Ngarrang Gulinj-al Boordup

"Caring for our Mob, in health and wellbeing"

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Acknowledgements and Thanks:

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Thanks are extended to the EACH staff members and Aboriginal and Torres Strait Islander clients for their time and insights.

Acronyms

ACCHO	Aboriginal Community-Controlled Health Organisation
AHWT	Aboriginal Health and Wellbeing Team
AOD	Alcohol and other drugs
ATOD	Alcohol, tobacco and other drugs
DDCAT	Dual diagnosis capability in assessment and treatment
DHHS	Victorian Government Department of Health and Human Services
EMPHN	Eastern Melbourne Primary Health Network
HOPE	Hearing Other People's Experiences
ITC	Integrated Team Care
THRIVE	Trauma-informed, holistic, recovery-oriented, integrated care, voluntary, engaging families

Acknowledgement of Country:

We would like to respectfully acknowledge the traditional custodians of this land on which we work and live - the Wurundjeri and Boon Wurrung People, past, present and future, speakers of the Woi Wurrung and Boon Wurrung language groups and members of the Kulin nation. It is upon their ancestral lands that we carry out our work.

We would also like to acknowledge, recognise and pay respect to all Aboriginal and Torres Strait Islander people as the traditional custodians of Australia, in their belonging caretakers to the land, the skies and waterways as the oldest living culture in the world. To their ancestors, elders, youth, and children past and present, and those of the future as the knowledge holders, we honour their ongoing and spiritual connection to this country.

Executive summary

Across Australia, the consumption of alcohol and other drugs (AOD) continues to cause a greater burden of disease within Aboriginal and Torres Strait Islander communities than in the non-Aboriginal population.

In the Eastern Metropolitan Region of Melbourne, two EACH programs located in Ferntree Gully – the Ngarrang Gulinj-al Boordup Aboriginal Health and Wellbeing Team (AHWT) and Project HOPE/THRIVE – have been successfully working together to provide wrap-around services to Aboriginal and Torres Strait Islander community members with alcohol, tobacco and other drugs (ATOD) concerns. Anecdotal evidence suggests that such collaborative care keeps clients with complex issues engaged, supported and hopeful along their recovery journey.

This report uses a case study approach to explore and develop a rich understanding of the key elements underpinning the collaborative model of care between EACH's Ngarrang Gulinj-al Boordup AHWT and its HOPE/THRIVE program of federally-funded AOD support. This includes relationships and trust; good communication and frequent contacts; co-location of multiple services; supported transport; flexibility and responsiveness; a team-oriented, family-centric and holistic approach to AOD misuse, health and wellbeing; and operationalizing a philosophy emphasizing welcome attitude, empathy and hope.

Three real-life client stories are presented, in order to reveal what this collaborative model looks and feels like, from the perspective of those benefiting from it.

Introduction

Purpose of this report

Across Melbourne's Eastern Metropolitan Region (EMR), there have been anecdotal reports in recent years around EACH's HOPE/THRIVE program – consisting of a dual diagnosis-capable Alcohol, Tobacco and Other Drugs team – having been successful in engaging Aboriginal and Torres Strait Islander community members in treatment and recovery. This would largely result from an informally-established collaborative model of care with EACH's Ngarrang Gulinj-al Boordup Aboriginal Health and Wellbeing Team (AHWT). The purpose of this report is to shed some light on what makes this collaborative model of care unique and effective, and share elements of good practice with the broader service sector.

Aim

To clarify and document the provision of culturally-competent alcohol, tobacco and other drugs (ATOD) and mental health services for Aboriginal and Torres Strait Islander people at EACH.

Objectives

- To identify and document the effective processes and key features for EACH's collaborative model of ATOD and mental health care for Aboriginal and Torres Strait Islanders; and
- To illustrate what the collaborative model looks and feels like, from a client and practitioner perspective.

Methods

A case study approach was used to develop a rich understanding of the collaborative model of care between EACH's Ngarrang Gulinj-al Boordup AHWT and HOPE/THRIVE teams.

Data collection

Data were collected using the following methods:

- Document review: Program-related documentation was consulted to identify key processes and principles of service delivery. Examples include HOPE/THRIVE's latest Dual Diagnosis Capability in Addiction Treatment (DDCAT) audit results and recent reports to the Eastern Melbourne Primary Health Network (EMPHN).
- Focus group with practitioners: A semi-structured discussion was conducted with practitioners from EACH's HOPE/THRIVE (n = 5) and AHWT teams (n = 3). During this discussion, participants were also given the option of drawing what collaboration felt like. One person took on this opportunity, and this data is presented later in this document.
- Client interviews: Five Aboriginal and Torres Strait Islander clients, with current or past experience of receiving services from both of EACH's HOPE/THRIVE and AHWT teams were interviewed. Interviews were conducted by two EACH employees who are not part of the AHWT and HOPE/THRIVE teams, and who were not known to participants. A trusted member of the AHWT or the HOPE/THRIVE team was present during interviews, to help participants feel comfortable with the process.

While formal ethics approval was not sought from an established human ethics research committee for this work, two key members of the project team have had extant experience with ensuring that past research projects were compliant with NHMRC ethical standards (National Health and Medical Research Council, 2018), including for vulnerable population groups. As a result, all engagement with staff and clients was guided by ethical principles, and precautions were put in place to ensure that participation in the focus group and in interviews was based on voluntary and informed consent. Further detail is found in Appendix 1. In accordance with EACH's Consumer, Carer and Community Remuneration Policy, interview participants were reimbursed for their time.

Data analysis and write-up

Analysis of focus group and interview data followed a two-step, iterative process. Focus group data was first thematically analysed by the project team, to identify key processes and elements of program design which practitioners thought were critical to enabling cross-team collaboration and the attainment of better outcomes for Aboriginal and Torres Strait Islander clients. The themes identified then informed the development of questions for the individual client interviews. Draft interview questions were tested and refined with practitioners from EACH's Ngarrang Gulinj-al Boordup Aboriginal Health and Wellbeing Team, to ensure that they were phrased in way that was culturally appropriate.

Interview data was then also thematically analysed, to uncover cross-case similarities and findings, and further refine the description of the collaborative model. Three case illustrations (i.e. client stories) were also prepared using interview data.

Background

Alcohol and other drugs misuse among Aboriginal and Torres Strait Islanders

Key statistics

Across all of Australia, the consumption of alcohol and drugs causes a greater burden of disease within Aboriginal and Torres Strait Islander communities than in the non-Aboriginal population.

In Victoria in 2014/15, 40% of Indigenous Australians aged 15 years and over reported having used an illicit substance in the previous 12 months. This is higher than the national average of 27%. National statistics from 2016 also demonstrate that recent[1] illicit drug use is more prevalent among Indigenous Australians than non-Indigenous Australians, with:

- Use of any illicit drug being 1.8 times higher;
- Use of cannabis being 1.9 times higher;
- Non-medical use of pharmaceutical drugs being 2.3 times higher; and
- Use of methamphetamines and/or amphetamines being 2.2 times higher (Australian Institute of Health and Welfare, 2019).

On a positive note, Aboriginal and Torres Strait Islanders across Australia are more likely to entirely abstain from drinking alcohol than non-Aboriginal Australians. Further, according to national data, the proportion of Indigenous Australians that consume alcohol at levels that exceeds lifetime risk guidelines has reduced from 19% in 2008 to 15% in 2014-15. However, Aboriginal and Torres Strait Islanders who did drink in 2016 were 2.8 times more likely to partake in binge drinking (i.e. consuming 11 or more standard drinks at least once a month) than their non-Aboriginal counterparts (Australian Institute of Health and Welfare, 2019).

Unhealthy behaviours such as addiction, smoking and alcohol and drug misuse within Aboriginal and Torres Strait Islander communities arise from the complex interaction of multiple determinants. These range from downstream factors, such as personal choices, to more important and pervasive upstream determinants, such as the enduring effects of colonization, dispossession, forced family separations, and resulting loss of culture and intergenerational trauma (Osborne et al., 2013). It is estimated that up to 39% of the gap in health outcomes between Indigenous and non-Indigenous Australians can be explained by social determinants (Australian Institute of Health Welfare, 2018).

Broad factors influencing choice and access to health services by Aboriginal and Torres Strait Islanders include availability, affordability, appropriateness, and acceptability (Commonwealth of Australia, 2017a). Importantly, the Australian Government's *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* acknowledges that "*culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander people's health problems generally, and mental health problems, in particular*" (Commonwealth of Australia, 2017b).

1 'Recent' use refers to the last months

Towards Aboriginal social and emotional wellbeing

Aboriginal conceptualisations of health and wellbeing are broader than the Western beliefs of the mainstream population, and place greater emphasis on family, community, connection to land, and culture:

> "Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people, this is seen in terms of the whole-life-view. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and must bring about the total wellbeing of their communities." (Gee et al., 2014)

Consequently, the holistic concept of 'social and emotional wellbeing' (SEWB) is preferred when referring to mental health and wellbeing-related matters for Aboriginal and Torres Strait Islanders. Central to this conception is the notion of self being "grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community" (Gee et al., 2014). Aboriginal social and emotional wellbeing depends on one self's connection to body; mind and emotions; family and kinship; community; culture; country; and spirit, spirituality and ancestors (Gee et al., 2014).

Therefore, unsurprisingly, a review paper from the Australian Institute of Health and Welfare has found that programs which show promising results to enhance Indigenous social and emotional wellbeing are "those that encourage self-determination and community governance, reconnection and community life, and restoration and community resilience" (Dudgeon et al., 2014). Critical program features include:

- A holistic approach;
- A focus on recovery and healing from stress and trauma;
- A means of empowering people to regain a sense of control and mastery over their lives;
- Strategies that are Indigenous-led, family-focused, culturally responsive, and context-specific;
- Interdisciplinary approaches that provide outreach services and transport; and
- Partnerships with Aboriginal Community Controlled Health Services (ACCHOS) and local communities (Dudgeon et al., 2014).

Aboriginal and Torres Strait Islanders in the Eastern Metropolitan Region of Melbourne

During the 2016 Census of Population and Housing, 3,977 residents of the Eastern Metropolitan Region of Melbourne identified being of Aboriginal and/or Torres Strait Islander descent (0.4% of the total regional population) (Australian Bureau of Statistics, 2017). The Yarra Ranges local government area is home to the highest proportion of Aboriginal residents across the region, with a sizeable community living in Healesville and surrounds. The City of Knox, where EACH's Ferntree Gully site is located, is also home to a growing number of Aboriginal and Torres Strait Islander community members (Australian Bureau of Statistics, 2017).

EACH social and community health

Originally established as Maroondah Social Health Centre in 1974, EACH was founded on the principle that all people are entitled to good health, regardless of socio-economic factors.

Fast-forward 46 years later, and EACH is now a large and responsive social and community health organisation, with locations along the Eastern seaboard. In the Eastern Metropolitan Region (EMR) of Melbourne, EACH has a long history of providing a comprehensive range of services that address the physical, mental and psychosocial needs of individuals and various community groups.

Ngarrang Gulinj-al Boordup: caring for Aboriginal health and wellbeing at EACH

The Ngarrang Gulinj-al Boordup Aboriginal Health and Wellbeing Team (AHWT), a program of EACH, supports and assists Aboriginal and Torres Strait Islander community members to access the health and community services they need, under the Commonwealth-funded Integrated Team Care program (ITC – previously known as Care Coordination and Supplementary Services). The team includes Aboriginal Health Facilitators, a Nurse Care Coordinator and an Outreach Worker. Staff work alongside and provide support to Aboriginal and Torres Strait Islander community members with chronic health conditions (including mental illness) to improve their self-management of their health conditions. They can provide advocacy, health and wellbeing assessments, referral(s) to mainstream and Aboriginal health and social services, arrange transport to and from medical and/or other health appointments, accompany clients during medical appointments, and assist in providing medical equipment. The team is based at EACH's Ferntree Gully site, but can outreach to home, health services or community locations as necessary.

Central to the Ngarrang Gulinj-al Boordup AHWT model is connection and belonging – to self, family, community, and culture. Also central is an understanding that Aboriginal health and wellbeing will be achieved when there is a balance across physical wellbeing, mental and spiritual wellbeing, emotional wellbeing, and social wellbeing. Figure 1 provides an overview of the team's model of practice. The model is also described in greater detail in Appendix 2. Further, the Team's work with community is informed by anti-oppressive theories, Aboriginal and Torres Strait Islander cultural meaning-making, and trauma-informed care.

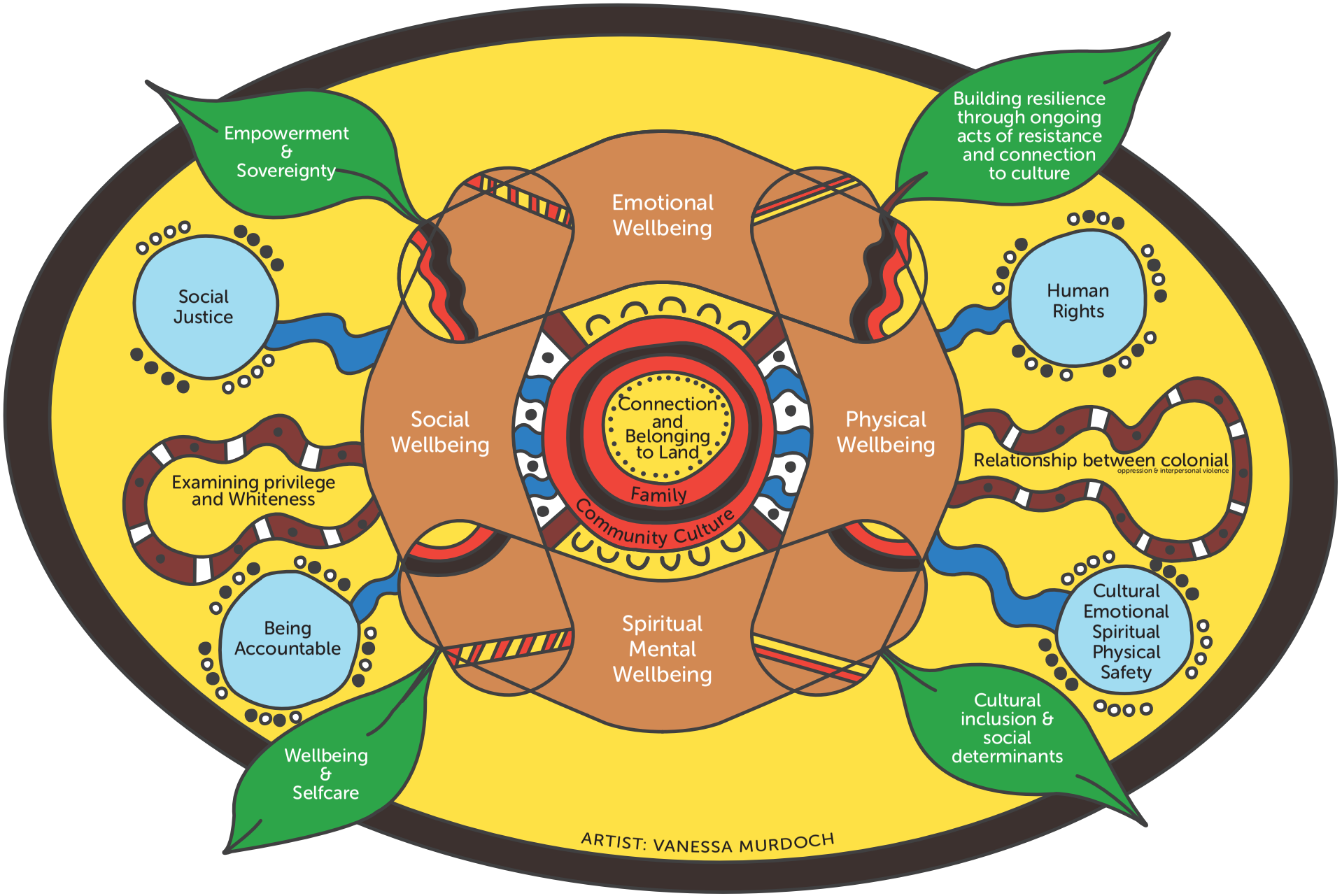


FIGURE 1: NGARRANG GULINJ-AL BOORDOOP ABORIGINAL HEALTH AND WELLBEING TEAM MODEL OF PRACTICE

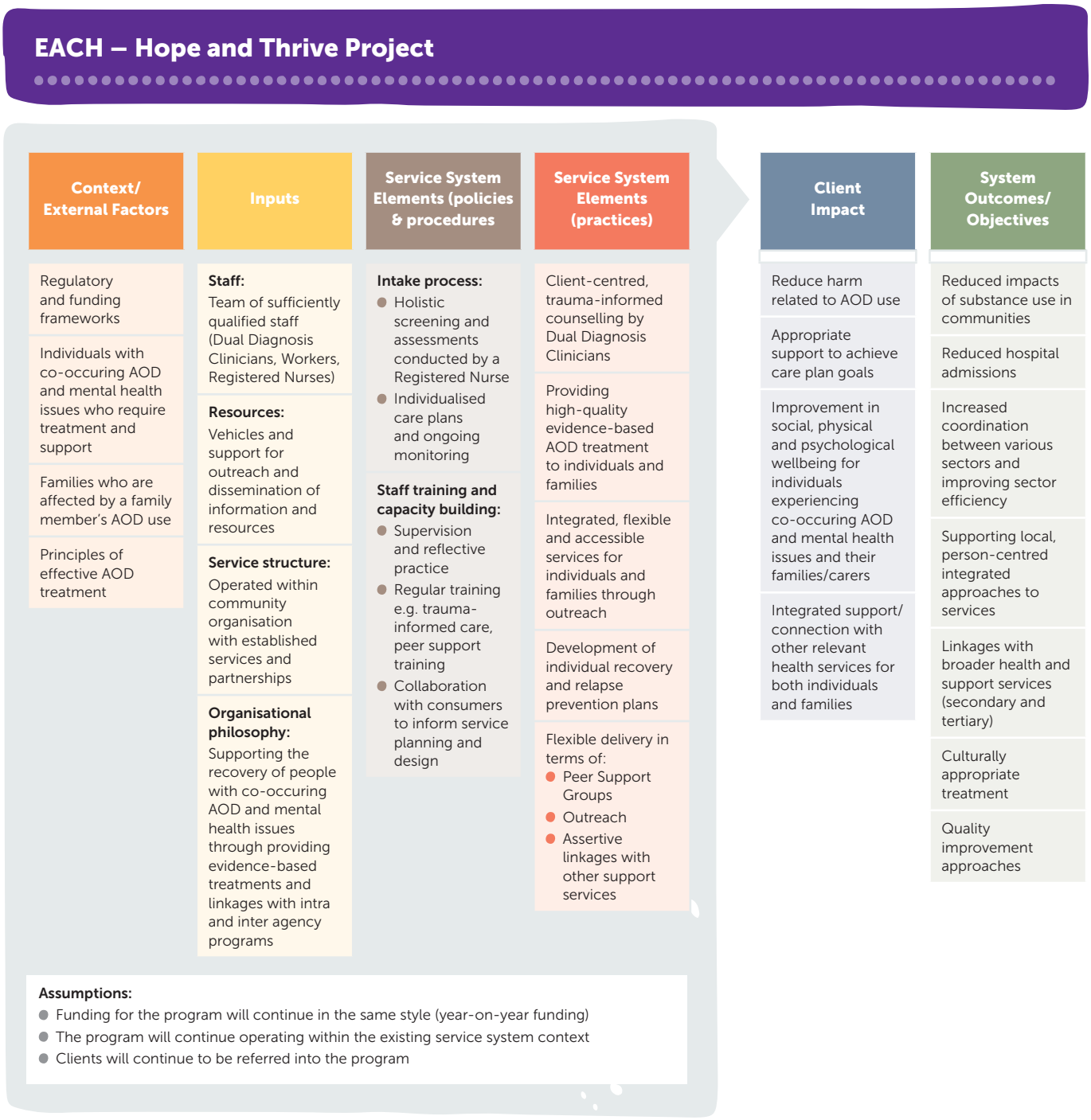
Project HOPE/THRIVE at EACH

EACH's Project HOPE/THRIVE program consists of a long-established team of dual-diagnosis capable Alcohol, Tobacco, and Other Drugs (ATOD) workers (Lime Management Group, 2016), based in Ferntree Gully. While HOPE/THRIVE each have their own objectives, these two program components work jointly to provide a service that is recovery-oriented, trauma-informed, strengths-based, family inclusive, and culturally capable. In short:

- Project HOPE (Hearing Other People's Experience) provides integrated AOD and co-occurring care utilizing a peer-led recovery and person-centred design approach; and
- THRIVE (Trauma-informed, Holistic, Recovery-oriented, Integrated care, Voluntary, Engaging families) provides clinical interventions for individuals with co-occurring substance use and mental health concerns and their significant others, through specialized therapeutic counselling.

Figure 2 shows a Logic Model for EACH's HOPE/THRIVE program, as developed by ARTD Consultants in 2019.

FIGURE 2: LOGIC MODEL FOR EACH'S HOPE/THRIVE PROGRAM (ARTD CONSULTANTS, 2019)

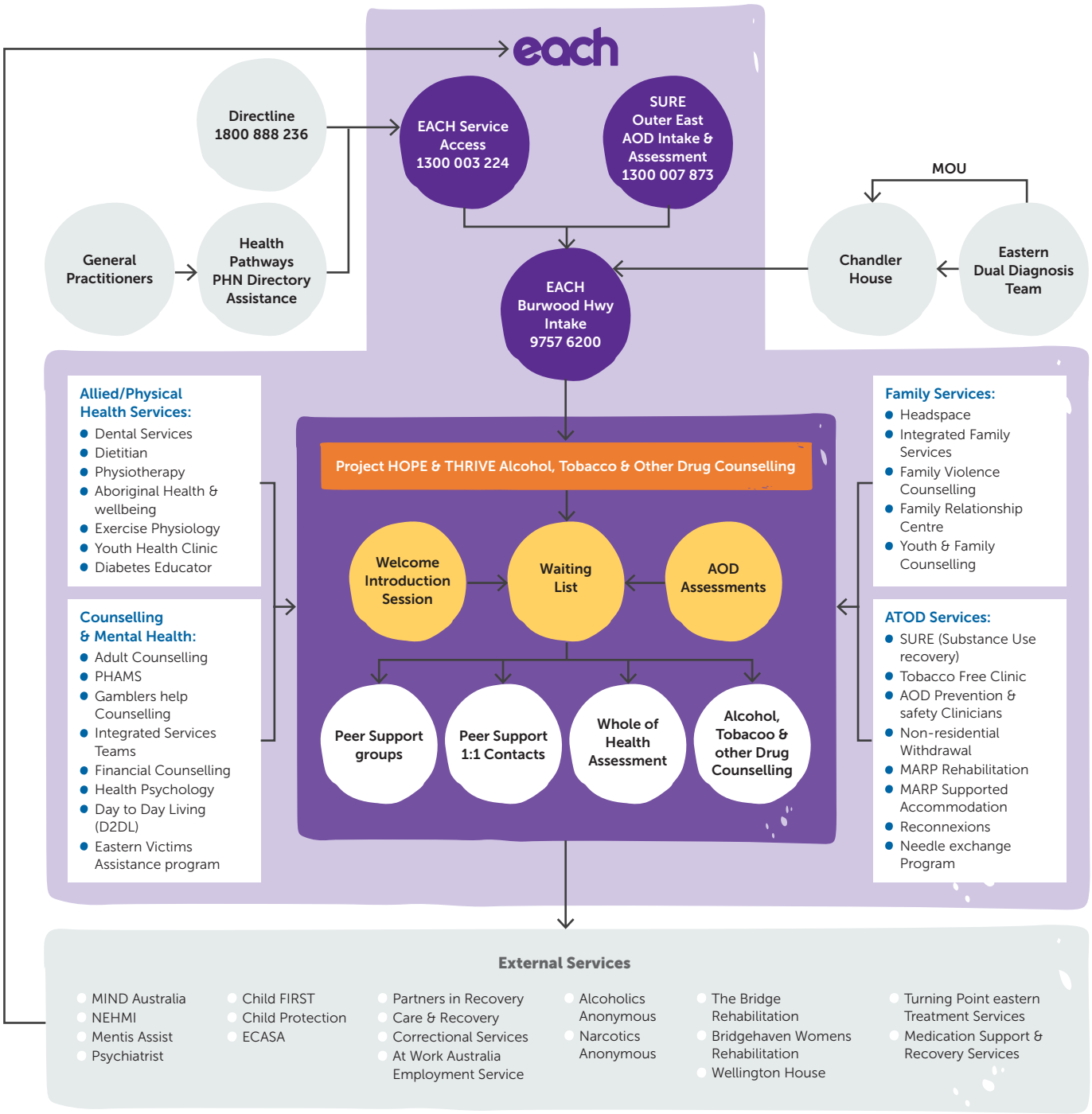


In addition to the availability and proximity of various EACH services (e.g. financial counselling, family, allied health and dental services, etc.), the HOPE/THRIVE program has a range of formal external partnerships in place, which can greatly benefit clients in their recovery journey. Key examples of partnerships include those with Eastern Health's Chandler House, Eastern Dual Diagnosis Service (EDDS), and the Association of Participating Service Users (Lime Management Group, 2016).

Through years of capacity building, this stable team has acquired a high level of dual diagnosis competency, and have the capacity to manage people with highly complex and unstable co-occurring mental health and AOD conditions (Lime Management Group, 2016). All those who access the service benefit from a comprehensive assessment of their mental health and AOD concerns, through the standard use of validated tools such as the Modified Mini Screen (MMS) and Depression Anxiety Stress Scale (DASS-21). A comprehensive, whole-of-health assessment conducted by a Registered Nurse is offered to all clients, to support the identification and joint management of other priority health needs. Figure 5 provides a diagrammatic overview of how the HOPE/THRIVE program operates.

EACH's HOPE/THRIVE program delivered over 330 episodes of care during the 2018-2019 financial year.

FIGURE 3: PROCESS FLOWCHART FOR EACH'S HOPE/THRIVE PROGRAM



Collaborative alcohol and other drugs care for Aboriginal and Torres Strait Islanders at EACH

How it began

Close collaboration between EACH's Ngarrang Gulinj-al Boordup AHWT and HOPE/THRIVE teams began in 2017, when eligibility criteria for Aboriginal and Torres Strait Islander clients to access the federally-funded, chronic disease-focused Integrated Team Care (ITC) program were expanded to include mental health. At the time, the Ngarrang Gulinj-al Boordup AHWT did not have expertise in mental health. But they knew that the practitioners in the HOPE/THRIVE program held such capability, and had a strong track record of supporting individuals and families with co-occurring mental health and AOD concerns. Collaboration between the two teams started slowly, and evolved gradually and organically into the shared care model described in this report.

During 2017-2019, the HOPE/THRIVE program received referrals for 42 individuals who identified as Aboriginal and/or Torres Strait Islanders, from the Ngarrang Gulinj-al Boordup AHWT. The latter also provided 326 instances of supported transport to enable clients to receive services from HOPE/THRIVE. During 117 of these visits, at least one other co-located service was also received.

Description of the model's key elements

According to practitioners and clients, the Ngarrang Gulinj-al Boordup and HOPE/THRIVE collaborative model features multiple key elements that make it particularly engaging and effective in working through AOD concerns with Aboriginal and Torres Strait Islander clients. These were identified during a staff focus group and individual client interviews, and are described here. At the end of this section, three real client stories help illustrate how these elements come to life as part of service delivery.

FIGURE 4: PRACTITIONER'S DEPICTION OF WHAT THE COLLABORATION BETWEEN EACH'S NGARRANG GULINJ-AL BOORDUP AHWT AND HOPE/THRIVE TEAMS LOOKS AND FEELS LIKE

Relationships and trust

EACH's Ngarrang Gulinj-al Boordup AHWT and HOPE/THRIVE teams recognise that trust and personal relationships between workers and clients are absolutely critical, as they form the basis on ongoing and genuine engagement.

Some interviewed clients already had good pre-existing relationships with members of EACH's AHWT, which facilitated their entry into the THRIVE program. For those who didn't, they came to EACH because family members had used various EACH services and already trusted them, or because they met AHWT team members at community events. Taking it slowly, having a cuppa, hearing about the extended family, and sharing stories are all part of building a long-lasting bond that will provide the backbone for each client's recovery journey.

> "I think it's a really good thing. It makes things easier. I know all of you know about my shit, or most of it. I'm okay with that. I'm comfortable about it. I trust youse."
>
> (ABORIGINAL CLIENT)

Once clients have a trusting relationship with a practitioner or the AHWT team, this facilitates referrals to other EACH services and practitioners, including the HOPE/THRIVE team. By having a AHWT team member tell a client 'I know Lynne, she's great nurse and she'll be able to help you out', trust partly transfers over and enables a more comprehensive service response through accessing additional services like dental, optometry, podiatry, etc. Long-standing relationships also mean that the AHWT workers often know their backstory well – and their family's – which can then make getting into the heart of the matter quicker when coming to appointments. AHWT and THRIVE team members discuss client situations amongst themselves, but in a way that still respects each client's confidentiality.

Good communication and frequent contacts

Regular communications and contacts with Aboriginal and Torres Strait Islander clients is critical to maintain trust and continually foster relationships. AHWT team members get in touch with Aboriginal clients regularly, through multiple channels: text message reminders ahead of appointments, weekly messages or phone chats just to 'check in' and see how a client is doing, or having a cuppa and a yarn before or after appointments. Communication is both proactive and highly responsive.

> "If I flick Erica or Uncle Des a text message, they get back to me pretty quickly. If they're in a meeting or something, they just text me back – 'Call you when we're out'"
>
> (ABORIGINAL CLIENT)

Being proactively contacted and checked upon on a regular basis is ensuring that many clients are better assisted to stay on track with their personal recovery goals, and various health and service appointments. Members of the Ngarrang Gulinj-al Boordup AHWT will continue to provide a supportive relationship even when clients have to periodically step away from EACH services during tough times to attend residential rehabilitation: "I had Uncle Des see me at least once a week while I was in detox. And they came out to the rehab I went to" (client).

The AHWT also help ensure that communication happens smoothly with other health practitioners outside of EACH – e.g. by accompanying clients to GP appointments to assist with interpreting medical information into plain English, or to help establish trust and clarify their medical background.

Co-location of multiple services

> "Having it all under one roof makes it all so much easier"
>
> (ABORIGINAL AND TORRES STRAIT ISLANDER CLIENT)

EACH's Ferntree Gully service hub houses a diverse range of allied health, dental, child and family, AOD counselling and team support, and Aboriginal health and wellbeing services. EACH AHWT and HOPE/THRIVE teams are also located within the same open plan office. Such proximity has supported the establishment of formal and informal relationships between members of the two teams, as well as with other services across the site. Proximity and relationships then foster the conduct of secondary consultations, both formally and informally. They also facilitate shared ongoing learning and capacity building across the two teams about AOD misuse and culturally appropriate service delivery, in a way that goes much deeper than theory-based, formal training.

For Aboriginal and Torres Strait Islander clients, co-location makes their life easier. As many of these clients have complex and diverse health needs, their attendance at the Ferntree Gully centre is often coordinated, such that two or more services will be seen in a single visit. For example, when Gary (see his full story later in this report) comes in to see his THRIVE counsellor, she will walk him to his podiatry appointment down the hall when they are finished with their session.

Supported transport

> "Transport is not just transport"
>
> (ABORIGINAL HEALTH WORKER)

When Aboriginal and Torres Strait Islander clients experience challenges to physically get to appointments – whether at EACH, the local GP, or specialist medical services – EACH's AHWT will provide assistance either in the form of taxi vouchers or supported transport. When provided with supported transport, an EACH worker will contact a client by phone, then pick them up from their home, bring them to their appointment(s), wait and bring them back home.

But this is not just transport – the worker also offers kinship, a social connection and a listening ear. For clients, it helps them to break social isolation, enables them to make it to appointments and to stay on track with their recovery. Most importantly, the friendly worker will also help ease out any anxieties the client may have with regards to attending appointments, and boost their motivation when enthusiasm is low.

Flexibility and responsiveness

> "I've had a couple of situations where I was really down and out... And they were just there"
>
> (ABORIGINAL CLIENT)

The flexibility inherent to the Commonwealth-funded HOPE/THRIVE service model enables greater client-centredness and responsiveness. It affords workers some time not to rush clients into treatment, and to let clients lead engagement in the service, based on their level of readiness. Service provision can be stepped up (i.e. greater multiplicity of contacts with various program components) or stepped down to suit each client's broader life circumstances and fluctuating capacity to engage deeply into treatment. Once a client is ready to reengage, they can re-enter directly into service provision with their preferred practitioner, through prioritised access. The usual service access and intake processes can be bypassed, and postponed until each individual is ready to revisit such information.

For clients, such facilitated, gentle re-entry into services means that the service they receive is more personal, less underpinned by rigid programmatic requirements (e.g. no need to do a full assessment every time), and devoid of the need to repeat their story multiple times. It also means that the supports they receive can vary based on what they need and their personal interests, as the team will continually make suggestions about different activities or programs to engage with.

Responsiveness also means that the Ngarrang Gulinj-al Boordup AHWT are there when Aboriginal and Torres Strait Islander clients need them. Many spoke of being able to pick up the phone, ring or message the AHWT and HOPE/THRIVE teams and feeling confident about their call being answered, or at the very least getting a prompt text message advising of when they would be contacted later in the day. Such responsiveness – through constant contact, communication and facilitated service re-entry – plays an important role in preventing relapses along each Aboriginal and Torres Strait Islander client's recovery journey.

Team-oriented, family-centric and holistic approach to AOD misuse, health and wellbeing

AHWT and HOPE/THRIVE team members work together with other EACH services (physiotherapy, podiatry, dental, nursing, etc.) and external service providers (e.g. GPs, detox and rehabilitation services) to ensure that the care of Aboriginal and Torres Strait Islander clients is coordinated and takes into consideration multiple aspects of their health. By understanding that family and community health are central to Aboriginal notions of social and emotional wellbeing, EACH workers include and work with family members when desired by the primary client. They also understand the need to be flexible with service provision, allowing clients to step in and out when they need to deal with complex family business. If and when necessary, EACH will directly assist clients in working through personal and family issues that are ancillary to AOD concerns, as these also form part of the recovery journey.

> "I've had a client tell me: 'They're like black fellas, in the way that they work!'"
>
> (AHWT TEAM MEMBER)

The diversity of EACH's services in the Outer East enables taking a holistic approach to the health and wellbeing of Aboriginal and Torres Strait Islander clients. Unlike specialist AOD services, EACH can also offer clients services to help address some of their physical health needs (e.g. podiatry, physiotherapy, oral health). This person-centred, one-stop shop service approach is similar to what they might get in Aboriginal-specific organisations.

Welcome, empathy and hope

The overarching philosophy at EACH is 'we welcome you with empathy and hope.' This philosophy describes the experience of clients at all points of contact with EACH. It describes the organisation's service culture: "No matter who you are, how complex your situation, or how multiple your issues of concern, we welcome you. Our empathy validates your concerns; we communicate hope through our belief that opportunity for improved health and quality of life is possible".

For Aboriginal clients, this means that EACH staff adopt a positively persisting, non-judgmental approach to their Aboriginal clients' recovery journey, as it goes up and down. A non-judgmental, hopeful attitude towards recovery is critical as many clients spoke of having lost trust in other external services, because of back-stabbing and unwelcoming, unsupportive, judgmental and fatalistic attitudes from staff. In some cases, it means that they have vowed never to return to such services, even when these are acute, highly specialized programs (e.g. detox) which should theoretically play a critical part in one's recovery journey. In other AOD-specific services, many clients felt that workers were just doing their job. At EACH, they feel genuinely care about.

> "The understanding when I left the last rehab, after the amount of work that was put in to get me in there, I felt really bad, and... I'd felt like I'd let the team down a bit because they put in so much work to get me in there. But then they kept harassing me and telling me 'Don't worry about it. It happens'. That kind of made me feel a lot better."
>
> (ABORIGINAL CLIENT)

Client stories

THE FOLLOWING STORIES ILLUSTRATE HOW THE COLLABORATIVE MODEL'S KEY ELEMENTS COME TO LIFE, IN THE WORDS OF ABORIGINAL AND TORRES STRAIT ISLANDER CLIENTS. RELEVANT ELEMENTS ARE IDENTIFIED (IN BOLD) THROUGHOUT THE STORIES.

Gary's story

Gary is 68 and a member of the Stolen Generation. He suffers from lifelong trauma as a result of spending his childhood and youth in foster care and institutionalized settings.

As an adult, he has spent over 15 years on anti-psychotic medication following a misdiagnosis of schizophrenia. For many of those years, he was in a bad way – having fits, struggling with alcohol abuse, using marijuana heavily, and at times behaving aggressively because of his medications.

He used to attend an Aboriginal Community-Controlled Health Organisation (ACCHO), where he used to have a yarn with good workers, attend Stolen Generation-specific counselling and see a GP: *"The doctor was good. But the Aboriginal guy, there was a bit of backstabbing"*. As he was related to many people using the ACCHO, receiving support from within the community also involved a lot of gossip and dramas. Bad stories and rumors were spreading about him, which negatively affected his recovery. He had also previously attended detox-specific services, but his experience there was very poor, as their staff were ill-equipped in handling his history of trauma in a culturally appropriate way.

Gary's brother-in-law told him about EACH. He is now linked in with two EACH workers – one from the AHWT and one from the THRIVE team. He much prefers them as there is no backstabbing compared to his experience in the Aboriginal-specific service **(relationships and trust)**. After carefully listening to Gary's story **(empathy and hope)**, EACH's team helped organize appointments with a psychiatrist, who confirmed that Gary didn't have schizophrenia and didn't need the strong medications he had long been using. By this sorting this out, Gary was then able to slowly get his life back on track: he stopped using marijuana 6-7 years ago and also stopped smoking cigarettes 4-5 years ago.

At EACH, Gary has used podiatry, mental health community support, AOD counselling, dietetics, dental and nursing services **(holistic approach)**. He thinks his AHWT and THRIVE practitioners work well together **(co-location)**. They help coordinate his care, so that when he comes to the centre in Ferntree Gully, he can attend multiple appointments **(co-location)**. If the weather isn't great or he is in too much pain from problems with his feet, Gary uses cab vouchers provided by EACH or gets a lift from someone in the team to attend appointments **(flexibility, supported transport)**. EACH also helps to link him in with other services and community activities, such as neighbourhood houses, as these are good for his social and emotional wellbeing.

At the moment, Gary does not use the AHWT much, but he knows that he can call on the team if he needs help. He really appreciates being able to keep this connection. It provides him with an outlet, and likes just being able to have a yarn so he can make sense of what's going on for him, and what he might need to stay well and maintain his recovery **(flexibility and responsiveness)**. His trusted workers will also come with him to appointments with new health practitioners (e.g. a new GP), to kick-start new relationships and help explain his complex story and medical background. When needed, they also help out with educating and raising awareness of the nature of addiction with family members, such as his sister **(relationships and trust; good communication)**.

Gary now feels that life is pretty good. His health is better and he has what he needs.

GARY NOW FEELS THAT LIFE IS PRETTY GOOD.
HIS HEALTH IS BETTER AND HE HAS WHAT HE NEEDS.

Maria's story

Before Maria started using services at EACH, her life was hectic and some of her choices were unhealthy.

She was struggling with drug and alcohol issues, chronic health conditions, blindness in one eye, and long-term musculoskeletal conditions related to a motor vehicle accident many years prior. She had previously attended another major specialist AOD organisation for drug and alcohol assistance. She thought that they were good, but mainly helped by renewing her pharmacotherapy prescriptions: *"They're just there to help you with your suboxone script, or your methadone script. They're not there to help you with your breathing or anything like that"*. She never got offered other types of services, such as counselling, or a helping hand with transport to get to her appointments.

Maria knew Erica from the Ngarrang Gulinj-al Boordup AHWT, who encouraged her to sign up. A whole-of-health assessment with the THRIVE team's nurse highlighted that she was struggling with multiple social and emotional health concerns, and that a bit of a yarn with a counsellor could be help *"to offload some of this stuff"*. As a result, her experience at EACH has been very different to that of AOD-specific services: *"They've got things here, they've got the dental here, they've got counselling here, (...) you've got more links here"*. EACH has been assisting her with much more than drug and alcohol services. In the past year she has seen counsellors, dentists, physiotherapists and podiatrists. She's also received help with her breathing and chronic lung disease **(co-location, holistic)**. She compared them to the Fitzroy-based Victorian Aboriginal Health Service: *"They're the next best thing, you know, if you're out here (...) it's a lot closer"*.

EACH's AHWT and THRIVE workers also understood that family life is incredibly important to Maria, even if it's sometimes chaotic: *"I had a lot going on in my life. (...) There was a big time there where no one could get in touch with me, so I left a bit of a gap there. But then I picked up again (...) without any hassles (..) And they were there, you guys were there."* EACH's THRIVE program was able to work around her needs, allowing her to step away from treatments, then step back up when she had time and headspace for appointments **(flexibility and responsiveness)**. Her THRIVE worker even helped her and her family to work through a crisis: *"I had bit of things going on in my family, still ongoing. And I just got on the phone. And Carly's on the phone, and I was able to put her on loud speaker and some members in the family were able to hear what she had to offer the family (...) And she's the only one that actually even asked about 'Have the girls got anybody to talk to?'"* **(family-centred, holistic)**. Maria had never experienced such family-centeredness at another service.

Maria does not have a car or driver's licence at the moment, so supported transport to attend appointments, provided by an outreach worker (Cathy), is very important: *"That's very big (...) She's good for me (...) I've had severe depression. She's a good sister to talk to"* **(relationships and trust)**. While taxis would also help her get to appointments, the presence of a support person makes a big difference **(supported transport)**. Cathy phones her before arriving at her house **(good communication)**. When sometimes Maria doesn't feel like attending appointments, Cathy listens without judgement **(welcome, empathy and hope)**. This usually helps Maria slowly change her mind and keep her appointments. She has also accompanied her to various external services such as the GP, gone the extra mile to pick up medication with her, and helped her to attend various programs and events (e.g. Healthy Mob Day, Sisters' Day). Cathy's help therefore not only supports Maria to remain healthy, but also to remain meaningfully connected to her community **(holistic)**.

CATHY'S HELP THEREFORE NOT ONLY SUPPORTS MARIA TO REMAIN HEALTHY, BUT ALSO TO REMAIN MEANINGFULLY CONNECTED TO HER COMMUNITY

Josh's story

Josh is a loveable character, with complex and layered health issues that have required him to have in excess of 300 surgeries in his lifetime.

He jokes that he can essentially discharge himself out of hospital, because he's done it so many times and the staff know him so well! Josh and his family have a long history of addiction. His mother and others in his mob have struggled with it, and he has also been battling with alcohol misuse for several years. *"That's the cycle I'm trying to break now"*.

Josh has used various other alcohol and drug services prior to EACH, and has been in and out of residential detox and rehab services in his local area. His experiences with these services were not always positive: *"Some organisations I've been through, they specialize in drug and alcohol treatment, but you walk in there and you just feel like you're judged as an alcoholic."* He has even previously been told by workers at a detox service that he would probably be better off not coming back, as he would end up worse if he stopped drinking.

He got in touch with EACH after seeing his mum get better with the THRIVE and Ngarrang Gulinj-al Boordup teams' support. In contrast to other AOD services, Josh's experience at EACH has been more welcoming and hopeful: *"The judgement is not there. There is always someone trying to come up with a way to help me. There are always different ideas getting thrown out there to try something that could work. It just feels a lot more positive, that there could be a light at the end of the tunnel."* **(welcome, empathy, hope)**

At EACH, Josh is supported by a team of three Aboriginal health workers (including a nurse) and a THRIVE counsellor. It used to be much bigger, but after listening to Josh's views, the service streamlined his support network to a small core of individuals **(flexibility and responsiveness)**. The team work together in the background to coordinate his care and appointments with various other EACH services, including physiotherapy or Project HOPE peer support **(team-oriented, holistic approach)**. They will also accompany him to various external health appointments – whether for emphysema testing at the Alfred Hospital or to see his local GP – to smooth out the establishment of relationships with new health practitioners, assist in explaining his personal and medical background, advocate for the right medications, and help translate some of the medical speak into plain English **(good communication, relationships and trust)**. As Josh cannot drive due to medications, members of EACH's AHWT will either arrange cab vouchers, or give him a lift so he can keep up with his various appointments. Getting a lift with Uncle Des also helps to break social isolation, as they have chats about everything and nothing **(supported transport)**. Except football – that subject has been banned!

For Josh, the constant communication and contact that he gets from his workers at EACH are a standout feature and point of difference compared to other AOD services. The team contacts his several times a week – Erica sends him weekly reminders about his appointments, while Uncle Des rings him, texts him, or even just shows up at his house for a coffee and a yarn **(good communication)**. Such frequent contacts with people he knows and trusts, and having a team that is responsive and there for him when he needs, is making a big impact on his recovery journey: *"Uncle Des gives me a bit of courage, stirs me up a bit and gets me back on track. But that goes back to him knowing me, and knowing my family so well. He knows how far he can stir me up!"*. Being able to be truthful and honest has been a key ingredient to his continued engagement with the service: *"If I've ever got a problem or something's not working... Me and Erica said from Day 1, just be honest. If I'm going to like it or not, just tell me. We're very straight out. And that's how you've got to be, especially with someone like me who bends the rules a bit here and there"* **(relationships and trust)**. Even when he relapsed while his usual THRIVE clinician was on extended leave, Josh was able to yarn with EACH's Peer Support Worker when he needed to. Being able to chat with someone with lived experience, who understood what he was going through, was very helpful and helped to get him back on track.

The AHWT and THRIVE teams at EACH are continually thinking about new and different ways of doing things, and giving him ideas and options to support his recovery. He then decides what he wants to try. By listening to Josh's story, and learning of his background as jockey, they linked him in with equine therapy with an external provider, in a farm-based environment: *"A good improvement with the drug and alcohol side of it was doing equine therapy (...) That's been a real eye-opener, and it's a very different surrounding. You're not in an office and confined."* **(responsive)**

"I've come a long way in the last few months. I've gone from drinking every day to having a few on the weekend. And that's due a lot to the support that I'm getting. (...) I have slowed down to the point where I can manage it [drinking] and I can keep my obligations through the week and that, now."

Conclusion

In summary, the collaborative model of care developed across the Ngarrang Gulinj-al Boordup AHWT and HOPE/THRIVE teams appears to be effective and culturally safe in supporting Aboriginal and Torres Strait Islander community members with AOD, physical, and social and emotional wellbeing concerns to make positive inroads towards recovery.

Key distinctive features of this model include a central focus on slowly developing trusting relationships; open and constant communication with clients; supported transport; taking a team-oriented and holistic approach to AOD, social and emotional health and wellbeing; co-location of multiple services under one roof; flexibility and responsiveness in service delivery; and adopting a welcoming, hopeful and empathic attitude towards each individual's healing and recovery journey.

What could be done better?

More community supports

Interviewed clients spoke positively of their experience at EACH. However, they also reflected on a range of gaps in the EMR's community and service sector with regards to supports that could assist with recovery and/or improving Aboriginal social and emotional wellbeing more broadly. Many of their suggestions related to breaking social isolation, and creating spaces to receive peer support and connection from within the Aboriginal community – e.g. older men's yarning circle, social activities for Aboriginal women, mentorship for young Aboriginal men, etc. The Ngarrang Gulinj-al Boordup AHWT will continue to work with the community and funding bodies to explore these possibilities.

Further flexibility in AOD funding models

The essential elements of EACH's collaborative model of AOD care for Aboriginal and Torres Strait Islander individuals and families converge in their demonstration that less rigidity is required in funding and structuring service models. Many clients spoke of the need for THRIVE workers to have the capacity to also do outreach. For example, to come to a client's home alongside the AHWT, or even to visit clients who are attending residential detox and rehabilitation services. They thought that this would further boost service responsiveness, flexibility and continuity of care, support better communication with new providers, and assist their navigation through the AOD system.

Extending the approach to other services?

Seeking to jointly address inter-generational trauma and AOD concerns through the Aboriginal lens of social and emotional wellbeing is a highly complex endeavour, and one that cannot be addressed using time-restricted, episodic approaches to treatment. EACH's experience further highlights that establishing trusting and long-lasting collaborative relationships among practitioners takes time. In addition to formal processes, it is also greatly aided by proximity and the opportunity to informally get to know and learn from one another through co-location. Such key features could be drawn upon and utilized across a range of health and wellbeing teams, such as mental health, primary health care and youth services. Opportunities should be sought by funding bodies (including the EMPHN) to explore how flexible, colocated, and integrated service offerings could be established between such services and Aboriginal and Torres Strait Islander-specific teams, in order to enhance access and service engagement, and ultimately, improve health outcomes for the region's first peoples.

Appendix 1:
Processes used to adhere to ethical principles

Both Aboriginal and Torres Strait Islanders and people who may be engaged in illegal activities (such as the use of illicit substances) are classified as population groups requiring specific attention and additional caution, in order to minimise any risk of harm from their participation in research-type endeavours (e.g. interviews and case study development). As such, all activities and data collection for this project were undertaken in accordance with guidelines from the *National Statement on Ethical Conduct in Human Research (2007)*, from Australia's National Health and Medical Research Council (NHMRC), in order to ensure that they respected core values and principles of research merit and integrity, justice, beneficence, and respect [4].

In particular, the following measures were put in place to ensure that interview participants (all Aboriginal and Torres Strait Islander clients with a history of substance misuse) felt safe and comfortable during interviews, and that risk of harm was minimised:

- Interviews were held in the largest and most naturally lit counselling room of EACH's Ferntree Gully site, in which most participants would have received services previously. The use of a such a familiar and/or welcoming environment helped to ensure that participants felt safe and comfortable;
- Interviewees were actively reminded that their participation was voluntary and would not impact in any way on their rights as a client, and service experience with THRIVE, AHWT or other services;
- Interviewees were able to choose who was present to support them during the interview. Members of the AHWT and THRIVE teams chose the independent interviewers carefully, to try and match their personality to each interviewee's; and
- Interviewees had the right to decide whether or not their interview would be audio-recorded.
- Interviewees had the right to ask for the interview to stop, at any point in time, or ask for their information/story not to be used.

A take-home Participant Information Sheet was prepared, as per the usual processes required by NHMRC-aligned human ethics committees. The sheet was be explained and handed over to participants prior to interviews beginning.

Additionally, and in accordance with EACH's *Consumer/Carer/Community Reimbursement Policy and Consumer/Carer/Community Reimbursement Procedure*, interview participants were remunerated for their time and contribution to this project. When necessary, participants were also be reimbursed for all travel, parking and/or childcare-related costs associated with their participation in an interview.

Appendix 2:
Ngarrang Gulinj-al Boordup Aboriginal Health and Wellbeing Team (a program of EACH)[2]

We endeavor to work alongside Aboriginal and Torres Strait Islander individuals, families and communities to recognise the ongoing colonial violence and oppression that has historically and continues, to shape their lives, their relationships and their resistance and struggle for wellbeing.

The colonial interventions into and on Aboriginal and Torres Strait Islanders lives have resulted in intergenerational transmission of trauma (violence, abuse subjugation and oppression) with direct links to Aboriginal and Torres Strait Islander communities' health inequalities.

As workers alongside these communities we acknowledge the unequal distribution of power and entitlements that continue for first nation Australians. It is from this location that we engage in our work with these communities as the Aboriginal Health Team responding to both chronic health issues and supporting the individuals, families and communities to find pathways towards social and emotional wellbeing.

Our Model:

Our model is necessarily built on a foundation of collective ethics that have been developed to address the misuse of power and discrimination that has been enshrined in government legislation and policies. We acknowledge from our own social, cultural, race, gender and class locations that we have also been socialised under white supremacy, neoliberalist/capitalist policies and patriarchy and need to have an awareness of how we stand aside from replications of power in our work.

Our work is informed by:

- Anti-oppressive theories
- Aboriginal and Torres Strait Islander cultural meaning making
- Trauma informed care

"Nothing for me without me"

The centre of our model is connection and belonging:

We are working to support individual's connection to self; to family, community belonging and strong connections to culture.

We understand that Aboriginal and Torres Strait Islander communities believe that health and wellbeing will be achieved when there is a balance across and connection to: **physical wellbeing, mental and spiritual wellbeing; emotional wellbeing and social wellbeing**. These are the areas that we work alongside Aboriginal and Torres Strait Islander individuals and families to support them to move towards a balance across these realms.

To ensure that we are working alongside Aboriginal and Torres Strait Islander individuals and families in ways that are relationally respectful, compassionate and culturally safe we are guided by the following collective ethics:

- Working in **culturally safe ways** and, understanding that family and culture are central to Aboriginal and Torres Strait Islander health and wellbeing
- Working in ways that understand the **relationship between structural oppression and violence and interpersonal violence** that gets enacted in families and how these multiple traumas may be held in individual, families and communities' responses. Understanding that this has resulted in a deep shame and that this be understood not as a pathology but a response to systemic and ongoing violence and the impact of this on individuals and families is represented in poor health outcomes for Aboriginal and Torres Strait Islander people.
- Working to be aware of and address how power is operating in our roles and relationships with others; in the organisation and service system, and social constructions of racism, sexism and multiple cumulative experiences of discrimination
- Examining our **own privileges and whiteness** where relevant to ensure that we are not blinded to the struggles and acts of resistance of those we work alongside
- Consistently looking for ways in our individual work **to be accountable** to those we are working alongside, to their families and communities and to team members.
- In the absence of a just society working **to address and speak to injustice** that is directed at and effecting Aboriginal and Torres Strait Islander peoples. This may be through child protection, internal and external services, police, criminal justice system and other services. We are working for justice through ongoing calls for sovereignty and self determination of services and the way that services engage with local Aboriginal and Torres Strait Islander community.

1 Model developed by members of the Ngarrang Gulinj-al Boordup Aboriginal Health and Wellbeing Team: Erica Lambert, Des Smith, Lynne Pharaoh-Hamer, Cathy Van Des Essen, and Vanessa Murdoch.

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health . hope . opportunity