [part of Child Wellbeing] so it sort of works hand and hand with it so they certainly saw that and it was meeting a community need as well I suppose. (Manager 4, I: 40-44)

Social Health's holistic approach is also evident in examples of the care provided to visitors. Counsellors presented a relevant example in the workshop. A group spokesperson set the scene as follows:

> The situation was that children had been removed because of aggression in the home, violence in the home, alcohol, drug situation. Father got sent to prison [details of location removed] ... he came out of prison. He was referred to counselling through Community Corrections as well as Child Safety. (Manager 1, W: 72-78)

Upon meeting this man, the spokesperson explained that his counsellor recognised that "reconnection with this guy's cultural and spiritual self was the catalyst for change" (manager 1, W: 112-113). Consequently, many of the counselling sessions explored the visitor's cultural and spiritual pursuits, focusing on how the insights and skills gained could be "planted and transported ... back to life here in Cairns" (manager 1, W: 90-91). The counsellor and visitor also discussed the social pressures he faced:

> Like being able to say no to family when want to ask you for drink ... on New Years Eve there was an Aunty there, you know, disrespecting him by saying:

> Oh you think you're too good for us now? You don't want to drink with us? That kind of stuff, that pressure is very real on our families. (Manager 1, W: 91-96)

Recognising the challenges inherent in resisting family pressures, the counsellor and his visitor identified strategies for dealing with situations where his new life choices were questioned. In its entirety the example helped illustrate exactly how Social Health promotes coping and resilience by working with visitors to address their mental, social, cultural and spiritual wellbeing.

Another example that also came out of the workshop related to the support provided to individuals with comorbid conditions. In this case counsellors spoke in general terms about how they would support:

> ... a person experiencing extreme sadness following the passing of a family member and high blood pressure, contributing factors to the high blood pressure – excessive weight, lack of physical activity and alcohol consumption. (Counsellor 1, W: 5-9)

The group said they would assist such an individual to make a connection between their mental and physical health. As the spokesperson put it:

> So, as the client's story becomes more and more, explain that the sadness can actually impact on the high blood pressure. (Counsellor 1, W: 15-16)

Moreover, counsellors raised the importance of education about contributors to and strategies for managing high blood pressure. The spokesperson said:

> Also get some, oh where is it, some information through medical [the Primary Health Care unit] so we can offer education around the blood pressure and also look at what coping mechanisms are in place. You know if there’s unhealthy behaviours going with it. You know maybe the alcohol consumption was mention. So we can get the education going. (Counsellor 1, W: 15-21)

The same spokesperson reflected:

> I actually had a lady who had similar stuff, you know and kept saying she couldn't exercise, she didn't have time. So, I actually offered her counselling sessions to be a bit of a walk and talk but she didn't take it up but I thought I'd throw it in ... (group laughter), just a way of making walking not looking so horrible and exercise you know start to become enjoyable. (Counsellor 1, W: 21-26)

There was also considerable discussion amongst the group on supporting the person through their grief. Counsellors raised three key strategies. The first focused on identifying available social networks, specifically:

> ... looking at family and friends. So who is a good support? Who's not such a good support? So who's coming around saying which way, come to the pub. So, do we look at them for support or do we look at the other person that sits and listens? (Counsellor 1, W: 32-35)

Another strategy related to spirituality. The group discussion revealed “sometimes that [spirituality] can be a bit lacking in times of sadness, so if that's something that we might need to reawaken” as one counsellor put it (counsellor 1, W: 45-46). Finally, the counsellors explored supporting constructive steps to deal with emotions. As a counsellor stated helping the person in “managing those um those feelings and emotions, those moods appropriately rather than avoiding it” (counsellor 3, W: 63-64). As with the previous case, the discussion revealed a holistic approach because the focus was on multiple aspects of wellbeing (mental, physical, social and spiritual) rather than just on the presenting concern (grief).

Holistic care is fundamental to how Social Health operate. The unit’s mix of programmes is designed to holistically address the various aspects of health and

wellbeing. Similarly, visitors to the unit receive personalised support that simultaneously focuses on multiple aspects of their wellbeing.

5.5 Advocating for system level change

Advocating for system level change reflects the Social Health unit's efforts to overcome or minimise structural barriers that can work to inhibit the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. As a counsellor explained:

> Advocacy can take the form of many different ways as we all know. You know, letters, go to court, appointments – going to other agencies, supporting them at other agencies. But really important is our input into policy and legislation, that's really, really important. (Counsellor 1, W: 68-72)

The importance stems from the opportunity that advocacy presents to change policy and practice in Aboriginal and Torres Strait Islander affairs. One manager described it as her responsibility to respond; to advocate on behalf of the community. They said "it's all part of the bigger picture, about bringing about systemic change" (manager 1, F: 22/04/2009).

The team's input into policy and legislation typically occurs on an ad hoc basis. Following a discussion with a manager I recorded the following comments about how it might work:

> The organisation might respond to discussion papers. Typically [name of Social Health team member] circulates them and says: If this is something that really blows your hair back and you want to comment then send your thoughts through to me, assuming you want them to come from the organisation. Otherwise feel free to respond personally yourselves. (Manager 1, F: 22/04/2009)

An example of a discussion paper some staff members elected to comment on were the proposed changes to the Queensland Mental Health Act (F: 22/04/2009).

As well as responding to discussions papers, the Social Health team seeks to share their expertise with a view to bringing about positive change in policy and practice. A member of the Child Wellbeing programme participates in different child protection related forums. They depicted their role as follows:

> It's me raising, when they talk about legislation and policies and procedures, wherever I can, comment in relation to how does this affect or work or not work for Indigenous children and their families on the ground, in practice. That's where my comments are. So, it's trying to keep yeah, yeah that in the loop. (Manager 3, I: 141-143)

Also with the view of bringing about positive change, representatives of the Culturally Appropriate Foster and Kinship Care Service made a submission to the Children's Commission. They wanted to raise awareness about impediments to the recruitment of new Aboriginal and Torres Strait Islander foster and kinship carers (people the service argues play a vital role in the social and emotional wellbeing of children placed in out-of-home care). In regard to their submission a manager explained:

> I think there's a lot of perceptions out there that the, the processes now with Blue Cards and different checks would exclude a lot of people but that's just that those people aren't aware of it. So we've actually made in conjunction with the RE [Recognised Entity] some suggestions that the Children's Commission have an Indigenous unit that will actually go out and promote the positives of having that Blue Card, of applying and what, what precludes and what doesn't preclude because these people have that assumption – look I've had a DUI [driving under the influence] ten months ago or twelve months ago I can't be a carer and that's certainly not the case. Those elements of their traffic and

> criminal histories don't necessarily preclude them but they've got that idea in their heads. So I believe that's a lot to do with it. (Manager 4, I: 156-165)

A tension that exists in relation to Social Health's advocacy work relates to resourcing. None of the programmes are specifically funded for this task. A lack of funding for this function means that programme staff rarely (if at all) attend training that would provide them with the expertise to undertake advocacy work. One manager expressed some frustration at these shortcomings most particularly in relation to the limits they place on the Child Wellbeing team's ability to challenge the operation of the child protection system. They said:

> The other part that I reckon I'd love to see us do – somewhere where we could grow or whatever, don't ever see that Child Safety would fund it necessarily – is to ... actually challenge it, seriously challenge it. So we can give advice, we can give advice, we can give advice but unless we do something when they're not taking that advice and it's serious, we can see a stuff-up. [But] ... it's only early days. It's only three years we've operating like this and it's about improving all the time and these are the areas I'm suggesting we can improve in. It's being serious about having someone who can deal with just complaints ... (Manager 3, I: 623-631)

This manager also pointed out that challenges to the system would be facilitated if a better balance existed between the skill sets of staff at Social Health and the Department of Child Safety:

> The gap is also here, [comparatively speaking] we are unskilled people, we're not coming with legal backgrounds ... And here we are comparing ourselves and trying to match and walk side by side of a government department. But what's the gap? And that's one area. We don't have like they've got a Senior

> Practitioner, they've got a legal unit and I'm not saying we want to match that but there's got to be some kind of balance and that's a bit of a gap when we're wandering and trying to challenge things to make a difference. (Manager 3, I: 639-656)

Even with the resourcing challenges, Social Health's commitment to ongoing advocacy remains strong. This commitment reflects the unit's strong leadership and a desire to facilitate the best possible wellbeing outcomes for Aboriginal and Torres Strait Islander individuals, families and communities.

5.6 Exercising professionalism

Social Health exercises the highest degree of professionalism to implement the above-mentioned strategies. For Social Health professional practice entails demonstrating empathy and respect to all visitors, maintaining transparent, complementary and supportive work processes with other agencies and seeking continuous improvements within the team.

5.6.1 What a professional approach looks like with visitors

Members of Social Health approach interactions with their visitors in an empathic and respectful manner. With regard to the team's empathic approach, one manager explained that it stems from the team's recognition that "but for the grace of God a visitor's fate could be our own" (manager 1, F: 16/09/2008). Consequently, the manager said that the team "seeks to cast no judgments" (manager 1, F: 16/09/2008), instead seeking to enter into the feeling or spirit of what someone is experiencing or has experienced. A group facilitator, who works with victims and perpetrators of domestic violence, outlined what an empathetic approach can mean in practice:

> But a lot of ‘em [perpetrators] they want that change you know and it's something that um like when you see them come in the first time with their partners you can see they really don't want to live like that you know. They can't help themselves. Because you think about it, they were bought up in a cycle as well. So, that's a normal lifestyle for a lot of ‘em. Yeah that's why I say we try not to judge, you know ... (Group facilitator 1, I: 438-442]

The team’s efforts to demonstrate empathy do not involve them excusing or trivalising destructive or harmful behaviours or attitudes. The group facilitator (highlighted above) said that while their team tries not to judge perpetrators of violence:

> ... We get angry like: What you do'n that for? ... to the point that, where it's: Come on now you gotta make that change, you know, come on you don't wanna be living like this, you're better than that. And you know showing them that there is other ways. (Group facilitator 1, I: 442-445)

A manager shared another instance when they needed to challenge community expectations about the appropriateness of excessive drinking following the passing of two community members:

> We've got two families in one town and probably four or five families in another town at the moment all grieving over two Grannies who died within two weeks of each other. So we're going through that business at the moment. And for a lot of them it's like oh they're gone you know, I'll just go and drink. And they drink and drink and drink and then they fight ... Oh they say, but you know they're grieving and I said that's a learnt behaviour that is not Aboriginal and Torres Strait Islander grieving, that is a learnt behaviour and what we need to do is get them through it and then work through why they feel the need to drink when something bad happens. (Manager 5, I: 283-290)

For Social Health respect is demonstrated in a number of ways. It starts with the team recognising visitors as the expert in their own healing journey. One manager described the primary role of programme staff as “clearing the clouds” so that visitors can more clearly see how to go about enhancing their wellbeing. I noted in my field notes:

> [Name of Social Health team member] explained that in truth many of Wuchopperen’s visitors are highly resilient. As such Wuchopperen staff work with visitors to clear the clouds so they can get a new perspective of what’s happening in their lives and take action accordingly. (F: 14/01/2008)

Additionally, the team shows respect by conducting the process of clearing the clouds at a pace most suitable to the visitor. One counsellor described it as “walking beside a person”, confronting issues as and when they are ready (counsellor 3, F: 23/02/2009). To illustrate how they have enabled visitors to set the pace, the counsellor relayed the example of working with a woman who was suffering from depression. I recorded in my field notes that:

> [Name of Social Health team member] explained it would be overwhelming for her to deal with everything [that is, all the issues negatively impacting on her wellbeing] at once so they’re tackling one issue at a time. (F: 23/02/2009)

When another counsellor was asked about how many sessions they might schedule to allow a visitor to address their wellbeing concern they indicated that:

> ... we have no lines on how long. It's basically up to us as individuals to work out how long we think it's going to work and usually just take the client's lead. And we haven't had a great deal of people like staying on forever, that's not seen to be a problem. Um yeah, it seems to be that yes, that once they've met their goals they’re ok to exit. So, it's pretty good that way because a lot of

> services don't allow for that, you know, you can have your ten sessions and that's it, yeah, whereas we're very broad. (Counsellor 1, I: 131-137)

Even programme staff that run scheduled activities (like a fixed length training or group therapy programme) find ways of supporting visitors who need extra assistance to address their issues. A group facilitator of a Women's Yarning Group explained that:

> ... we do have about three women that have come back again that are really enjoying it. I'm like, ok so that we've done that with ya I can't do the power and control wheel. Yeah but it's really good because it is just a yarning group we bring up the power and control wheel but we say ok how did you, have you been able to use this, to acknowledge and that's how we're dealing with these clients, that we're not repeating. So in the end it's them saying, pretty much giving us the Women's Group around DV [domestic violence] because they're aware of it. We're just seeing how much they took in the first time. (Group facilitator 1, I: 613-620)

Finally, a visitor's choices around how to enhance their wellbeing or resolve a particular issue are respected by the team. The team's general approach is to provide enough information so that a person recognises the available options and then to support that person in taking their desired course of action. As one group facilitator explained:

> I don't believe in telling an adult what to do. I wouldn't like to be told what to do so why should I tell someone else what to do. ... I don't mind saying to them you're the one that needs to make the change. You need to make yourself, you're the only one that can do it so if this group, you know Women's Group, is suitable for you and it can help you then maybe you need to go to that Women's Group. You know and when I talk to the women it's like this, you

> know it's just straight out, just – How you sis? You know, how you been? How's things at home? Good? You know? Oh what? And then they'll tell me some stuff and I'll go oh true? Oh have you tried da da da dah? (Group facilitator 1, I: 625-633)

A manager from the Culturally Appropriate Foster and Kinship Care programme provided another illustration of this approach when they described how the team supported a carer when the child they were responsible for went missing:

> ... one of those things was actually highlighted to me this morning by a worker where a child in prep actually went missing from the class and then the bus driver didn't actually tick the child's name off to get on the bus and when the carer was out the front waiting for the child he didn't turn up. So ... the Department has to know. The carer's frantic and our advice was to her was to do the right thing so you're notifying the case worker, you're notifying the school that this has gone amiss and then you're also actually notifying the police. Now the child's actually been found. (Manager 4, I: 132-139)

Social Health's respect of visitor choice and autonomy is not without its challenges. When a visitor or their family is at risk of harm or neglect Social Health sometimes needs to initiate action that takes that visitor out of the immediate decision making loop. A former counsellor (now predominantly working in another role) shared an example of such an occurrence. Below is a record of their experience from my field notes:

> [Name of Social Health team member] explained how they'd had to report a visitor to Children's Services given something that gave cause for concern during a counselling session. At the time [team member's name] had to make a judgment call. If she had advised the mother during their session of the need to

> report then it was likely she'd skip out with her child. So [team member's name] elected to stay silent and make the report without the visitor's knowledge. [Team member's name] admitted this was a difficult decision but understood it was necessary as it reflected what was in the best interests of the child. (F: 14/01/2008)

All of the Social Health team's interactions with visitors are founded on the values of empathy and respect. The compassion shown to visitors is balanced by the team's preparedness to gently challenge people to pursue life changes and to exercise a duty of care if individuals (or their family) are at immediate risk of harm. Respectful relationships are established through the team's efforts to position the visitor as the 'expert' in how, when and where their healing journey will unfold.

5.6.2 What a professional approach looks like with other agencies

When working with other agencies, Social Health maintains transparent work practices. The unit shares work products, such as manuals, with external organisations. The aim is to present opportunities for other workplaces to enhance their expertise, which in turn may bring about better service delivery responses for Aboriginal and Torres Strait Islander peoples. A case in point is the Child Wellbeing procedures manual. A manager explained:

> ... that manual we never once not shared it with a Child Safety Service centre or a departmental person or not once with any NGO [non-government organisation] out there who wanted to do RE [Recognised Entity] work because our view is that it's not about being protective like that. If that's **going to make a difference with a service improving to provide service to Indigenous kids and families so be it** [my emphasis]. (Manager 3, I: 535-539)

In the same way, the Culturally Appropriate Foster and Kinship Care Service planned to offer other agencies training to share around their expertise. A manager explained:

> We also want to take on a role probably within the Indigenous Child Protection agencies as well to say look, well it's a bit of a I suppose it's pounding our chests too, to say look we do have these skills and the staff to do it but we also want to deliver training here to the organisation and with those other organisations as well. (Manager 4, I: 343-346)

Moreover, Social Health looks to other organisations to share their work processes. Through knowledge of the practices of other agencies the unit can establish complementary work practices, designed to facilitate constructive working relationships and ultimately promote the wellbeing of individuals seeking support. A member of the Substance Misuse programme provided such an example. This programme receives referrals from agencies like Corrective Services (of which Probation and Parole is a part). Consequently, staff learnt what these agencies expected of the unit when they supported individuals mandated to attend counselling to address their addiction/s. A manager said:

> You get your non-voluntary who come in and then you have all of the statutory requirements built around them from Probation and Parole and also the Department of Communities. So, you not only have that thing of looking at them, if they're serious addiction people to get them through the medical, you're also dealing with the other agencies to see what their requirements are and try to put a blend for both of them and you know try to address those things. (Manager 2, I: 243-248)

Another instance of the unit's efforts to build complementary practices came from the Child Wellbeing programme. Staff from this programme worked with the Queensland

Department of Child Safety to harmonise each organisation's work processes. A manager recalled:

> I guess that we've done is work collaboratively with Child Safety. Child Safety haven't really told us what to do, we've just worked together and saw that how they function and basically tried to mirror so that we're actually making sure we capture and respond to how they work. It just made perfect sense. (Manager 3, I: 71-74)

A key advantage of matching up procedures is that workers have a practical means of promoting cross-organisational collaboration (or of overcoming an 'us versus them' mentality). The manager said:

> ... in that manual [a Child Wellbeing manual] there's other um graphs, not graphs, diagrams and those diagrams have been pulled straight out of the Child Safety's procedures manual. So when some of the old and new, sorry the new comers – CSOs [Child Safety Officers] – came along and flick through and say in your manual it says you've got to do this, this and this and I say: 'You know what this reflects on your manual, we didn't invent this, this is from your manual so don't go there with the yours, it's you know our work. (Manager 3, I: 545-550)

Proof the Social Health unit's professional practice is also evident in the support afforded to other agencies to manage any challenges or issues they may face. A key way the team offers this support is by being available if members of other agencies need to de-brief. A counsellor said:

> ... it's about being there for other agencies, if they've got stressful things that are going on then they need to get away from their agency, somewhere fresh, we can actually help there. (Counsellor 5, W: 56-58)

The team may also provide very practical support with tasks like grant applications or funding submissions. A manager said:

> We were very happy to support them in terms of their funding you know ... I got permission to develop a letter of support for one of the agencies here so they could go on with their funding. But yeah nah we've done quite a bit of good work with them now. (Manager 5, I: 134-138)

When working with other agencies Social Health is transparent, receptive and supportive. The team openly shares work products with other agencies and seeks to establish effective means of working together to achieve shared goals.

5.6.3 What a professional approach looks like in-house

Internally Social Health demonstrates professional practice through its commitment to continuous learning. The team is enthusiastic about reflecting on their practice and adjusting their approach to bring about the best possible outcomes for their visitors. One way the team achieves this result is through looking to their visitors for new ideas and feedback. Counsellors, for instance, mull over past sessions in order to identify key learnings they might take away from their visitors. A counsellor explained:

> We always say we want to learn from our clients, that's that two-way learning, you know they might learn from us but we also learn a hell of a lot from them. (Counsellor 1, W: 88-90)

I recorded a specific example of how this two-way learning can occur as follows in my field notes:

> [Name of Social Health team member] asked their visitor to describe her anger. She said it was like lightening, unpredictable. [Team member's name] and the visitor talked about the nature of lightening, agreeing that in nature there are

> warning signs like storm clouds and thunder. From here they started to explore the idea that person might have some warning signs for her growing anger and that if she could identify these signs she might be able to better manage her growing feelings of frustration. Overall, [team member's name] indicated that de-constructing the idea of anger equating to lightening proved a powerful coping tool for this particular individual. As such [team member's name] asked for permission to share the ideas they'd discussed with other people dealing with anger management issues. (F: 22/04/2009)

Visitors are also asked for direct feedback about the support they are receiving. A group facilitator recalled how they check with visitors to see if they are effectively communicating important messages:

> If we've talked about a topic around self care or um self care or doing something for someone else and I'll turn it around at the start of the week and you know just say hello to everyone and just say oh before we start did anyone get a chance to do any self care or what did you get up to this week? Oh I did this and I helped my mother do the shopping. How'd you feel about it? Oh I felt really good. It got me out of the house. And I said see, and that's how I start my programmes. So that's how I kinda get my feedback to say well they're listening you know. (Group facilitator 1, I: 337-343)

A further aspect of the team's professional practice is the care and support afforded to each other. This care is provided through both formal and informal channels. The Cairns based Recognised Entity team (part of the Child Wellbeing programme) adopts a formal mentoring type arrangement. In this team there is a senior level of staff who receive advice and guidance from an experienced manager. The manager explained:

> ... certainly in the larger Recognised Entity team in Cairns, is that, there is a more senior level of staff [details of staff members] .... so those four staff members are the ones that I have a lot of discussion and support with so that they can again support their smaller teams ... and I do rely on those senior persons to provide advice, to provide support for me. And I usually call on them too if it means acting up in positions that may backfill me or attend a meeting or whichever for me. So, yeah, so I guess I'm trying to mentor them as well in doing the work that I do as well. And not all together but in portions, you know? (Manager 3, I: 54-65)

Members of other programmes appear to take less formal approaches. A prime example of these informal approaches came from a manager who spoke of the team bouncing ideas of each other on a needs basis:

> ... the social and emotional wellbeing team sort of like bounce things off me ... I also work very closely with [name of Social Health team member] in terms of, like there's some areas that I'm not really au fait with like child counselling and that sort of thing, so, I bounce things off them ... (Manager 5, I: 19-24)

On top of the efforts for care and support within different programme teams there is a ‘whole of unit initiative’. Every week the entire Social Health team meets at a Review and Referral meeting. The purpose of the meeting is to review the Social Health Referral forms, completed every time a person is referred to the social health programme (be it a self referral or a referral from another agency). For new referrals the team shares ideas about what type of assistance the person might need and who represents the most appropriate Social Health representative to make the first, official contact. If the referral is marked as actioned the team discusses whether the person did actually attend a social health programme and confirms that the most appropriate

care has been provided to that individual. After attending a meeting I recorded the following observations in my field notes:

> The team members' expertise in their fields was clearly evident during the processing of Reviews and Referrals. Background information about the client was shared in a succinct yet highly informative manner. If any of the group knew of family contacts these were raised promptly (e.g. isn't that so and so's son?)... Courses of action were identified with seeming ease. Again this appeared to come down to experience. Over time staff had learnt that particular needs were best addressed by a particular social health programme / service or referral agency.... Finally, no-one's ego seemed to come into play. Staff shared information and advice freely. Everyone seemed open to ideas and feedback. Overall the process was handled in a highly proficient, professional and supportive manner (F: 18/01/2008).

Finally, the unit promotes continuous improvement through internal performance related reviews. A manager relayed details of a feedback session they were involved in:

> We've got to be mindful I suppose when we're dealing with clients they can become very dependent ... I actually had to have a talk with someone about it. I said, you know what you've done is you've created a dependency. This person's on the phone four times a day wanting to talk to you ... she is forming an unhealthy relationship here, she is now totally dependent on you ... I understand that you did it for all the right reasons, however, what you have to do is you have to put in place other strategies, the strategy can't be that ok every time she doesn't do it right you run up there and do it for her. (Manager 5, I: 421-428)

In this particular case it proved difficult to break old habits and change the ‘unhealthy’ relationship. As a result the person receiving care was very carefully and respectfully referred to another member of the Social Health team for ongoing assistance.

While it was clear that Social Health endorse a variety of methods to advance continuous improvement, what was less clear is how consistently these methods are adopted in practice. With some notable expectations (such as the weekly Review and Referral meeting and scheduled external supervisions for counsellors), the highlighted techniques place the onus on an individual to privately reflect on and/or publicly seek feedback about their practice. However in the busy environment of Social Health, time for these activities might not always be available. Prior to the workshop, for instance, pressing work commitments had kept the counsellors from coming together to reflect on their work practices. On the day I noted:

> At the beginning of the workshop [name of Social Health team member] made the point that while she understood the workshop was about the research it was great that the counsellors came together as they might be able to learn from each other ... by the end of the workshop most participants were saying it would be great for counsellors to catch up on a regular basis to share experiences and learn from each other. [Name of another Social Health team member] said let’s call it QCC, Quarterly Counsellor Catch-up, and there was lots of laughter about the acronym and that now it was named it would have to happen. (F: 17/02/2009)

The establishment of such a forum (and ideally its promotion as a performance development strategy that other programmes might like to consider) represents a good first step for the counselling team. Beyond this step the team may also want to consider how often efforts to review their methods actually achieve real change in adopted work practices.

There are many examples of the Social Health unit's attempts to promote a professional approach in-house. Team members reflect on their practice, provide professional development opportunities for their colleagues and offer constructive performance related feedback to each other. In keeping with the team's dedication to continuous learning, further improvements may come through the implementation of workplace practices that ensure time is consistently allocated to these activities.

5.7 Summary

This chapter presented the strategies adopted by Social Health to realise their overarching goal of promoting the coping and resilience of Aboriginal and Torres Strait Islander individuals, families and communities. These five strategies are: personalising support, responding to community priorities, integrating culture into programme delivery, advocating for system level change and exercising professionalism. The words and experiences of the Social Health team were utilised to illustrate how, why and when these strategies are implemented.

In the following chapter Wuchopperen's model of social health care is analysed to determine where it matches or diverges from existing research evidence and documented practice experience concerning how to deliver appropriate care to people or groups with social and emotional wellbeing related concerns.

Chapter 6 Positioning the Model within the Literature

6.1 Introduction

For 10 plus years Wuchopperen's Social Health unit has worked with Aboriginal and Torres Strait Islander communities in Cairns and surrounding regions to develop programmes that address the social determinants of health. A former manager revealed that much of this work is inherent. They explained "we instinctively do what is right for our mob" (F: 24/10/2007). In commissioning this study Social Health sought to test their instincts. The team wanted to know what evidence (if any) existed to support their assumptions and expectations about how their programmes function to realise desired outcomes.

The study included three phases to address the need for research as expressed by the Social Health team. Phase one and two entailed identifying and validating exactly how and why Social Health delivers its programmes. The key output from these phases is a comprehensive model detailing the social health care approach as specific to Wuchopperen (presented in the preceding two chapters). Phase three involved assessing the model.

This chapter presents the findings from phase three. It juxtaposes elements of Wuchopperen's model of social health care (introduced in section 4.1) against relevant literature. The aim is to consider whether, and how, the Social Health unit's particular approach to social health care is supported by existing research evidence and documented practice experience. The chapter reviews the findings concerning Social Health's operational environment (detailed in section 4.2) to examine the extent to which the team's experiences of working in the health sector correspond to comparable

service providers. It considers the five strategies (described in chapter 5), adopted by the programmes to promote coping and resilience, to reveal how feasible it is to expect these strategies to enhance wellbeing. The chapter also considers the degree to which these strategies complement or extend on current understandings of promising practice in social health care.

To conclude the chapter re-visits the model as a cohesive whole. While the process of positioning an element of the model within the available literature is helpful for understanding its dimensions in greater detail, this method fails to adequately capture the complexities of Wuchopperen's approach to social health care. This failing does a disservice to the unit. The true strength of Wuchopperen's model of social health care is its seamless integration of the various elements. This integration enables the team to deliver multi-faceted, needs based support to Aboriginal and Torres Strait Islander individuals, families and communities.

6.2 The operational environment

6.2.1 Resourcing issues

Forces in a broader operational environment shape the design and delivery of Wuchopperen's social health programmes. Many of these forces relate to the resources required to run programmes. Short-term funding agreements, changing priorities around the type of initiatives sponsors will support over time and limited backing for infrastructure projects can all work to inhibit what, how and when social health programmes are delivered. High demand in the health care sector for suitably qualified personnel can also leave key positions unfilled resulting in the postponement of scheduled programme activities.

A number of reports have addressed the organisational challenges associated with delivering health care services to Aboriginal and Torres Strait Islander peoples. The Learning from Action project explored the staffing trials confronted by a cohort of senior Aboriginal Community Controlled Health Service managers (Dwyer, Shannon and Godwin, 2007). Like staff in the Social Health unit, these managers spoke of ongoing workforce shortfalls despite continuous growth in demand for care (Dwyer et al., 2007). A report by the National Aboriginal Community Controlled Health Organisation and Oxfam (2007) also picked up on the theme of staff shortages. In 2007, it noted a shortfall of more than 400 doctors, more than 600 nurses and associated shortfalls in the numbers of Aboriginal Health Workers and allied health personnel supporting Aboriginal and Torres Strait Islander services. Furthermore, the report indicated that recruitment opportunities were hindered by the inability of Indigenous-specific healthcare services to compete with the salaries of the State hospital sector and private sector salaries, which were substantially higher (National Aboriginal Community Controlled Health Organisation and Oxfam Australia, 2007).

Ongoing funding challenges are also well reported. The Overburden report highlighted the administrative burden posed by short-term funding agreements (Dwyer, O'Donnel, Lavoie, Marlina and Sullivan, 2009). An illustration of what this burden means in practice comes from the Danila Dilba Aboriginal Medical Service in Darwin. To deliver chronic disease prevention, care and management programmes this organisation pursued 26 funding streams and hence had 26 separate accounts and 26 demands for accountability (Henry, Houston and Mooney, 2004). While the Overburden report acknowledged that many funders were moving to lengthen the standard funding term from one to three years, substantial barriers still continue to exist. These include the nature of government budget appropriations and the need for

cooperation among different levels of government and different departments (Dwyer et al., 2009).

Even given well acknowledged operational challenges, Social Health has negotiated solutions that enabled sustained programme delivery. For example, Social Health reached an accord with a key funding body to have a recurring one year funding contract for the Healthy Happy Families programme translated into a three year agreement (F: 14/01/2008). Similar success stories exist in the literature. Dwyer et al. (2007) highlighted how managers in Aboriginal Community Controlled Health Services used evidence of the need or effectiveness of services to advocate for ongoing funding. Like other providers, Social Health recognise the importance of the use of "influencing methods" (Dwyer et al., 2007) to secure the flexible and recurrent long-term funding that is so essential to the delivery of programmes in accordance with community needs and requirements.

Staff recruitment and development is one area where the Social Health experience extends on reported tactics. Many authors highlight the difficulties that health services face in employing suitably qualified staff (Dwyer et al., 2007; National Aboriginal Community Controlled Health Organisation and Oxfam Australia, 2007) without necessarily proposing grass root driven solutions to this problem. While undoubtedly policy level change is required to address shortfalls in the numbers of suitably qualified health workers, the Social Health team's approach of providing in-house development opportunities represents an important part of the overall answer to the need for an expanded workforce.

Another feature of the Social Health experience that has to date been given limited consideration in the literature relates to the disconnect that can occur between funding bodies and health care providers over what represents a service delivery

priority. To illustrate, Social Health was forced to terminate a well attended parenting programme after shifting government funding priorities resulted in a loss of ongoing financial support (see chapter four, section 4.2.1). Experiences such as this highlight the need for more discussions between government and community controlled health organisations about what represents meaningful strategies for addressing the health inequalities and wellbeing concerns experienced by Aboriginal and Torres Strait Islander peoples (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Dwyer et al., 2007). Social Health plays their part by approaching agencies about new programme. Members of the Healthy Happy Families team, for instance, approached law enforcement agencies about trialling a new service delivery response to people who consistently breach protection related orders (like the Domestic Violence Protection Order). A group facilitator described the response as an important step to "break the cycle, cause a lot of 'em are just breaching orders up to 20 something times and ending up back in, where they started and not getting any supports" (group facilitator, I: 27-33). This initiatives draws on a key strength of community controlled health organisations, namely their ability to deliver healthcare focused on community needs and priorities (Dwyer et al., 2007). Social Health shows how this capacity can be realised through open and ongoing dialogue about appropriate community driven responses to identified issues and problems (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005).

6.2.2 Issues within the life environment of visitors

The life circumstances of the individuals, families and communities approaching Social Health for assistance represent another key determinant of its operations. Many visitors to Social Health confront stressful living situations in which substance misuse, unemployment, violence and inadequate housing are commonly experienced problems. Additionally, visitors may be suffering the consequences of traumatic events

like separation from land, culture and family or racial discrimination. These factors largely determine the nature and scope of the social health programmes.

The work that Social Health undertakes to understand and appropriately respond to the life circumstances of their visitors is strongly supported in the literature. Many writers advocate for preventative and therapeutic frameworks that address the various dimensions and multiple causes of poor social and emotional wellbeing (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Australian Medical Association, 2008; Banks, 2007; The Commission on Social Determinants of Health, 2008; UK Department of Health, 2009). Fittingly, Social Health provides their visitors with multi-faceted support. Individual programmes, like Healthy Happy Families, address the different aspects of social problems (which in the case of the identified programme include domestic and family violence and school yard bullying). Different programmes also work together to assist people in addressing key contributors to their life stressors. Individuals may, for instance, work with a Drug and Alcohol Counsellor to beat an addiction and/or the Bringing Them Home Counsellor to reunite with family members. Consistent with the literature, it is an approach borne from the Social Health team's knowledge and experience of the fact that poor health and wellbeing not only has various dimensions, but also has multiple causes.

Social Health also plays an important role in filling gaps in service provision. The inability of non-Indigenous specific health providers to fulfil the social and emotional wellbeing needs of Aboriginal and Torres Strait Islander peoples has been a point of focus in many reports (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Gallaher et al., 2009; National Aboriginal and Torres Strait Islander Health Council, 2003; Paradies et al., 2008; Scrimgeour and Scrimgeour, 2007). Typically the failings of non-Indigenous specific providers relate to the themes of

accessibility, acceptability and appropriateness (addressed in chapter two, section 2.3). Social Health actively works to address the factors that make non-Indigenous health care providers inaccessible, inappropriate or unacceptable for Aboriginal and Torres Strait Islander peoples. Examples include providing transportation to ensure physical accessibility; demonstrating cultural respect to promote acceptability, and; employing a multi-disciplinary team to enable appropriate responses to the diverse health care needs of visitors. Furthermore, given the team's commitment to regular community consultations these tactics are bound to grow and/or adapt in keeping with the needs of visitors to the unit.

6.3 Strategies

6.3.1 Personalised support

An important element of Wuchopperen's model of social health care is personalised support. A manager adeptly described personalised support as the equivalent of care that is "developed individually around [a] person and wrapped around 'em" (manager 2, I: 265). In essence it entails developing a care plan that meets the specific goals, needs and circumstances of a visitor.

Social Health is not alone in adopting this style of practice. Other practitioners report the importance of delivering care that responds directly to the lived experiences of individuals in need of support, along with those of their family members and carers (Dudgeon and Williams, 2000; Haswell-Elkins et al., 2009; Urbis Keys Young, 2001; Vicary and Bishop, 2005; Westerman, 2004; Wright, 2000). The overarching aim is to provide preventative and therapeutic responses that address all aspects of a person's life (Dudgeon and Williams, 2000; Swan and Raphael, 1995; Westerman, 2004). This approach directly acknowledges that fact that if one aspect of a person's life – be it

physical, mental, spiritual, cultural or social – is somehow lacking then enhanced wellbeing will not be realised or sustained (Swan and Raphael, 1995).

The methods employed by Social Health to deliver personalised support correspond with writings on culturally appropriate therapies, models and services. These techniques included undertaking a comprehensive assessment process to allow for the joint identification of suitable therapeutic responses (Garvey, 2008; Haswell-Elkins et al., 2009; Wright, 2000), providing expertise that enables individuals to improve their immediate social situation and overcome future life challenges (Con Goo, 2003; Garvey, 2008) and working within a strengths-based framework so that individuals appreciate their capacity for change (W. Thomas and Bellefeuille, 2006; Tsey, Gibson and Pearson, 2006; Wright, 2000). A key asset of the Social Health model is that it draws together these techniques, illustrating how workers apply them simultaneously. Much of the identified literature explores only one or possibly two methods. By contrast the model of social health care adopted by Wuchopperen provides a rich picture of what practitioners need to consider when delivering personalised support to visitors.

In addition to the above mentioned techniques Social Health relies on experiential knowledge of what has worked in the past to inform the delivery of personalised support in the present. Authors typically give little attention to this tactic. Notable exceptions include Roe (2000) and Thomas and Bellefeuille (2006) who both explicitly acknowledged the high value that Aboriginal people place on the provision of support grown from practitioner experience. Given the limited writings about this technique, the Social Health model provides a leading example of how experiential knowledge can be applied and why its application is significant.

Many published practitioners clearly back how Social Health delivers personalised support. Less clear from the available research and documented practice experience is the role this strategy plays in promoting coping and resilience (the goal at the core of Wuchopperen's model). Some insights are available from two identified anecdotal accounts. Wright (2000) revealed how consultative partnerships – which involve working alongside Aboriginal and Torres Strait Islander peoples to jointly identify and implement treatment options – contributed to the overall achievement of wellbeing goals. Likewise, Pratt (2007) shared how his experiences of counselling reinforce the notion that enhanced wellbeing comes about in large part due to reciprocity – that is, a relationship in which the person (as the expert) directs the specialist in planning their therapy. As a point of reflection on the potential efficacy of personalised support, these narratives represent some value because they come from professionals who have worked with similar audiences and in similar contexts to the Social Health team. However, further research is needed to establish whether a direct link exists between personalised support and enhanced wellbeing.

Given the Social Health team's commitment to continuous learning and improvement, they may decide to seek their own evidence of the role that personalised support plays in enhancing wellbeing. If so, insights into how this evidence can be obtained are available from documented practice experience outside of the field of Aboriginal and Torres Strait Islander social and emotional wellbeing. Miller, Hubble and Duncan (2004 and 2008) sought empirical evidence of the factors that impact on a therapist's treatment success, that is, their ability to bring about desired outcomes in partnership with the person seeking therapy. They discovered that the best therapists (or those with the highest treatment success) work harder at improving their performance, most particularly by seeking and acting on feedback from the people they are working with (Miller, Duncan and Hubble, 2004 and 2008). The adoption of such a

systematic approach offers two possible benefits to the Social Health team. It represents a way of refining current methods of collecting feedback (which can be ad hoc) and also a means of further increasing the evidence base for the team's work.

6.3.2 Responding to community priorities

Complementing the work that Social Health undertakes with individuals and families are the unit's community based initiatives. The team collaborates with community members to identify their priorities for social health programmes and activities. It is about "getting feedback from our people ... what's useful?" as a group of counsellors put it (counsellors, W: 29-31). The aim is to grow programmes that address community issues and concerns.

The team encourages community consultations at various points in the lifecycle of a programme. Feedback may be sought about the design of a programme, its ongoing usefulness and/or the most appropriate way to finalise an activity and exit from a community. The ability of the team to work across what some writers label a "continuum of engagement" (Shannon et al., 2002, p. 12) augurs well for their ability to deliver successful programmes. Research shows that community participation and involvement in the design and implementation of health and wellbeing programmes positively contribute to the realisation of demonstrated improvements in health outcomes (Burns et al., 2002; Urbis Keys Young, 2007). Such research points to the worth of the Social Health team's efforts to work with and for communities in and around Cairns.

While the literature acknowledges the need for community engagement, less is written about the process of making community participation a reality in the context of the community controlled health sector. The Social Health team's experience shows

that community engagement is not without its challenges. In brief, some team members have felt stifled in their attempts to undertake community consultations on behalf of the unit. These revelations represent an opportunity for Social Health to reflect on the appropriateness of their community consultation processes. A useful starting point for this endeavour is the work of Martin (2003). Martin (2003) argues that Aboriginal and Torres Strait Islander organisations need to place more emphasis on developing robust relationships between themselves and their constituents than on the formal procedures of corporate governance. The frustrations felt by some line staff could indicate an imbalance between these two factors at Wuchopperen. Given the few concerns highlighted in the study, it is recommended that the team pursue further discussions around how, when and who conducts community consultations to determine whether organisational change is required.

6.3.3 Integrating culture into programme delivery

The Social Health team's strategy of integrating culture into programme delivery is fundamental to how they go about promoting coping and resilience. To implement this strategy the team carefully considers how their places of practice, the people engaged in that practice and the actual approaches to practice recognise and value Aboriginal and Torres Strait Islander culture. Each element underpins the team's commitment to culturally appropriate or culturally sensitive practice.

Place

Social Health creates or finds places in which their visitors feel culturally safe and respected. For example, Aboriginal and Torres Strait Islander artefacts and flags are displayed in waiting rooms. Programme staff locate natural environments, like parks and beaches, to help visitors feel at ease and to incorporate cultural pursuits into programme activities. The team's experience that these undertakings contribute to

enhanced wellbeing is reinforced in the literature. Other practitioners have found that the 'right' environment – that is, one in which Aboriginal and Torres Strait Islander peoples feel accepted and secure – enhances self-esteem and feelings of wellbeing (Mckelvie and Mallard, 2000). Experiences like this one reinforce the Social Health team's efforts to promote coping and wellbeing through the creation or identification of places that are meaningful to their visitors.

The Social Health team also incorporates place into their therapeutic responses in another way. Sometimes visitors undertake cultural pursuits on Country outside of the scheduled programme activities. Programme staff discuss these activities with their visitors. The aim is to identify any lessons learnt on Country with a view to "transport[ing] those skills back to life in Cairns" as a manager put it (manager 1, W: 91). The link between cultural pursuits on Country and enhanced wellbeing has been substantiated by research. Of particular note is the work of Burgess, Berry, Gungthorpe, Ross and Ross (unknown) and Garnett and Sithole (2007) (cited in Ganesharajah, 2009, pp. 34-35). Each study found a significant relationship between participating in Caring for Country activities and indicators of health and wellbeing. While the Social Health team is not itself facilitating Caring for Country activities, it is looking at how the feelings generated by such pursuits can be sustained and replicated in other contexts. This practice extends thinking around how cultural pursuits might be drawn on when working with Aboriginal and Torres Strait Islander peoples to achieve greater wellbeing.

The Social Health experience of utilising place to promote wellbeing both complements and extends current thinking about how and why this strategy is important for Aboriginal and Torres Strait Islander peoples. The team's experiences of working with visitors to transport the lessons learnt during Caring for Country activities

into other contexts represents a practice that other practitioners may choose to incorporate into their caring routines.

People

People represent another important component of how Social Health integrates culture into programme delivery. The unit seeks people with knowledge and skills that will positively enhance their ability to work with Aboriginal and Torres Strait Islander peoples. Often times this recruitment imperative means that the unit employs workers from the same cultural groups as visitors. Consistent with the literature (Dudgeon and Williams, 2000; Urbis Keys Young, 2001, 2007), the team's experience reveals that this approach facilitates culturally appropriate practice.

Depending on the particular needs of a visitor, Social Health may also seek expertise from outside the organisation to ensure visitors receive appropriate support. Examples include Traditional Healers and survivors (that is, people who have learnt through adversity and elect to share their insights on coping and resilience). Many writers advocate for the engagement of Traditional Healers (Casey, 2000; Haswell-Elkins et al., 2009; Kirmayer, Simpson and Cargo, 2003; Roe, 2000). These authors reveal that traditional methods of healing fulfil two important functions. They offer individuals a system of meaning for making sense of suffering and afford a source of strength and guidance in times of difficulty (Haswell-Elkins et al., 2009; Kirmayer et al., 2003). Less is written about the Social Health team's occasional practice of enabling survivors to speak with visitors (typically at public forums). While further research into the efficacy of this practice is required, it is known that group therapy sessions can work to enhance wellbeing because of the learning and insights that participants gain from other each (W. Thomas and Bellefeuille, 2006). Consequently, one extrapolation

is that sessions from survivors offer real opportunities for Social Health visitors to gain new understandings about what it takes to achieve sustained wellbeing.

Given the substantial shortfalls in the number of Aboriginal and Torres Strait Islander health professionals (National Aboriginal Community Controlled Health Organisation and Oxfam Australia, 2007), it is a reality that non-Indigenous people fill roles in many Aboriginal and Torres Strait Islanders health organisations. The Social Health experience reveals that the employment of non-Indigenous workers can be extremely positive, provided that their ways of working are culturally appropriate. The methods employed by non-Indigenous Social Health staff to facilitate culturally appropriate practice align with those documented by other practitioners. Examples include: asking Aboriginal and Torres Strait Islander colleagues to make introductions and vouch for their helping abilities (Westerman, 2004); making referrals if a visitor expresses a preference to work with someone from their culture (Vicary and Bishop, 2005), and; networking with Aboriginal and Torres Strait Islander colleagues to broaden understandings of the cultural ways and lived experiences of visitors (Vicary and Bishop, 2005; Westerman, 2004). By understanding and implementing these techniques, non-Indigenous personnel form a valuable component of the Social Health workforce.

Approach

Approach is the third area in which Social Health's integration of culture into programme delivery is clearly evident. The team adopts a holistic approach, meaning the overall composition of the unit and the content of individual programmes are designed to address many facets of health and wellbeing.

A key strength of the Social Health unit is its ability to operate across a service continuum. The notion of a service continuum speaks to the unit's ability to address a range of social problems in a range of ways. For example, the unit is set up to address issues like violence, substance abuse and trauma utilising both preventative and therapeutic responses. Strong support for this approach exists across many disciplines. Scott (2006) presented evidence that this type of approach represents the most appropriate way to address increasing notifications to child protection services. Similarly, research by Memmott, Chambers, Go-Sam and Thomson (2006) showed that sustained reductions in domestic and family violence in Aboriginal and Torres Strait Islander communities can be achieved through interventions that address all dimensions of the problem along with the multiple contributing factors. These findings lend weight to the Social Health unit's ability to achieve positive wellbeing outcomes for individuals, families and communities.

Social Health also works holistically within the context of individual programmes. The team aims to support individuals, families and communities to address the different factors that may be negatively impacting on their health and wellbeing. Many writers support this approach (Dudgeon and Williams, 2000; Garvey, 2008; Urbis Keys Young, 2001; Vicary and Bishop, 2005; Westerman, 2004). Dudgeon and Williams (2000) capture the rationale, explaining that if any aspect of a person's wellbeing is somehow lacking then enhanced wellbeing will not be realised and sustained. The Social Health team acknowledges this reality working with visitors to address the mental, physical, cultural, spiritual and social wellbeing.

6.3.4 Advocating for system level change

Social Health undertakes advocacy to contribute to debate and discussion about the development of appropriate strategies to address Aboriginal and Torres Strait

Islander health disadvantage. The aim is to seek action on health risk factors and health determinants. The Commission on Social Determinants strongly supports such efforts. Their research shows that every aspect of government, society and the economy – including finance, education, housing, employment and health care – has the potential to affect health and health equity. Increased community involvement and social participation in policy processes helps to ensure fair decision-making on health equity issues (The Commission on Social Determinants of Health, 2008).

Social Health undertakes advocacy in a variety of ways. Examples include preparing written submissions about what a proposed policy change will mean for Aboriginal and Torres Strait Islander peoples and joining forums to share their expertise about practices that work on the ground to promote health and wellbeing. Such insights into how to advocate for system level change are significant as few authors are so explicit about their methods. On exception is the work of Bartlett and Boffa (2005) who presented strong evidence of the capacity of collaborative forums to bring about positive changes in policy and practice for Aboriginal and Torres Strait Islander peoples. A past success of such forums is increased access to 'mainstream' funds by the community controlled health sector (Bartlett and Boffa, 2005).

A key challenge for Social Health moving forward is selecting the appropriate forums in which to participate. Like other community controlled health organisations limited resources create ongoing tensions between advocacy work and direct service provision (Bartlett and Boffa, 2005; Urbis Keys Young, 2007); therefore, considered decisions around where to direct advocacy efforts will prove vital. Presently, Social Health staff members predominantly participate in forums directly related to their profession. For example, a member of the Child Wellbeing programme sits on working parties that exchange ideas about appropriate responses to child protection related

matters. While at one level it makes sense to ensure a direct match between a worker's job and their advocacy work, this particular approach may result in missed opportunities to contribute to substantial health and wellbeing gains for Aboriginal and Torres Strait Islander peoples. Since many determinants of health and wellbeing fall outside of the direct ambit of the health system (Shannon and Longbottom, 2004), improvements in Aboriginal and Torres Strait Islander health rely on changes in many areas (The Commission on Social Determinants of Health, 2008). Yet intersectoral collaboration, most particularly at a community or grassroots level, represents a major area requiring further development (Bartlett and Boffa, 2005). Any role that Social Health could play in facilitating effective collaboration between appropriate sectors would ultimately benefit the individuals, families and communities they support.

6.3.5 Exercising professionalism

The Social Health team exercises the highest degree of professionalism in all of their undertakings. With visitors the team demonstrates respect and empathy. When working with other agencies the unit maintains transparent, complementary and supportive work processes. When working together the team actively pursues opportunities for workplace improvement.

The adoption of professional standards of practice is a little explored area in the context of the Aboriginal and Torres Strait Islander community controlled health sector. The literature that does exist comes predominately from non-Indigenous health professionals working in other health care sectors. These writings reinforce the importance of a therapeutic relationship. Practitioners have attributed up to 30 per cent of positive change in mental health results to the quality of the relationship established between visitor and therapist (Asay and Lambert, 2006). This finding strongly supports the Social Health team's experience that relationship skills, such as acceptance and

compassion, are related to positive outcomes for visitors. Another key report points to the significance of reflective practice (Walker, McPhee and Osborne, 2000)[12]. Reflexivity has been shown to support ongoing learning and improve practice, both of which are important contributors to positive results for visitors (Walker et al., 2000). This reported practice experience lends weight to the Social Health's desire to enhance visitor outcomes through internal professional development related activities such as mentoring and peer-to-peer feedback.

Given the little that is written about exercising professionalism within community controlled health organisations, this research claims a unique space. It explores how a team of Aboriginal and Torres Strait Islander and non-Indigenous health professionals work together to ensure ethical, accountable and supportive work practices. Other practitioners can learn from the Social Health unit's example.

6.4 Revisiting the complete model

For all the value inherent in the individual strategies adopted by Social Health, the real strength of the approach lays in the team's ability to seamlessly integrate the various elements. The simultaneous application of the strategies is at the core of how Social Health supports individuals, families and communities to cope with adversities and work towards the achievement of greater wellbeing.

The intertwining of strategies enables responsiveness. As the team wraps care around an individual, delivering support in accordance with their unique needs, it is also works at a community level to identify where programmes can be implemented to support others at risk of confronting similar difficulties. Likewise the team advocates for system level change, acknowledging that for all the success they achieve in the field

[12] One of these authors is Indigenous. McPhee is a Yamatji/Waanyi person (Walker et al., 2000).

lasting change will only be possible when structural barriers to health and wellbeing are broken down.

Equally, the holistic approach is about sustainability. Individuals and communities are positioned as the expert in their journey to greater wellbeing. Guided by empathy and respect, the team provides individuals and communities with the resources they identify as critical to achieving enhanced wellbeing. The team also supports visitors to appreciate and draw on their inherent strengths, privileging the role that culture can play in promoting wellbeing. Furthermore, the professional way in which the team engages with other agencies to grow their understandings of culturally appropriate practice means that visitors have access to ever expanding support networks.

Overall, this is an approach that dynamically fulfils the unique social and emotional wellbeing needs of Aboriginal and Torres Strait Islander individuals.

6.5 Summary

The purpose of this chapter has been to analyse Wuchopperen's model of social health care in light of existing evidence and documented practice experience on what works to enhance the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. The final chapter considers the implications of the research for practice, research and policy.

Chapter 7 Conclusion

7.1 Introduction

Wuchopperen's model of social health care comprehensively documents how and why the organisation delivers social and emotional wellbeing programmes for Aboriginal and Torres Strait Islander peoples in Cairns and surrounding districts. For Wuchopperen's Social Health unit, the articulation of this model encouraged critical reflection about the operation of their programmes. Programme staff identified not only the strategies they adopt but also their assumptions about the ways in which these strategies promote coping and resilience.

Strong support for many of the assumptions underpinning programme delivery was found in existing research and documented practice experience. In particular, the literature reinforced the strategies of delivering support that directly responds to the diversity of Aboriginal and Torres Strait Islander experiences and of integrating culture into programme delivery. An emerging theme in the literature relates to the need for programmes to heighten their advocacy work, most particularly to overcome structural barriers to wellbeing. The Social Health experience reveals some insights into how this can be done. The model also privileges an Aboriginal and Torres Strait Islander voice on what represents ethical and professional conduct in social health care.

This chapter explores the significance of these findings to the field of Aboriginal and Torres Strait Islander social and emotional wellbeing. To set the scene, the chapter revisits the research aim, the significance of the study and the research limitations and strengths. It then presents implications for policy and practice and suggests ideas for further research.

7.2 Revisiting the research aims and significance

The overarching research aim for the study was to determine:

- Whether, and how, the approach to social health care adopted by the Wuchopperen Health Service is supported by existing research evidence and documented practice experience.

To promote a full exploration of this aim I sought to achieve the following research objectives:

- Identify the strategies that all social health programmes routinely adopt to enhance the social and emotional wellbeing of their target audiences
- Ascertain the assumptions and expectations held by programme staff as to how adopted strategies enhance wellbeing
- Determine whether the presumed links between adopted strategies and desired outcomes are congruent with existing research evidence and documented practice experience
- Discuss how the adopted strategies support chronic disease management and prevention.

With this aim and these objectives at its core, the research set out to capture and examine the Social Health unit's particular approach to social health care. A rich data corpus about the unit's operations was collected through document analysis, field research and interviews (one-on-one and group). The analysis of this data revealed a complex interplay of factors, all influential in how and why the unit functions in the way it does. To portray this complexity, the research findings were assembled into a model detailing the social health approach as specific to Wuchopperen. This model was scrutinised against available literature to determine whether the assumptions and

expectations of the team concerning how the model is supposed to work were supported by available research and documented practice experience.

The significance of the study to Social Health is manifold. First, the study grows the evidence base for the unit's work. The team has long acknowledged that an evidence base will enhance their understandings about how adopted strategies contribute to the realisation of desired outcomes. Additionally, this knowledge will enable the team to identify where changes are needed to better support the fulfilment of these outcomes.

The research findings also represent a resource that Social Health can use for other activities. The findings can inform induction materials for new recruits seeking insights into how and why programme operate in the way they do. Similarly, the findings represent a tool for supporting and assisting other agencies in how to go about working with Aboriginal and Torres Strait Islander individuals, families and communities to enhance their wellbeing (an endeavour very important to Wuchopperen).

Within a broader context the study's significance may be viewed in light of calls for more research on how to enhance the social and emotional wellbeing of Aboriginal and Torres Strait Islander populations. The NHMRC Road Map calls for more practitioners to make their models of practice accessible. As this study shows organisations like Wuchopperen are keepers of invaluable practice knowledge and experiences about how to work with and for Aboriginal and Torres Strait Islander peoples to promote coping and resilience. As more organisations are supported to share their expertise and to learn from the promising practices of others (through the provision of appropriate funding and expertise) the more likely it becomes that real gains will be achieved in Aboriginal and Torres Strait Islander wellbeing.

7.3 Limitations and strengths

There are limitations to the study. First, the study is based on the stories and experiences of programme staff only. This limitation needs to be considered in the light of the fact that Social Health is at the beginning of their evaluation journey. Prior to this research there was no official documentation about how or why the unit operates in the way it does. Therefore, this study represented a way to document and examine the plan or blueprint that represents the way it is supposed to work. Putting this blueprint in place enabled the team to critically analyse their approach and established a foundation around which other evaluations can be built.

A further limitation relates to the issue of generalisability. The study is about how one Aboriginal and Torres Strait Islander community controlled health organisation delivers programmes within a particular context and with a particular audience. Given the diversity of Aboriginal and Torres Strait Islander experiences the promising practices evident at Wuchopperen may not be readily transportable to other environments (or for that matter to other population groups). The research does, however, offer insights into the capacity of responsive, needs-based programmes to deliver wellbeing outcomes of benefit to communities and society.

There are also strengths to be acknowledged. Given the cross–cultural nature of the study, it entailed extensive consultations with the Social Health team to ensure they had a degree of ownership and control over the research (Lee, 2007; Scougall, 2006; Taylor, 2003). The team and I worked together to determine the research aim, thus ensuring the study represented a direct response to the team's information needs. Social Health programme staff supported me to design and implement the research methods. Together we determined who held knowledge and experiences that could shed light on how and why the Social Health programmes operate as they do. We set

up one–on–one interviews and a group workshop to facilitate maximum engagement and minimise interruptions to pressing work commitments.

The research processes adopted to recognise and demonstrate respect for Aboriginal and Torres Strait Islander ways of knowing, being and doing (K Martin, 2003; Taylor, 2003) represents another key strength. By working with a cultural mentor and drawing on the experiences of other researchers experienced in conducting cross–cultural research (Lee, 2007; Letiecq and Bailey, 2004; Scougall, 2006: Taylor, 2003), I came to appreciate the significance of investing time and energy into relationship building. As part of this commitment I worked onsite with the Social Health team. This time allowed me to establish social connections with the team, connections that support the collection of rich, meaningful information (Letiecq and Bailey, 2004; Scougall, 2006). It also presented me with opportunities to share research and information relevant to the delivery of social health programmes. This exchange enabled me to give back to the team (Taylor, 2003). Finally, my presentations of the research findings to the team acknowledged their ownership of the knowledge and enabled them to confirm their views and experiences were accurately represented (Scougall, 2006; Taylor, 2003).

7.4 Implications for policy and practice

The research has important implications for policy and practice in the context of Aboriginal and Torres Strait Islander Australia. The study illustrates the vital role that community controlled health organisations play in the provision of health care for Aboriginal and Torres Strait Islander peoples. Organisations, like Wuchopperen and more specifically the Social Health unit, deliver programmes that respond to the unique needs, goals and circumstances of Aboriginal and Torres Strait Islander individuals, families and communities. Historical, cultural and structural factors have prevented

many non-Indigenous specific service providers from delivering a similar type of care. While reforms are underway to enhance the responsiveness of non-Indigenous specific services, the large health disparities between Aboriginal and Torres Strait Islander and non-Indigenous Australians dictate that accessible, appropriate and acceptable care is needed now (Dwyer et al., 2004). For this reason, Aboriginal and Torres Strait Islander community controlled health organisations represent an essential component of an effective health care system for Aboriginal and Torres Strait Islander populations.

Yet merely recognising the important role played by Aboriginal and Torres Strait Islander community controlled health organisations is not enough. The environment in which Social Health operates contains both enablers and constraints. Policy makers and funding bodies need to partner with community controlled health organisations to ensure opportunities are fully exploited and barriers are minimised or eliminated. By working together the essential contribution made by Aboriginal and Torres Strait Islander community controlled health organisations can be further strengthened.

The exploration of Wuchopperen's model of social health care is also valuable from a practice perspective. The model presents a holistic approach for social and emotional wellbeing service delivery. This represents a rarity in the field. Other practitioners or researchers typically highlight particular strategies – such as the integration of culture into programme delivery – without necessarily bringing together different strategies into one complete model. As such this model provides a framework that other practitioners and researchers can draw on when considering how and why to deliver social health care with and for Aboriginal and Torres Strait Islander peoples.

7.5 Scope for further investigations

Given the Social Health unit's commitment to continuous learning and improvement, this study most likely represents the beginning of further team initiated investigations. In planning these investigations the team needs to consider what they have already achieved and what they aspire to achieve in the future. To undertake such deliberations, it may be helpful to consider how different kinds of evaluations can complement or supplement each other (depicted in figure 7.1). To date, the team's desire to grow an evidence base for their work indicated the need for an evaluation. This study was undertaken to answer the team's questions about whether their model of practice was supported by evidence. Next the team may like to conduct a process evaluation to determine whether programmes are implemented as planned (that is, as shown in the model). An impact and outcome evaluation would then establish whether the team's efforts to promote coping and resilience are actually realised and sustained. Ultimately the direction of future investigations will be determined by the team considering what types of information they need to enhance their operations.

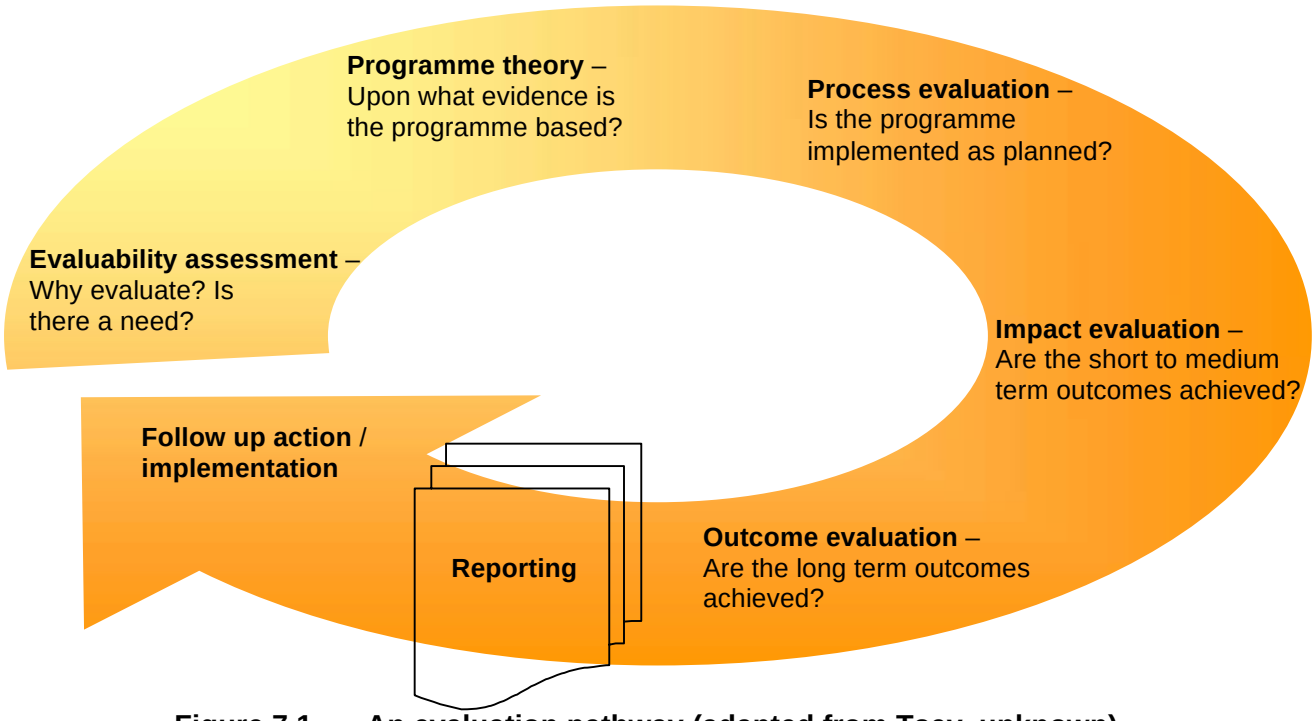

Figure 7.1 An evaluation pathway (adapted from Tsey, unknown)

In addition to representing a springboard for other evaluations, the findings from the study are also useful for other endeavours. They can inform quality improvement related initiatives. This idea is based on the success of the Audit and Best practice for Chronic Disease (ABCD) project. An important element of this project is an assessment tool that health centres use to collect data on whether their practice incorporates a number of components found to be important in achieving high quality care for people with chronic conditions (Bailie, Si, Dowden and Lonergan, 2007). While an innovative prospect for a social health care environment, the team might consider adapting the research findings into a similar type of assessment tool.

An example helps to illustrate how this idea could work in practice. The study confirmed that traumatic life experiences negatively impact on the health and wellbeing of visitors. These experiences are a point of discussion and promote therapeutic action across the programmes. One suggestion for the team is to formalise the process followed by workers to identify and address life stressors in collaboration with visitors. It could be a matter of creating a checklist that encourages workers to document how, when and why they and their visitors nominate different therapeutic responses for different life stressors (see figure 7.2 for an example). Similar to the ABCD model, this approach ensures that workers consistently adopt practices (such as detailed assessments) considered essential by the team to superior social health care.

Furthermore, information from such checklists could inform other programme activities. At set intervals the collected data could be reviewed or audited. The aim would be to identify recurring themes in the nature of care provided and/or the experiences of visitors. For instance, an audit might reveal that inadequate housing is placing severe strain on individuals and families. The results of these audits could then feed into advocacy efforts. Therefore, the team might initiate discussions with the

government agencies responsible for public housing and rental subsidies. Using the evidence generated by the checklist, the team could present a strong case for housing action for Aboriginal and Torres Strait Islander peoples in Cairns and surrounding districts. In essence the idea is to find new or innovative ways to work with information that the team collects to further strengthen the support extended to visitors.

Social Health Practice Checklist		
Environmental scan Discussion points: • Living situation • Family life • Employment • Lifestyle choices (diet, physical activity, substance use).		
Areas for follow up	**Action**	**Due Date**
Concerns about diet	*Refer to medical for consultation*	
Assistance finding accommodation	*Prepared housing letter*	

Figure 7.2 Monitoring adherence to the Social Health Care Model – Proposed Checklist

7.6 A final thought

While as the team acknowledges there is always room for improvement, it is important to conclude by acknowledging the value of the Social Health unit's approach. From its humble beginnings as a counselling service, the unit has conceptualised a dynamic model of social health care. Its work represents a compelling example of, as one manager put it, a "collective sense of taking power back and doing for ourselves" (manager, F: 26/07/2009). By initiating this study the Social Health team have both increased their understanding of the capacity of their model to produce intended social and emotional wellbeing outcomes and delivered a framework from which practitioners can learn.

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Appendices

Appendix A The Health Status of Aboriginal and Torres Strait Islander Australians

Aboriginal and Torres Strait Islander peoples experience the lowest standard of health compared to any identifiable group in Australia. Large disparities exist between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians across most indicators of health, particularly those relating to life expectancy, chronic diseases, mental health and wellbeing and infant mortality (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008). Text Box One presents national and state based statistics to help illustrate the current status of Aboriginal and Torres Strait Islander health.

Text Box One: Overview of the health status of Aboriginal and Torres Strait Islander Australians

Life expectancy[@]	Life expectancy is an indicator of how long a person can expect to live on average given prevailing mortality rates. For the period 2005-2007, the national estimate of Aboriginal and Torres Strait Islander life expectancy was 67.2 years for males and 72.9 years for females; compared with 78.7 years for all males and 82.6 for all females for the period. This data reveals a difference of 11.5 years for Aboriginal and Torres Strait Islander males and 9.7 years for Aboriginal and Torres Strait Islander females.

Long-term (chronic) health conditions*	In 2001–2005, around 65 per cent of the Aboriginal and Torres Strait Islander population reported at least one long-term health condition. The most commonly reported conditions were eye / sight problems (30%), asthma (15%), musculoskeletal related complaints (such as back pain and arthritis) (13%) and circulatory diseases[13] (12%). Aboriginal and Torres Strait Islander peoples had a higher prevalence of most types of long-term health conditions compared with non-Indigenous people.
Self-assessed Health Status*	Self-assessed health status provides an overall measure of a group's health based on individuals' perceptions of their own health. Such perceptions are guided by individuals' experiences and/or particular understandings of what represents healthy. These assessments are particularly important for Aboriginal and Torres Strait Islander peoples whose definition of health incorporates not only the physical well-being of the individual but also the social, emotional and cultural well-being of the whole community (Swan & Raphael, 1995). In 2004-05, Aboriginal and Torres Strait Islander peoples (15 years and over) were twice as likely as non-Indigenous people to report their health as fair or poor.
Social and Emotional Wellbeing (Mental Health) #	Social and emotional wellbeing is a concept based on the Aboriginal and Torres Strait Islander perception of health. This perception acknowledges that attaining optimal conditions for health and wellbeing needs a holistic view of health that includes the social, emotional and cultural wellbeing of the entire community.

[13] Diseases of the circulatory system include rheumatic fever, hypertension and coronary heart disease (World Health Organisation, 2007).

Mental health is a component of social and emotional wellbeing. The concept of mental health focuses primarily on the individual and their level of functioning in their environment; whereas, the social and emotional wellbeing concept is broader and recognises the importance of other factors like connection to land, culture, family and community.

A range of measures were employed by the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey to capture data on social and emotional wellbeing. One of these measures related to psychological distress. Information on psychological distress was collected by asking questions like: How often do you feel without hope? How often have you felt so sad nothing could cheer you up? Nine per cent of Aboriginal and Torres Strait Islander adults (18 years and over) reported feeling nervous all or most of the time. Seven per cent said they felt without hope all or most of the time. Similarly, seven per cent reporting feeling so sad nothing could cheer them up all or most of the time.

The response items for each question were scored from one for ‘none of the time’ to five for ‘all of the time’. These scores were added together to reveal a psychological distress score. The results indicated that 27% of Aboriginal and Torres Strait Islander peoples experienced high or very high levels of psychological distress.

Psychological distress among Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians was compared. It was revealed that Aboriginal and Torres Strait Islander Australians are twice as likely as non-Indigenous Australians to report high to very high levels of psychological distress.

Hospitalisations*	Hospitalisation data is indicative of a population's use of hospital services. In 2005-2006 hospitalisation rates for Aboriginal and Torres Strait Islander peoples were higher than for other Australians for many diagnoses. For care involving dialysis Aboriginal and Torres Strait Islander peoples were hospitalised for care at 14 times the rate for other Australians. For diseases of the circulatory system hospitalisation rates were more than twice those of non-Indigenous Australians in the age brackets 25-44 years and 45-64 years. For respiratory diseases[14] Aboriginal and Torres Strait Islander adults (25 years and over) were hospitalised at three to five times the rates of other Australians. For mental and behavioural disorders[15] hospitalisation rates were around twice those of non-Indigenous people.
Infant mortality and child health*	Infant mortality rates reveal the number of infants, out of every 1,000 born in a given year, who die before reaching age one. From 2001–2005, the infant mortality rate for Aboriginal and Torres Strait Islander infants from the Northern Territory, Queensland, South Australia and Western Australia combined was approximately three times that of non-Indigenous infants. In 2004–05 Aboriginal and Torres Strait Islander children (aged 0 to 14 years) were more likely than non-Indigenous children to have asthma (14% compared with 11%), ear / hearing problems, especially partial deafness (5% compared with 1%) and/or inflammation of the middle ear (4% compared with 2%).

Sources:

@ Australian Bureau of Statistics (2010)

* Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008)

Australian Institute of Health and Welfare (2009)

[14] Respiratory diseases include acute upper and lower respiratory infections, influenza and pneumonia (World Health Organisation, 2007).

[15] Mental and behavioural disorders include schizophrenia, mood (affective) disorders (like bipolar or depression) and personality disorders (World Health Organisation, 2007).

Many of these health disparities are long standing, with little or no change in the above-mentioned indicators in the last 30 years (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Couzos & Murray, 2003; Ring & Brown, 2002). The continuing significant gap in life expectancy represents a prime example of Australia's poor progress in addressing the existing health disparities. In 1991-1996[16] Aboriginal and Torres Strait Islander peoples could expect to live approximately 20 years less than non-Indigenous people (Australian Medical Association, 2002). Current data (2010) indicates the gap in life expectancy to be 11.5 years for Aboriginal and Torres Strait Islander males and 9.7 years for Aboriginal and Torres Strait Islander females (Australian Bureau of Statistics, 2010).

Australia's overall poor performance in achieving positive changes in these health measures stands in stark contrast to the experience of other developed countries (Australian Medical Association, 2002). New Zealand, Canada and the United States have all achieved improvements in the gap in life expectancy within a generation, for instance. In New Zealand in the 1950s the gap in life expectancy was between 13-15 years; by the late 1990s it had dropped to between 5-7 years. Similarly, in Canada and the United States the gap in life expectancy was narrowed from between 7-12 years in the 1970s to between 5-7 years by the late 1990s (Australian Medical Association, 2002)[17].

[16] Reliable national data on the life expectancy is hard to come by prior to this time period. New South Wales, Victoria, Tasmania and the Australian Capital Territory are reported as having incomplete data on life expectancy in the early 90s and Queensland did not record Aboriginal and Torres Strait Islander deaths at all (Australian Bureau of Statistics, 1993).

[17] International experiences are included to highlight the comparatively poor progress made in Australia towards improving the health status of Aboriginal and Torres Strait Islander peoples. The use of these examples is in no way designed to suggest that the health status of Indigenous populations in New Zealand, Canada or the United States is considered satisfactory by these populations. In New Zealand, for instance, there has seen little improvement in Māori life expectancy since the substantial progress of the 1990s. Consequently, the disparity between Māori and non-Māori life expectancy still requires further action (I. Anderson et al., 2006).

Of the health gains that have been achieved for and with Aboriginal and Torres Strait Islander Australians they are generally not of the same magnitude as the gains experienced by the non-Indigenous population. Consequently, there has been minimal impact on the inequality gap between the health status of Aboriginal and Torres Strait Islander peoples and other Australians (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005). For example, over the period 1991 to 2005 infant mortality rates for Aboriginal and Torres Strait Islander infants decreased significantly in Western Australia, South Australia and the Northern Territory[18]. Even with these improvements the infant mortality rates in the identified States and Territory are two to three times those of non-Indigenous infants (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008).

[18] In Western Australia the infant mortality rate fell from 26 per 1,000 live births in 1991 to 12 per 1,000 live births in 2005. Over the same period the rate in South Australia fell from 20 to 10 per 1,000 live births and in the Northern Territory from 25 to 16 per 1,000 live births (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008).

Appendix B Programmes delivered by the Wuchopperen Health Service's Social Health Unit

Programme	Key Role or Function	Examples of Activities
Counselling and Support	The Counselling and Support programme's primary function is to assist individuals, families and communities with social and emotional wellbeing related concerns.	• Individual, group and family counselling • Day to day living support for Aboriginal and Torres Strait Islander peoples dealing with a mental illnesses or physical disabilities • Advocacy for people connecting with agencies like Centrelink • Community education about the prevention and management of social and emotional wellbeing related concerns
Substance Misuse	The Substance Misuse programme supports people to become free of tobacco, alcohol and other substances that pose health risks.	• One-on-one counselling • Health promotion and education to groups (such as school children) and communities • Outreach to people suffering from the negative affects of substance misuse or at risk of substance misuse • Day to day living support for those seeking to be free of an addiction

Programme	Key Role or Function	Examples of Activities
Healthy Happy Families	The Healthy Happy Families programme provides education and support to individuals, families and communities experiencing, or who are at risk of experiencing, family and domestic violence.	• Group yarning sessions about the dynamics of family and domestic violence and how it can be managed and prevented • School based education around issues like bullying and how to build relationships built on mutual respect and equality • Mentoring and support of youth with behavioural problems typically associated with experiences of family and domestic violence
Culturally Appropriate Foster and Kinship Care Service	This programme is responsible for recruiting, training and supporting Aboriginal and Torres Strait Islander foster and kinship carers.	• Assessment of potential foster and kinship carers • Education about the roles and responsibilities of carers • Facilitation of safe, culturally appropriate placements • Ongoing support and mentoring of carers • Advocacy for carers seeking additional support or assistance from the Queensland Department of Child Safety

Programme	Key Role or Function	Examples of Activities
Child Wellbeing	The Child Wellbeing programme seeks to ensure that Aboriginal and Torres Strait Islander children, as far as possible, are raised within their own families and/or communities. It does this by fulfilling the Recognised Entity function for the Queensland Department of Child Safety. Recognised Entities provide cultural and family advice in Aboriginal and Torres Strait Islander child protection matters (Queensland Government Department of Child Safety, unknown). The programme also runs a Family Intervention Service to support Aboriginal and Torres Strait Islander families in the child protection system.	When a child comes to the attention of the Queensland Department of Child Safety a process is enacted to determine the best outcome for that child. The Child Wellbeing programme activities mostly revolve around key decision making points within this process. For example, programme staff will be involved with: • Intake – where a decision is made on whether to officially record a notification of suspected harm or neglect • Investigation and assessment of an official notification • Court proceedings • Placement of children in out-of-home care. Additionally a Family Intervention Service Support Worker helps children and families referred by the Department. They work with parents to help them maintain contact and ideally reunify with children placed in out-of-home care.

Appendix C Research Agreement

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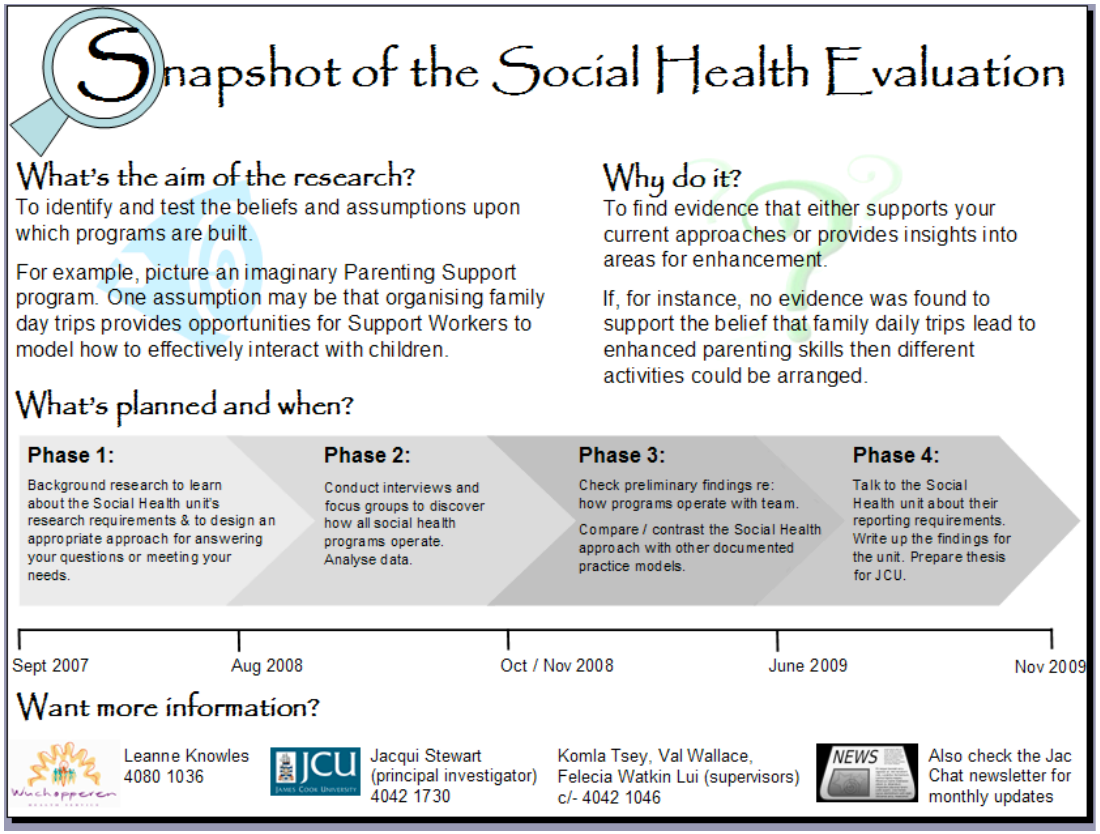
Appendix D Poster for Social Health about the Research Study



Appendix E Example of Monthly Newsletter prepared for Social Health

Jac Chat: **Social Health Unit Evaluation* Update**

Welcome to another monthly update of my progress on the Social Health Unit's research project. Below you'll find a summary of what I've been doing in August and what is planned for September. Please feel free to ask for earlier editions of the newsletter if you missed out.

Reading, Writing and Yarning

I finished reviewing evaluations of other health programmes and submitted a report to my JCU supervisors for comment. Let me know if you'd like a copy too.

This review will inform the research with the Social Health unit. To date, the review has helped me to clarify what questions to ask in the first round of interviews with programme staff.

The interviews conducted in August have focused on how the Social Health unit's programmes have developed over time and how they operate today.

Thanks to everyone who consented to participate. I'll use your valuable insights to contextualise the research study.

What's next?

Toni R and I will be preparing a presentation for the Creating Futures Conference on September 25, 2008.

I'll also be typing up interview transcripts and analysing the data to start documenting background information about how and why your programmes operate the way they do.

Prepared by Jacqui Stewart, August 2008
Contact me on (07) 4042 1730 or at jacqueline.stewart@jcu.edu.au

*Ethics approval for the project has been granted by the JCU Human Research Ethics Committee (approval number: H2951).

Appendix F Examples of Field Observations

Date:	10/09/2008
Location:	[Name of programme] office
Present:	[Name of Social Health team member] and I

Spoke to [team member's name] today. She explained her team was attending training relevant to intervening with people using cannabis. [Team member's name] revealed that she'd never been involved in the intervention side before.

"I've never been involved in the intervention side before. In my previous work, like with [name of organisation], I might have identified substance users, assisted in the assessment process but a third party intervened for rehab".

[Team member's name] was very open about the fact she had a lot to learn. Perhaps seemed a little overwhelmed – her eyes were wide and she spoke a little tentatively. Explained she could have worked for [name of programme] but choose [name of programme] so she could learn new stuff.

This made me reflect on the Wuchopperen recruitment processes. How do they decide who is the 'right' person for the job? If [team member's name] didn't have the exact previous experience required of the position what made her the 'right' candidate?

Date:	16/09/2008
Location:	[Name of programme] office
Present:	[Name of Social Health team member] and I

Said to [team member's name] that I realised how important recruitment was to ensure the 'best' possible team. I asked for some insights into what the team looks for when recruiting. Here's what she identified:

- Team work

  If examples aren't provided by interviewee they will be asked questions like: What constitutes a good team? Give examples.

- Unconditional positive regard

  As [team member's name] explained this concept I recorded the following quotes:

  - "Wouldn't turn nose up at someone who came in smelling of camp fire"
  - "Cast no judgments"
  - "Undeniable dignity of every human being"
  - "But for the grace of God a visitor's fate could be our own"
  - "Sensitivity communicating with Aboriginal and Torres Strait Islander peoples"
  - "Learning person" (that is, committed to learning)
  - "Keeping focused on people coming in here for help".

[Team member's name] talked about the tough decision they've made re: needing to let people go. They said it helps to remember it's all about the people coming in for help and ensuring the right staff are there to offer that help.

Appendix G Interview Schedule

The following interview schedule was used during the first round of interviews with senior representatives of different social health programmes.

Purpose of the interview: Your responses to the following questions will help me to learn about how and why the Social Health Unit's programmes have developed over time and how they operate in the present day.

The information you provide will be used to explain the context or background within which the evaluation is taking place. Your comments will also help to direct my activities because I will gain insights into what the unit might need or expect from the evaluation.

Questions:

1. Describe your role within the Social Health unit including your key responsibilities or duties.

2. When and how did the <insert division / programme name> come to be established?

3. Who are your clientele?

4. What programmes[19] does your team currently deliver?

[19] The term *programme* is used to represent a distinct set of resources and activities organised to intervene to help solve a social health problem or provide a service.

5. What issues or problems are these programmes / services seeking to address?

6. What results or outcomes does the unit set out to achieve through the delivery of its programmes and services?

7. How does the team know when these results have occurred? What type of evidence satisfies the team that the result was achieved?

Appendix H Group Workshop Run Sheet

Working towards a Counselling Practice Model

Facilitator Run Sheet

Wuchopperen Social Health

Version No 2
February 2009

Duration: 120 minutes

Working Towards a Counselling Model of Practice

Introduction

Duration	***Objective***	***Key Points***	***Materials***
2 mins	Welcome and acknowledgements	Good morning. To begin, I'd like to acknowledge the traditional owners of the land on which we meet and pay my respects to Elders past and present.	Timings (Appendix 1)
	Introduce yourself	For those of you who don't really know me, my name is Jacqui. I'm a Masters candidate with the School of Indigenous Australian Studies at James Cook University here in Cairns. Originally from Melbourne, I moved up to Townsville in 2005 to commence a course in Indigenous studies at JCU. In late 2006 one of my lecturers told me that an organisation called Wuchopperen was interested in conducting research. I was fortunate enough to be selected to work on the project and moved up to Cairns in late 2007 to start work with Wuchopperen. Prior to going back to study I worked in a variety of roles – most of them related to training and development for private businesses like banks or insurance companies.	

Duration	***Objective***	***Key Points***	***Materials***
	Thank participants	I wanted to share something about myself because over the next two hours I'm going to be asking you to share your specialised knowledge and experiences of counselling. I want to thank you in advance for electing to come and share that specialised knowledge. I look forward to working with you today to explore Social Health's model[20] of practice.	

[20] Model – framework or structure for achieving desired outcomes.

Duration	***Objective***	***Key Points***	***Materials***
10 mins	Group agreement	To kick start the workshop I'd like us to spend up to ten (10) minutes negotiating a group agreement around behaviours or actions that everyone agrees will support open and honest communication. **Question: What should be some ground rules for today's session?** • **Respect** – Give undivided attention to the person who has the floor (permission to speak) • **Confidentiality** – What we share in this group will remain in this group o If you'd like to share any information perhaps obtain permission first. • **Openness** – We will be as open and honest as possible • **Right to pass** – It's always okay to pass or not to answer a question • **Non-judgmental approach** – We can disagree with another person's point of view without putting that person down • **Minimise disruptions** – We turn our mobile phones off or switch them to silent if expecting urgent calls • **Commit to time management** – Try to finish exercises within suggested times and return from breaks promptly. Thanks for your input. I'll put this on the wall to remind us of what we've striving for throughout the session.	

Duration	***Objective***	***Key Points***	***Materials***
3 mins	Audio recording and confidentiality	I'd also like to raise with group some issues surrounding audio recording and confidentiality. Over the course of the next two hours I'll ask you to participate in a range of exercises – small group work and whole-of-group discussions.	

Duration	*Objective*	*Key Points*	*Materials*
		For the whole-of-group discussions I'd like to take an **audio recording** to ensure I don't miss any of your comments. I'm the only one that will listen to the recording and I commit to keeping your comments confidential. I will most likely end up typing up direct quotes from the recordings to reinforce key findings or recommendations in the research. However, I will not attach any identifying information to those quotes. So, a quote will not be linked to a name, specific job title or location. Also for the **small group work** I'd like the opportunity to move around the room and just listen to what you're saying. • **Notes** – I may take some notes just to remind myself of what's going on and these notes may end up written up in the research. • **Confidentiality** – However, again I won't attach them to any identifying information, like a name or specific job title, to any comments or observations. **Question: Is that ok with everyone?**	

Duration	***Objective***	***Key Points***	***Materials***
	Informed consent	These issues around audio recording and confidentiality are also outlined in the Informed Consent Form. As a sign that everyone is happy to proceed can I please check that everyone's read and given me a signed **Informed Consent Form**?	Informed Consent Forms General Information Page
	Other	Feel free to help yourself to food or drink as the session goes along.	--

Counselling Outcomes and Activities

Duration	***Objectives***	***Key Points***	***Materials***
5 mins	Introduction	The first exercise I'm going to ask you to complete involves: • Identifying the **outcomes** the counselling services set out to facilitate in partnership with the individuals, families and communities you work with • Identifying the **activities** that you carry out to help bring about these desired outcomes.	--
	Set up small group activity	**Break into small groups** For this part of the session I'd like you to break into **three (3) groups of three (3)**. Ideally try to mix up who's in each group – so there's a mix of people from different locations and perhaps different counselling specialities. So if we could do this now; perhaps trying to set up in different parts of the room. *Allow time for people to move around.*	Exercise instruction card (Appendix 2) Activities Diagram (Appendix 2)

Duration	*Objectives*	*Key Points*	*Materials*
		Within your group, please nominate a **note taker** and a **presenter**. Presenter will be asked to deliver a five (5) minute presentation of your findings back to the group. **Exercise Instructions** *Distribute instruction cards (see Appendix 2)* You'll see from the cards that I'm passing around that this activity has two parts: **1. Desired Outcomes** First I'd like your group to discuss why counselling is offered; to identify the expected outcomes or end results the counselling service as a whole is striving for. **2. Activities** Next I'd like you to identify the activities that you carry out to facilitate or bring about these desired outcomes. To start you off with your discussion about activities I'd like you to consider a **diagram**.	

Duration	*Objectives*	*Key Points*	*Materials*
		The diagram was prepared following interviews with representatives of each social health programme. It reflects my understanding of the activities that all programmes seem to carry out to bring about desired outcomes. So let's perhaps start by considering the relevance of this diagram to what you do as counsellors. Then either add to this diagram or come up with something totally new that describes what you do in order to facilitate desired outcomes. **Any questions or comments?**	
		Cues / probes: • **Desired outcomes** ▪ What changes to you expect to see in your visitor's behaviour, knowledge, skills or level of functioning? ▪ What are your short-term outcomes? (1 to 3 years) ▪ What are your long-term outcomes? (4 to 6 years)	

Duration	***Objectives***	***Key Points***	***Materials***
		• **Activities** ▪ At this stage the aim isn't to identify specific activities that worked with particular individuals. Instead you're looking for activities that seem to be carried out in the majority of cases. **Timing** You've got 20 minutes to complete the exercise. Then we'll join up together and I'll ask your nominated presenter to share with everyone what you came up with.	
20 mins	Conduct activity		Butchers paper Markers

Duration	***Objectives***	***Key Points***	***Materials***
25 mins	De-brief	**Cues:** ▪ Call time after 20 minutes ▪ Explain it's now time for presentations, of up to five (5) minutes, about the group's findings on: • The counselling service's desired outcomes • The activities carried out to facilitate achievement of desired outcomes. ▪ Time permitting, after everyone's presentations we'll have a five (5) minute wrap to enable us to reflect on similarities or differences of each group's findings ▪ Identify presenters from each group and obtain a volunteer to report back first ▪ Time permitting; allow five (5) minutes for any comments regarding the similarities or differences between the various findings.	
10 mins	**Break**		

Counselling Case Studies

Duration	***Objectives***	***Key Points***	***Materials***
5 mins	Introduction	Our final exercise for the session involves coming up with case studies. What I'm looking for are examples which: • Demonstrate how the activities that you carried out in particular situations facilitated the fulfilment of desired outcome/s.	--
	Set up small group activity	**Break into small groups** Again we're going to do this in smaller groups. With these groups please try to ensure that you end up with a mix people who have been with Wuchopperen for different periods of time. Can you please break into **three (3) groups of three (3)**? *Allow time for people to move around.* As before, please nominate a **note taker** and a **presenter**. Presenter will be asked to deliver a five (5) minute presentation of your findings back to the group.	Exercise instruction card (Appendix 3)

Duration	*Objectives*	*Key Points*	*Materials*
		Exercise instructions *Distribute instruction cards (see Appendix 3)* Each of the cards that I'm passing around asks you to consider a particular set of circumstances. For example, I might ask you to consider identifying a case study that demonstrates how you'd support someone with a co-morbidity – such as depression and high blood pressure. Please don't feel too restricted by my suggested starting points. Anything that loosely fits the circumstances I've described will be fine. Cues / probes: • Reinforce commitment to Wuchopperen's privacy policy and reassure people that no names or other identifying information needs to be shared. **Any questions or comments?** You've got 15 minutes to complete the exercise. Then we'll join up together and I'll ask your nominated presenter to share with everyone what you came up with.	

Duration	***Objectives***	***Key Points***	***Materials***
15 mins	Conduct activity		Butchers paper Markers pens
15 mins	De-brief	Cues: ▪ Call time after 15 minutes ▪ Explain it's now time for presentations, of up to five (5) minutes, about the group's discussions ▪ Identify presenters from each group and obtain a volunteer to report back first ▪ Key information to look for in the presentations: • The age, gender and wellbeing concerns of the individual who is the focus of the group's case study • Desired outcome/s • How counselling activities contributed to the achievement of the desired outcomes.	Presentation format written up on butchers paper

Summary

Duration	*Objectives*	*Key Points*	*Materials*
1 min	Summary of this Session	Summarise what was covered: ▪ **Outcomes** – Looked the results that you as counsellors support people to achieve ▪ **Activities** – Considered things that you do – as counsellors – to facilitate the achievement of desired outcomes ▪ **Case studies** – Identified some practical examples that demonstrate the link between what you do and the outcomes you're seeking to achieve in partnership with the people you meet with.	--
7 mins	Workshop feedback	As one final activity I'd like you to fill in a feedback sheet that is design to help me reflect on how the workshop went today. I'd like you to spend no more than five (5) minutes completing the sheet now. I'll then finish up with a quick review of what is planned post workshop. *Distribute feedback sheet (see Appendix 4).*	Self Reflection Sheet (Appendix 4)

Duration	***Objectives***	***Key Points***	***Materials***
2 mins	What next?	Cues: ▪ Examine all the outputs of our discussion today – so butcher's paper and audio recording ▪ Consolidate this information to come up with a model of counselling practice ▪ Talk to [names of two Social Health team members] about the best way to come back to you to fill any gaps in my understanding of what you do • Analysis and interpretation phase is most critical part of the process so may take a number of months • Again talk to [names of two Social Health team members] about most appropriate way to get feedback on my findings.	--
	Thanks	Thanks so much for taking time out of your busy schedules to participate. I really value everyone's contributions.	

Facilitator Run Sheet Appendices

Appendix 1 – Outline of Session Topics and Timings

Time	***Session***	***Total Duration***
9.30 to 9.45 am	Introduction	15 minutes
9.45 to 10.35 am	Counselling Outcomes and Activities	50 minutes
10.35 to 10.45 am	Break	10 minutes
10.45 to 11.20 am	Counselling Case Studies	35 minutes
11.20 to 11.30 am	Summary	10 minutes

Appendix 2 – Outcomes & Activities Exercise Instructions

Small Group Exercise 1: What are your desired outcomes and how do you go about achieving them?

1. *Identify desired outcomes*

   Why offer counselling? What outcomes or end-results does the counselling service as a whole aim for?

2. *Identify activities*

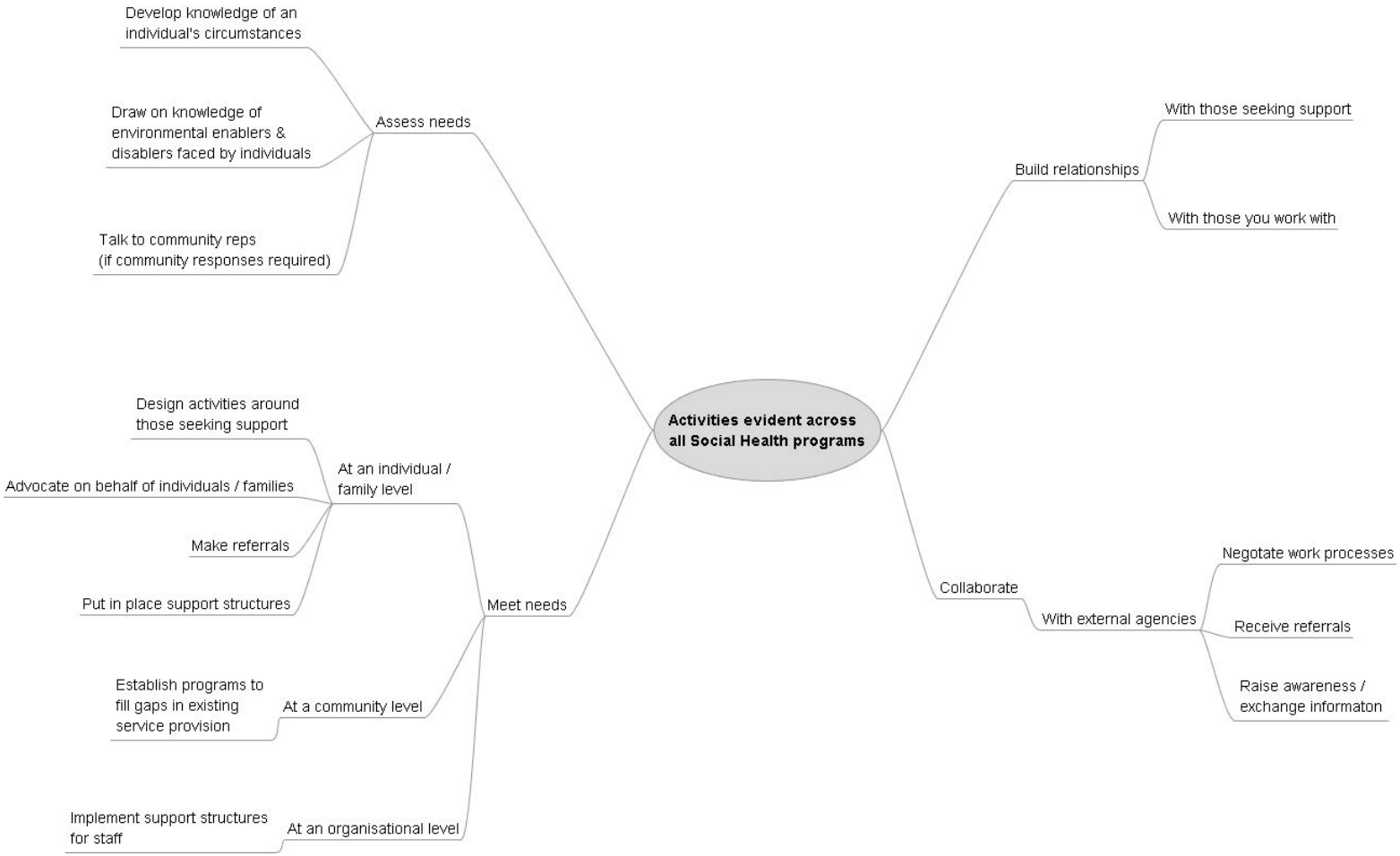
   What activities do you undertake with the majority of people you work with to facilitate the achievement of desired outcomes?

   To assist your deliberations, consider Diagram 1:

   - Does the diagram capture activities undertaken by counsellors and others?
   - What's missing?
   - What needs to be changed?, or
   - Is it better to forget the diagram and start again?

Prepared by J. M. Stewart, School of Indigenous Australian Studies, James Cook University

Diagram 1 – Draft Mind Map of Activities Common to all Social Health Programmes



Appendix 3 – Case Study Exercise Instructions

Small Group Exercise 2: Example of the link between counselling activities and outcomes

Setting the Scene

Imagine you are counselling a person experiencing extreme sadness (following the passing of a family member) and high blood pressure.

Contributing factors to the high blood pressure are excessive weight, lack of physical activity and alcohol consumption.

Discussion Points for the Group

Identify how you would support this person to manage their grief and high blood pressure.

- What outcomes might you seek to achieve in partnership?
- What counselling activities would you carry out to facilitate the achievement of the desired outcome/s?
- How do you anticipate that these activities would support the achievement of the desired outcome/s?

Prepared by J. M. Stewart, School of Indigenous Australian Studies, James Cook University

Small Group Exercise 2: Example of the link between counselling activities and outcomes

Setting the Scene

Think back to a time when you were counselling an individual who required the support of at least one other Social Health programme or service.

Discussion Points for the Group

Identify how you supported this person:

- What outcomes were you seeking to achieve in partnership with this individual?
- What referrals did you make and why?
- What activities did you carry out to facilitate the achievement of the desired outcome/s?
- How did you anticipate that these activities would facilitate the achievement of the desired outcome/s?

Prepared by J. M. Stewart, School of Indigenous Australian Studies, James Cook University

Small Group Exercise 2: Example of the link between counselling activities and outcomes

Setting the Scene

Think of a counselling situation that demonstrates the importance of adopting a culturally sensitive approach.

Discussion Points for the Group

- What was the situation?
- What made your approach to counselling in this situation culturally sensitive?
- What outcomes were you seeking to achieve in partnership with the individual, family or community you were working with?
- How did the culturally sensitive approach facilitate the achievement of desired outcomes?

Prepared by J. M. Stewart, School of Indigenous Australian Studies, James Cook University

Appendix 4 – Workshop Feedback

What did you like about the workshop? Please explain why.

What didn't you like about the workshop? Please explain why.

How could the workshop be improved?

Would you like a one-on-one follow up?

If you'd like to speak with me further about today's workshop please include your name and preferred contact time below. Otherwise feel free to submit an anonymous feedback sheet.

Appendix I Ethics Clearance

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