WADAMBA WILAM
PRACTICE APPROACH

Neami National
Improving Mental Health and Wellbeing

Prepared by Julia Chiera

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Language Statement

We recognise the diversity of Aboriginal people living throughout Victoria. While the terms 'Koorie' or 'Koori' are commonly used by Aboriginal people of Southeast Australia, we have used the term *Aboriginal* in this report to include all people of Aboriginal and Torres Strait Islander descent.

We will describe a person utilising Wadamba Wilam services as a *consumer*, and recognise the contested nature of this term in mental health services and research. Wadamba Wilam consumers may be referred to in other documents or by other services as a client, service user, customer, participant or other descriptor.

Acknowledgement

The Neami Group acknowledges the Traditional Owners of all lands on which we do business and we pay our respects to their Elders, past and present. We recognise the unique position of Aboriginal and/or Torres Strait Islander Peoples as the first sovereign nations of the Australian continent.

Consumer Names

Names of consumers in all stories and reflections have been changed. Identifying details have been altered in order to protect the identities of consumers whose stories have been described here.

Consumer Voice

This document is intended as a practice guide for services and support workers, and was not conducted as formal research. We acknowledge that consumer voices are not foregrounded and see this as a major limitation of the work. Preparations of this document occurred during the Covid-19 pandemic of 2020, which reduced the opportunity to directly engage with consumers.

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Design

Lauren Watson and Cristal Hall, Neami National

Neami acknowledges the Traditional Custodians of the land we work on and pays its respects to Elders past, present and emerging.

Neami celebrates, values and includes people of all backgrounds, genders, sexualities, cultures, bodies and abilities.

Neami National acknowledges the support of the Victorian Government.

COVER ARTWORK
Darryl Sanderson
***Untitled*, 2019**

CONTENTS

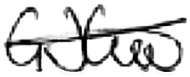
FOREWORD

When supporting people experiencing long term mental health difficulties within the context of entrenched social disadvantage and histories of complex trauma, there are rarely, if ever, simple solutions.

Most often, healing is a uniquely personal journey that requires time, and a great deal of courage, commitment, and support. None of us heal alone. Authentic relationships that are developed over time, based on trust and safety, are key. Within the context of Aboriginal mental health and social and emotional wellbeing, being able to provide cultural safety and cultural responsiveness is another critical foundation. While working as a clinician at the Victorian Aboriginal Health Service, I was fortunate enough to meet, and at times work in tandem, with the Wadamba Wilam team soon after they were established in 2013. Wadamba Wilam was the first non-Aboriginal organisation that I encountered where it was clear from the outset that the staff understood these fundamental needs to put relationships and cultural safety front and centre of their practice. It didn't take long for me to see how their assertive out-reach approach to supporting vulnerable community members allowed for much more flexibility and a far greater level of engagement than I had seen previously.

Later, I watched the team slowly develop a culturally respectful and meaningful assessment process that was clinically sound, included Aboriginal designed tools, and drew on an Aboriginal social and emotional wellbeing framework. This practice approach report is a culmination of the Wadamba Wilam teams' efforts to synthesis their knowledge and experience, and get it down on paper. A great strength of this report is the way in which it integrates trauma-informed practice with Aboriginal mental health and social and emotional wellbeing principles. It also provides a coherent theory of change based upon Aboriginal and non-Aboriginal practitioners' experiences of supporting community members, while also privileging the voices of those community members.

Another strength of the report is that it uses real world scenarios via case studies, to illustrate the extent of adversity and prominent role that complex trauma often plays in peoples' lives. However, the stories shared by Wadamba Wilam staff also reveal that healing and re-connection for community members is happening — it too is a lived experience. Importantly, the organisation is using appropriate tools and the gathering of quantitative and qualitative data to try and capture these important outcomes. I highly recommend this report to practitioners, researchers and those involved in policy related to Aboriginal mental health and social and emotional wellbeing services. Thank you Wadamba Wilam for your commitment to getting it right and for not taking short cuts.



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EXECUTIVE SUMMARY

This document describes the practice and impact of Wadamba Wilam, one of many programs delivered by Neami National and funded by the Victorian Department of Health and Human Services.

Neami National (Neami) is a specialist community mental health provider with over 30 years' experience supporting people to improve their wellbeing, live independently and pursue a life based on their strengths, values and goals. Neami operates in five states and from over 60 service locations across Australia, supporting over 9000 individuals each year via services spanning community mental health, residential mental health, suicide prevention and homelessness.

Neami has a strong track record of strategically partnering to improve service outcomes for the client group. Using a collaborative engagement approach, Neami works in a coordinated way with key partners and other health and community services to achieve system change.

The document describes in detail the population of people served by Wadamba Wilam, the approach that guides team practice and their ways of working, and the outcomes achieved for this group of people through their engagement with the service.

What is Wadamba Wilam and *who* do they work with?

Wadamba Wilam has worked with Aboriginal and Torres Strait Islander people with a history of homelessness or rough sleeping and mental illness in Melbourne's north since 2013.

People who have used the Wadamba Wilam service have presented to the service with many physical and mental health needs, complex histories of trauma and neglect, and a mistrust of services that have been historically difficult to overcome by a disjointed and discriminatory service system. Very high rates of homelessness and rough sleeping, very high rates of substance use, poor physical health, high rates of contact with the justice system and a significant proportion of consumers who experience psychotic illnesses all contribute to the intense complexity of needs within this group.

Wadamba Wilam's approach has sought to address these needs in a holistic and integrated manner. This approach brings the service to where people are located, both physically and to whatever stage they are on in their healing journey. Throughout this process, the strength and resilience of Aboriginal and Torres Strait Islander people has been apparent, as the consumers of this service continue to move forward in their healing journeys with an unwavering desire to improve the lives of themselves, their families and communities.

What has been achieved?

The people with whom Wadamba Wilam works have been consistently failed by service systems, government programs and pervasive racism and stigma. For many people who have been in an endless cycle of homelessness and rough sleeping, psychiatric admissions, emergency department presentations and interactions with the justice system, Wadamba Wilam has been the turning point from which their lives begin to transform. Many people who have used Wadamba Wilam's service experienced vastly improved physical and mental health, enjoy stable accommodation and have an overall increase in their social and emotional wellbeing.

Significantly, for consumers of the service between July 2016–June 2020, some of the outcomes achieved include:

- 81% of consumers are housed in sustainable tenancies. 69% of consumers have sustained these tenancies for over 12 months.
- 61% decrease in the number of inpatient psychiatric admissions post-referral. The average yearly psychiatric admissions reduced from 1.5 per year per person, to 0.1 per year per person.
- 67% of consumers have experienced an increase in their meaningful activity, shifting from 73% of consumers engaging in survival activities only at service entry.
- 72% of consumers have reduced both their use of alcohol and ice. 67% of consumers have reduced their use of opioids

In addition to this, through Wadamba Wilam's support, consumers have been supported to:

- Attend to complex physical health needs and connect to trusted GPs and other specialists.
- Navigate the justice system and in many cases, avoid incarceration.
- Connect to family violence services.
- Strengthen connections to culture and family.

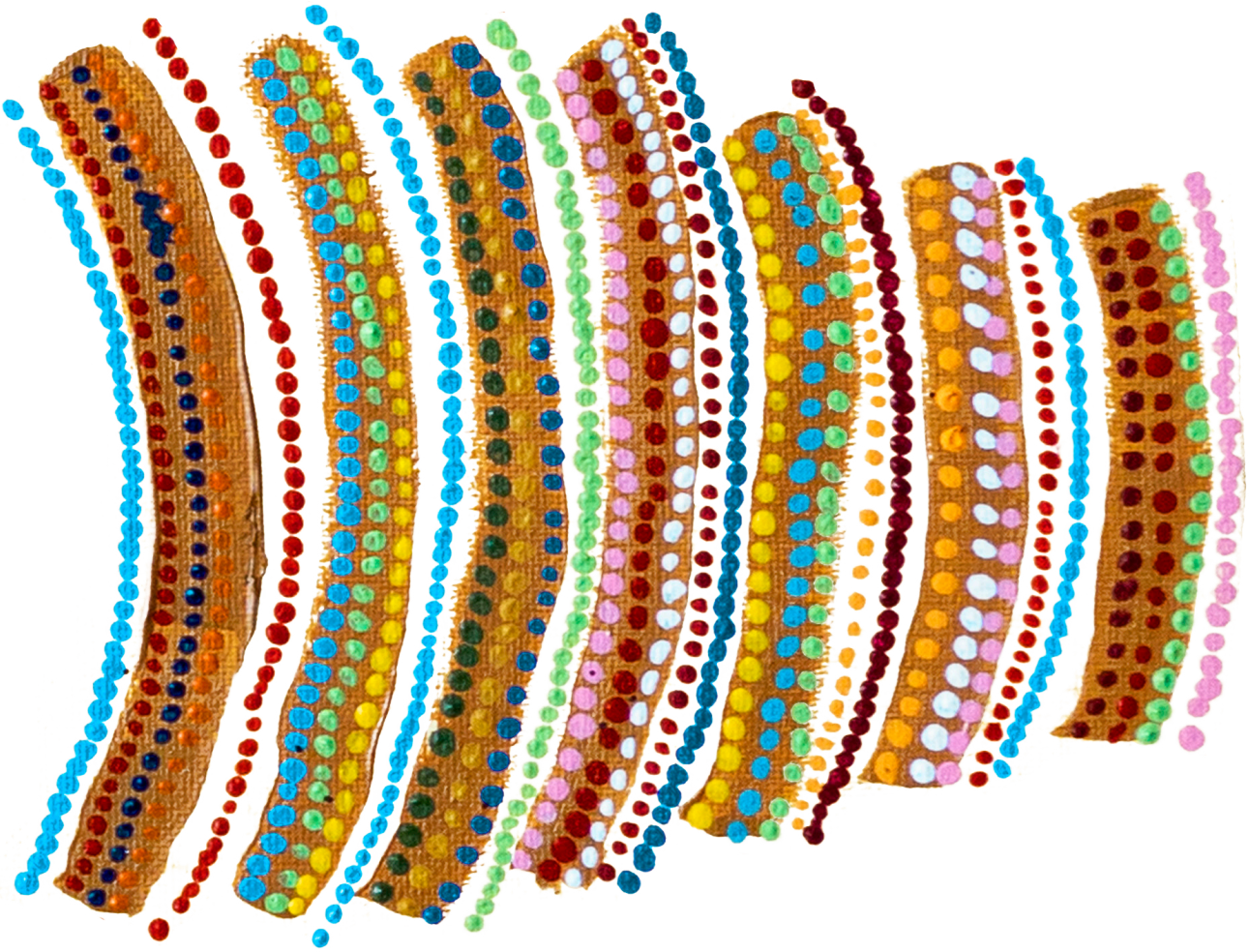
How was this achieved?

Interdisciplinary team	Staff bring a range of specialty skills that can be utilised to meet complex needs with immediacy.
Interagency collaboration	Specialist organisations are drawn together in a single team and work together to overcome service disconnection.
Length of support	Long term support allows trust and rapport to be meaningfully established. This acts as the building block upon which all healing activities can then be accessed.
Staff/consumer ratios	Low case numbers and a high ratio of staff to consumers ensures staff have adequate time and collegial support to provide the care required to manage complex needs.
Intensive Assertive outreach	Flexibility and responsiveness facilitate workers to overcome service access barriers and to support consumers when in crisis.
Trauma-informed care	Staff are trauma-informed, understand the impacts of trauma and understand trauma behaviours. They work accordingly to utilise strengths-based interventions to improve people's wellbeing.
Social and emotional wellbeing principles	A foundational understanding of the nine-guiding principles of social and emotional wellbeing (**Appendix I**) is applied to all aspects of the program.
Culturally appropriate tools	Culturally appropriate tools are utilised to facilitate meaningful and respectful assessment processes.
Culturally safe practices	Staff behave in a culturally competent and safe manner.
Family-centred practice	The service works with multiple family members at once, which supports healing to multiple generations and strengthens connections to community and family.
Care coordination	Staff support consumers to navigate various parts of the service system, sharing knowledge and resources with intersecting services to promote effective interventions and avoid re-traumatisation of consumers.
Continuity of care	Continuity of care supports the maximising of available interventions, to promote meaningful co-ordination of services and discharge planning.
Maintenance period	Workers continue to provide support to consumers after basic needs, such as housing, are met. This supports consumers to make the profound shift from surviving to thriving.
Soft endings	A slow exit process whereby support is provided with less frequency and intensity allows for consumers to build up independence. Quick re-entry to the service if the need arises, without any formal intake process, also allows for consumers to quickly re-engage with their trusted supports to avoid a severe decline in social and emotional wellbeing.

Many lessons have been learnt by the Wadamba Wilam team since the program's inception Indicative of the teams' dedication to supporting the consumers who use their service, is the continuing reflection, refinement and growth to the program's approach and way of working.

With the same understanding that the damage and trauma inflicted on Aboriginal and Torres Strait Islander people was created by many integrated systems over a long period of time, in order to facilitate a healing journey, systems must be integrated in their approach with adequate time taken to attempt to build the social and emotional wellbeing needed to live a meaningful life, rich in connections.

> **"I am not comfortable using mainstream services, because in mainstream services workers aren't able to understand cultural needs. They are just fixed on a diagnosis and also on medications, but that's not the therapy I wanted. They are also limited on time, rushed and don't listen. And you never see the same people, which means you have to keep re-telling traumatic events over and over again."**
> **(Lovett, 2019, p. 3)**



RATIONALE

Since 2013, Wadamba Wilam has developed a practice approach that has delivered positive outcomes for Aboriginal and Torres Strait Islander people experiencing mental illness, poor emotional and social wellbeing and a history of homelessness. This community group has been chronically left behind by systems and services that have not reached them effectively or provided culturally safe support to improve social and emotional wellbeing.

Through an interdisciplinary and interagency approach, along with long term engagement, Wadamba Wilam has developed practice principles and a theory of change that incorporates: person-centred care; culturally respectful and culturally safe care; trauma-informed care; and the guiding principles of social and emotional wellbeing (**Appendix I**), in an integrated approach to enable positive outcomes for the consumers they support.

The Wadamba Wilam team has refined, reviewed and reflected upon their work and approach regularly, seeking to improve consumers' holistic wellbeing and maintain workers' wellbeing, focus and efficacy, in order to build a unique and robust service that is respected by and responsive to the community it serves.

This report aims present an overview of Wadamba Wilam's approach, as an example of best practice, in order to inform the design, implementation and funding of other services that seek to support this community. It will outline:

- The service's structure and key features;
- The social context and the barriers to service that the consumer group face;
- Trauma-informed care and its importance in this service setting;
- The principles of social and emotional wellbeing and their application by Wadamba Wilam;
- Wadamba Wilam's Theory of Change and the specific relational activities undertaken by the team to bring about positive change;
- Evidence of Wadamba Wilam's impact;
- Recommendations for program replication or similar services.

The *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023* contends that "for Aboriginal and Torres Strait Islander people with weakened social and emotional wellbeing, care is effective when multi-dimensional solutions are provided, which build on existing community, family and individual support [and] culturally informed practice" (Commonwealth of Australia, 2017, p. 7). Wadamba Wilam's approach builds on the Framework's guidance and in doing so has created a service that seeks to meet the holistic needs of consumers, nestled in their community.

SECTION 1
WHAT IS WADAMBA WILAM?

Wadamba Wilam translates to 'renew shelter' in the Woiwurrung language of the Wurundjeri people.

Established by Neami National in 2013, Wadamba Wilam is an intensive support service for Aboriginal people experiencing mental illness and poor social and emotional wellbeing, with a history of homelessness. Neami National (Neami) is a specialist community mental health provider with over 30 years' experience supporting people to improve their wellbeing, live independently and pursue a life based on their strengths, values and goals. Neami operates in five states and from over 60 service locations across Australia, supporting over 9000 individuals each year via services spanning community mental health, residential mental health, suicide prevention and homelessness.

Wadamba Wilam has proven to be an innovative and successful approach to working with this community group in an urban setting in Melbourne. This small but significant service offering caters to people who have fallen through the gaps in standard service provision. It is unique in that it has multi-agency involvement and provides holistic, intensive, long-term support for people with multiple healthcare, cultural, social and housing needs.

The service is located at Neami's Fairfield site and supports thirty to thirty-five consumers at any one time, located primarily in the Darebin and Whittlesea local government areas, with flexibility to accept consumers from outside these boundaries.

Wadamba Wilam's intensive assertive outreach support, includes the following services:

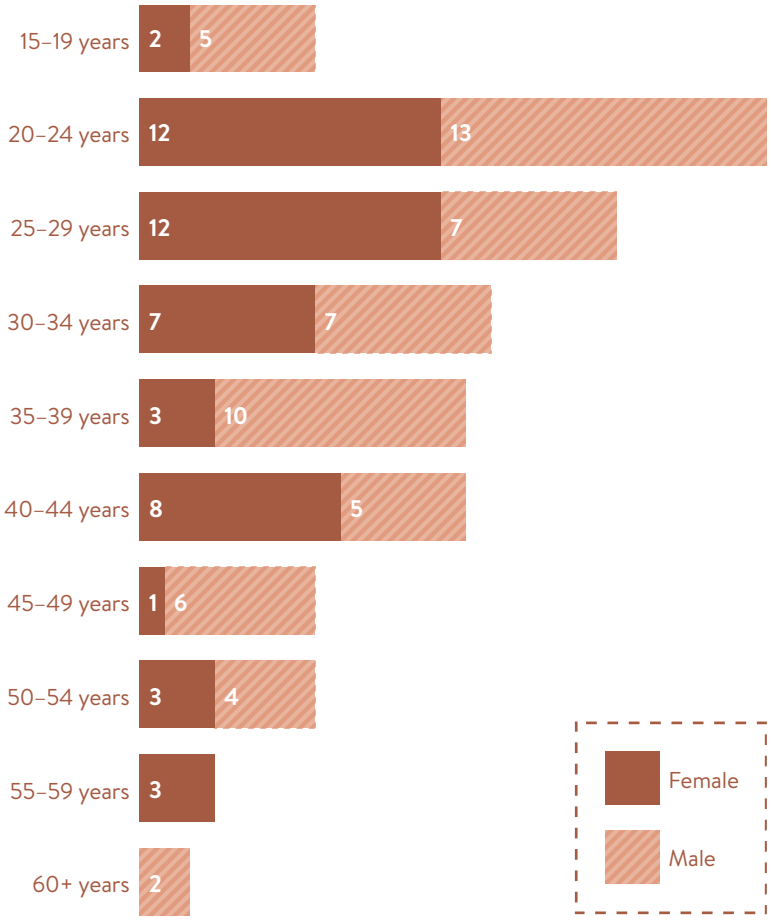
- Holistic mental health treatment and psychosocial support with a focus on trauma recovery and improving social and emotional wellbeing;
- Specialist Alcohol and Other Drug (AOD) treatment and support;
- Case management and care co-ordination, which involves facilitating engagement with necessary social services and community resources such as cultural groups and camps;
- Advocacy and support for navigating the myriad systems involved in consumers' care, including housing;
- Promoting and facilitating engagement in meaningful activity that is identified as important by the consumer to improve their social and emotional wellbeing; and
- Liaison, education and involvement with the identified family to support and empower the consumer.

Target group

Wadamba Wilam's service supports Aboriginal and Torres Strait Islander people from the age of 16, with links to the city of Whittlesea and city of Darebin (catchment area of the Northern Area Mental Health Service), with scope to accept referrals for consumers in surrounding local government areas. Additional eligibility criteria includes: people experiencing poor social and emotional wellbeing, including severe and enduring mental illness and/or sustained high psychological distress; and/or homelessness and/or a history of repeated homelessness. Over time and the further development of the service, referral criteria have become more fluid and reflective of the identified needs of the person, based on their specific context. This may include working with other members of consumers' families that live outside the catchment areas, or accepting referrals from people who do not have a history of homelessness or rough sleeping but who experience poor social and wellbeing and for whom Wadamba Wilam's approach is well-suited.

Since its inception until 30th June 2020, Wadamba Wilam has provided service to 111 consumers.

Age at service entry × gender



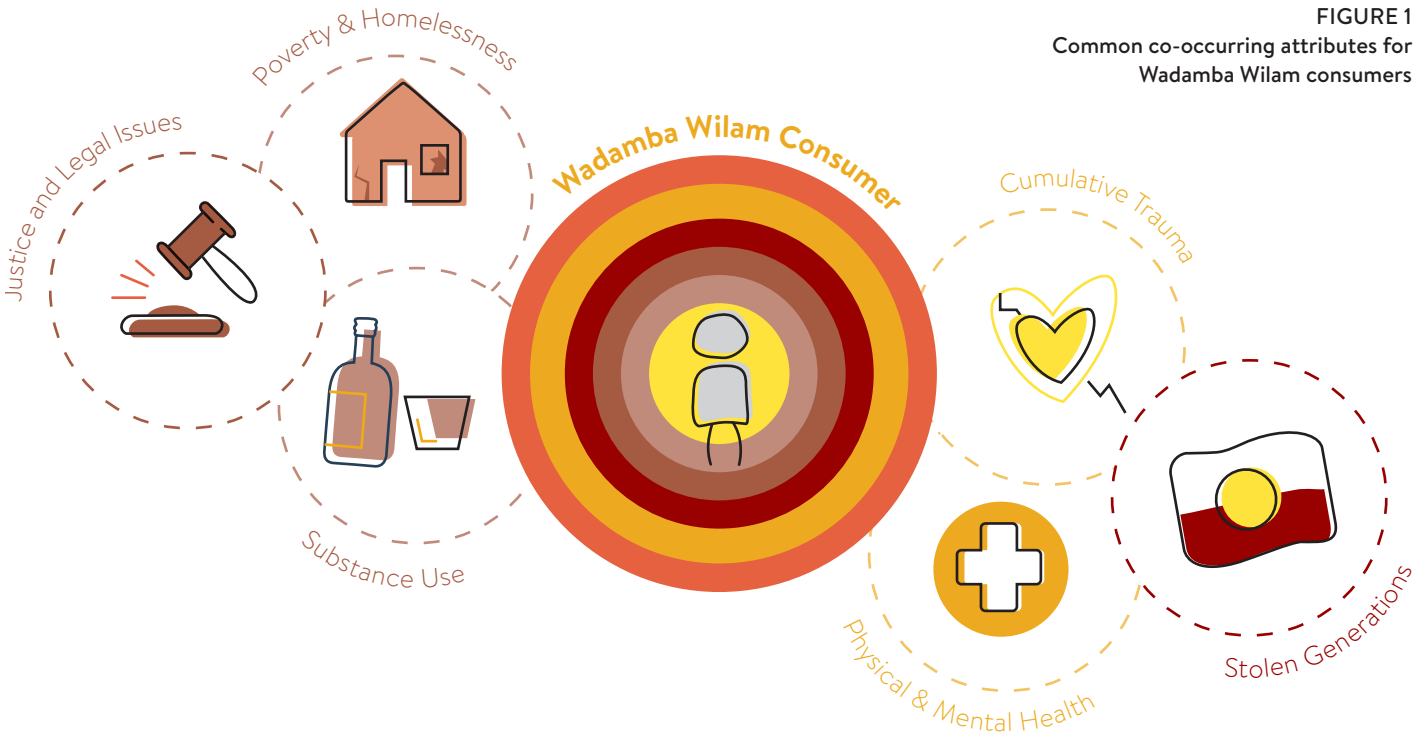


FIGURE 1
Common co-occurring attributes for Wadamba Wilam consumers

In addition to homelessness and mental illness, the target group often has other co-occurring attributes such as:

- High levels of problematic alcohol and drug use;
- Co-existing disability such as a physical or intellectual disability and/or acquired brain injury;
- History of significant trauma, including sexual, physical and/or psychological abuse and neglect as a child;
- An experience of entrenched poverty, profound social exclusion and discrimination, including having little education, poor employment records, poor physical health, and frequent engagement with Victoria Police and correctional services as both victims and offenders.

An analysis of Wadamba Wilam consumers from July 2016–June 2020 (**Section 4**) shows high rates of cumulative trauma, substance use (especially with regards to alcohol, tobacco, cannabis and diverted prescription medications), justice and legal issues, as well as a large cohort of consumers as members of the Stolen Generations or descendants thereof.

In addition, there are higher rates of brain injury in Aboriginal and Torres Strait Islander people, as risk factors for head injury, substance use and stroke are represented more heavily in this group (Bohanna I et al., 2013, p. 15). These higher than usual rates of brain injury alongside cognitive impairment are also represented in people who utilise the Wadamba Wilam service. 23% of people who have utilised Wadamba Wilam's service between July 2016 and June 2020 have a serious brain injury or have experienced serious head trauma. In addition, in this same timeframe, 25% of consumers have a suspected serious brain injury or head trauma and 25% of consumers also experience learning disabilities or development/ intellectual disability. It is not uncommon for these conditions to be undiagnosed. High rates of intellectual and cognitive disabilities contribute to the complexity of needs that people utilising Wadamba Wilam experience, as well as the challenges of meeting these needs.

Referral sources

Wadamba Wilam receives referrals from varied sources:

Services

- Mental Health services, both Inpatient/ Clinical services and Community services;
- Alcohol and Other Drug (AOD) services;
- Aboriginal Community Controlled Organisations (ACCOs);
- Aboriginal Community Controlled Health Organisations (ACCHOs);
- Justice System including Prisons (for example Dame Phyllis Frost Centre, Ravenhall Correctional Centre) and Forensics services;
- Housing services.

Community

- Self referral;
- Family members;
- Community/mob members.

As Wadamba Wilam has become more established and well-known amongst local Aboriginal communities an increasing number of referrals have been received via family and community members who have vouched for the program within their informal networks and recommended it to potential consumers. These word-of-mouth referrals have "fast-tracked" the establishment of trusting relationships with new consumers.

Inter-agency and multi-disciplinary approach

Wadamba Wilam's integrated, intensive outreach team consists of healthcare professionals representing four different organisations: the Victorian Aboriginal Health Service (VAHS); Neami National; Uniting Care ReGen Alcohol and Other Drug Service; and the Northern Area Mental Health Service (NAMHS). The interdisciplinary team includes an Aboriginal Social and Emotional Wellbeing support worker, a Nurse Practitioner, a Senior AOD Clinician, two Community Rehabilitation Support Workers (CRSW), a Consultant Psychiatrist and a Service Manager.

Funding

Wadamba Wilam was initially federally funded under the "Breaking the Cycle" initiative and is now funded by the Victorian Department of Health and Human Services. It is currently funded until June 30, 2021.

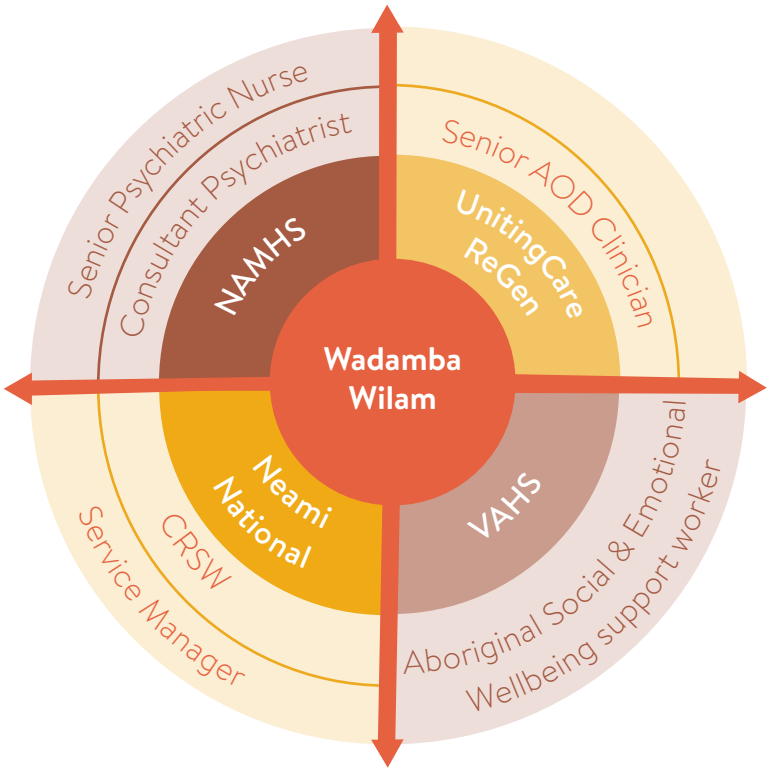


FIGURE 2
Make up of Wadamba Wilam's inter-agency, multi-disciplinary team

SECTION 2

PRACTICAL AND THEORETICAL CONTEXT

Social Context and Barriers to Accessing Services

> **"One of our greatest challenges in dealing with mental health is that all of these inequalities [physical and mental health, higher rates of removal of children, higher rates of children in out-of-home care] — social determinants such as housing, employment, education — combined with high rates of childhood removal, children in out-of-home care, incarceration rates, elevated rates of family violence, the damage to cultural continuity in terms of loss of language, dispossession of land – these are legacies of colonisation that those most vulnerable in our Aboriginal communities experience as multiple, co-occurring risk factors. It is these adults, children and families that present to our services with serious mental health problems and often experiencing multiple, accumulating crises. It is near impossible to address the mental health side of things unless there are coordinated efforts to address these issues. Our services are not even reaching those most in need, because often those people and families are too unwell to be able to manage getting to our services. Our very real challenge is thinking about what kind of resources and integrated mental health systems will reach those most vulnerable."**
> **(Gee, 2019, p. 3)**

In addition to higher rates of mental illness and psychological distress, Aboriginal and Torres Strait Islander people have lower access to, or use, primary mental health care according to need, and are therefore over-represented in other parts of the health and mental health system. In the two years to June 2018, the hospitalisation rate for mental health issues for Aboriginal and Torres Strait Islander males was 2.1 times the rate for non-Indigenous males, and the rate for Indigenous females was 1.5 times the rate for non-Indigenous females (Commonwealth of Australia, 2017, p. 34).

The last National Aboriginal and Torres Strait Islander Health Survey (2018–19) conducted by the Australian Bureau of Statistics found that around one-quarter (24%) of Aboriginal and Torres Strait Islander people aged 2 years and over reported having a mental or behavioural condition (Australian Bureau of Statistics, 2019). It found that 31% of people aged 18 years and over experienced high or very high levels of psychological distress (Australian Bureau of Statistics, 2019). These levels are 2.8 times as high as those for non-Indigenous Australians at 11%, (Australian Institute of Health and Welfare, 2018). Data from 2015 found that suicide accounted for over 1 in 20 Aboriginal and Torres Strait Islander deaths, compared to just 1 in 50 for non-Indigenous deaths (Commonwealth of Australia, 2017, p. 34).

Despite higher rates of psychological distress in Aboriginal and Torres Strait Islander communities than in non-Indigenous cohorts, the 2012–2013 ABS Australian Aboriginal and Torres Strait Islander Health Survey found only 27% of adults with high/very high levels of psychological distress had seen a health professional in the previous four weeks (Commonwealth of Australia, 2017, p. 34). There are several barriers that explain the discrepancy in access to these services and can be summarised as follows:

- Lack of culturally specific support, including incorporating principles of social and emotional wellbeing and trauma-informed care;
- Mistrust of mainstream services;
- Traditional appointment-based approach does not suit cohort.

Wadamba Wilam's approach seeks to reduce and remove these barriers, delivering culturally safe and appropriate services. Wadamba Wilam has been proactive in destigmatising mental health services by employing Aboriginal staff, embedding the principles of social and emotional wellbeing and trauma-informed care into practice, and working from an assertive outreach model.

During the service's genesis, the service manager, Jamie Waring, met with a Wurundjeri Elder, Aunty Di Kerr, in order to choose a cultural title for the program. Jamie presented Aunty Di with the intention of the proposed program, to provide mental health and housing support and improve social and emotional wellbeing in the community. Jamie and Aunty Di sat together considering various names before "Wadamba Wilam" was chosen. Aunty Di then supported the ratification of the use of this name with the Wurundjeri Woi Wurrung Cultural Heritage Aboriginal Corporation who gave permission to use Wadamba Wilam as the program title.

Wadamba Wilam's approach to practice relies upon "meeting people where they are at", which includes an understanding of the social and historical context of Aboriginal and Torres Strait Islander consumers in metropolitan Melbourne. Wadamba Wilam's approach considers the extensive and pervasive trauma load borne by many Aboriginal and Torres Strait Islander people and the manner in which this detrimentally impacts consumers' social and emotional wellbeing. This trauma is both historical and intergenerational in nature.

Historical trauma refers to the impacts of colonisation, dispossession of land, loss of language and culture, and numerous oppressive and abusive policies that have had a devastating impact on Aboriginal and Torres Strait Islander culture and health, including the removal of Aboriginal children from their families. The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (2017–2023)* acknowledges that a broad range of problems "resulting from colonisation and its intergenerational legacies: grief and loss, trauma and abuse, removal from family and cultural dislocation, substance abuse, racism and discrimination and social disadvantage" affect social and emotional wellbeing (Commonwealth of Australia, 2017, p. 7).

Intergenerational trauma refers to trauma that is passed on through the generations, including entrenched disadvantage and social exclusion, and this is linked to the dispossession of land, policies of discrimination and child removals associated with colonisation (Commonwealth of Australia, 2017, p. 7). There is extensive evidence that intergenerational trauma is passed on biologically, psychologically, environmentally and socially.

Historical and intergenerational trauma are compounded by individual traumatic events as well as trauma experienced via the current mental health system, structures and practices. Historical and intergenerational trauma is all-pervasive and influences every interaction with support services and systems.

The experiences of historical and intergenerational trauma have deprived people of many of the key elements of social and emotional wellbeing. Additionally, the historical trauma experienced by many communities, families and individuals contributes to a distrust of mainstream support services and a reluctance to access any culturally specific services that may assist with social and emotional wellbeing.

Compounding this trauma, Aboriginal and Torres Strait Islander people experience racism, stigma, environmental adversity and social disadvantage as ongoing stressors that have negative impacts on social and emotional wellbeing (Commonwealth of Australia, 2017, p. 8). Alcohol and drug misuse, intergenerational poverty, poor access to education and housing, family violence, neglect, physical, emotional & childhood sexual abuse neglect, all contribute to re-traumatisation (Gee, 2019, p. 7).

Appointment-based services are a type of systemic barrier for many people as the factors discussed previously can significantly impact on a person's capacity to attend appointments. This results in high non-attendance rates in people experiencing complex Post Traumatic Stress Disorder (PTSD). The fragmented nature of service provision and focus on crisis intervention means that the person must tell their story and be assessed by numerous services at different times, resulting in the increased possibility of re-experiencing of traumatising events. Most systems require the person to fit to the service rather than the service fit to the person. Assertive outreach can overcome many of these barriers and take the service to the person in an environment where they feel safe and comfortable. There is also a pervasive perception held by mainstream services that non-attendance at appointments means that a consumer does not require the service or is not interested in the what the service provides, and therefore the consumer is exited, their file is closed or their referral cancelled. When considered from a trauma-informed lens, non-attendance can instead be seen as a flag for concern and an indicator of increased distress or decreased available resources to engage with the services that are required to decrease this distress. Non-attendance or erratic attendance may flag a need for patience and persistence and an increase in the offered support in a more flexible model.

The pervasive effects of trauma and the disproportionate incidence of psychological distress in Aboriginal and Torres Strait Islander communities demand that for services to be effective, they must be grounded in Trauma-Informed Care and the principles of social and emotional wellbeing.

Trauma-informed care

Trauma-informed care refers to healthcare that is aware and sensitive to trauma and individual and community responses to trauma. It involves a consideration of trauma in all levels of care, from staff knowledge, attitudes and training, to policy, the clinical environment and assessment tools. Trauma-informed care contributes significantly to mental health outcomes and social and emotional wellbeing. Poor mental health is often directly underpinned by past traumatic experiences, therefore assessment and treatment options need to be considered through a trauma lens. Trauma-informed care extends to awareness of historical trauma, intergenerational and individual trauma, including sexual, psychological, physical abuse and neglect. Trauma-informed care also involves awareness that people may still be living in positions that are insecure and unsafe. It involves targeting the intervention at the relevant stage of trauma recovery for each individual.

Aboriginal and Torres Strait Islander people face many barriers at a systemic level to accessing trauma-informed care. The main factor for effective treatment of trauma is a consistent, trusting and therapeutic relationship. The time taken to build this trust is usually longer than the prescribed hours available in an episode of care. The large volumes of people accessing mainstream mental health services means that contact can be limited and a person may have multiple points of contact with many different workers. Therefore it is difficult and sometimes impossible for workers and systems to provide the time, consistency, flexibility and responsiveness required to build meaningful, trusting and therapeutic relationships.

At Wadamba Wilam, the engagement and trust-building phase can take over twelve months of minimum weekly outreach support. Low case numbers, combined with assertive outreach and flexible assessment period with a focus on relationship building, means that Wadamba Wilam persists to overcome this barrier to service. (See **Foundational Activities, page 20**).

Wadamba Wilam's service model and approach to practice seeks to overcome these systemic barriers, through implementing the guiding principles of social and emotional wellbeing, ensuring staff have cultural competency and behave in a culturally safe manner, and utilise culturally specific tools. (See **Cultural Responsiveness, page 20**).

Building rapport

Worker reflection – Anne

I met Aaron four years ago when he was living in his car. He is an Aboriginal man in his 60s and at the time was experiencing poor physical health. Aaron had experienced major psychological, emotional and physical trauma throughout his adult life, with major impacts on his mental health and social and emotional well-being. Sustained trauma had resulted in extreme anxiety, depression, hypervigilance, extreme weight loss, shame and complete lack of trust in others and the world around him. He never smiled or laughed and would ask me "what was there to laugh about?"

At our first meeting Aaron consistently refused help with food and other supports, despite his ill health. We knew that establishing rapport and trust with Aaron would be a long-term effort. We persisted and kept turning up at the sub-acute facility where Aaron was staying, with daily visits for a month. We listened to Aaron's stories where he "offloaded" his life. We asked Aaron what he would like support with. He stated he had no idea, and that no one had ever asked him before.

To establish trust, transparency was key. With all the work that was attempted, from the first point of engagement, we shared what we were doing. Any plans or discussions with Aaron were consistent, honest and respectful.

Aaron had little respect for himself or others when we first met him and we understood how life traumas had eroded his self-respect and self-esteem. We understood that mutual respect was critical in gaining his trust and building rapport and that this would take time. Respect was shown by listening and acknowledging him and his stories, and showing him we would walk with him on his journey; his journey, in his time. Aaron came to see we cared – otherwise "why would you keep coming back?" he'd say.

Aaron had needs in relation to health, housing, family and justice issues. None of these were being addressed. Over time, by continually returning to offer support, Aaron began to work out what he needed and was able to verbalise it. He got what he needed without judgement.

The work with Aaron has involved patience and investment, daily engagement for many months, leading into years, supporting him every step of the way with clinical and mental health supports, medical services and housing. Over time, Wadamba Wilam has reduced our support as Aaron is able to manage these things independently.

Other systemic barriers for trauma-informed care for Aboriginal and Torres Strait Islander people

Concept

- Medical model dominates.
- Little consideration of more holistic concepts of social and emotional wellbeing.
- Poor understanding of non-western conceptualisation of mental illness and its symptoms.

Process

- Little or no access to cultural competence training.
- Service environments do not promote cultural safety or make Aboriginal people feel welcome.
- Poor knowledge of the many ways in which trauma can present and manifest.

Instrumentation

- Lack of culturally specific instrumentation and care planning tools.
- Mainstream assessment tools are used that are not culturally validated or have not been developed with Aboriginal and Torres Strait Islander people.

Intake and Assessment

- Intake processes are rigid in the time and place of their offering.
- Direct-questioning methods conflicts with culturally safe communication styles of Aboriginal communities.

Social and Emotional Wellbeing

Social and emotional wellbeing can be described as a holistic view of mental health, incorporating, physical, social, emotional, spiritual and cultural wellbeing of individuals and their communities. Mental illness, as it is understood in a Western mainstream context, is therefore viewed as one dimension within a broader social and emotional wellbeing framework, which is shaped by connections to culture, land, extended kinship, the ancestors, and spirituality (Gee, 2019, p. 2). Social and emotional wellbeing may change across a person's life course; that is, what is important for a child's social and emotional wellbeing may be different to that of an adult. However, a positive sense of social and emotional wellbeing is essential for Aboriginal and Torres Strait Islander people to lead fulfilling lives (Commonwealth of Australia, 2017, p. 6). Social and emotional wellbeing is distinguished from conventional understandings of mental health, in that it incorporates the historical, political and cultural factors that "shape the presentation and meaning of how mental health symptoms are understood for Aboriginal consumers, in many different ways" (Gee, 2019, p. 2). The nine guiding principles of social and emotional wellbeing can be found in **Appendix I**.

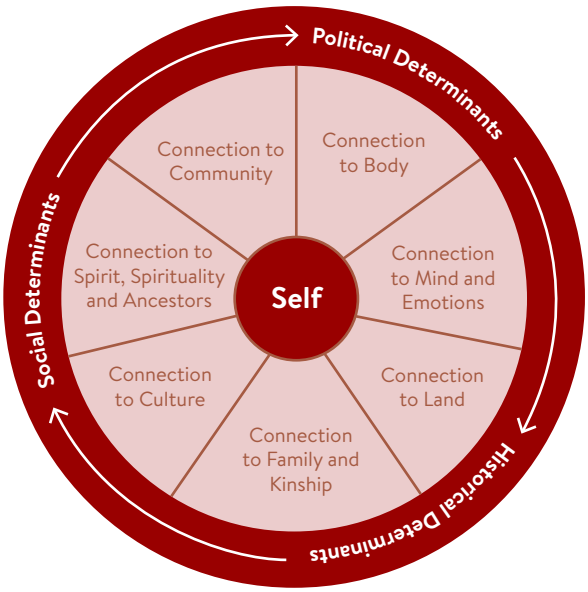


FIGURE 3
"Determinants of Social and Emotional Wellbeing"
(Dudgeon et al., 2014, p. 57)

Figure 3 highlights Aboriginal and Torres Strait Islander peoples' view of health and wellbeing as holistic, incorporating mental, physical, cultural and spiritual health and recognises the importance of land, community and family, culture and ancestry and how this impacts on the individual. It also reflects political, social and historical determinants and how these impact on a person's social and emotional wellbeing.

Strengths, Resilience and Protective Factors

Despite the significant challenges that people who use Wadamba Wilam's service have experienced, there are continuing strengths, resources and protective factors that are drawn upon that demonstrate the resilience of consumers. Wadamba Wilam workers remarked that they were in a privileged position to witness the strength and resilience of the people they work with, as well as the optimism and humour that is brought to sometimes challenging circumstances.

Wadamba Wilam workers identified that the impacts of colonial dominance itself, and the historical and current trauma inflicted by government bodies have driven a cultural resilience and resistance in the people they work with. Resilience has been borne out of hardship and is particularly exacerbated by the impacts of child removal through the Stolen Generation. Given the extent of trauma experienced, as well as stigma and discrimination, the daily practice of people getting up and on with their day, every day, speaks to the individual strength of people and their motivation to improve their lives, and the lives of their families and communities.

Wadamba Wilam workers understand that trauma fragments parts of the self, and that recovering from trauma includes entering a journey towards wholeness. Healing activities connects a person back to a sense of who they are, an understanding from which they may have been disconnected for many years in the struggle to survive.

Connection to culture and engaging in healing activities around this connection are protective factors that consumers of Wadamba Wilam's service engage in. Observations from Wadamba Wilam workers note that this connection is to a culture that is both living and thriving, and that for many is both a mindset and a spiritual set. These connections can be further strengthened by attending Men's Camps, Women's Camps, spending time with Elders, spending time at cultural events or in places of cultural significance. Other cultural activities such as participating in smoking ceremonies, experiencing a cleanse from an Elder, or burning a smudge stick in the home are also of great significance, whereby people feel they are part of a culture bigger than themselves.

These activities also provide a grounding sensory experience. These connections to culture lessen a sense of isolation. Spending time painting, weaving or engaging in other artistic cultural activities are both grounding activities as well as opportunities to make something of beauty from which a person can draw pride. Connections to land including spending time in the bush or on country, walking along waterways, finding bush tucker, spending time amongst plants and enjoying the sensory experience that the smells and sounds of nature bring, are all healing activities that also help improve trauma symptoms. These activities build a solid foundation upon which a person can strengthen their response to stress and build both self-esteem and self-efficacy.

Wadamba Workers also specifically noted the strength and resilience they have witnessed over many years in the matriarchs and mothers they have worked with. For those women with many caring responsibilities, Wadamba Wilam workers speak of the motivation they have witnessed within these mothers to improve their own mental and physical health, in order to be look after those that depend on them. There is an understanding that for women to be able to look after their children and dependents, they must first look after themselves. A desire to improve the lives of their children, and to get everyone well enough to be together again is ever present. Hope for a better future is a motivating and protective factor.

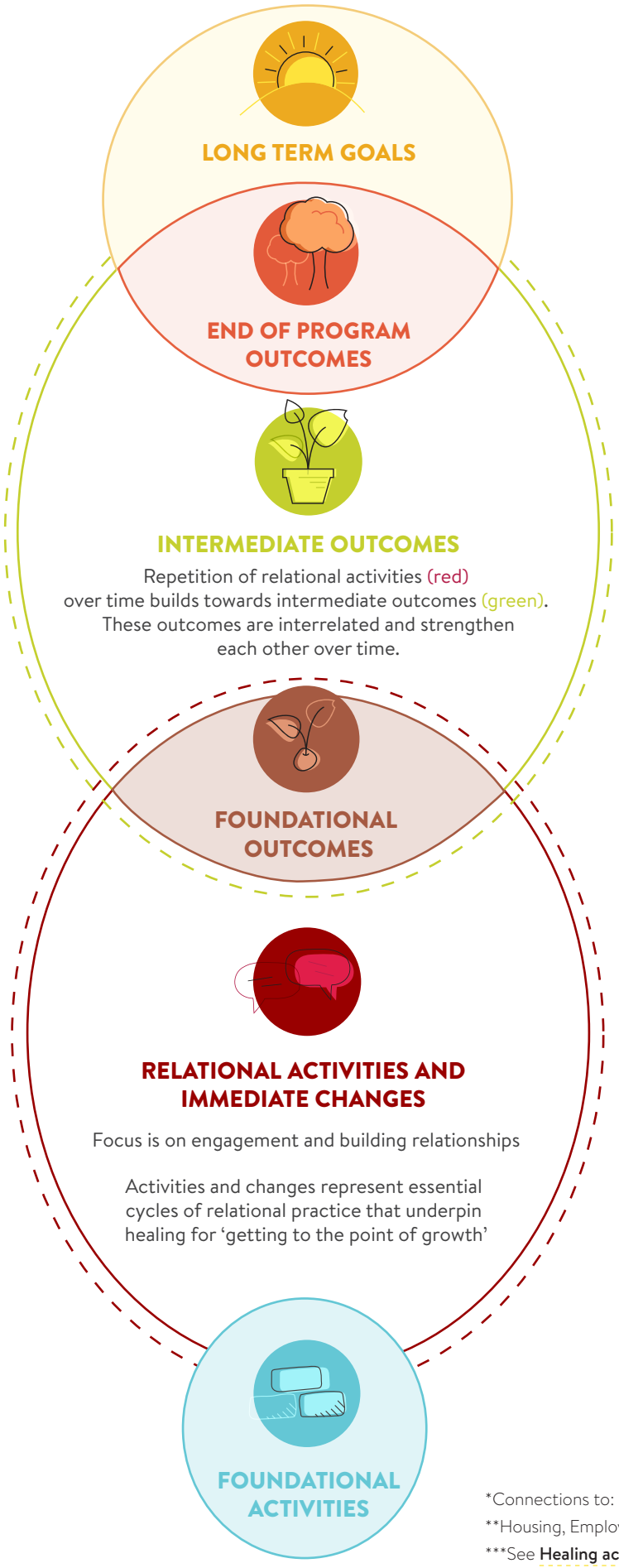
SECTION 3
WADAMBA WILAM'S PRACTICE APPROACH

> "Closing the Aboriginal and Torres Strait Islander mental health gap requires challenging current models and assumptions about mental health, treatment, and healing across the mental health system."
> (Calma, Dudgeon, & Bray, 2017, p. 255)

Theory of Change

Since its inception, Wadamba Wilam has been refining and reflecting upon its service, in order to effectively meet the needs of the community it serves. As previously described, there has been an expectation that Aboriginal and Torres Strait Islander consumers will adapt to the mainstream medicalised mental health service system within a Western understanding of mental illness, rather than the system being designed to meet the needs and culture of the people it seeks to support. Wadamba Wilam's "Theory of Change" (**Figure 4**) emphasises practices that seek to overcome the barriers to accessing services chronically experienced by these consumers, in order to build positive outcomes that improve the holistic social and emotional wellbeing of Aboriginal and Torres Strait Islander people. Key concepts and practices in this theory of change are described in further detail in this section.

FIGURE 4
Wadamba Wilam's Theory of Change



Holistic social and emotional wellbeing for Aboriginal people

Aboriginal people feel increased sense of their wellbeing, strength and connection

- Flexible & responsive access
- Service is accepted and valued by community
- Consumers choose to strengthen connections* in relation to their wellbeing
- Consumers can link with and use systems** towards wellbeing
- People feel safe to engage in healing activities***

- Sense of hope is generated
- Workers are trusted
- People are understood within a context of culture and trauma, informed by their social historical context

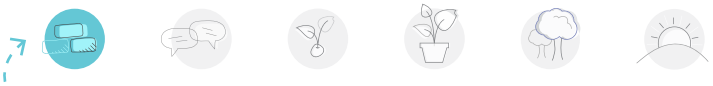
- Basic needs are met
- Hooks are offered in relation to need
- The service meets people where they are at
- Not shaming
- Being with people in crisis
- Slow and flexible assessment
- Tools used at the right time, over time
- Early use of service systems
- Staff look for therapeutic windows
- Permission to spend time to build relationship
- Persistence — workers come back again, and again
- Staff seek to understand rather than react
- Staff hold issues and come back to them at the right time

- Cultural responsiveness
- Staff understand Social & Emotional Wellbeing
- Recruiting the 'right' people
- Interdisciplinary team approach
- Discretionary budget
- Build networks who will vouch for the program

*Connections to: Family, Community, Country, Spirituality, Ancestors, Cultural practice

**Housing, Employment, Education, Positive justice, Welfare, Physical health, Mental health

***See **Healing activities and their outcomes, on page 40**



FOUNDATIONAL ACTIVITIES

Wadamba Wilam's service is grounded in the following understandings and theoretical principles. All relational activities can be traced back to these concepts being embedded in the practice approach.

Cultural Responsiveness

Cultural safety is paramount to prevention and recovery of mental illness as it allows the provision of care consistent with and respectful of holistic concepts of health and social and emotional wellbeing. Practicing with cultural safety and competence allows the healing elements of social and emotional wellbeing to be facilitated and accessed at the right time by Aboriginal and Torres Strait Islander people.

Staff have completed cultural responsiveness training through the Australian Indigenous Psychology Association and also utilise the cultural knowledge of Aboriginal staff in the team and Victorian Aboriginal Health Service (VAHS) staff. The team have participated in cultural mentoring and in joint reflective practice sessions with the local Aboriginal Community Controlled Health Service (VAHS). Staff have also been requested to present their model of practice to Aboriginal communities and mainstream service providers. Team members are supported to attend relevant cultural forums and social and emotional wellbeing conferences and utilise the social and emotional wellbeing framework in conjunction with Neami National's approach to practice, the Collaborative Recovery Model (CRM).

The Collaborative Recovery Model (CRM) is a person-centred and strengths-based coaching practice model (Oades L. G., 2017, p. 99). This approach emphasises, in its updated delivery; creating opportunities for connection, understanding and cooperation; amplifying choice, voice and decision making about what matters; enhancing skills and confidence to act on what matters; and supporting access to resources to do what matters. This approach is culturally sensitive to the understanding of recovery as a process of healing for Aboriginal and Torres Strait Islander people, and is appreciative of culturally specific understandings of mental distress and opportunities to strengthen social and emotional wellbeing.

The process of screening and assessment needs to be carried out in a sensitive manner and there are many skills and considerations that are relevant in the process to avoid assessment tools being poorly received by Aboriginal and Torres Strait Islander consumers. There are many differences in communication style and expressions of distress by Aboriginal people and non-Aboriginal people that may impact the screening and assessment process. For instance, the direct questioning that is often part of screening and assessment may not be considered an appropriate manner to commence a relationship by Aboriginal people and a narrative approach or having a 'yarn' while conducting assessment is more successful in obtaining an accurate and meaningful assessment (Dawe, Farnell, & Harlen, 2010). Specific aspects of the process such as interview location, language and style, cultural idioms of psychological distress and awareness of areas of particular sensitivity are vitally important to the assessment process. A knowledge of areas of particular sensitivity such as men's and women's business and sorry business are of considerable importance for culturally competent practice.

Engrained in Wadamba Wilam's rapport building activities is an understanding that yarning and listening is essential, and that people can only be known and understood over time.

Incorporating of Social and Emotional Wellbeing Principles

Social and emotional wellbeing is the key principle for working with Aboriginal and Torres Strait Islander people and is incorporated as a foundation into Wadamba Wilam's approach to practice.

The holistic strength-based approach allows Wadamba Wilam staff to facilitate access to many protective factors within the community.

Maintaining a spiritual, physical and emotional connection to the land is intrinsic to many Aboriginal and Torres Strait Islander people's beliefs about social and emotional wellbeing, and culture is therefore critically important in the delivery of health services (Commonwealth of Australia, 2017, p. 7). Wadamba Wilam supports consumers to connect with culture through accessing community groups such as VAHS' men's group and women's sister circle, alongside cultural camps and outings to places of cultural significance, such as Coranderrk and the Koori Heritage Trust. The team recognises the importance of connection to land, spirituality and ancestors as integral to social and emotional wellbeing for Aboriginal people. Many consumers have been supported to return to country on a regular basis and the team have observed the many healing benefits of this.

The key factors that protect social and emotional wellbeing are:

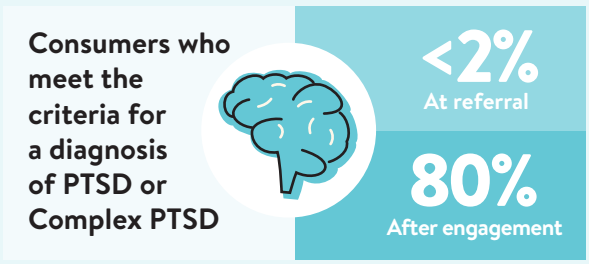
- Access to community and community resources;
- Awareness of cultural history, family and country;
- Spending time on country;
- Access to specific cultural groups (such as women and men's groups);
- Contact with family;
- Engagement in meaningful activity.

These factors can be utilised to promote healing and resilience from trauma, allowing the person to proactively manage their mental health and wellbeing using coping strategies that are positive for the individual, family and community.

It is important to combine effective medical treatments as an adjunct to enhancing social and emotional wellbeing. Targeted treatment of distressing post-traumatic symptoms with medication can assist in reducing the intensity of symptoms and allow the person to more fully engage in interventions that promote social and emotional wellbeing. Effectively treating post-traumatic symptoms can reduce addictive behaviours that are often utilised by people to dampen or numb post-traumatic symptoms. Addiction is often a counterproductive coping mechanism and reducing distress can provide some space for the individual to consider changing some of their addictive behaviour. Peer support and access to role models can be an important protective factor for social and emotional wellbeing. Engagement in meaningful activity such as art, physical activity, time in nature, writing and creative expression, sport, music and other hobbies is vitally important for rebuilding self-esteem and confidence that has been eroded by previous traumas, racism, discrimination and chronic grief and loss.

Staff are Trauma-informed, and look for and understand behaviours impacted by trauma

Levels of trauma exposure are high within this cohort and it is not uncommon for Wadamba Wilam consumers to have experienced in excess of thirty significant traumatic events over their lifetime. Many Wadamba Wilam consumers experience symptoms consistent with PTSD and Complex PTSD. At the point of referral to Wadamba Wilam less than 2% of consumers have had a diagnosis of PTSD or Complex PTSD. After a period of engagement with Wadamba Wilam more than 80% of consumers meet the criteria for diagnosis of one or many of the post-traumatic stress diagnostic formulations.



Receiving an accurate diagnosis that aligns with the consumer's experience and symptoms is crucial in developing an appropriate support plan, with appropriately targeted therapies and/or medications. In addition to this, recognising the role of trauma in a person's distress steers away from the western practice of medicalising distress and mislabelling cultural trauma as individual illness.

The Wadamba Wilam team uses elements of several Trauma-informed approaches including Judith Herman's Three Stages of Trauma Recovery Model (Herman, 1997). The course of recovery observed in many consumers of Wadamba Wilam is reflected in Herman's work:

> "In the course of successful recovery it should be possible to recognise a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatised isolation to restored social connection." (Herman, 1997, p. 155)

Building trust and understanding

Worker Reflection – Adam

John regularly slept at the local park. He had a longstanding diagnosis of schizophrenia and primary homelessness and was referred to Wadamba Wilam.

John consistently referred to derogatory voices that were commanding in nature when he was highly stressed. The Wadamba Wilam team built up a trusting relationship with John over two to three years.

Following this period of trust and rapport building, John made his first disclosures of significant childhood abuse. John had kept this abuse secret his whole life. He revealed that the derogatory and command hallucinations he experienced were the voices of his past perpetrators. John experienced catharsis at revealing his abuse history with a trusted worker where his experiences and psychotic symptoms were viewed through a trauma lens. John experienced the most therapeutic benefit in renaming these voices in his own derogatory nicknames. He had previously denied any trauma and the team was able to gain a better understanding of his symptom profile which included many post traumatic symptoms including nightmares, flashbacks, hypervigilance, avoidance and negative self-concept. The team assisted John to live with these post traumatic symptoms and reduce the impact on his daily functioning which led to significant improvements in managing his mental health and social and emotional wellbeing.

John's story highlights that many people are reluctant to disclose their abuse histories before trust has been established. Providing consumers with a space to share distressing experiences in a safe and contained manner provides the team and the consumer with an opportunity to work in a holistic and trauma-informed manner as well as engage in targeted therapies and support to enable healing and improve social and emotional wellbeing. The team's well-rounded understanding of the various symptoms of mental distress and trauma provide opportunities for healing, that many people have never had access to before being with Wadamba Wilam.

The recommended treatment model involves three stages or phases of treatment, each with a distinct function as follows (Cloitre et al., 2012, p. 5):

Phase 1 focuses on ensuring the individual's safety, reducing symptoms, and increasing important emotional, social and psychological competencies.

Phase 2 focuses on processing the unresolved aspects of the individual's memories of traumatic experiences. This phase emphasizes the review and re-appraisal of traumatic memories so that they are integrated into an adaptive representation of self, relationships and the world.

Phase 3, the final phase of treatment, involves consolidation of treatment gains to facilitate the transition from the end of the treatment to greater engagement in relationships, work or education, and community life.

Many people supported by Wadamba Wilam experience poor health and social and emotional wellbeing as they are part of the Stolen Generations or descendants of the Stolen Generations. These consumers in most part do not have connection to culture, community and may not be aware of their country or have not been on country for many years. This contributes significantly to the physical and mental health gap experienced by many Aboriginal people. The numerous interpersonal traumas experienced by many Aboriginal people has the most significant impact on social and emotional wellbeing and the health gap.

The experience of significant post traumatic symptoms and presentations of complex trauma is a consequential barrier to consumers remaining engaged with standard service approaches. Wadamba Wilam's holistic and culturally safe approach allows the team to tailor treatment to the consumer's preferences while making the most of resources from partner organisations to meet the individual's needs in a targeted manner. Many consumers are now experiencing the type of recovery Judith Herman discusses, after two to three years of intensive support with over a thousand hours of input and support from Wadamba Wilam staff.

The coordinated and collaborative nature of service delivery is fundamental to Wadamba Wilam service provision. Using assertive outreach as the mode of service delivery by a clinician or health care professional is imperative, as accessing fragmented services can further traumatise the person who must constantly re-tell their story.

Trauma, Healing and Growth

Worker reflection — Adam

A man in his 50s, Tom, was referred to Wadamba Wilam and has since had two long-term engagements with the service. Tom had been itinerant for most of his life, had a history of multiple incarcerations and consistent contact with the justice system, but had little interaction with the mental health system.

Tom presented as very dysregulated and easily triggered. He would have flashbacks and nightmares. He was so dysregulated it was hard to maintain a conversation with him and he would spew out all his traumas throughout his whole life, to the point where I [worker] would have to say "I want to help you but I find it so hard to follow along. I want to help you through this, but can you pick one or two things to work through. Focus on how you manage your response to this". I was able to bring his awareness to what he was saying as he didn't have any mental connection to it, it was just spilling out. During the first two year engagement, Tom reached a point of stability however serious issues with his family led him to leave Victoria.

A few years later, Tom rang Wadamba Wilam from an interstate inpatient unit. Tom stated he had several inpatient admissions due to a decline in his mental health and he wished to return to Melbourne to engage with Wadamba Wilam's services again. Due to Wadamba Wilam's flexible intake processes, Tom was able to be picked up straight away by Wadamba Wilam and received services. Wadamba Wilam was able to support Tom with both housing and his mental health. Wadamba Wilam engaged Tom in treatment around psychosis, post-traumatic symptoms, as well medication to manage nightmares.

Over a couple of years, Wadamba Wilam regularly maintained contact with Tom, and through his hard work and with the support of the service, he was able to reduce his substance use, manage his other health issues and stabilise his mental health.

The first episode of service was characterised by a trust and engagement process. It was quite powerful to have someone call from another state and say: "Hey bud, I'm coming back to Victoria because you were the last place that provided me with support and the last place I felt safe". The second episode of service was one of growth and healing, and reflects the three stages of Herman's trauma recovery model. The Tom we see now is a far cry from the man we first met. His social and emotional wellbeing, his knowledge of trauma and how he responds to stress is vastly improved.

Appropriate and relevant assessment tools

Appropriate and culturally relevant assessment tools are important in ensuring a safe space for consumers to share what they are comfortable to talk about and to support workers to gather important information that enables them to better understand a consumer's experience and situation.

The timing of these assessments is critical, and poor introduction and use of these tools can become a barrier to engagement and a source of distrust between consumers and the service. Workers are skilled in identifying the relevant assessment tools necessary as well as timing their offering so that these assessments are both acceptable to consumers and actively contribute to a therapeutic process.

International Trauma Questionnaire

Wadamba Wilam has implemented the International Trauma Questionnaire (ITQ) (Cloitre et al., 2018) to help support effective assessment. This questionnaire aims to measure the severity of impact of traumatic experiences and intensity of trauma symptoms. Ideally the questionnaire is completed six-monthly to observe an increase or decrease in trauma symptoms.

In Wadamba Wilam's experience the majority of the consumer population experience many symptoms of PTSD and Complex PTSD, a diagnosis that has recently being recognised in the ITOM 11 (*International Classification Diseases – 11th Edition*). As a result, utilising the ITQ has assisted the team to accurately assess, plan and evaluate their support of the consumer group.

The questionnaire focuses on the three core features of PTSD in: re-experiencing in the here and now; avoidance; and sense of current threat. Each feature has two items, to consider a diagnosis of PTSD and the consumer has to endorse at least one item in each of the three features of PTSD to a level of functional impairment. The consideration of Complex PTSD requires the endorsement of the core features of PTSD and additional endorsement of disturbance in self organisation (DSO). DSO is divided into three features in affective dysregulation; negative self concept; and disturbances in relationships. A diagnosis of complex PTSD requires three features of DSO in addition to the features of PTSD.

The ITQ is relatively quick and easy to fill out and can provide an opportunity to explore key areas of post traumatic responses in a non-threatening manner. The measure is usually completed with the consumer to give time to explore meaning and the narrative of their responses. It can also be an effective way of educating people about the common post traumatic responses they might experience and allows clarification of specific experiences the person may be having.

The Aboriginal Resilience and Recovery Questionnaire (ARRQ)

Wadamba Wilam was introduced to the ARRQ by Dr Graham Gee. This tool was developed from Koori and Aboriginal Victorian understandings of resilience, healing and recovery from trauma. Gee believes the ARRQ has the potential to assist Aboriginal Community Controlled Health Organisations and, other organisations, to evaluate whether their services and programs are supporting community members to strengthen individual, relational, community and cultural resilience resources.

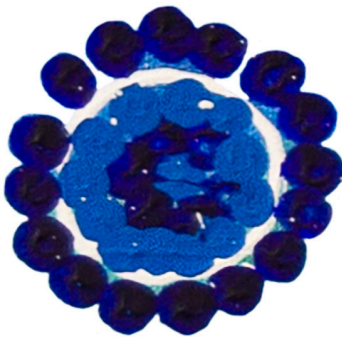
The Aboriginal Resilience and Recovery Questionnaire (ARRQ: Gee, 2016) is a 60-item multidimensional strengths questionnaire that was designed by Dr Graham Gee in partnership with the Victorian Aboriginal Health Service. The ARRQ is being used to assess strengths and resources associated with resilience, healing and recovery among Aboriginal and Torres Strait Islander help-seeking populations. The questionnaire uses a 5-point Likert scale response format (1=not at all, 2 = a little, 3 = somewhat, 4 = a fair bit, and 5 = a lot) and includes a wide range of resilience constructs such as community connection, community opportunity, cultural identity, self-worth, emotion regulation, positive emotions, strong relationships, safety, social support, a personal sense of mastery, spirituality as a source of strength, and participation in cultural practices.

The psychometric properties of the ARRQ were adequate with the measure showing good internal consistency (item reliability) and convergent, discriminant and predictive validity. The ARRQ has two subscales that include a 21-item Personal Strengths score, and a 29-item Cultural Community Relationship Strengths Score. The first 50 items from the two subscales can be added together to produce a Total Strengths Score. It is also possible to examine smaller sub-scales (2–5 items) of separate constructs such as safety, community connection and so forth. The final 10 items of the ARRQ are single items that enquire about constructs such as cultural practices, spirituality and self-care.

Wadamba Wilam trialled use of the ARRQ during 2017–2019. The ARRQ was piloted with approximately 20 consumers. The majority of these consumers filled out the ARRQ once, although a small number also filled it out at across 2-4 time points over two years. The results of the trial period highlighted the complex, real-world nature of supporting consumers with complex mental health and social and emotional needs, to build resilience and resources. For example, some consumers reported uniform increases in both Personal Strengths and Cultural Community Relationships Strengths, while other reported increases in one or the other. In addition, some consumers unexpectedly reported a decrease in resilience after a period of time, followed by an increase. Staff reflected that this may have been consistent with the idea that some consumers may initially present in acute, unwell states, and after a period of stabilisation they experience new and greater insights into their strengths and resources. It could also have been associated with greater levels of trust with staff as time progressed with service engagement.

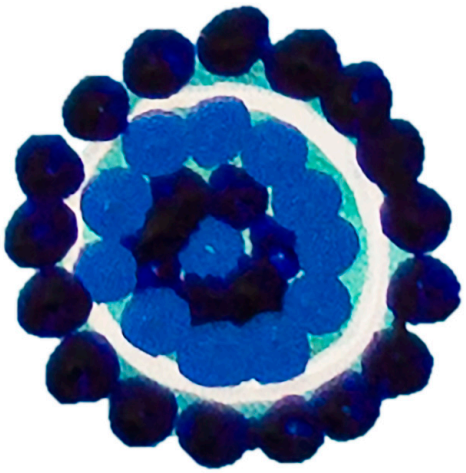
Wadamba Wilam concluded the trial period by conducting some yarning groups to explore both consumer and staff experiences of using the ARRQ. Both consumers and staff shared how use of the tool opened up different conversations about culture, spiritual and emotional wellbeing, and recovery. When used at the right time the ARRQ was powerful in supporting reflection and generating discussion and plans. Both Aboriginal and non-Aboriginal staff found the tool provided a useful way into these conversations.

> **“as a non-Aboriginal worker I think the ARRQ gave me a good way of looking at cultural strength and resilience and I think it gave me a language around it…something that I could visualise the [SEWB] wheel and it brought it all together for me.”**
> **–Adam**



Staff contain, manage, mitigate and reflect upon risk

A number of Wadamba Wilam consumers can display behaviours that can be experienced by others as challenging, including verbal and physical aggression, and have historically been banned from multiple services. Herman (1992) stated that following a traumatic experience, a person can go into permanent alert, as if danger may return at any moment, in self-preservation. This state of hyperarousal may become present through consumers who are agitated and/or hypervigilant, as well as exhibiting fear responses such as anxiety, anger, dissociation or numbing, (Portman-Thompson, 2020, p. 34). As staff are trauma-informed, behaviours are seen through the lens of complex trauma where consumers can experience problems handling their emotions, have unexpected shifts in mood and dissociative experiences. It is common for consumers to re-experience emotions from trauma in an intrusive way, and have difficulty in having trusting relationships. Through viewing these behaviours through the lens of PTSD/Complex trauma, the Wadamba Wilam team are able to see the underlying causes, which promotes empathy. It also allows for interventions which enhance sense of safety and trust.



Nevertheless, these presentations are challenging for staff and support is provided through the following means:

- Professional supervision;
- Team based reflective practice;
- Secondary specialist consults when required;
- Two staff attend outreach appointments when risks have been identified;
- Considered allocation of consumer to key worker to balance out the complexity amongst the team;
- A team approach ensures all staff are aware of pressures and challenges arising and the capacity to 'step in' and change the support structure when needed;
- Buddy-up system for new staff;
- Staff are well oriented and trained.

For staff and consumers alike, containing and mitigating risk and cultivating safety requires a focus on engagement and strong relationships. Skilled and experienced workers trust their capacity to minimise and disperse risk, through investing time in developing trusting relationships. This includes looking for and highlighting protective factors and working with consumers to strengthen those protective factors, such as connections to kin, family, land and country.

Risk is dynamic and can be affected by circumstances that can change over a short time. The team is responsive to this and the Senior clinician and psychiatrist are able to support the team in providing strengths-based risk assessment and management plans that weigh up the benefit of interventions and autonomy.

Recruit the *right* people

Wadamba Wilam's success is grounded in ensuring that staff feel the support to work patiently, flexibly and assertively with consumers to develop trusting, safe relationships. Sensitive recruitment of staff who are well matched to this style of service provision has also ensured the program's success.

During recruitment and employment, the following behaviours and values are highly valued:

Workers who...

- Challenge racism
- Are self aware and owning of unconscious bias
- Tolerate uncertainty
- Have patience and are happy to play the long game
- Opportunistic in approach
- Can hold unconditional positive regard

Managers who...

- Trust their workforce
- Are lateral thinkers
- Can build strong relationships with people and communities who can vouch for them

A values-based approach is the foundation of the recruitment process, as it is understood that certain skills can be taught, however values are more difficult to shift. An expectation of cultural knowledge, community knowledge and cultural sensitivity are essential as well as a strong display of emotional intelligence. Specific qualifications are required for distinct roles within the team, for example, a nurse practitioner requires the relevant qualifications.

There is an emphasis on hiring and retaining Aboriginal and Torres Strait Islander staff in the program and a commitment to increase this.

Interdisciplinary team approach

Establishing an integrated outreach team comprised of staff from partner agencies has required careful planning and a genuine desire by all parties to collaborate and design a model which is culturally responsive and innovative. A project management group consisting of senior managers of the partner organisations was established in 2013 and a consultant was procured to assist with solidifying the partnership and developing terms of reference for the group.

All Wadamba Wilam service staff from partner agencies receive supervision directly from the Wadamba Wilam service manager. They have been supported to develop 'back to base' work plans which include additional supervision/support from their employing agency, alongside accessing mentoring and team based reflective practice both at Neami and their own organisations. Staff appraisals and development plans are conducted as per each agency's requirements in conjunction with the Wadamba Wilam service manager. Through these processes staff are able to stay connected to their own organisation's culture and promote the Wadamba Wilam program in an ongoing basis. Wadamba Wilam's facilitation of access to these services has contributed to a significant increase in Aboriginal consumers accessing sub-acute and residential rehabilitation facilities which have formerly had minimal Aboriginal representation. The use of Northern PARC (Prevention and Recovery Care, located in Preston) in particular has proven to be a consistent therapeutic option for Wadamba Wilam. The program has supported many referrals into Youth and Adult residential support services and the Northern CCU (Community Care Units, also in Preston). Wadamba Wilam provides continuity of care to consumers both while they are in these facilities, along with effective and ongoing follow up after discharge.

The team brings expertise in mental health, healing and recovery, Drug & Alcohol support and cultural knowledge, which has provided a platform to effectively respond to the often multiple and complex needs that consumers experience. Staff have the expertise to conduct assessments 'in house' which reduces the need for consumers to recount distressing experiences. The interagency partnership within the team breaks down some

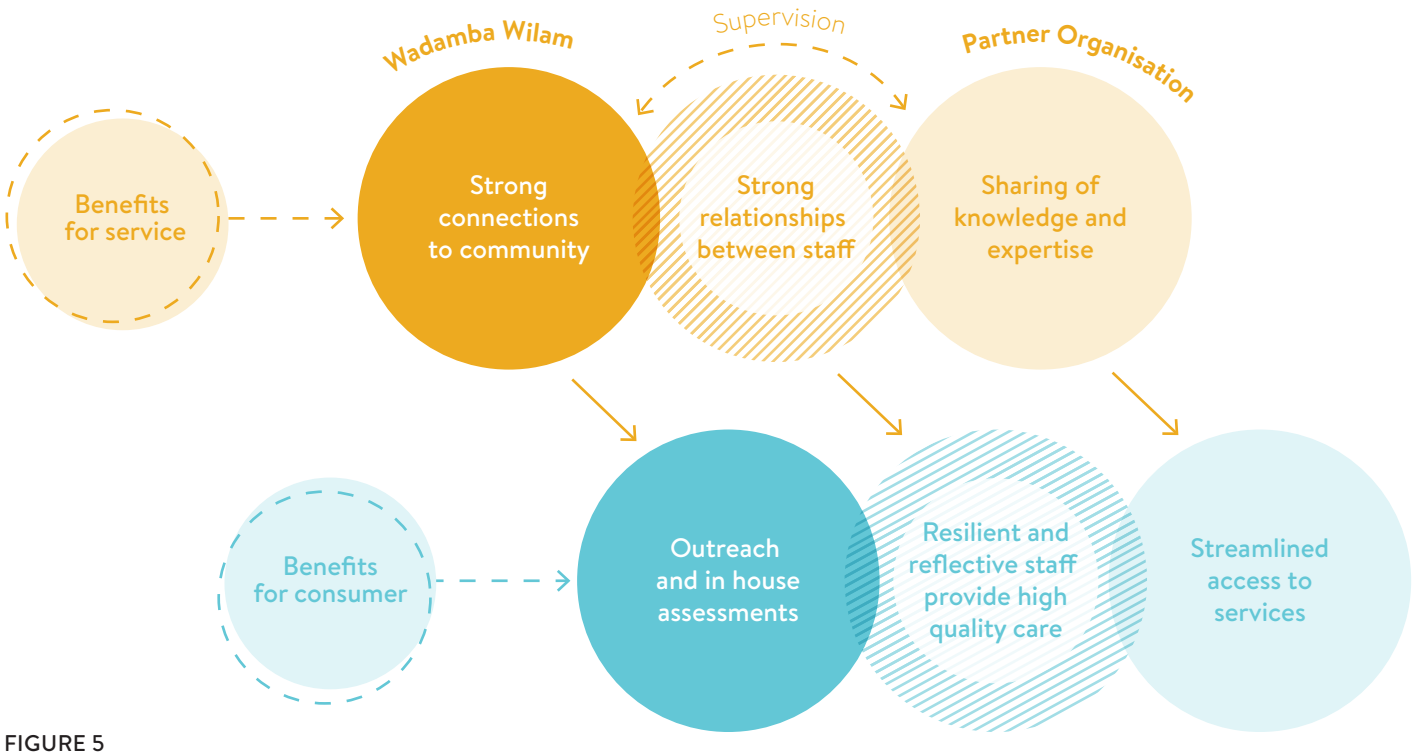


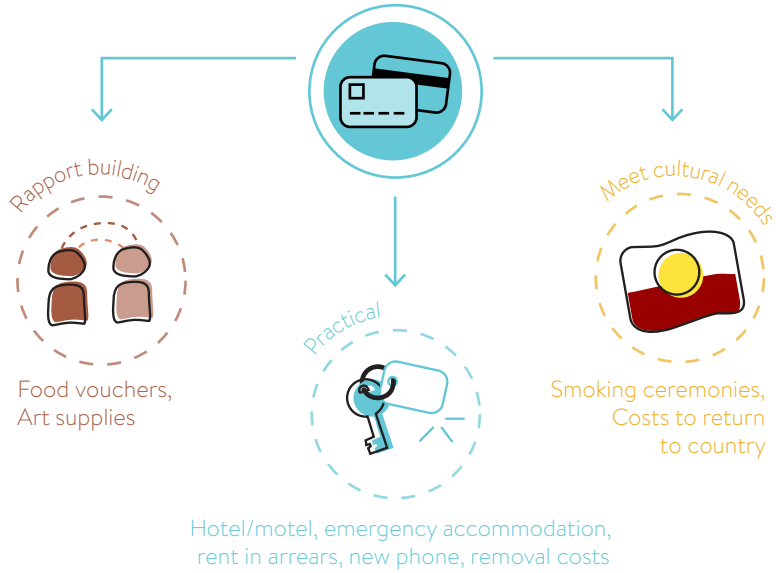
FIGURE 5
Benefits of inter-agency team approach for service and consumers

of the systemic barriers to accessing relevant services involved in a timely and targeted manner. For instance, Wadamba Wilam can facilitate admissions directly to the acute psychiatric inpatient unit, the inpatient withdrawal unit for AOD support, Neami National services such as Northern PARC, or relevant service components of the Victorian Aboriginal Health Service and cultural groups and camps. This streamlining of processes minimises what has historically been a traumatic experience for Victorian Aboriginal people accessing mainstream services.

Wadamba Wilam employs a 0.1 (FTE) consultant psychiatrist in the team whose role is to provide clinical governance to the team, meet all consumers and provide psychiatric assessments. The assessments occur at the Fairfield site and also on an outreach basis. Through this interface consumers have been supported in receiving psychiatric care through Victorian Aboriginal Health Service Family Counselling and a timely response to clinical mental health needs, such as medication changes. Whilst the inclusion of the psychiatrist in the service is essential, an expanded FTE for this position would be welcome as demand for psychiatric consultation often is beyond the limited time allotted.

Discretionary Budget

Wadamba Wilam receives a monthly budget which can be used at its discretion to meet consumer needs provided it meets the consumer brokerage guidelines. All spending is approved by the manager, and every use of this fund is aimed to enable and empower a consumer in their situation, and avoid fostering dependency on the program. These items are paid via Tax Invoice through Neami National's finance department, or by the program's credit card.



Build networks of supporters who will vouch for the program

It has been essential for the service to be nestled in the local community, to work collaboratively with local Aboriginal Community Controlled Health Organisations (ACCHO) and Aboriginal Community Controlled Organisations (ACCO) services, and to be trusted within the Aboriginal and Torres Strait Islander community.

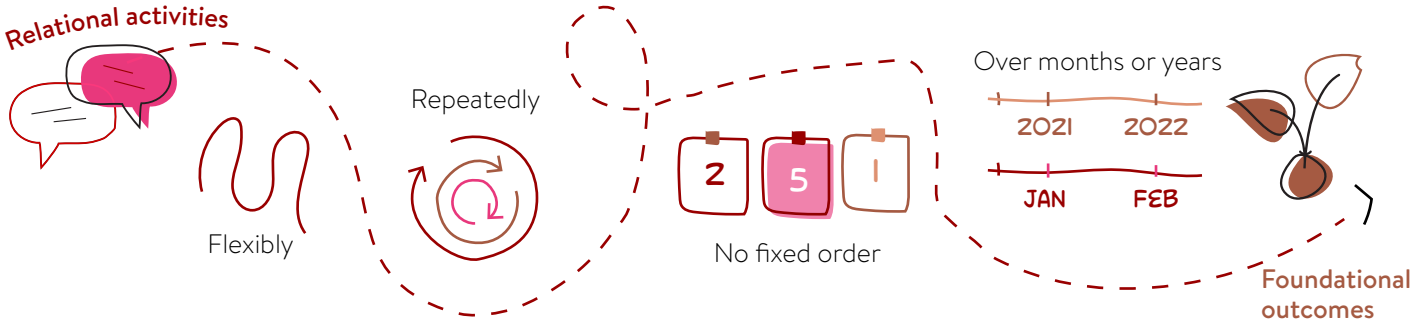
Prior to the service's opening and during its foundation, the following activities were undertaken to achieve this aim:

- The redesign of the original funding tender to include the Victorian Aboriginal Health Service into the consortium and to recruit an Aboriginal worker. Originally the Victorian Aboriginal Health Service was only tendered as a partner, however early in the design process it was acknowledged that they needed to be represented in the consortium;
- The consortium senior management met with a specialist facilitator to develop the Terms of Reference and establish a Governance group;
- Consortium managers and Wadamba Wilam team received approved cultural training through Australian Indigenous Psychology Association
- During the early stages of the service, the Service Manager received mentoring from an Aboriginal community member;
- Wadamba Wilam team met with key ACCHOs and ACCOs to promote the program alongside promotion through consortium services.

In order to maintain this connection between services and to ensure interagency co-operation, the following maintenance activities take place:

- 'Back to base' days and continued promotion of the program in workers' employing service. This has been essential in keeping Wadamba Wilam on the broader agenda of base services;
- The Wadamba Wilam service manager regularly meets with the manager/team leader of VAHS to discuss the partnership and any issues that have arisen;
- Co-presentation (by Neami/VAHS/NAMHS in particular) of Wadamba Wilam at national and state conferences including TheMHS, NACCHO and VICSERV;
- Co-presentation at the Northern Psychiatric Unit, VAHS and other services with consumers to promote social and emotional wellbeing approach;
- Male workers have attended regional men's Aboriginal camps over the years as well as fortnightly Aboriginal men's group;
- The Nurse Practitioner sat on multiple round tables for the Royal Commission into Mental Health and provided a witness statement;
- The team, consumers and carers met with politicians to talk about the service, including local Victorian Minister Martin Foley and the Parliamentary Secretary for Mental Health;
- The service works closely with key Aboriginal clinicians and researchers, including Dr Graham Gee.

RELATIONAL ACTIVITIES AND IMMEDIATE CHANGES



These activities conducted by workers prioritise engagement and building relationships. Activities of relational practice underpin healing, and support consumers to arrive at a point of growth. These activities occur flexibly, repeatedly, in no fixed order and over months or years.

Through these activities, some immediate changes occur, for instance, a consumer's basic needs are met. More importantly a sense of hope and unconditional positive regard is cultivated and workers are trusted. These activities implicitly communicate to consumers that they are understood within a context of culture and trauma awareness and this is informed by their social and historical context. All these activities align with trauma-informed care and developing a sense of safety and security.

"Basic needs are met" and "Hooks are offered in relation to need"

A key factor that detrimentally impacts social and emotional wellbeing relates to people not having their basic needs of housing, food, safety and belonging met. Wadamba Wilam workers are keenly aware that in order to ensure the service or support is Trauma-informed, a sense of safety and security must be established to enable a therapeutic relationship, for connections to be strengthened and social and emotional wellbeing to be improved.

The service's monthly consumer brokerage fund allows workers (with manager approval and according to brokerage guidelines) to provide practical support when required. These "hooks", offered during the initial engagement phase, help build rapport, build trust, and acknowledge the practical difficulties consumers must overcome in order to engage in other positive changes. For example, Wadamba Wilam provided travel costs for transportation so that "Narelle" could access Country, as part of her self-care and coping strategies (Victorian Government, 2017, p. 30).

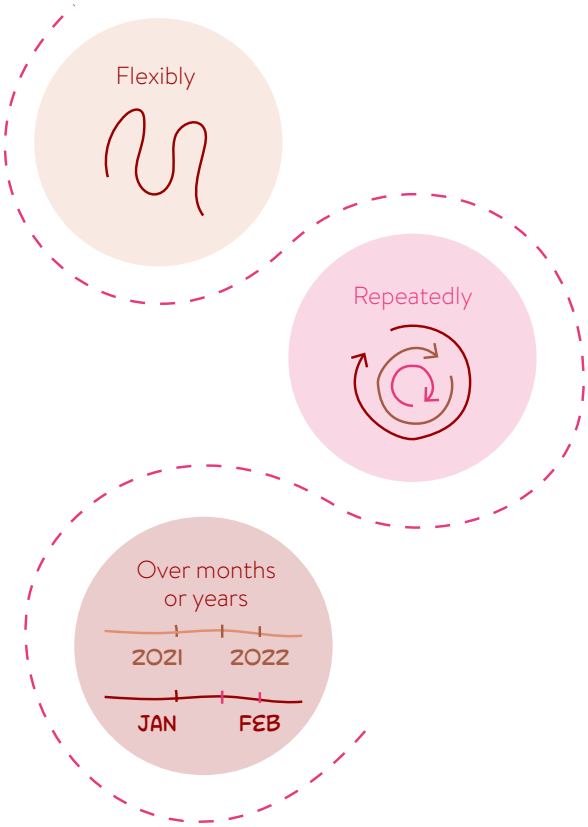
Worker reflection — Molly

"At the start, we connect with someone and offer really practical things to them, like helping out with a grocery voucher, or doing something practical housing-wise, submitting a form or making an appointment. It helps you then develop the relationship and start hearing their story. Thinking about peoples' Hierarchy of Needs, establishing safety and stability helps to build trust and builds a stronger foundation for your rapport."

The service meets people where they are at

The assertive outreach model ensures that staff are not restricted to an appointment-based system. This means that not only can staff go out into the community to meet people where they are at any particular moment, they can assertively seek to reach people who are in crisis or struggling to make it to appointments for many reasons . As many consumers are homeless, rough sleeping or in insecure housing, this is especially important to maintain contact with consumers.

In other services, including mental health services, there is an expectation that consumers are "ready" for change, able to articulate their distress and needs, and to accept support from services and systems. The expectation is that consumers engage seamlessly with services and show up to appointments and "comply". If consumers do not meet these requirements, they will be exited from the services they need. This understanding is counter-intuitive to trauma-informed understanding of the behaviours of people in crisis or those that are struggling, that may be engaging in avoidance, risk-taking behaviours or resisting change, or have a distrust of services and systems.



Worker reflection — Molly

"So much of the focus has been on slowly building rapport and trust, and I've found in that way, it's taken five months, she'll call me when she changes her phone number, which is hugely significant, because prior to that, she would change her phone number, services would lose contact and say "We can't contact her, we've closed her" or "We didn't get any contact, she can't have contact with her kids" or "We don't have contact, we can't do this family violence assessment even though she is at risk". People can change their phone numbers often because their phones are stolen, or they lose it or they don't have enough money for credit, or because of safety issues around family violence, they'll change their phone number.

Our approach is different in that if I can't reach someone I won't just send them a letter saying that "We will close your case", I will go and knock on her door if I haven't heard from her for a while, or leave a note for her, or try and contact her through her sister. A lot of the work is explaining to other services this way of working, liaising with them to insist that they don't close her, she is here, she is engaging, but it's a different framework of working. From our end, we notice if someone is in crisis or avoiding us, that means we actually need to ramp up our assertiveness in trying to reach them, as opposed to what occurs in other services where those behaviours serve as a trigger to exit someone from a service."

Not shaming

An understanding of the social, political and historical determinants of social and emotional wellbeing, as well an approach founded in trauma-informed care, supports workers to approach all relational activities with consumers through a lens of empathy and in a culturally safe manner.

Shame, as understood in Aboriginal communities and culture, describes stigma and embarrassment associated with gaining attention through certain behaviours or actions (Adams, 2014, p. 8). Shame can be expressed in a range of ways, for example a person may be nervous when speaking or keep quiet all together. Shame can be caused by a person behaving aggressively or in a heightened manner when in crisis, and this can lead to a person avoiding engaging with others including services. Wadamba Wilam seeks to reduce this shame by sensitively observing and listening to a person's body language, silences and indirect language, employing Aboriginal staff and taking the time to develop trusting relationships.

Worker reflection – Molly

"You just have to keep moving, and take that soft consistent approach. If something happens (an aggressive outburst for instance), for the consumer to be feeling embarrassed or shamed about it, we just move on and I still show up the next day for the next appointment and I don't mention it. Freezing people where they were at in a particularly bad moment, can impact their engagement, and increase cultural shame. The sensation, experience and feeling of shame freezes you, it can be a barrier, it stops people from being able to move forward. We want to be really careful about it in not being punitive or reactive and if something happens we don't focus on it too much, unless they initiate wanting to talk about it. We keep that consistency in still showing up for them and we're predictable in that way, which again strengthens the trust in the relationship and the belief that the service won't just abandon them because of one bad day.

The whole idea of rolling with resistance, meeting them where they're at, not reacting to the surface level outbursts underpins the interpersonal relationships. If someone is having a bit of a moment, we just engage in de-escalation, we stay neutral, we let them ventilate. Obviously if you as a worker feel unsafe, that's a different matter, but in Wadamba Wilam we have a certain tolerance for these behaviours and an understanding that people might not have other ways of expressing their emotions. Sometimes this is just what happens and that's ok and we're not going to make you feel bad about it."

Being with people in crisis

The delivery of services through assertive outreach allows for flexibility and responsiveness with relative immediacy. The service can therefore adapt to the person's needs and situation and reduces the impact of systemic issues. Assertive outreach allows the consumer to develop coping skills in the moment when they are triggered and awareness of how trauma impacts them and how they can develop self-soothing strategies. Assertive outreach also provides workers with environmental information about consumer's living situation, family or other relationships, which can be used to develop rapport, appropriate assessment and potential therapeutic intervention.

Flexible and assertive outreach means that staff can maintain weekly or fortnightly contact, but increase this to daily if necessary if a consumer is in crisis or distressed. During this time, crisis can become a space that people can be coached through and learn from, rather than be removed from or fixed. In other services these might be occasions where the Mental Health Act is employed and consumers are involuntarily hospitalised, which is still an option for Wadamba Wilam if deemed necessary as an option of last resort. However there is an understanding that crisis does not necessarily need to mean forced treatment or forced removal. When workers are with people during crisis they can enhance choice, control and support consumers in finding their own solutions, self-soothing techniques and provide psychoeducation around trauma responses and behaviours that empower consumers.

Worker reflection – Adam

"He would call me up and say "I'm losing my mind here and I'm thinking of trashing this building and going to hit someone" and then I could talk it through with him, provide that active feedback, and then two hours later he could say "I didn't hit anyone or damage any property". That positive reinforcement is really important and we can provide that because we have that flexibility in the moment, and have the trust and engagement. It's the best time, to connect with someone in that crisis, because you can bring so much insight to that, and ask "What does it feel like in your body". We can normalise it and ask what can you do about it?" [Consumer]: "I might go for a walk". We can provide some distraction and build in those other coping and resilience skills."

Permission to spend the required time to build relationship

The development of trust is the cornerstone of the therapeutic process of healing and this is, in many ways, the most important phase of engagement with Wadamba Wilam, a process which can take six to twelve months of intensive work. For example, "Megan" was referred to Wadamba Wilam whilst in jail, and staff were able to visit weekly for five months prior to her release. This established a rapport and the beginnings of the therapeutic relationship that could be used as a foundation upon Megan's release.

Worker reflection – Anne

"They [Aboriginal community] don't trust until they get to know you and that can take a long, long time, based on what has happened historically. The way I work is to get to know them and let them talk and call the shots in terms of engagement and how that might work for them. Initially contact might be a hit and miss, but then they might call you every day. So, you've got to run with that, it's like a warm up for a race. If they don't want anything for a while and tell you to get lost then you do and step back for a bit. You wait for their call or their text message. I do a drive around to suss out their hang out spots if I'm concerned and haven't heard from them for a while."

Slow and flexible assessment & tools used at the right time, over time

There is no fixed time frame at Wadamba Wilam to "assess" a new consumer to the service. There is an understanding that getting to know someone, especially someone who may be experiencing significant distress, trauma and the impacts of homelessness, can only happen over time, and be led by the pace of the consumer. The focus for Wadamba Wilam is to establish rapport and trust with a new consumer, and to get to know them patiently in order to develop a strong understanding of them as a person. The flow on effect of this approach is the wealth of information that is gathered in hearing a person's story over time, with an ability to reflect, pause and return to certain topics at the right time.

Assessment processes are not time restricted, and comprehensive assessments may take a year or more to complete. There is a strong focus on engagement and rapport building, and an understanding that assessments can occur flexibly, without sticking to a standardised rigid formula. Consumers are encouraged to share their story at their own pace and staff acknowledge and accept that it takes time to gather a full history, and that a person's story will be revealed over time as trust develops. Workers posit themselves in a non-threatening dynamic, avoiding insistence on set timelines, and do not hold expectations that can provoke resistance.

Worker reflection — Adam

"Everywhere else in the system, [a worker] has to get an assessment done within the first few sessions. It's not essential for us to do that, we might take six to twelve months to get a full assessment, which is very different to what you get in a sixty to ninety minute intake assessment. It's important to emphasise the elements of trust and time, and going at the pace that's required. We know they [a consumer] meet our criteria for support, but we're not hung up on capturing diagnostic stuff and data, we're more interested in capturing the narrative and doing it in a respectful and timely way."

Persistence — workers come back again and again and again

Low case numbers, long term engagement and an assertive outreach model, allow workers to "show up", both literally and figuratively for consumers. This "showing up" helps demonstrate to consumers that Wadamba Wilam works differently to appointment-based and time limited services, that workers hold hope and unconditional positive regard for them, and that consumers are not required to fit into the service in a way that is unachievable for them.

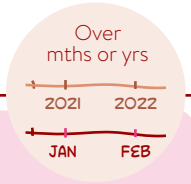
Workers are encouraged to check-in with consumers flexibly and assertively. For example, if the service has not heard from a consumer for a week or so, they can opportunistically look for them in the places they usually attend in order to check-in and through this behaviour communicate to consumers that they are worthy of care.

Worker reflection — Molly

"We're going to keep showing up, we're here for them. I think with a lot of programs and other services, whether it be outreach in mental health or homelessness, the consumer's engagement is used against them in a way and they will close them really quickly. "I tried to call them and their phone was off so I'm going to close them", or "They haven't turned up to X amount of [appointments], they mustn't want the help. Because we [Wadamba Wilam] have an open door policy, it's very flexible, and we have that assertive aspect, consumers trust that we're not just to going leave them because they didn't do something right, or what the system says is the right thing in the right way."

Staff seek to understand rather than react to the behaviour

Through taking the time to yarn and build rapport with consumers, workers are offered the opportunity to listen to consumers' stories as they are revealed at a pace that the consumer feels comfortable. Workers, taking a Trauma-informed approach, seek to understand behaviours as a result of the significant trauma load borne by consumers and as part of a larger social, historical, political picture for Aboriginal and Torres Strait Islander people.



Worker reflection — Molly

"Trauma behaviours have spiked because of a pressure-cooker situation, I'm finding the clinical mental health services are not looking at her presentation through a trauma lens but instead they assess her through a behavioural lens. I am in the care-coordination meetings to advocate for her, writing assessments for her in their clinical mental health documents outlining and focussing on the psycho-social situation, as well as her trauma response, her behaviours and trying to reframe them with a trauma lens."

Early use of service systems

Workers facilitate consumer access to the breadth of services required to provide support, advocacy and minimise the impacts of trauma. Workers seek to avoid overwhelming consumers with the breadth of necessary services and collaborate with consumers to identify the areas most important to the individual first. Workers can attend services alongside consumers, in order to help present the person's needs in a supportive manner, improve follow-up and implementation of recommended interventions.

Worker reflection — Adam

"Our guys have so many needs, you don't know where to start. You take your cue from them where to start, but you take the time, and there's a whole lot of opportunities that come about. That's when you bring the specialties of the team in, and that's where we're we are really responsive. Where an intervention is required we kick in straight away, where an opportunity presents itself, we can do it that day, or the next day. Whereas if you're working with a different service, if a person needs a drug and alcohol assessment, you need to refer them externally and then they've got to get an appointment and they've got to meet someone else and that might take three or four weeks and then the opportunity is lost. It's important to highlight, once a therapeutic opportunity arises, we can offer it straight away. The specialty skill is already in the team and also more importantly, the organisational framework is in place. With me [Nurse Practitioner] and NAHMS and Jeremy with Regen, there's no organisational barriers – because we have already established organisational pathways for consumers."

Staff hold issues and come back to them at the right time

Issues may become apparent during times of crisis (for example family conflict, disconnection from country) however it is not necessary or ideal to support consumers with those issues at that time. Long term flexible support means that once a consumer is out of a crisis period, issues that contribute to poor social and emotional wellbeing, can start to be addressed, and connections (to Country, Culture, Family, Spirit, Land, Mind, Body, Community) can be supported to be strengthened.

Worker reflection — Adam

A young woman, Marge, with a significant trauma history, an acquired brain injury and polysubstance use had made occasional and infrequent contact with the service over five years. She had been a chronic rough sleeper since a teenager. Marge would drop into the service or make contact on the phone at regular intervals and present as extremely disorganised, thought-disordered and appeared to be experiencing an untreated psychotic illness. Marge would make contact for a couple of days, receive material aide in the form of clothing, food and mobile phones. Over the years, the Wadamba Wilam team would gently encourage Marge to engage with supportive treatment. Marge would rarely stay engaged for more than a week at a time and there had been around thirty instances of this engagement pattern over the years.

More recently Marge has been residing with her mother and the Wadamba Wilam team have been able to reach her in stable housing for the first time. Marge's presentation is similar to previously but through sensitive assessment and gentle respectful suggestions of treatment, Marge agreed to give medication a go. This could only occur in this instance with the encouragement of Marge's mother and a willingness on her part to challenge the stigma associated with mental illness and support her daughter to take medication by administering it to her on a daily basis. There has been a quick and significant therapeutic response to treatment with a dramatic reduction in disorganisation, psychotic symptoms, sleep problems and improvements in self care, including having a shower for the first time in over two months. Marge's mother rang in tears of joy on day five of treatment stating "I have my daughter back".

In this instance, medication is an adjunct to the other work we do to support overall social and emotional wellbeing. For some people, it [medication] can be the missing puzzle piece in managing distressing symptoms and providing relief from those symptoms that affect so much of someone's daily life and wellbeing. This may be the first occasion that someone has enacted informed consent about taking medication, as they may have been compelled to before by treatment orders. As we have developed trust with the person over time to really understand what they experience in terms of trauma symptoms, we can use that really specific expertise to match the appropriate medication to the person, provide education along the way about what to expect and what the medication will be able to help to improve. We're able to provide a new way of looking at medication as something that can be helpful in the right circumstances, not something that is forced upon you.

Staff look for therapeutic windows

Long-term support, a flexible assessment period and the interdisciplinary team means that workers can play "the long game" in terms of therapeutic interventions and react quickly when an opportunity arises. Insisting on medical or referral interventions can compromise rapport, so instead staff are patient with waiting for opportunities when a consumer might express a desire or motivation to engage with a new intervention, or when they are generally open to making a change. Workers utilise their own specialty skills, as well as the established referral pathways, to match a possible intervention to the consumers' need in a timely and efficient manner, where consumers can avoid re-telling otherwise traumatising stories.

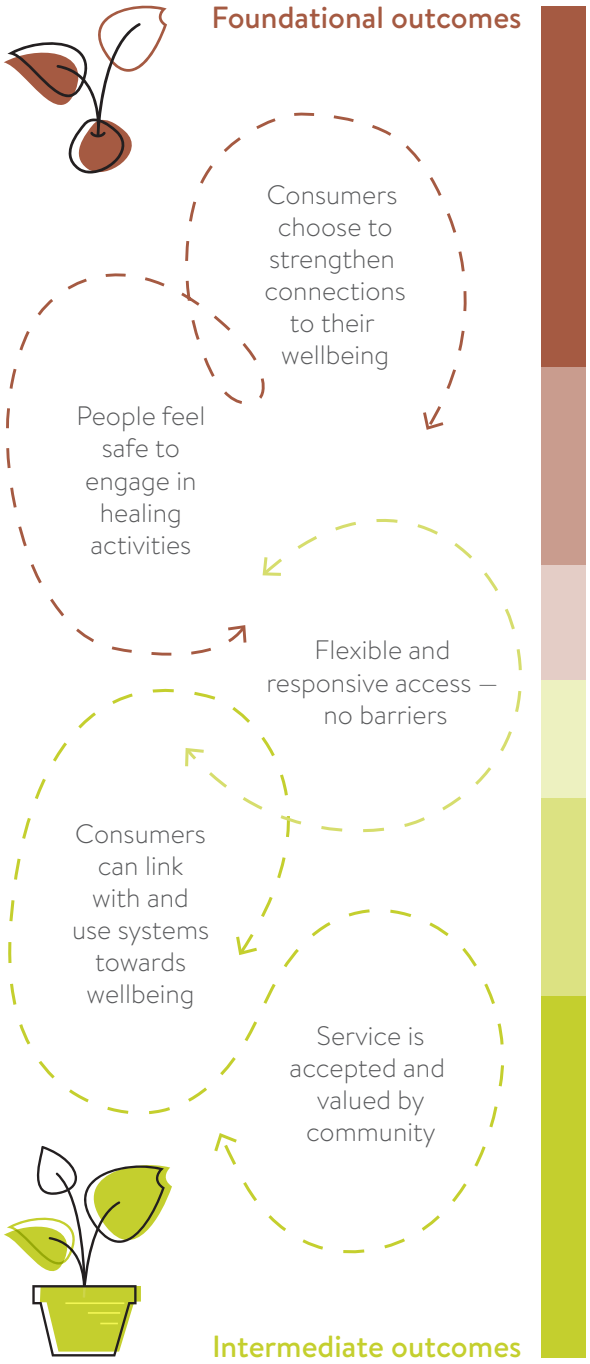
Worker reflection — Adam

"People might not be interested in medication and have had it drummed down their throats the whole time, but after a while and talking about things and informing them how trauma impacts the whole person, they may look at a medication or even ask for one, and then you the nurse practitioner comes in because you can prescribe, and monitor and follow up. It's about it not being the focus of the medication, it's another nice example of that opportunity. They might say "I've got some distressing stuff", [Me:] "Well there's some medication that might help with that – I can go get it from the chemist now and drop it off", [Consumer:] "Oh yeah, ok". It's not a big thing but it does have a big impact. People that have never taken medication in the past, at least not outside being on an involuntary order or having been forced to, are now taking it consistently without supervision and without an involuntary treatment order."

INTERMEDIATE OUTCOMES

Once rapport and trust have been established, and basic needs have been met (noting this can be a dynamic process), Wadamba Wilam staff can begin to support activities for healing, to strengthen connections in relation to consumer's social and emotional wellbeing.

Relational activities are repeated and build towards intermediate outcomes. These intermediate outcomes are inter-related and strengthen over time, as evidenced through many of the worker reflections shared through this document.



Healing activities and their outcomes — the journey to holistic social and emotional wellbeing

Connection to	Activities	Outcomes
Land	→ Support access to attend cultural camps → Support people to be on country → Facilitate conversations with Elders → Conversations with Elders	→ Strengthened cultural connections → Respectful connections with Elders established → Increased agency and sense of personal capacity/responsibility for own health and wellbeing → Strengthened connection to country which underpins identity and strengthens a sense of belonging
Spirituality/ ancestors	→ Facilitate cleansing ceremonies/ house smoking, etc. → Curiosity around expressions of distress and cultural solutions → Invite conversations regarding spirituality → Support access to cultural camps → Visit gravesites	→ Misinterpretation of cultural experiences are avoided → Spiritual healing and spiritual connection are strengthened which helps provide a sense of purpose and meaning
Physical wellbeing	→ Hep C Program → Link with ACCHO → Link with GP → Dental program → Support health system navigation → Practical support and skill building	→ Individuals cured of Hep C → Regular nutrition → Decreased ED use → Decreased hospital admissions/bed days → Stable housing → Increased overall physical health, increased ability to participate as fully as possible in life

Connection to	Activities	Outcomes
Mental and emotional wellbeing	→ Timely Response to triggers/distress → System buffering → Support mental health system navigation → Support change of diagnosis to Complex Trauma and offer appropriate therapies → Assess and sit with risk → Use of culturally appropriate tools, for example, the Aboriginal Resilience and Recovery Questionnaire	→ Decreased self-harm → Increased self-soothing → Acceptance of medications and therapeutic interventions → Decreased MH hospital admissions/bed days → Decreased suicidal ideation → Re-traumatisation avoided → Decreased isolation → Access to services as needed → Willingness to re-engage → Positive justice system outcomes → Bans from services are avoided
Family/kinship	→ Work with kin → Open supports to family members → Support kinship care → Support around death and loss	→ Increase social connection → Family actively seeks support from service → Decreased unnecessary child protection notifications → Increased connection to family → Decreased family justice issues
Community	→ Take people to funerals → Support around death and loss → Work with communities → Spend time in community → Invest in community relationships	→ Community trust in service → Increased involvement in community groups → Self-referrals from community → Engagement in meaningful activities, for example work, education, gym
Culture	→ Support people to be on country → Facilitate conversations with Elders → Conversations with Elders → Offer cultural approach to symptoms → Attend cultural events	→ Representing self/culture/organisation, for example speaking at conferences, involved on job interview panels → Increased connection to culture creates a sense of continuity with the past which helps underpin a strong identity and strengthens social and emotional wellbeing

Supporting connections to spirit, land and culture to improve social and emotional wellbeing in the context of homelessness

Worker reflection — Anne

On referral to Wadamba Wilam, Joe had been homeless for thirty years or more. He was suffering from Complex PTSD in response to the multiple significant traumatic incidents he had experienced throughout his life, physical, psychological and emotional. This had a significant impact on Joe's mental health and social and emotional wellbeing over the years, resulting in extreme anxiety, depression and hyper vigilance, making it difficult to have trusting relationships. Joe had never disclosed to anyone the significant abuse and trauma he had experienced throughout his life and was reluctant to share any concerns due to a lack of trust in others. He had episodes of depression and anxiety which led to ongoing suicidal ideation.

Prior to referral Joe had a strong connection to spirituality but little connection with culture. This changed dramatically on referral to Wadamba Wilam. Some years ago, Joe would not move into his flat prior to a cleansing ceremony by a Wurundjeri Elder due to the presence of bad spirits.

Joe would also visit the graveside of deceased friends to talk about his worries, which he found cleansing and healing, especially in times of distress or anxiety. Over the years Joe had spoken to spirits and with the voices of Elders following the death of a close friend which he found very comforting.

Whilst homeless for thirty years Joe was well connected with the wider Aboriginal community but had limited access to it. Over the last few years Joe developed a thirst for more knowledge about culture. He attended men's camps, culturally specific exhibitions and special days of significance with Wadamba Wilam support. He thoroughly enjoyed these experiences and spending time with his mob.

Whilst homeless and prior to referral, Joe had little connection to land or his birthplace, with no connection to anywhere in particular. Joe was not interested in obtaining his birth certificate or finding out about his birth country, however in more recent times Joe felt a strong connection to land around Melbourne as he has lived on Wurundjeri country for the last twenty-five years or so and stated that it is his country now. This connection to land strengthened, along with his connection to community, culture and ancestors hence improving social and emotional wellbeing.

Over the last few years, with housing and supports, Joe's self esteem strengthened and he felt more sure of himself which in turn enabled him to develop better coping skills. He was able to disclose over time to workers and trust again which had a flow on affect in supporting health. This allowed for more effective management of diabetes, asthma, respiratory issues and any other health related issues that arose for him leading to stability of his mental health concerns.

Fostering connections — Men's Camp

Worker reflection — Jeremy

A long term approach to support allows for workers to introduce the idea of various interventions and opportunities over many years, and people can choose to engage with these opportunities when the time is right for them.

Frank had been with Wadamba Wilam for many years and had been invited on several Men's Camps but had always declined. Workers encouraged Frank again to come to a future camp by mentioning that other consumers that Frank had met at other community events would also be attending. Frank searched deep in his heart, and decided to come.

Frank along with other Wadamba Wilam consumers were given an opportunity to speak in front of many men at camp, where they told their stories and were listened to by the group of forty or so other attendees. This opportunity to share his story, to be listened to, and to have others relate to these deeply held stories was healing for Frank. Frank felt safe in this environment to engage in this healing activity.

During the drive to the camp, Frank was quiet and reserved, but on the return journey, Frank was open and conversational, discussing his adopted and biological family, as well as singing along with music in the car.

This camp continued to be discussed amongst the Wadamba Wilam attendees for months afterwards, continuing the positive thoughts that it supported. This opportunity to spend time on country, have time away from usual city life, and make stronger connections to community, translated into strengthened social and emotional wellbeing for Frank.

Without Wadamba Wilam staff to facilitate, coordinate, encourage and transport Frank to this camp, he would have not had this opportunity for healing and to bolster his connections to community and spirituality.

MOVING ON FROM WADAMBA WILAM

As support is individualised based on a particular consumer's circumstance and need, the length of support can vary from person to person, with the majority of consumers staying with the service for a period of twelve months to four years. An assumption is made that good practice for this consumer group requires an extended period of support, an evidence-based approach that is reflected in the trauma recovery model (Cloitre et al., 2012, pp. 10–11). This support may fluctuate in frequency and intensity over the duration of service.

Primary exit points for consumers are to their established GP as well as to lower intensity supports such as the local aboriginal health service and the local aboriginal GP clinic, where they transition from an outreach to appointment-based service.

The NDIS is increasingly involved in support for Wadamba Wilam consumers, however the Wadamba Wilam team continue to offer support as the complexity of need (for example Complex PTSD, psychotic features and chronic substance use) demands this. However in regards to providing an exit point for consumers, the NDIS is not consistently utilised due to a lack of clinical and cultural components to NDIS offerings.

Formal "exits" from the Wadamba Wilam service may occur because consumers move out of the area or back to Country. Commonly however, consumers experience a "soft exit", whereby Wadamba Wilam support is slowly and deliberately reduced in frequency until contact ceases, with the door to re-entry left ajar. For consumers, this means that if they experience a social or emotional stressor, an adverse life event, or a more significant decline in their mental health, they are then able to re-enter the service, without formal registration or intake process. The Wadamba Wilam team can then become involved for short term interventions to support consumers to get back on track and return to the care of their GP.

SECTION 4
CONSUMER EXPERIENCE AND OUTCOMES

> **“ Wadamba works from a strengths-based approach and were able to help me see things in a more positive light. They believed my journey and didn’t try and diagnose me or blame me for my past. My case workers listened and took my journey on board. Wadamba Wilam and my GP have been the only ones who helped me. They are there when I need to talk, for medication or whatever it is I might need.”**
> **(Lovett, 2019, p. 3)**

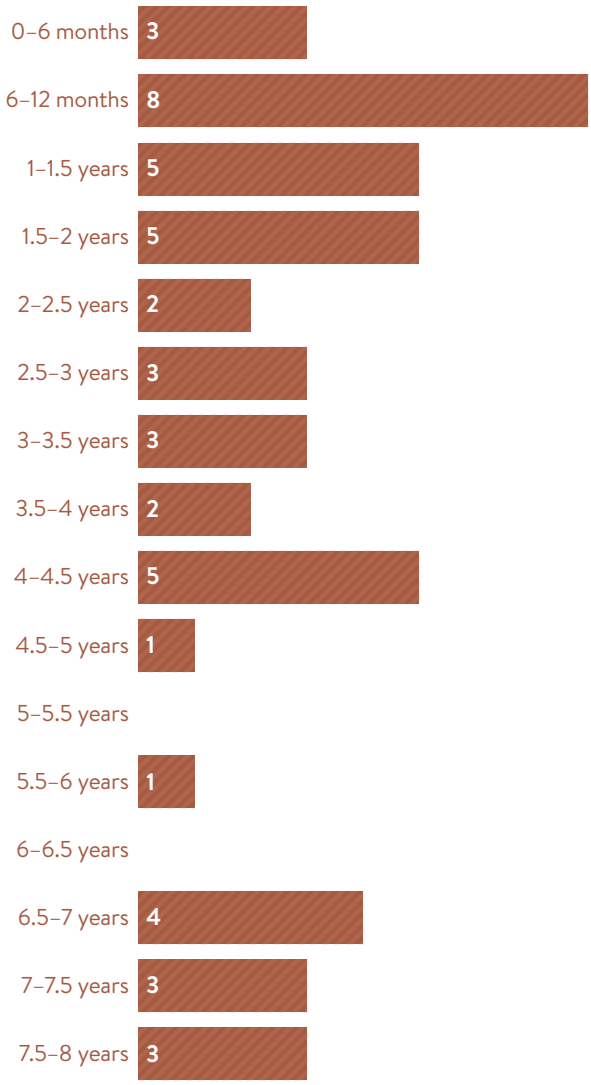
The Wadamba Wilam team reviewed both the presenting issues and the outcomes achieved of the 48 consumers who were with the service from 1st July 2016 until 30th June 2020. This reporting period was chosen due to the high-quality data available from this period and to accurately reflect the work of the team in this now-mature model of service.

The analysis has revealed that the idea of success is not defined by the attainment of broad goals. Success and healing is unique to each person, and better represented by distance travelled than final outcomes.

This analysis illustrates the complexity of needs within the consumer group, the time and labour involved to support meeting these needs and the positive outcomes across a number of domains that can be achieved through the Wadamba Wilam approach.

People have engaged with Wadamba Wilam for varying lengths of service, commonly punctuated by active engagement along with infrequent contacts or absences. Overall periods of support for the 48 people who have exited during the reporting period are represented in the following chart.

Length of service of all exited and active consumers from July 2016 to August 2020



Mental Health

Inpatient admissions

Wadamba Wilam's support ensures that preventative treatment and support is provided to all consumers to help ascertain and sustain positive mental health, and that inpatient admissions are minimised and only sought when other less restrictive interventions are not appropriate.

Pre referral

56%

of consumers had at least 1 inpatient admission (average of 3)

Post referral

23%

of consumers required an inpatient admission following engagement

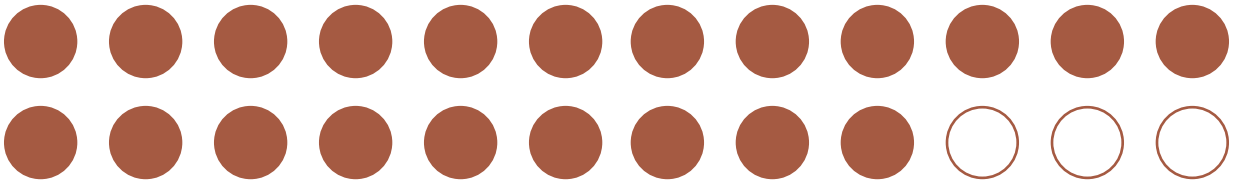
Inpatient admissions pre and post referral

79 admissions 2 years prior to referral

31 admissions post referral

61% decrease after referral

Inpatient admissions post referral for those who had an inpatient stay prior to referral



89% had a decrease in admissions

11% had an increase in admissions

For the 89% with decreased admissions:

- Yearly average admissions prior to referral was 1.5, the minimum was .5 (i.e. 1 stay in two years) and the maximum was 4.5 (i.e. 9 stays in 2 years).
- Taking into account the length of time engaged with the service, the yearly average post referral dropped to .1 hospital stays, a minimum of 0 stays and maximum of .6.

24 consumers (of the total 48) prior to referral had no inpatient admissions. Post referral, only 4 of these 24 (16%) of consumers had a psychiatric admission. In many cases, these admissions were an opportunity to address severe symptoms often psychotic in nature, as well as compounding social factors. Prior to referral, these consumers may not have had contact with public mental health services before, were experiencing an emerging psychotic episode for the first time or were in custody. For some consumers, repeat inpatient admissions can be attributed to being discharged before achieving a stable mental state, into unstable circumstances, such as homelessness, violent environments, or other psycho-social stressors. In other instances, inpatient admissions are planned, between the person and their workers, in order to address symptoms and severe mental distress, and where this treatment is most appropriately received in an inpatient environment.

In this two year period, Wadamba Wilam has facilitated 21 Prevention and Recovery Care (PARC) admissions, a sub-acute setting which provides short-term site based support for people who are at risk of requiring hospital admission or who are leaving hospital and require additional support to transition back into the community. As workers have strong rapport, trust and knowledge of consumers, planned PARC admissions are utilised very early when a person's mental health has just started to become unstable. PARC admissions are also utilised as respite from a person's living environment, to provide skill development (for instance around skills of daily living such as cooking and self-care), to provide an opportunity for Occupational Therapy assessments and to support people post-detox in a supported facility.

Diagnosis

Wadamba Wilam's long-term approach, with a focus on trust and rapport building, leads to a rich understanding of a consumer's history, their mental health including symptoms, and experiences of trauma. Cumulative trauma, abuse, and disadvantage are all common experiences within this cohort of consumers.

It is very important that the working diagnoses fit as closely as possible to the consumer's experience and symptoms, as this informs effective treatments.

On referral, diagnoses ranged in breadth, with depression, anxiety, schizophrenia, varied personality disorders and drug dependence commonly attributed to consumers. As many consumers had infrequent or emergency-only contact with physical or mental health services, the ability to make accurate diagnoses may have been made difficult in these short-term interactions.

Only two consumers entered the service with a PTSD or Complex PTSD diagnosis. Following lengthy engagement with the Wadamba Wilam team, 83% of consumer (40/48) have had diagnoses updated to include either PTSD, Complex PTSD, PTSD symptoms, and or symptoms of trauma. Many people may have co-occurring diagnoses.

This can be attributed to many factors, including the use of the International Trauma Questionnaire to accurately access trauma symptoms and their impacts, as well as investment in creating trusting relationships so that consumers feel safe to more fully share their experiences as well as an opportunity to explore the severity of symptoms, their causes, and possible treatments.

In addition, psychotic illnesses are also highly represented with 67% (32/48) of consumers diagnosed with psychotic illness.

Diagnosis of either PTSD, Complex PTSD, PTSD symptoms, and or symptoms of trauma

Treatment Orders

On referral to Wadamba Wilam, 20% of consumers (10/48) had an Involuntary Treatment Order (ITO). Only one of these Orders remains current. Of the 38 consumers who did not have an ITO in place at referral, 2 consumers now have an ITO.

20% of consumers had an ITO on referral

6% consumers have an ITO after engagement

Physical Health

Long standing histories of rough sleeping, homelessness and disadvantage, as well as poorly managed mental health has contributed to many Wadamba Wilam consumers experiencing poor physical health, which significantly impacts daily life and overall social and emotional wellbeing.

On referral to the service, 34 consumers (71%) had major physical health issues (1 or more chronic health condition, for example cancer, chronic obstructive pulmonary disease (COPD), diabetes, asthma), 13 consumers (27%) with minor health issues (no major conditions, some risk factors) and 1 consumer (2%) with no physical health issues. At the time of referral, only 6 consumers (12.5%) were engaged with medical support at a level to have needs met, whereas 42 consumers (87.5%) were not engaged closely enough to have their needs met. Nearly half were engaged irregularly (48%, 23 consumers) or only in emergencies (40%, 19 consumers).

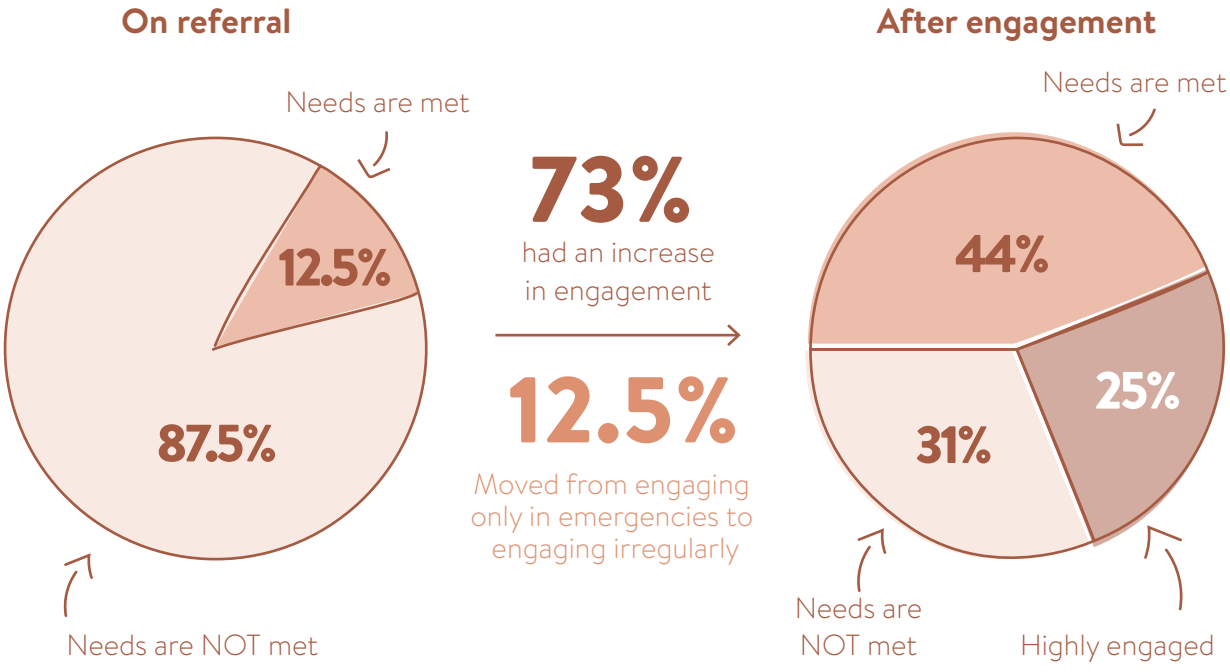
After engagement 73% of consumers (35/48) had an increase in engagement, with 44% (21 consumers) engaged at a level to have their needs met and 25% (12) described as highly engaged. 6 consumers (12.5%) had moved from engaging only in emergencies, to engaging irregularly.

Importantly, 60% (29/48) consumers were connected to a GP with Wadamba Wilam support. Establishing this primary health care service is essential in managing health issues and for many consumers, they did not manage health concerns or only attended emergency services when absolutely essential.

The time and labour involved in connecting Wadamba Wilam consumers to relevant health services is significant. As per **Figure 6**, 29% (14/48) of consumers required weekly support to attend to physical health needs, which includes transporting to medical appointments, with 12% of this group requiring this support multiple times a week. 21% (10/48) of consumers mostly attend independently to their physical health needs, with occasional support from Wadamba Wilam. For many consumers, this independence has been built up over time, with Wadamba Wilam providing education, support, referrals and encouragement to reach this level of self-efficacy.

As many consumers have not tended to physical health issues for many years, they may have many co-occurring issues, that require substantial support to attend to. Financial disadvantage including limited access to good nutrition has compounded these issues.

Engagement with medical support



Rates of physical health conditions (current or at exit)

Condition	%	N°	Diagnosed	At risk
Diabetes	73%	35	4	31
Dental problems	73%	35	26	9
Heart disease, arrhythmia, or irregular heartbeat	71%	34	7	27
Respiratory Conditions including emphysema/COPD/Asthma	71%	34	29	5
Hep C	44%	21	12	9
Chronic digestive condition	40%	19	19	
Liver disease, cirrhosis, or end-stage liver disease or at risk	31%	15	10	5
HIV+/AIDS and/or STIs	23%	11	2	9
Other conditions — Chronic pain	23%	11		
Female reproductive conditions e.g. Endometriosis, PCOS, etc.	21%	10	7	3
Cellulitis or at risk	21%	10	7	3
Kidney Disease/end stage renal disease or dialysis or at risk	17%	8	6	2
Cancer	8%	4	3	1
Epilepsy	6%	3	3	

Management of most prevalent health conditions

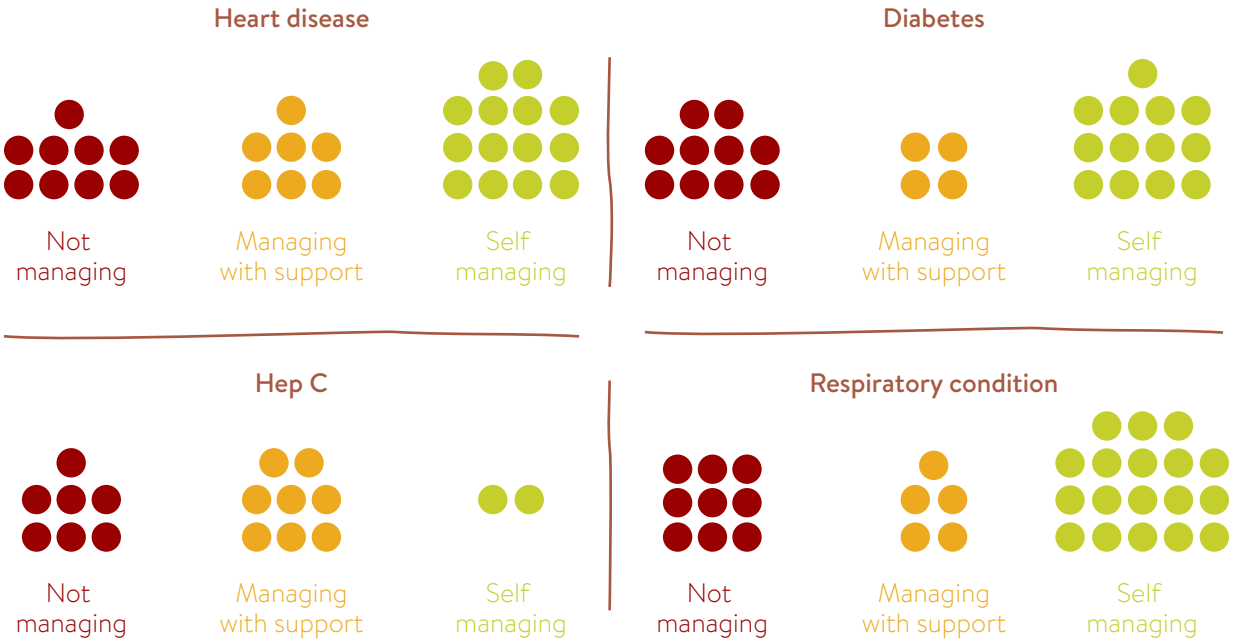
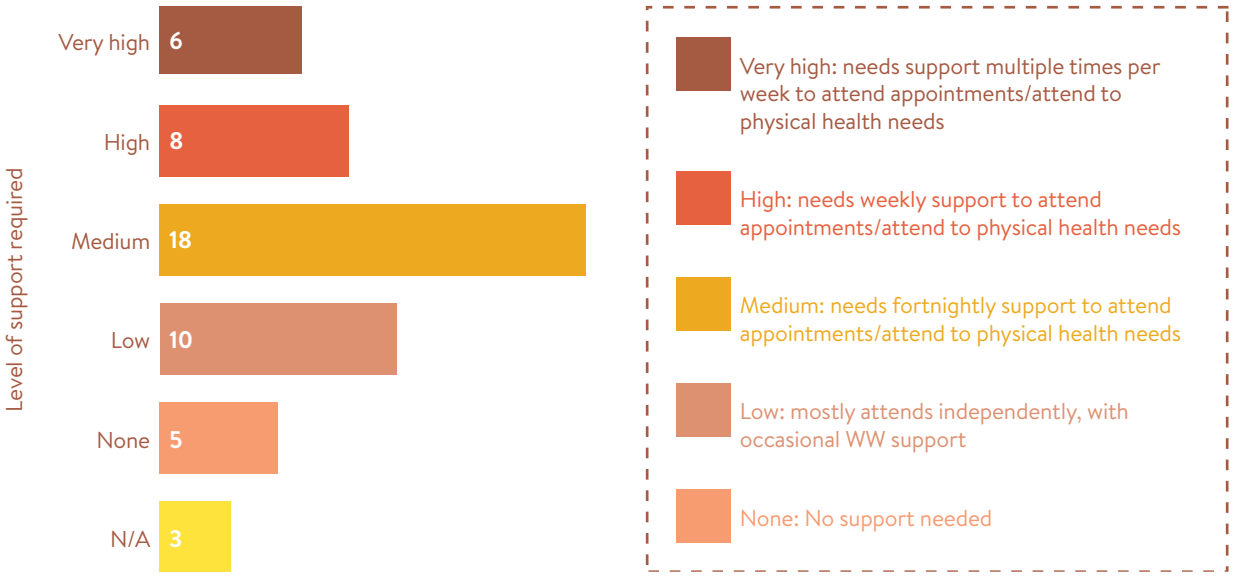


FIGURE 6
Level of support required to attend to physical health needs and achieve improved health outcomes



Connecting a consumer to a culturally specific GP

Worker reflection — Molly

A man in his 40s was undergoing a reunification process with his children. He was having difficulty producing urine screens to Child Protection. His avoidance could be understood as a disempowered response to a system that has facilitated generations of trauma related to child removal for the consumer. At the time the consumer had experienced discrimination from his regular mainstream GP service, with them refusing to continue service with no reason provided or avenues for appeal, so he was feeling particularly unsupported and misunderstood. He received encouragement and facilitation from Wadamba Wilam to connect with an Aboriginal Controlled Health Care Clinic with GP access. Wadamba Wilam made the appointment on his behalf, and provided material aid in the form of taxi vouchers to support the consumer with transportation. The consumer went for his first appointment and completed his first urine screen since the Child Protection order was in place. The consumer is very proud of his Aboriginal heritage and this service reflects this pride in their messaging, signs of welcome, and language of the clinicians which is strengths-based rather than deficit-focused as is often the case in mainstream services. Importantly the service allowed him to feel safe to complete his urine screens without instilling further shame around the process.

Working with multiple untreated physical health needs

Worker reflection — Adam

When Tom first came to us, he had untreated epilepsy. This included multiple seizures a day, as well as memory loss where he would lose time, which put him in constant danger. The prevalence of these daily seizures were related to substance use. He was homeless and transient, which made treatment and follow-up almost impossible. Tom had not seen a GP or had a check up for a long time. It took a lot of trust-building and conversations to get him to a GP in the first instance. Once he got to the GP, we had a lot of work to do to support him to manage his epilepsy. Once in the GP's care, it was discovered that he had some significant cancerous lesions on his tongue and multiple melanomas. It turned out he had got to the GP just in time.

Once Tom started to stabilise, he reduced his substance use, which meant he started to have less seizures. This led to more consistency in management of his other conditions, including the cancer treatments, but he then went walkabout. A while later, he came back to Wadamba Wilam where he was experiencing uncontrolled seizures again. Once we had housing and support in place, he was able to reduce his substance use, which led to better managed epilepsy. We supported him to link in with a neurologist and developed a medication management plan. He became engaged with a GP again, which led to health screens which discovered gastro-intestinal cancer. Tom said then if he had got this diagnosis at any other time he would not have engaged in managing it. We then supported him with his multiple specialist appointments, including chemotherapy and radiation treatments. We were able to connect directly with the hospital to receive appointment letters, as Tom could at times lose track of them. We were then able to support him in those appointments, listening to the large amount of information and ensuring that he was on top of his appointments and treatments.

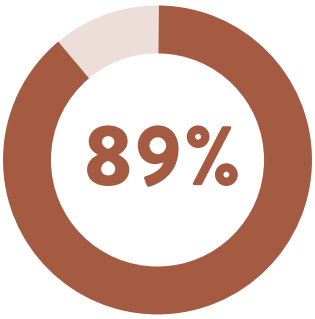
It was also very important during this time to maintain our support of his mental health, as well as to reassure hospital staff that he was doing well in this regard. Tom was able to utilise all his strengths and resilience from previous experiences to get him through it. He was positive through it all and proved what a survivor he is.

Importantly, Tom now follows up his health appointments and issues independently. He makes his own GP appointments and transports himself. He has gone from intensive support and engagement to being very independent. He will proactively ask for help if he needs it, and we can jump in to offer a little extra support if it's required.

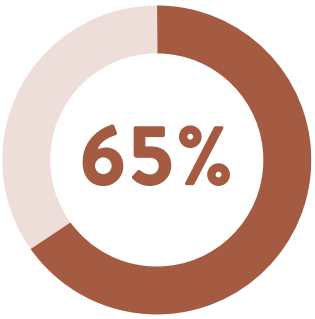
Legal

Many Wadamba Wilam consumer's have a history of legal issues on referral to the service. Economic insecurity, disadvantage, experiences of violence and substance use play a significant role in these consumers interactions with the justice system.

History of legal issues



Legal issues present on referral



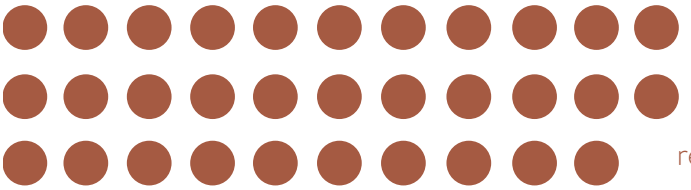
During engagement

52%

of consumers had a reduction in offending

65%

of those who re-offended avoided incarceration



66%

of consumers have received active court support

89% of consumers (42/48) had a history of legal issues, with 65% of consumers (31/48) having legal issues at the time they were referred to the service and 43% of consumers having a history of custody. 52% of consumers (24/42) had a reduction in offending since engaging with the service. Of the 24 consumers who reoffended since being engaged with the service, 65% (15/23) avoided incarceration. In many cases community treatment orders or corrections orders were put into place, with several consumers completing these with Wadamba Wilam support.

66% (32/48) consumers have received active court support by Wadamba Wilam. In this setting, staff are able to provide emotional support as well as advocate for consumers, liaise with police, lawyers and magistrates, with the aim to achieve more favourable outcomes and avoid incarceration where possible. Significant support is required to assist consumers to navigate these legal issues.

Koori Court

Worker reflection – Adam

The Koori court is set across many magistrates courts in Victoria. A person can choose to attend the Koori court if they are Aboriginal or Torres Strait Islander and will be pleading guilty to a criminal offence. The Koori court offers a more informal process compared to a mainstream Magistrates court. In the court, the process is conducted around a table, and include the magistrate, Aboriginal Elders, a Koori Court officer, the person, their family and lawyer, the police and the prosecutor.

All parties, including the person pleading guilty and their family and supports, have a chance to yarn and can avoid using legal language. This provides an opportunity to discuss and be sensitive to the contributing factors to the offending, in order to initiate a judgement that is culturally appropriate and helps reduce the likelihood of reoffending. (Magistrates' Court of Victoria, 2020)

For a service like Wadamba Wilam, the Koori Court is an ideal forum for our support to be linked into the justice process. It aligns in values and principles to our approach to look at the whole person, their situation, history and circumstance. It is very unusual to get an opportunity to speak in court about a person you work with, but in the Koori Court, we can share what is going on for someone at the time of offending, and can provide some background and social context. In addition, we can be utilised in the sentencing to be part of the solution.

For some people it can be very challenging to plead guilty and sit before Elders, discussing what they have done and they are held to more account in some respects because it is a more personal conversation. Some Elders can deliver a verbal spearing, they'll say: "This is not your culture or your family. You have a lot of strength and resilience that you can draw on to change your life and behaviour." It's confronting for someone, but also very powerful.

For example, Ed, a man we have worked with for many years, had many driving offences from driving without a license. He kept driving unregistered, he would receive fines he couldn't pay and multiple driving charges, and they had stacked up. He went to Koori Court and rather than continuing through a punitive process, the court was able to recognise that Ed was going well in other areas of his life and was very engaged with our program. The court's judgement was then to dictate to Ed that he had three months to get his license. If he didn't get his license in that time, the charges would stand, so there was a big risk there. With Wadamba Wilam support, he got his license. He still has his license today and hasn't been before the court again. He could have been sent to jail, but instead he was able to rise to the challenge given to him with our support and continue on in his healing journey.

Advocating for targeted support to avoid incarceration

Worker reflection — Adam

Doug was referred to Wadamba Wilam with a significant criminal history, we had tried for ten or so initial periods of engagement, trying to build some rapport and momentum. His legal troubles came to a head where he had bench warrants out and then a supreme court hearing. We were able to go to the hearing and provide some really meaningful support to him and we started to gain traction. We provided multiple court reports, meeting with the barristers, going to the hearing and then going to the judicial monitoring. Public mental health services won't provide any court liaison or reports unless they are paid for and organized in advance, so I wrote numerous reports about Doug's situation and background in order to bring a broader understanding of the reasons behind the offending, and looking at some meaningful solutions. We were able to put a support plan around him and present this to the judge. The judge gave him a chance to stay out of prison and engage in the plan we were putting into place. Doug was otherwise looking at time (in prison) but instead was put on a corrections order with conditions and judicial monitoring.

Doug took that opportunity and successfully completed the corrections order and his offending reduced significantly. We provided the advocacy to give him the opportunity to complete the corrections order and avoid jail time.

In a way we put ourselves on the line, by illustrating what we could offer and asking the judge for a chance to give it a go. The judicial monitoring supports us because there is a legal back-up in case it goes pear-shaped. Doug had to go back in front of the judge three times a year and evaluate how he was going. The judge can then revisit the conditions and sentence appropriately. The consumer has some accountability to that process as they have to go back and demonstrate what they are doing proactively to address some of the things behind their offending.

Once the corrections order is delivered, we (Wadamba Wilam) are in a good position to deliver those interventions. It will usually include anger management, trauma counselling, psychology, reduction in drug use, and we can do all that in one service. It's unrealistic for a person to meet that corrections order without us because they have to meet with a number of different services and people, retell their story over and over and coordinate all the appointments and treatments that are disjointed from one another.

We were able to support Doug in dealing with the underlying issues around his offending behaviour, which was based on the trauma-triggering response, cycle of violence, long term homelessness and not having access to money. From a trauma perspective, we could ask, 'What was the initial trigger that led you to that?'. We were also able to support Doug in making sure his basic needs were met including housing, food and finances. Doug was also able to address his substance use, which for him was coming from trauma-numbing position which then further contributed to the cycle of violence. It was all linked, so we needed to work on all of it at once, in a broader trauma-informed way, and look at the impacts of the trauma and how they can be navigated differently. We're able to provide psycho-education around trauma symptoms and support him to develop his own healthy coping strategies.

We use the trust and engagement in a meaningful way to demonstrate to the person that they can have different outcomes, as well as demonstrate to the system that there can be different outcomes than jail.

Supporting parents to navigate the legal system to retain custody of children

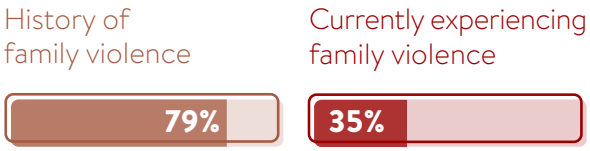
Worker reflection – Molly

A young couple moved to Victoria from interstate in the context of prolonged primary homelessness and lowered social and emotional wellbeing, with polysubstance use to cope with trauma-related illnesses and rough sleeping. At the time, the young woman was about to give birth to her second child. The daughter was immediately removed by child protection upon her birth, a month after arriving in Victoria. With intensive daily support from Wadamba Wilam including access to long term accommodation; transporting to access visits and related appointments; linking with a Maternal Child Health Nurse/other community supports; mental health and AOD assessments; assistance to complete urine screens, and advocacy by means of court support and comprehensive support letters, the couple had their child returned to their care within two months. With the complexity of their support needs this is a mammoth achievement particularly for a family with a long history of transgenerational child removal.

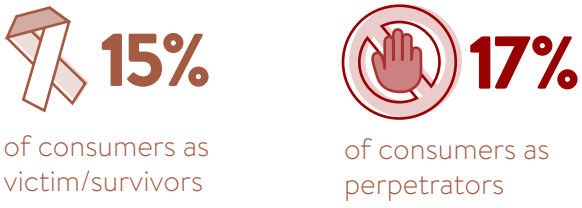
Family Violence

Experiences of family violence, both historic and current, as victim and/or perpetrator, have a significant impact on consumers' social and emotional wellbeing, and contribute to their interactions with the police and justice system. 79% (38/48) of consumers have past experiences of family violence, with 35% (17/48) currently experiencing family violence. 15% (7/48) of consumers are engaged with Family Violence services as victims/survivors, with Wadamba Wilam support. 17% (8/48) of consumers are engaged in Family Violence services as perpetrators, with some on corrections orders, Intervention Orders, and receiving supportive counselling.

Experiences of family violence also impact housing and access to safe housing. 73% of female consumers have experienced unsafe housing as a result of family violence. 36% of males have experienced unsafe housing as a result of family or domestic violence. Structural difficulties can arise for consumers as they navigate both the family violence service system alongside the housing system.



Engagement with family violence services



Experienced unsafe housing as a result of family violence

Navigating Family Violence, Housing and Child Protection services

Worker Reflection – Molly

Sarah was a parent of three boys with a history of family violence who was attempting to reunify with her children after they were removed from her care. Sarah lost her public housing property in Whittlesea after fleeing due to violence perpetrated by her ex-partner. She began couch surfing and staying with friends, who could also be violent. She had not sought out police intervention or family violence services due to a deep distrust of mainstream systems.

Sarah was able to secure a transitional property after a period of secondary homelessness. Paradoxically, if she had housing or family violence support at the time of leaving her original public housing property due to violence, she might have been able to secure another permanent property on those grounds.

In housing/homelessness work it is known that narrow definitions of primary homelessness and rough sleeping often excludes women, who may instead remain in insecure or unsafe housing with or near perpetrators of violence. This is the "hidden nature" of women's homelessness (Brotherhood of St Lawrence, 2017, p. 43).

When violence occurred Sarah was afraid to involve police due to this distrust in systems that had mistreated her in the past, treating her as a stereotype, without considering the intersecting oppressions faced by Aboriginal woman. Sarah also felt that police intervention would increase the risk of violence to her by perpetrators.

Working with Sarah, it was important to consider the impact of not only interpersonal but systemic violence on Sarah's experience of family violence and engagement with services. Sarah and her family had experienced intergenerational child removal, incarceration and poverty. Sarah's distrust in systems meant an increased need for Wadamba Wilam to walk by her side as an advocate to assist in navigating these barriers.

Without police or legal intervention, gaining access to housing on grounds of family violence or personal safety is extremely limited. Further, because Sarah was in a transitional property she would only be able to transfer into another short term, unstable property. The scarcity of affordable housing options in Melbourne is a continual problem.

Another potential option was to pursue housing through Child Protection. Paradoxically, Sarah must have achieved a satisfactory level of engagement with Child Protection before they would intervene with housing, however it was apparent that in order to reach this satisfactory level of engagement, Sarah required safe, stable housing where she was not living in constant fear and disruption. As highlighted Sarah was sitting with the intergenerational trauma of child removal, meaning engagement with Child Protection for her was highly traumatic and distressing.

With intensive support and advocacy from Wadamba Wilam over several months, we were able to support Sarah to complete the application process with the local specialist family violence organisation. They have now generated a support letter to be provided to housing to assist in advocating for Sarah to be prioritised for housing based on family violence.

This is one example of many system barriers which Wadamba Wilam consumers have to navigate to obtain safe housing. In order to gain access to housing on grounds of family violence or personal safety, a person must "evidence" this with Intervention Orders, police reports, or comprehensive assessments from a specialist Family Violence organisation. Without our support, it is difficult for consumers to meet these requirements, and our flexible and assertive approach supports them to meet these bureaucratic requirements to ensure they have access to the services they need.

Homelessness & Housing

As a history of homelessness and rough sleeping is a key criteria for entry to Wadamba Wilam's services, most consumers have a history of primary, secondary and tertiary homelessness, as well as chronic rough sleeping. However in recent years, some referrals for family members or other community members have been made where homelessness is not a feature, but for whom Wadamba Wilam's approach will support a specific individual's social and emotional wellbeing.

Shelter, a most basic need, is essential in order to improve social and emotional wellbeing, therefore supporting consumers to ascertain and maintain stable and secure tenancies is at the forefront of Wadamba Wilam support. Secure accommodation provides the foundation to address other facets of wellbeing.

Rates of homelessness and rough sleeping

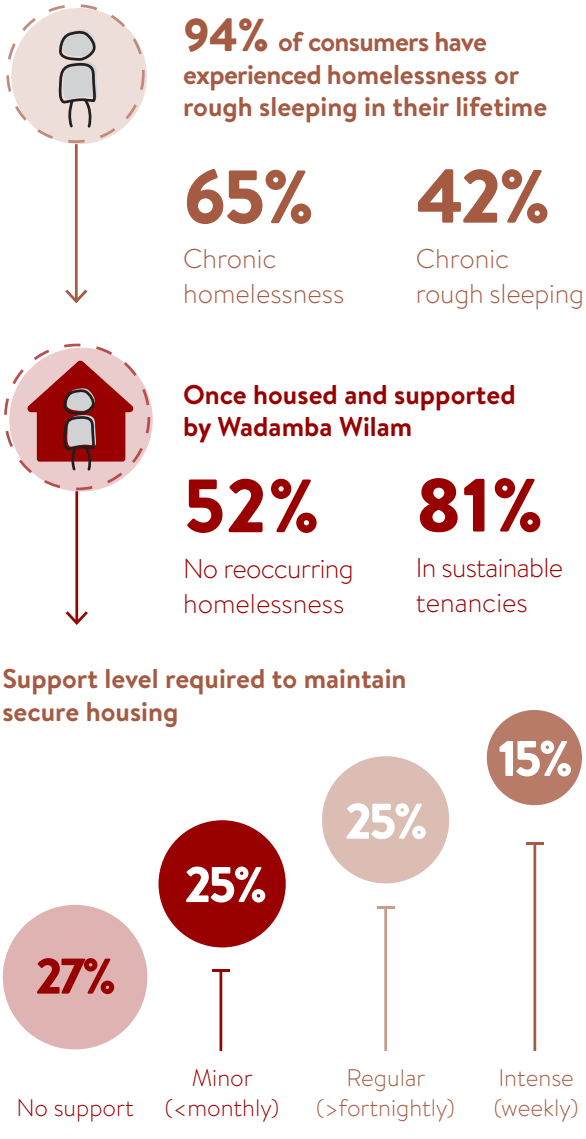
Overall, 94% (45/48) of consumers have experienced homelessness or rough sleeping in their lifetime. Chronic homelessness has been experienced by 65% (31/48) and chronic rough sleeping by 42% (20/48). A history of residing in unsafe or unsuitable housing related to experiences of family violence has been experience by 56% (27/58) of people, overwhelmingly women in this cohort.

Housing outcomes

Once housed and supported, 52% of consumers have not experienced recurring homelessness. At the time of this analysis, 81% of consumers (39/48) were housed in sustainable tenancies, with the majority of these tenancies supplied by the Office of Housing or through Community Housing programs.

Support required to maintain secure housing tenancies

However, securing a lease is not the end of the story. Maintaining these tenancies requires a significant amount of support from Wadamba Wilam staff to ensure that the requirements of tenancies are met. This includes support with budgeting, other financial issues, legal issues, liaising with housing providers and support navigating these systems.



Housing retention

Most people who have received Wadamba Wilam's service in this period have been housed, with 69% (33/48) of people having maintained their tenancies for over twelve months as of 30th June 2020. An additional 10% (5/48) of people are securely housed, but have not yet reached their twelve month mark, and another 8% (4/48) live with family members.

The remaining people from this group are in temporary accommodation, in supported accommodation, or have left the Wadamba Wilam program. In addition, three people from this analysis are deceased.

Navigating housing services and sustaining accommodation

Worker reflection - Anne

Tim was a proud Aboriginal man in his 60s who accessed Wadamba Wilam for seven years. He had experienced homelessness and itinerancy, including primary homelessness for over thirty years. In the year of referral, Tim was provided a single unit by Community Housing provider, but found this too isolating and kept going back to the local park to sleep as he felt 'safer' he stated.

After approximately eight months, a referral was made and Tim was accepted into the local specialist Mental Health support accommodation units. It was hoped he would be able to live independently but with company around him and learn daily skills whilst having his mental health managed. With his basic needs met, Tim's mental and physical health stabilised and he gained some new friends. He stayed for eighteen months until discharge. The question of where he could go arose again.

From this point on Tim was in and out of three different Supported Residential Services with some primary homelessness and couch surfing in between. The worker was constantly chasing up and liaising with housing services and the accommodation providers whilst supporting Tim to attend to his mental and physical health, attend activities, support his cultural needs and encourage Tim to work on all activities of daily living. Tim's tenancy ended due to conflict with the accommodation provider, which led to another three months of primary homelessness. I recall Tim saying at this time, regarding sleeping in the park, "It's so peaceful with no-one yelling at me and telling me what to do all the time and questioning me."

Another Supported Residential Service bed was finally found and we provided Tim with a referral and he was accepted. Tim slotted in well. Management staff were kind and understanding, and made Tim feel welcome. Tim's health improved, he went back to the Men's Shed and increased his circle of friends whom he caught up with regularly. This tenancy lasted two years, but unfortunately conflict arose between Tim and another tenant, which resulted in Tim fracturing his hip. Tim then left the accommodation of his own accord and couch surfed for two months. Tim's health began to rapidly decline with obvious weight loss and his mental health also declined during this period. Another Supported Residential Service was found but soon after a lump was detected in Tim's neck and he was admitted to hospital with advanced cancer. He passed away five weeks later.

Tim's story illustrates the difficulty in finding and sustaining secure accommodation, especially after decades of rough sleeping and primary homelessness.

Meaningful Activity

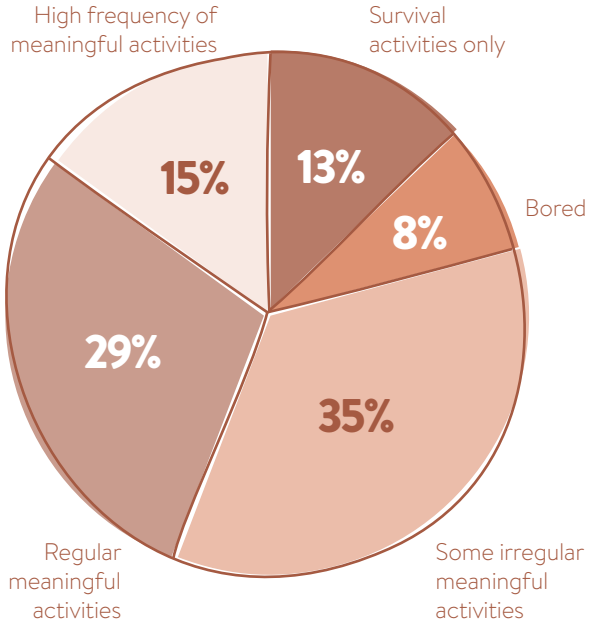
As basic needs are met, consumers who had once previously spent most of their time engaging in survival activities can shift to engaging in more meaningful, or less crisis-driven, activities.

On referral to Wadamba Wilam, 73% (35/48) of consumers were engaging in survival activities only. As of July 2020, this has significantly reduced to 13% of consumers. 67% of consumers (32/48) experienced an increase in meaningful activity.

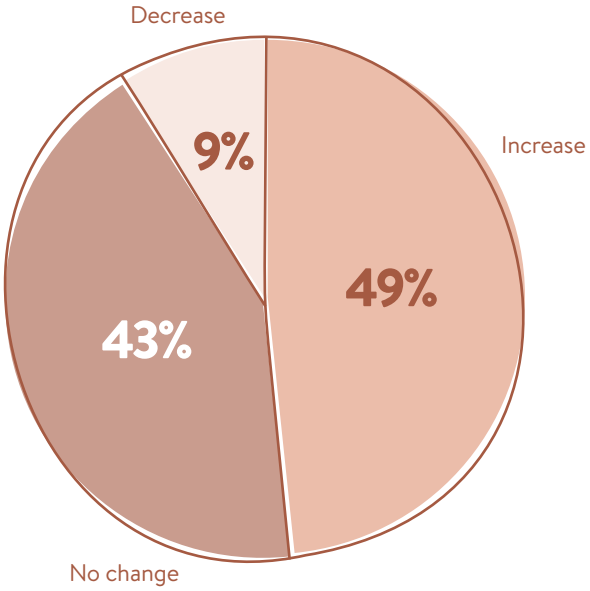
A small number of consumers have engaged in full and part time work as well as study, (1 consumer in part-time work, 4 consumers in full-time work, 2 recorded as having a job for any length of time).

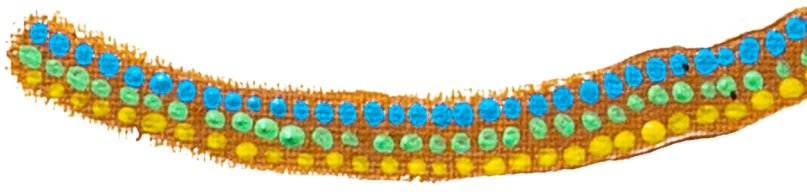
For 49% of consumers, social connections have increased. However 9% of consumers have experienced a decrease in social connections as they move out of homelessness.

Current meaningful daytime activity



Change in social connection





The "real" work begins – what happens after housing is secured?

Worker reflection — Adam

It's important the support doesn't cease after secure housing has been established. We have noticed a trend in that approximately three months after someone has moved into secure housing, their social and emotional wellbeing declines, and Wadamba Wilam naturally ramp up our support. Quite often housing is seen as an end point, but that's usually only the beginning. Once the more basic needs are taken care of, such as shelter, there's a honeymoon period and then there's a recognition that "I've still had a lot of awful things happen to me and the housing isn't making me feel as good as I thought it would". We have to do a lot of work around that.

We provide support and education around budgeting and practical skills, but more importantly timely emotional support is important. In addition for those with AOD issues, once you take away the time it takes to seek and use and recover from substance use, there's a lot of time left in the day. As people transition out of just surviving, from doing all those survival activities that take a lot of time, they then have the time to think and reflect and it can be painful wondering "what do I do now?". That's a common theme.

Moving beyond Wadamba Wilam — finding employment and staying in touch

Worker Reflection – Adam

Tess is very culturally connected, a strong and resilient woman who had problematic contact with mainstream services, as well as multiple admissions. She had been on treatment orders for most of her life. Wadamba Wilam had a holistic approach which married with her spirituality. Tess went from secondary homelessness to getting her own home, reconnecting with her children and she is now not on any medication. She has a rental property and works full time. She was in a community housing property, and because she earned too much she had to move out. She's gone from being homeless to employed and managing a rental property.

She has said that having someone to meet on her level, and who was able to see some of her experiences, not as illness, but from a spiritual perspective, and who believed in her, had hope for her, told her she could do it, were the most important ingredients. She has said that "I never thought I'd be working". It took her two years to get a job.

We now provide a mentor role as she is no longer an official consumer. She will often call every couple of weeks, just to say how she's going. Quite often ex-consumers will call to check-in, and we're flexible around that.

Sometimes when they are a bit wobbly, they will give us a call. We can provide a reassuring chat and a visit and they are back on track again. They have got all the resources themselves, we just provide some reassurance. But a mainstream service would say "You're no longer a client, you need to come back through triage" then people have to start from scratch with a service.

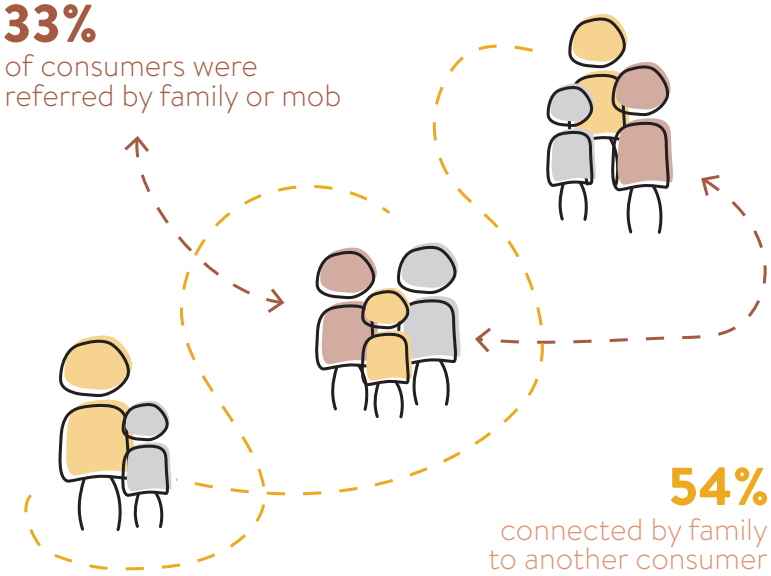
Family & Culture

Family

Wadamba Wilam's approach is informed by and recognises the centrality of Aboriginal family and kinship and the bonds of reciprocal affection, responsibility and sharing.

Wadamba Wilam's team is able to work with multiple members of an immediate or extended family, whereby unique therapeutic opportunities can arise. 33% (16/48) of consumers were referred to the service by family or mob. 54% (26/48) of Wadamba Wilam consumers are connected by family to another consumer using the service.

On many occasions, Wadamba Wilam is able to not only work with multiple members of the one family, but with matriarchs or patriarchs, essentially, the lynchpins of families. The support of this person creates a positive domino effect throughout the wider family group, with the understanding that "if we make them strong, we make everyone strong".



Working with several members over multiple generations in the one family

Worker Reflection – Adam

At Wadamba Wilam we work with multiple members of the same immediate or extended family. One example came about as I started working with the son, Brett, who has had a chronic psychotic illness. I came into contact with his mum in her role as carer. She was quite involved in helping Brett and after working with her in that carer capacity for a couple of years, I was able to ask "How are you travelling?", which developed into taking her on officially as a consumer of the service. I started with some very targeted treatment, which included starting some medication, and some knowledge around trauma.

Currently, I check in with the mum once a week on the phone. Sometimes about her carer responsibilities, and sometimes about her own social and emotional wellbeing, as well as practical support for her medication. I have taken her to the GP on occasion and supported her to have health screens. I can bring the treatment to her. I doubt that she would be on treatment without that. We have provided material aid at times, for example for her grandson who needed things for school or to go on school camp. There's a mixture in what we provide to support the overall social and emotional wellbeing of the whole family.

More often than not, her son will be over at this mum's house so I can see him there. Prior to establishing this relationship, I would struggle to touch base with him regularly. But now she will ring up and say "Brett's here now" so I can take that opportunity to go over to see him and I can see both at once. It saves a lot of time and provides unique therapeutic opportunities to talk to them together.

In my experience working with Wadamba Wilam, the older women in community have lots of caring responsibilities and they don't prioritise their own physical or mental health. They often have custody of grand children, and dealing with their own grief and loss where there are multiple family members who have died. They would be the matriarch of the family, running a household that people live in or pass through and they are the 'go-to' for all the problems. They are well down the pecking order in dealing with their own health. They have extreme carer's burn out and often have historically experienced a lot of trauma, usually connected through the stolen generations. They might have had their own children removed but now they are in the position of caring for their grand children. They are at a different point in their trauma journey, but they can do so much healing at that time. They are very resilient and they would never make an appointment or even get to an appointment because something will come up within the family, but we can slowly start introducing support to them personally. They would have twenty years of opportunities to go to a GP or try counselling on occasions, but quickly it peters out because they don't have time to dedicate to their own health. So we just take it to them. It's very targeted treatment, usually starting with an antidepressant that can have significant impact on post-traumatic symptoms, mood and anxiety, and that in turn translates to a reduction in substance use. I would call it a simple intervention that has a significant impact. By providing really targeted, but fairly basic support to the older generations that they would not otherwise access, it has such a big impact. Their mental health improves and it has a ripple effect on the whole family.

In this example, I work with several of her children and the change in the family dynamic, from working with her as a carer then providing direct support to her as well, it makes the whole family system stronger and improves the social and emotional wellbeing of everyone involved.

Prior to working with the family as a whole, where they have come to know and trust us, they would be reluctant to call services if their son was relapsing. But now they just call up straight away, and say "He's not travelling too well". We can act a lot earlier before things get worse.

It destigmatises mental illness as well in a way because the children start to say; "Well my mum is getting some treatment and so can I". There's been no tension in treating all members of the family. It's such a different approach to mainstream services where each member of the family would have to be with a different service because it's a conflict of interest. Whereas now the family will say "We trust you, why would we go anywhere else?".

With regards to issues of confidentiality, you take their lead and are governed by them. I give the son an injection that requires two hours monitoring, so in that two hours I need to be there, and it's an opportunity to chat to his mother and siblings, and you get such a richness of information and insight into how they are tracking. I don't share individual conversations with other family members but it hasn't been an issue so far. The family give permission and they feel comfortable that they don't have to tell their story over and over. There's permission to work openly with multiple family members of different generations. I take my lead from them if they are talking openly in front of one another that gives me permission to talk openly as well.

I do explicitly ask permission to share information on occasion, particularly if they're not travelling well, for example, "Would you like me to contact your Mum and have a chat to her about how you're going?" They quite often give permission for that and I can facilitate a discussion. It takes the burden of responsibility off the matriarch of the family, they then start to do some self-care.

It's worth noting that quite often in Aboriginal culture, if the treatment isn't endorsed by a senior family member, it won't be supported or have traction. The vouching we get is invaluable. Mainstream services need to consider this more, that unless Mum or Dad or Uncle or Aunty vouch for the treatment and say "That's alright", you won't get any buy in from the person of the family. You need to spend more time working with the families to establish that trust, instead of targeting an individual to ensure compliance with a treatment.

Culture

Essential for any Wadamba Wilam consumer in strengthening their social and emotional wellbeing, is supporting a stronger connection to culture. 95% (46/48) consumers are connected to the Stolen Generation, either as direct members or as descendants of Stolen Generation members. This experience has drastically disrupted these consumers connection to culture.

The majority of consumers have this cultural connection specifically supported by Wadamba Wilam, including many activities for healing, including attending Men's Camps, support to spend time on country, and attend cultural events.

ARTWORK
Catherine Watt
Untitled

Supporting the connection to Spirituality

Worker Reflection – Adam

I had been working with Lou for seven years. He has always been on treatment orders, had had many inpatient admissions, and a few long term admissions of six months or more in a secure unit and residing at the local mental health residential facility.

I went with him on a Men's Camp, which happened to be on his Country. When you ask Lou what he wants to do, he normally has a grandiose defence, where he has multi-million dollar businesses and he is a high-roller. At the Men's Camp there was a well-respected community Elder, and we were sitting around the fire. This Elder knew Lou's family, and he asked him: "Now, what do you want to do young man?" and Lou replied, "I just want to get off the drugs, and get my own place". They then had an extended conversation where the Elder reassured Lou that there was no reason why he couldn't achieve this aspiration, and they talked further about Lou's family lines and their history.

I was flabbergasted at Lou's response, because I have heard Lou's answer to similar questions before. But this time he said "Look I just want to make something of my life". He felt comfortable enough in that moment to be honest – because he was on Country, around the fire in an informal environment, a respected Elder taking the time to speak to him and telling him he can do that was priceless. This conversation was three years ago, he has since left the residential facility, has come off treatment orders. It has changed his view about taking responsibility for managing his own health and wellbeing. He still states that he doesn't have a mental illness, but he acknowledges that the medication helps him on some level and he has reduced his substance use, and moved into independent housing and stayed in housing. He hasn't been seen by public mental health services in three years, and prior to that he would have had twenty-five inpatient admissions, several secure admissions and mental health residential facility admissions per year.

Only recently when Lou was not travelling too well, I revisited that conversation with him, and Lou managed to turn himself around again, almost instantaneously. The conversation at Camp was powerful for a couple of reasons. It happened with an Elder, on his Country, with someone who knew his family extensively. It was useful for me as a worker to witness that, so I could continue to use that conversation going forward as a motivation. It has been the single most powerful intervention, his mental health is infinitely better than it was, and there's been no other change in his treatments and medications.

That spiritual connection, time on Country, that conversation with an Elder was instrumental to Lou's healing, and would not have happened without our support, or the way we can work.

Lou has strong cultural knowledge and cultural connection, however his mental health issues and confidence have prevented him from joining in with spiritual activities like this. Without Wadamba Wilam support, Lou would not have had this opportunity to connect with Country and spirituality.

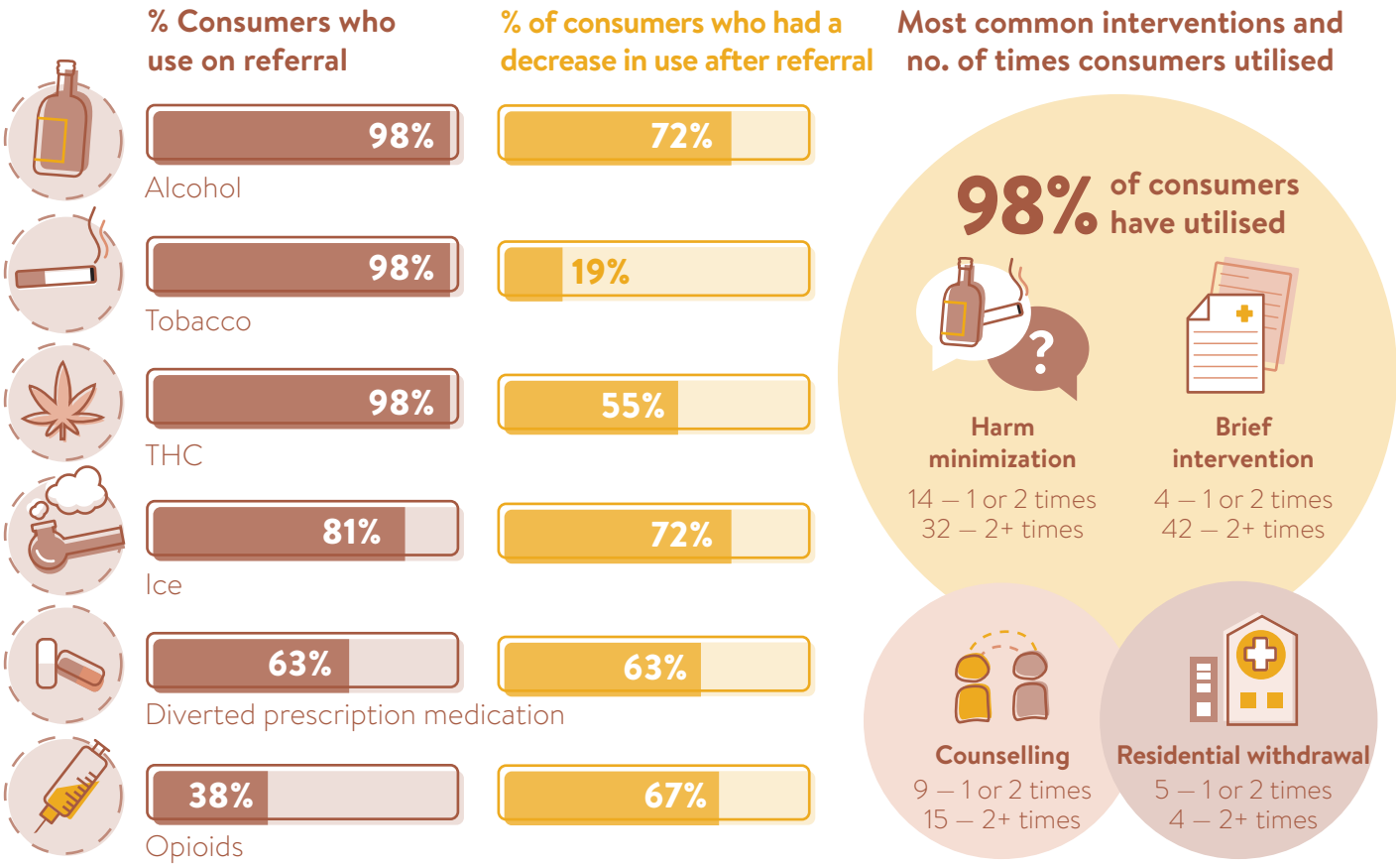
The support and encouragement of Wadamba Wilam, and our trusting relationship with him, has helped conquer the barriers to access these types of things.

It just goes to show that sometimes we over complicate things and focus on treatment and medication, and we don't recognise the power of hope and meaningful conversations with respected community members.

Alcohol and other drug issues

On referral to the service, there were high rates of substance use amongst consumers, with almost universal use of Tetrahydrocannabinol (THC), alcohol and tobacco. There are also significant rates of Ice use as well as misuse of prescription medications.

Wadamba Wilam staff utilise a breadth of interventions to help support a reduction in substance use. The most common are brief interventions and harm minimization (offered to 98% of consumers), which are repeated as necessary. An example of a brief intervention is the provision of information and education about THC use and the effects it can have on the body and brain, as well as the long term impacts of continued use. Workers will also, through non-threatening and non-judgmental conversations, support people to understand and explore the reasons they use substances, what it means to the person using and what role it plays in their life. Supportive psychotherapeutic interventions as well as Motivational Interviewing techniques are also utilised by workers. Through these conversations, consumers can begin to explore their motivation to make changes about their substance use and are supported by the Wadamba Wilam team to make these changes in a safe way.



Where appropriate, small numbers of consumers are able to access rehabilitation and withdrawal programs, however public demand for these services can make it challenging for consumers to access them in a timely manner.

Despite demand for rehabilitation services exceeding supply and other service barriers, 9/47 (19%) of consumers have been supported into residential withdrawal programs, and 4/47 (9%) into residential rehabilitation programs. Non-residential withdrawal programs have been accessed by 8/47 (17%) of consumers and 4/47 (9%) to non-residential rehabilitation programs. Many consumers have attended and completed withdrawal programs for the first time.

For many, substances are used as a trauma-numbing self-soothing technique. Through Wadamba Wilam's psycho-education around trauma symptoms and coping techniques, as well as the provision of prescribed medication where appropriate, some consumers are able to reduce their substance use. Reduction in use of tobacco remains stubborn, however consumers have significantly reduced their use of other substances.

Access to Rehabilitation Services

Worker reflection – Jeremy

A constant challenge for staff and consumers with regards to making positive changes with alcohol and other drug issues, is the limited access to rehabilitation services. In Victoria, demand well outstrips supply in terms of residential rehabilitation places, and a consumer can commonly wait six months to access a rehabilitation place. This structural issue is counter-intuitive to common understandings of harnessing consumer's motivation to reduce their substance use, and undermines the work done by Wadamba Wilam staff to support a consumer's motivation to change this part of their life.

Wadamba Wilam staff have many preparatory conversations with consumers, exploring their readiness for change, and reasons for use. The staff listen carefully for signs that consumers are ready to reduce their use or engage in harm minimisation, and are opportunistic in the interventions they provide. However, this work is undone, when residential rehabilitation is the necessary next step or circuit breaker in supporting a consumer to reduce with their substance use, and these facilities are inaccessible. This means that consumers lose momentum, as well as compound a further distrust of the mainstream system. One consumer, who has consistently not been able to access residential rehabilitation when ready, has stated "They don't want me at rehab, everytime I want to go, I can't get in". In this case, this is seen as a personal rejection and deflates motivation and momentum to change.

Navigating a breadth of Alcohol and Other drug services and interventions

Worker reflection – Anne

Matt started using in his early teens and is now in his thirties. Matt had been attending the local Aboriginal Health Service daily whilst homeless and was eventually referred to the Wadamba Wilam program, after recognising that his alcohol, ice and heroin use was causing significant negative impact. Matt had attempted multiple withdrawals, detox admissions and rehabs in various locations over many years with varying degrees of success. On referral to Wadamba Wilam, Matt was quickly referred to an AOD rehabilitation program and a PARC stay.

Whilst in rehab, Matt with Wadamba Wilam workers completed housing forms and lodged various housing applications which resulted in an offer of a community housing property a few months later. Matt stayed for five months at rehab and completed the program which was a first for Matt who felt proud of this achievement, since previously he had left similar programs prior to completion.

On being housed after rehab, Matt worked hard to attend education programs, keep fit and look after himself before sliding again into daily substance abuse to keep his anxiety at bay.

Matt's experiences of depression and anxiety ebb and flow with the degree of substance abuse. However Matt was making all efforts to attend the pharmacy for his pharmacotherapy dose and prescribed medication however he couldn't maintain this as the pressure of seeing friends and using was too great.

Matt was again referred to the same rehabilitation program after he decided he needed another try to get it right, however this time only stayed two weeks before leaving.

Over the ensuing months Matt has stated he doesn't need pharmacotherapy as he feels ok without it. However his substance use is the same or higher. Currently Matt's communication with Wadamba Wilam is erratic due to Covid-19 and continually losing or breaking phones supplied by the service. The team attempt to make contact via the phone numbers they have or home visits in the hope of catching him.

SECTION 5

RECOMMENDATIONS: INTEGRAL FACTORS FOR SUCCESS

Wadamba Wilam's success is a result of a targeted approach in overcoming the entrenched systemic barriers that have prevented this cohort from accessing appropriate services. When considering the foundation and funding models for like services, it is recommended that the following features are included.

Intensive Assertive Outreach

Wadamba Wilam is underpinned by flexibility and responsiveness when working with consumers. Intensive assertive outreach facilitates workers to overcome access barriers, to be with consumers during crisis, to support meeting basic needs and to facilitate consumers participating in healing activities. The team can provide more intensive support when required, while also providing opportunities for consumers to build resilience over time and capacity to manage independently in the future.

Outreach is also essential as it allows workers to be in the community where they have a visible presence. This facilitates network-building amongst other workers and services, but more crucially, with Aboriginal and Torres Strait Islander communities. This visibility contributes to the service being known, trusted and vouched for in the community it serves. Until the community vouches for the individual worker or the mental health service, it will be a challenge to keep sustained engagement. A community presence also provides opportunities for early intervention and empowers the community to seek and access support in a proactive manner.

Length of Support and staff/consumer ratios

Low case numbers (30 to 35 consumers at any one time between 5 workers) allows for sufficient time to develop strong, meaningful and trusting therapeutic relationships, which ensures sustained engagement. Low case numbers allow the intensity of contact to be responsive to need, including daily contact during periods of crisis.

The long-term focus allows the team to target interventions at the person's pace with consideration to the relevant stage of trauma recovery.

Interdisciplinary team/ Interagency Collaboration

The consortium model, where staff from a range of specialised organisations are drawn together into a single team, is well placed to support consumers with multiple, intersecting needs that are unlikely to be met by single, siloed organisations. This model supports the timely and opportunistic delivery of therapeutic offerings and it streamlines referrals and acceptance into appropriate services to support an improvement in social and emotional wellbeing.

As there are high rates of psychotic illness as well as almost universal substance misuse in the consumer cohort, in-house psychiatric, nurse practitioner and AOD support is essential. The nurse practitioner can support medication and prescription management in conjunction with the psychiatrist, and the specialist AOD worker supports consumers to manage safe substance use and reduce their substance use. Access to these specialised workers ensures that these interventions can be delivered and monitored responsively and that consumers' motivation to make positive changes can be seized in a timely manner. That these interventions are also delivered by workers known and trusted by consumers increases the likelihood of their success.

An increase to the availability of a consultant psychiatrist (currently 0.1 FTE) would further support workers to act quickly and responsively to consumer need.

Trauma-informed care and the incorporation of social and emotional wellbeing principles

Staff understand and identify trauma behaviours and symptoms, the same behaviours and symptoms that may see the same consumers excluded or banned from other services. They use moments of crisis as times to ramp up support and become even more assertive in their approach. Staff are educated about the stages of trauma recovery and utilise strength-based interventions to improve peoples' symptoms, functioning and social resources.

Staff incorporate the nine guiding principles of social and emotional wellbeing (**Appendix I**) into all aspects of their work, from lengthy assessment and rapport building periods, to the empathy and understanding they employ to understand a consumer's story and needs, to the culturally safe manner in which they approach all interactions with consumers.

Family-centred practice

Wadamba Wilam works with multiple family members at once, which allows support and healing to multiple generations and several members of the one community. It also facilitates building connections to community, family and kinship. As community trust in the service has been established, increasingly, referrals are received from community or family members. This creates an informal vouching process, whereby trust and understanding of the service is already built, which provides a more established foundation from which individual workers can further develop trusting relationships.

Culturally appropriate tools and practices

Staff ensure that they work in a culturally competent and safe way. Training in these areas are offered to staff and there is an expectation during hiring practices that staff bring their own cultural knowledge as well as a curiosity to learning more and ensuring they act in a culturally safe, anti-racist manner. A key focus in hiring practices is ensuring that aboriginal staff are employed within the service.

The service employs culturally appropriate tools, including assessment tools, in order to develop a rich understanding of people's history, holistic physical and mental health, as well as to ensure that assessment processes are not re-traumatising.

Continuity of Care and Care Coordination

Care coordination and continuity of care ensures connection is maintained with consumers and providers as people move through the service system. For example, between justice, health, housing and social services (including child protection). Having the combination of expertise within the team means a range of needs can be met internally and ensures ease of connection to specialist supports and resources.

The continuity of care enables a developing formulation of each consumer, their history, their context, and the most effective ways of meeting their needs. It contributes to meaningful discharge planning and reconnection if required in the future.

Maintenance period and "Soft Endings"

Wadamba Wilam continues to work with many people after housing has been secured and a stabilisation in mental health has been established, for years. In many instances, this maintenance period, where workers are still on hand to offer support, provide counselling, psychoeducation, develop coping skills and living skills as well as connect people to relevant services including for physical health needs continues. This support is crucial in helping navigate times when social stressors negatively impact social and emotional wellbeing which are essential in helping to build resilience and independence.

When a person has reached the stage where they no longer need Wadamba Wilam support, the service pulls back slowly, still checking in with the person fortnightly or monthly. There is less formality than mainstream services in official "exiting" procedures, and consumers who have left the service still call workers on occasion to catch up, and to receive support, reassurance and sometimes reminding about coping skills and strategies over the phone or if appropriate, in person. If someone, post exit, is in need of re-engaging with the service for more consistent support, then that person is immediately brought back to the service, without needing to complete any formal intake procedures. As they are already known to the service and trust has been established, immediate service re-entry enables the person to receive support straight away, and in many cases, avoids a severe decline in social and emotional wellbeing.

Maintaining and sustaining social and emotional wellbeing

Worker Reflection – Adam

Prior to referral to Wadamba Wilam, Jim had experienced over twenty psychiatric ward admissions. Jim was in a constant cycle of being released from the ward with a Treatment Order, then discharged to a GP, then discontinuing his medication, whereby his mental state would deteriorate and he would be readmitted.

When unwell Jim could be threatening and aggressive to family members and damage property. Jim was referred to Wadamba Wilam several years ago and since that time he has not had a single psychiatric ward admission. The Wadamba Wilam team developed a trusting relationship and good rapport with Jim over the years that have contributed to Jim's increased social and emotional wellbeing, increased mental health and reduction in admissions.

The Wadamba Wilam team visits Jim once a week for a cup of tea and check-in, and at the same time, provide Jim with his weekly medication, update any prescriptions, and the nurse practioner in the team will administer Jim's depot injection every three months which manages his symptoms. The team support Jim with material aid including art supplies which Jim uses to strengthen his connection to culture. Jim has referred family and friends to the service and after many years of distrusting services and the medical system.

REFERENCES

Adams, K. E. (2014). *Koorified: Aboriginal Communication and Well-Being* Retrieved from **http://www.vaccho.org.au/vcwp/wp-content/uploads/2011/03/Koorified-Aboriginal-Communication-and-Well_Being.pdf**, Fitzroy, Australia

Australian Bureau of Statistics. (2019). *National Aboriginal and Torres Strait Islander Health Survey, 2018-19*. Retrieved from **https://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4715.0Main%20Features72018-19?opendocument&tabname=Summary&prodno=4715.0&issue=2018-19&num=&view=**

Australian Government. Australian Institute of Health and Welfare. (2018). *Australia's Health 2018*. Retrieved from **https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents**

Bohanna I, Stephens A, Wargent R, Catherall J, Timms C, Graham D, & A, C. (2013). *Assessment of acquired brain injury in Aboriginal and Torres Strait Islander Australians: Guidancze for DisabilityCare Australia*. Retrieved from Cairns, Australia **https://www.braininjuryaustralia.org.au/wp-content/uploads/PDF_Project_Report_9Jul13_FINALx.pdf**

Brotherhood of St Lawrence. (2017). *Rough Sleeping In Victoria – Situation Appraisal*. Retrieved from **https://www.dhhs.vic.gov.au/sites/default/files/documents/201709/Rough%20Sleeping%20in%20Victoria%20-%20Situation%20Appraisal.pdf**

Calma, T., Dudgeon, P., & Bray, A. (2017). Aboriginal and Torres Strait Islander Social and Emotional Wellbeing and Mental Health. *Australian Psychologist*, 52(4), 255–260. doi:10.1111/ap.12299

Cloitre, M., Courtois, C., Ford, J., Green, B., Alexander, P., Briere, J., … Van der Hart, O. (2012). *The ISTSS Expert Consensus Treatment Guidelines For Complex PTSD In Adults*. Retrieved from **https://istss.org/clinical-resources/treating-trauma/new-istss-prevention-and-treatment-guidelines#documents**

Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., … Hyland, P. (2018). The International Trauma Questionnaire: development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatr Scand*, 138(6), 536-546. doi:10.1111/acps.12956

Commonwealth of Australia. (2017). *National Strategic Framework for Aboriginal and Torres Straight Islander Peoples' Mental Health and Social and Emotional Wellbeing*. Canberra

Dawe, S., Farnell, L., & Harlen, M. (2010). *Assessing substance use and mental health in Indigenous clients: What appears to work and where to next*. Brisbane, Australia: Griffiths University.

Dudgeon, P., Milroy, H., Walker, R., Australia. Department of the Prime, M., Cabinet, Australia. Department of, H., … University of Western, A. (2014). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (Second edition.. ed.). West Perth, WA: West Perth, WA: Kulunga Research Network.

Gee, G. (2019). *Witness Statement of Graham Gee*. Royal Commission into Victoria's Mental Health System. Retrieved from **https://rcvmhs.vic.gov.au/download_file/view/207/419**

Herman, J. L. (1997). *Trauma and Recovery*: New York, BasicBooks.

Lovett, T. (2019). *Witness Statement of Tamara Lovett*. Royal Commission into Victoria's Mental Health System. Retrieved from **https://rcvmhs.vic.gov.au/download_file/view/208/419**

Magistrates' Court of Victoria. (2020). Koori Court: A court for Aboriginal and Torres Strait Islanders who have taken responsibility and pleaded guilty to a criminal offence. Retrieved from **https://www.mcv.vic.gov.au/about/koori-court**

Oades L. G., D., F. P., & Crowe, T. P., . (2017). Collaborative Recovery Model: From Mental Health Recovery to Wellbeing. In L. O. M. Slade, & A. Jarden, (Ed.), *Wellbeing, Recovery and Mental Health* Cambridge, UK: Cambridge University Press.

Portman-Thompson, K. (2020). Implementing trauma-informed care in mental health services. *Mental Health Practice (2014+)*, 23(3), 34-41. doi:10.7748/mhp.2020.e1443

Victorian Government. (2017). *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*. Melbourne: Victorian Government

APPENDIX I

Wadamba Wilam's approach to practice has been purposely aligned with the nine guiding principles of social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples, as found in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Dudgeon et al., 2014, p. xxiv).

These nine principles are:

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that while the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.
2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally and mental health problems in particular.
4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continue to have intergenerational effects.
5. The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health (as against mental ill health). Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.
7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.
8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in urbanised, traditional or other lifestyles, and frequently move between these ways of living.
9. It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009

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