Closing the (Service) Gap: Exploring Partnerships between Aboriginal and Mainstream Health Services

Abstract

Background

Achieving reduction of the substantial life expectancy gap between Aboriginal and non-Aboriginal Australians requires renewed attention on improving health service delivery. Strong, cohesive and sustainable partnerships between Aboriginal and mainstream services can offer important benefits in addressing some of the complex and chronic issues in the Aboriginal population. Understanding the factors that challenge and enhance such partnerships is critical to improving health service delivery and thus Aboriginal health outcomes.

Methods

A literature review was conducted using keyword searches of electronic databases. Research articles, government documents, discussion papers and organization reports were reviewed for relevance regarding the benefits and challenges of Aboriginal mainstream health service/staff partnerships, and the lessons learnt and factors contributing to making such a partnership successful.

Results

While there is literature around partnerships and collaboration, few have specifically examined Aboriginal-mainstream partnerships. 24 sources were identified and reviewed in detail. Benefits of successful Aboriginal-mainstream partnerships include broadening service capacity and improving the cultural security of health care. Challenges facing such partnerships are the legacy of Australia's colonial history, the difficulties of sharing power in a western-dominated health care system, different approaches to servicing clients and resource limitations. Recommendations for successful partnerships include having a common goal (important for all successful partnerships), recognizing tensions early and committing to working through them, allowing time to develop trusting relationships between staff and building linkage protocols, and having strong leadership.

Conclusion

Successful, sustainable partnerships are vital to optimize client care and help ‘close the gap’ between Aboriginal and non-Aboriginal life expectancy. However, failed partnerships risk inflaming sensitive relationships between Aboriginal and non-Aboriginal service providers and the community, with ramifications for Aboriginal chronic condition management and health outcomes. Given the current environment which favors partnerships to deliver culturally appropriate services and improve Aboriginal health, it is critical that the factors supporting Aboriginal-mainstream collaboration are understood.

The crisis (in terms of Aboriginal health in Australia) is that we as a people and service agencies don't know how to come together to find solutions to these problems and to create the synergy necessary to respond

Attributed to Kerry Colbung, 2004[1]

Background

There are many reasons for organizations to collaborate in the delivery of human services around complex issues. Cost efficiencies in planning, research, training and other development activities as well as avoiding duplication of effort are key benefits, as is making services more likely to meet the complexity of client needs (1). According to Mattesich et al, "Collaboration results in easier, faster and more coherent access to services and benefits and in greater effects on systems. Working in synergy is not a substitute for adequate funding although the synergistic efforts of the collaborating partners often result in creative ways to overcome obstacles" (1) (p 3-4). It is therefore not surprising that governments at all levels have been increasingly interested in whole-of-government approaches and collaboration between services, as well as new ways of planning, funding and delivering services to deal with social and health problems.

Since the release of the Social Justice Report in 2005, the 'Close the Gap' campaign has advocated for the Australian Government to reduce the 17 year life expectancy gap between Aboriginal [2] and non-Aboriginal Australians by 2030 (2). Partnerships between mainstream and Aboriginal health services are strongly supported as a means of improving Aboriginal life expectancy (3) and there has been increasing focus at the state level for strategic partnerships to improve Aboriginal health service access and outcomes (4-6). Such partnerships are seen as fundamental if services are to address the complex social determinants driving poor Aboriginal health (7) whilst working towards a more culturally competent model of service delivery. Yet while these partnerships may have benefits, those working in Aboriginal health are aware of the tensions that exist and can impede robust Aboriginal-mainstream relationships, while acknowledging that different approaches to health service delivery often creates challenges for staff and clients. To assist such partnerships to be genuinely successful, it is important they are informed by best practice.

[1] Kerry Colbung, an Aboriginal woman from Ceduna was the Chair of the South Australian Premier's Aboriginal Advisory Council

[2] In this paper, the term 'Aboriginal' is used to refer to Aboriginal and Torres Strait Islander people of Australia, and the term 'Indigenous' is used to refer to Indigenous people of New Zealand and Canada.

A seminal literature review conducted first in 1992 and updated in 2001 by Mattesich et al sourced (in total) 414 studies and identified six key factors that characterize successful collaborations (Figure 1) (1). The World Health Organisation emphasizes that collaboration involves joint planning, joint implementation and joint evaluation between individuals or organizations working towards a common purpose (8). However, relatively little information is available that addresses how to build effective partnerships between Aboriginal and mainstream health services (9).

This literature review was undertaken at the request of an Aboriginal community controlled health service that had entered into a partnership with mainstream health services, to understand the issues and strategies for enhancing cross-cultural collaborative arrangements. Given that the purpose of the review was to explore the *relational* aspects of a partnership (as opposed to simply contractual) we adopted Mattesich et al's definition of collaboration as most pertinent to the joint arrangements which are the subject of our study:

> *A mutually beneficial and well-defined relationship entered in to by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards* (1) (p.11).

In this paper, the terms 'partnership' and 'collaboration' are used interchangeably to refer to a joint arrangement between Aboriginal-mainstream health services (and the staff employed by them).

Methods

A number of articles discussing inter-organizational collaboration informed our thinking and provided general background for this study (1, 8, 10-17). The process of literature sourcing and assessment to specifically focus on Aboriginal-mainstream service partnerships is shown in Figure 2. The databases Science Direct, Australian Aboriginal Health*Infonet*, Wiley Interscience, Blackwell Synergy, Proquest, Sage, PubMed, Informit and Google Scholar were searched for articles covering the period 1993-2009 using a combination of the key words (Aboriginal or Indigenous) and health service and (partnership or collaboration) and (Australia or New Zealand or Canada). From the initial retrieval of articles (n=97), publications not specifically related to the Aboriginal context (n=63) were excluded. The

remaining articles (n=34) were then assessed for relevance to the following research questions:

- What are the benefits of Aboriginal mainstream service/staff partnerships?
- What are the challenges facing Aboriginal and mainstream health service/staff partnerships?
- What are the lessons learnt and what factors contribute to making a mainstream-Aboriginal partnership successful?

The authors independently reviewed each article, with any discrepant views regarding suitability for inclusion resolved through discussion. Articles were included if they referred to any aspect of a partnership (whether between organizations or between staff/individuals and their roles) in the context of service delivery in a health care setting or public health initiative or if they discussed a project (for example research) directly linked to improving health outcomes. Papers referring to partnerships with community members were included only if they described an Aboriginal organization or community group partnering to *directly deliver a health service* – either established or as a result of the partnership. Articles were excluded if they explored service relationships with the Aboriginal community *as recipients only* or only described a joint arrangement to deliver a service without interrogating the components involved in developing or delivering the partnership. Publications referring to partnerships in other sectors were excluded unless they explicitly mentioned health outcomes.

Situations where staff from an Aboriginal or mainstream organization were based in the partnering service were included if they reflected an inter-agency agreement and could offer lessons for inter-professional partnering. One research project published both a study report and journal article; in this case both publications were included (although this project was attributed to only one source in Table 1). Following this process 10 papers were excluded, leaving 24 final sources which were read and re-read to ensure content familiarization, with key ideas within each source coded and codes collated under broad descriptive themes (18).

Findings

The 24 sources relating to Aboriginal-mainstream partnerships reviewed in detail (Table 1) included qualitative research (9, 19-25, 48), descriptive case studies (26-31), discussion papers (32-34), project reports (10,35,36) and conference presentations (37,38). No study with an experimental or comparative research design was identified. The partnerships

discussed were in various stages of planning, development, delivery or evaluation. A number of papers explored inter-professional relationships between staff in Aboriginal and mainstream services, either where an individual was based in the partnering organization (such as a psychiatrist in an Aboriginal community controlled service (29), or by reflecting on a service arrangement from the perspective of staff roles. The list includes two government documents that outline consensus principles rather than specific case studies regarding partnership approaches in Aboriginal health (39, 40). Key themes were collated to identify frequency of appearance (Table 2). A further 30 documents provide context including background to partnerships generally (1,2,8,11,13-17,44), collaboration and/or Aboriginal health (7,41-43,45-47,49,50,53,54) and references to specific Aboriginal health partnership programs (3-6).

Improving service capacity: the benefits of Aboriginal - mainstream health service partnerships

The support for coordinated approaches between Aboriginal and mainstream health services to address the complexity of Aboriginal health issues (41) reflects experience that synergistic partnerships offer creative approaches to broaden service capacity (25, 26, 37). Aboriginal-mainstream partnerships in chronic disease can ensure continuity of care and assist service integration, enabling clients to move between services more easily between services as needed (41, 42). The complex interplay of socio-cultural determinants underlying poor Aboriginal health and complicated conditions arguably requires collaboration rather than organizations working in isolation (10) to ensure optimum outcomes for all individuals.

Given the legacy of mainstream health care for Aboriginal people, improving the cultural security of services has become a major public health focus. Multiple studies highlight breaking down access barriers and improving the cultural appropriateness of mainstream services as an important benefit arising from a partnership with an Aboriginal health service (9, 27, 31, 37). Partnerships with Aboriginal services offer a powerful mechanism for helping build mainstream providers' socio-cultural awareness and overcoming 'paternalistic' care where mainstream health providers see themselves as the experts and the Aboriginal patient as naïve recipients (13, 28). In this way, partnerships can honor the knowledge of Aboriginal people. Importantly, as more Aboriginal health professionals become involved in the health system, institutional racism (that is, normative and codified differential access in health structures) should be broken down (37,43).

Building the capacity of staff to provide more effective health care to Aboriginal clients is another important benefit. However this capacity building must be two way, with non-Aboriginal staff learning about providing more culturally appropriate clinical care and Aboriginal staff increasing their clinical capacity and confidence (27-29). For Aboriginal organizations, balancing health service delivery between Aboriginal community control and mainstream 'evidence-based' approaches also means there may be benefits arising by partnering with mainstream services (32).

Challenges facing Aboriginal-mainstream health service partnerships

Historical baggage, different approaches and lack of knowledge about partners

As partnerships are exercises in social relations (11) they inevitably reflect characteristics of the broader society. In the Aboriginal-mainstream context, a major challenge facing partnerships is the enduring remnants of Australia's colonial history resulting in difficulty developing relationships based on trust. Trust is widely recognized as a fundamental facilitator of collaborative work (14), describing a situation where there is a reliance on partners to fulfill obligations, behavior is predictable and there is an expectation that partner's will negotiate fairly (44). One study identified how complications can arise as a result of the deep suspicion and mistrust many Aboriginal people have of mainstream control (20). In New Zealand, a history of mainstream funding appearing to support Indigenous self-determination only to then impose restrictions has reinforced Indigenous mistrust of mainstream (21). While partnerships across any social group involve negotiating differing perceptions and emerging tensions (38), the historical canvas underlying an Aboriginal-mainstream partnership can contribute to mistrust and compound service differences.

Issues can arise due to the inherently different value systems that Aboriginal-mainstream services operate from. A Canadian study found challenges in an Indigenous-mainstream partnership developed based on the parties different understandings of health, society and culture (32). Furthermore while objectives may be the same, perceptions of how to get there may be different due to the systems with which they operate (38). Mainstream services often fail to appreciate the time needed to build trusting relationships, and in combination with the time-bound nature of funded projects, this is incompatible with Aboriginal values and approaches to working (22).

Experience strongly suggests that the lack of familiarity staff have with the different organizational processes that influence the other's work practices creates difficulties (20) and affects partner confidence. An example is preference for informal referral and assessment systems by Aboriginal staff (due to the socio-cultural context) compared to that of mainstream 'proper' administrative processes. Poor communication and linkages coupled with a lack of knowledge about the services delivered by a partner will compound these situations. While geographical distance can challenge inter-agency engagement (19), partnerships involving multiple services can face even greater difficulties in maintaining contact and relationships as the combined demands of distance and workload take over. Despite this, maintaining communication and linkages is an area for attention and integration to avoid becoming a source of partnership tension (29).

Partnership difficulties can arise for Aboriginal staff in meeting both their community obligations and the demands of mainstream health care (such as clinical and training requirements) (29). High community need and socio-cultural demands mean many Aboriginal health staff are expected to become all things to clients, assuming 'generalist' roles that address far more than their job descriptions require (28). While working within the patient's whole social context is a signature strength of the Aboriginal health worker approach, in partnerships with non-Aboriginal service providers the perceived role ambiguity can be a primary source of tension, with many mainstream staff lacking confidence in their Aboriginal co-workers and complicating communication and client referral processes (22, 28, 36, 45). In fact, lack of clarity about staff roles - whether they are from a mainstream or Aboriginal service - can create significant partnership strain (19) and have negative implications for clients. A lack of knowledge of each other's service can significantly affect the capacity of partners to determine appropriate client referral (9).

Power sharing and the dominant health-care system

It is argued that the domination of western culture in health care delivery coupled with the limited knowledge many Aboriginal staff have of the health system means that partnerships struggle to be truly equal (22,32). Further, both Aboriginal and non-Aboriginal authors suggest mainstream health professionals are limited by an inherited paternalism that results in a tendency to place themselves in a superior position to their Aboriginal colleagues, significantly affecting their ability to share power (23, 46). Continued disparities in terms of training, position and pay between Aboriginal and mainstream staff create strain on

Aboriginal staff retention and partnership outcomes (22), ultimately characterizing the Australian health care system as plagued by 'institutional racism' (37, 47). In an evaluation of a training program for Aboriginal people working with a mainstream partner, issues such as differences in qualifications, lower pay and a lack of recognition of professional standing in relation to mainstream colleagues created dissatisfaction for Aboriginal staff (24). In another project, the inadequate use of the knowledge and skills of Aboriginal staff by mainstream partners was a major issue (25).

Echoes of professional inequity can also be seen within many processes of 'capacity building'. Studies caution mainstream organizations from reverting to subtle paternalistic training provision from the 'skilled' mainstream professional, lecturing to the 'unskilled' Aboriginal worker (25, 48). Salisbury has reflected on the challenge for mainstream in having to 'step back' from their traditional role of expert and leader to one of support, with implications for resource allocation (33). Ultimately it is essential that mechanisms are developed to ensure professional workplace equity so historical patterns of mainstream dominance do not proliferate (23).

Resourcing issues

Experience shows that limited resourcing reduces the capacity of Aboriginal providers to effectively engage with their mainstream partners (22). Caution is given to partners (and funders) who fail to identify in the preliminary stages the real costs associated with planning, consulting and operating an effective partnership. Having sufficient resources allocated to *realistically* support the partnership process as it develops and for operations is critical for success (21, 35). Ineffective resource planning leading to an unsuccessful partnership can compound past government and mainstream failures in addressing Aboriginal health, angering communities and service providers (40).

Improving partnerships between Aboriginal and mainstream health services: what has been learnt?

Addressing conflict and sharing power

Successful Aboriginal-mainstream partnerships demonstrate that recognizing early the inevitable tensions that arise through different perceptions of health, allowing for conflict and having effective mechanisms to approach it are key features for success (22, 28, 48). Similarly, Canadian experience highlights that identifying historical baggage and committing

to starting fresh is an important beginning to a partnership, with facilitated workshops to address tension a powerful enhancement strategy (19). The different (and sometimes competing) philosophical underpinnings of health service delivery means negotiations may sometimes be difficult and protracted, requiring mediation to move forward. Robust problem solving mechanisms to work through differences are strongly recommended (22, 25).

The reality of internal structures of power within most organizations (whether mainstream or Aboriginal) can create challenges for achieving equality in partnerships (33). However for Aboriginal-mainstream partnerships, developing mechanisms for sharing power is important in order to traverse historically-linked imbalances. Yet for this truly to occur, mainstream partners operating within the dominant western paradigm of health care will have to undergo a genuine 'shifting down' to make space for Aboriginal approaches to health. One publication discusses the importance of non-Aboriginal staff supporting processes that particularly engage 'the structures of the Aboriginal system' to challenge institutional racism (38). While the practical associations of this may be difficult (having implications on referrals and administration for example), a partnership that has developed over time and built trusting relationships is more likely to be able to explore this space and find creative, mutually beneficial solutions.

How can services address the power imbalance that exists between Aboriginal and mainstream services for better partnerships? Jackson argues that a fundamental step in power sharing involves mainstream staff examining how they are treating their Aboriginal co-workers by analyzing subtle forms of paternalistic thinking and practices (23). The greatest challenge for many mainstream partners may well be to 'shift down' from their historically privileged position, and work to implement strategies that re-enforce and complement the expertise of their Aboriginal partners (21). Mechanisms for equal power sharing, mutual respect and reflective staff practices are essential attributes for success (21). Practical actions that are recommended to facilitate power sharing include rotating the chair and location of meetings and the organization of logistics and arrangements (19). Formal documentation (such as Memorandum of Understanding and Service Agreement) illustrating power sharing as a value and in practice and joint resource allocation may be other factors to support power equity in an Aboriginal-mainstream arrangement. Naming the expertise each partner brings to the collaboration within formal documentation, as well as their rights and responsibilities, is also critical (21).

Building trust, knowing your partner and developing linkages

Mainstream services have been criticized for failing to recognize the time it takes to develop trust with Aboriginal partners (22). Yet the pressure to develop and deliver within the boundaries of funding cycles can strain a partnership before it is suitably mature. Given Australia's history with Aboriginal people, it is imperative that partnerships are not forced in this way. Successful partnerships in New Zealand and Australia provide evidence of the importance of developing trust sensitively, with sufficient time allocated to build and respect the other's autonomy (21, 31, 33, 48). Experience suggests that allowing a developmental period exclusively devoted to building relationships can be critical (30).

Attention to relationship building between individuals is a key factor in successful partnership development (19). Regular exposure to build knowledge of one another's professional and personal context (9, 28) as well as having the opportunity for reflexivity of self and practice are all inherent in building trust. Enabling a social feeling to these interactions, such as by serving food and keeping things informal, will support relationship building (19, 30). Regularity is also critical with experience highlighting the importance of meetings that are consistent despite staff changes or individual non-attendance. Geography must not be a barrier so using alternative methods to communicate, such as teleconferencing or videoconferencing, can help mitigate challenges associated with distance and time (19). Partnerships are not simple exercises in administrative paperwork so an effective partnership requires regular communication and exposure to each other's contexts. Failure to stay attentive to the relationships embedded within the partnership creates distance that is not a function of geography.

Integral to effective inter-agency relationships is clarity around roles and responsibilities and a commitment to the services offered through the partnership. (25) It is important that staff are clear about one another's roles, not only in terms of providing service, but also in the collaborative process itself (19). Experience suggests attention to the partnership in job roles can be stressed by developing 'linkage protocols' and ensuring that job descriptions have written expectations for individuals to participate in partnership activities (28). Being clear about the expertise of one's partners, with genuine inter-professional confidence and knowledge of when to call on each another's skills, is important in enhancing linkage. However, a partnership must not become reliant on individual relationships: basing a partnership too much upon one person can itself create strains (25). Further, staff retention

has been shown to have a significant impact on the success of a partnership (22, 25, 35). Given that staffing changes do inevitably occur, more distributive relationships between services can assist transition through staff changes and absences. Formalizing linkages with defined shared care protocols can help to sustain a partnership through staff changes.

Linkages may also be strengthened by basing staff within the partnering organization, a strategy that can bring significant insight into the environment and perspective of one's partner (32). In one project, having an Aboriginal staff member placed in a mainstream service allowed closer links to be created with the Aboriginal service, resulting in a project that had a higher profile in the wider Aboriginal community (36). Such a system also has important implications for improving referrals and triage processes for clients with multiple health needs.

Two-way learning

Cultural awareness describes a basic understanding of different cultural perspectives and approaches to particular situations and is the necessary foundation for developing practical skills in cultural security- the direct link between awareness of cultural difference and action (49). Further elaboration of the concepts of cultural awareness, safety and security has been provided by Thomson (50). Building the bi-cultural awareness of mainstream *and* Aboriginal partners must be considered as the foundation for a cross-cultural partnership. This requires an open negotiation of the different approaches and interpretations of health and culture that each service brings to the partnership (32,49).

However, while cultural awareness training for non-Aboriginal partners is important (particularly knowledge of the local community they are servicing) (33, 36, 38), with a high number of non-Aboriginal staff working within Aboriginal services, cultural awareness training must not be restricted to mainstream services. Similarly, the challenges facing many Aboriginal staff in terms of understanding the culture of the mainstream health system *itself* illustrates another layer of training that may be needed. Exploring joint cultural training programs between partners may strengthen two-way learning and assist the partnership to be founded in local (Aboriginal *and* mainstream) experiences and organizational values. Successful partnerships illustrate capacity building as a two-way process of skill sharing, with everyone having something to learn and teach (23, 48). Approaching partnerships as a

process of learning rather than a service structure is important to allow for service development (34) and creates possibilities for additional partners in the future (40).

Leadership

Australian reports identify that partnership success is characterized by effective communication, the nature of leadership at the senior management level (22) and mutually supportive management structures that receive ongoing focus (28). Strong organizational leadership with senior staff commitment has an important trickle-down effect on staff within the service to participate in the partnership (22). However, while a partnership relies on strength at the management level, it must also attend to the daily working environment (28). With burnout for health professionals and high staff turnover common in Aboriginal settings, management of staff stress and organizational support must remain firmly on the management agenda (37). Partnerships are demanding, and making commitments can result in increased pressure on staff if internal management support processes are weak or non-existent.

Community partnerships- involvement and engagement

An effective Aboriginal-mainstream service collaboration is as much about inter-agency relationships as it is about the clients and community. Building a partnership that has strong community linkages and visibility and is based on their articulated needs is a critical feature in the success of Aboriginal-mainstream partnerships (25, 31, 33, 36). Giving the partnership or service arrangement an Aboriginal name is also an important consideration (33, 38), helping to build community recognition and relationship to the service arrangement. In one partnership, a key moment occurred when the project was collaboratively given an Aboriginal name (30). Having a community 'launch' of the project as well as regular community forums have served as important ways to build and maintain relationships, while ensuring the partnership service is in alignment with community needs. It is important that mainstream partners do not rely on the Aboriginal partners for community linkages; rather active community engagement must be demonstrated from all angles. A partnership committee to oversee and build encouragement for the arrangement and keep the community engaged is strongly recommended (21).

Adequate resourcing and accountability

Partnerships built on unrealistic resource possibilities can create staff stress; have negative implications for client care, and contribute to a sense of broken commitment and promises. Having adequate resources is vital for Indigenous-mainstream partnerships (19). Recognizing the resources required for relationship building exercises and regular linkage development activities requires considerable foresight in investment. Consideration must also be given to resourcing developmental components of the partnership such as effective problem solving processes that require investment of time (25). Importantly, adequate and sustainable resources are also critical for building community engagement, enthusiasm and support.

Each partnership is unique

A recent Canadian study which explored lessons from an Indigenous -mainstream health service partnership proposed three 'domains', with supporting activities and investment that were needed to drive a successful collaboration (19):

1. Domain of need – unpacking community identified needs and reframing these for health service priority.
2. Domain of the organization – involving shared commitment and vision and sourcing of adequate resources to support the collaboration.
3. Domain of the individual – development of trusting relationships between individuals.

A key finding from this study was that as collaborations by nature are interactive, activity-based models cannot be linear. Thus, it is attention to the core relationships within a partnership and the factors to support this developing that are the most important contributors to success. Ultimately, as each collaboration manifests differently (26), it is imperative that the process is able to respond to the local context *as it emerges*. Building relationships by exposing people to one another and the situations they are working in may be one of the most important ingredients for success.

How do we know a partnership is working well?

Despite the inherent difficulties in measuring partnership success, experience suggests a lack of clear targets and evaluation can weaken a collaboration (22). Poor quality data and the resulting inability of managers to demonstrate the value of a partnership and secure ongoing funding have also been shown to severely disable a partnership (28). Clearly, while setting target priorities with quality data collection systems are necessary (22), evaluation is critical to communicate the value of a partnership both internally and externally (21, 28). Applying

both quantitative and qualitative approaches can ensure a more nuanced effective evaluation outcome. Evaluating an Indigenous-mainstream partnership using mixed methodology has been shown to help contextualize social colonial history and the contemporary move towards self-determination (21).

While measuring service outcomes may seem attractive, lessons from an Indigenous-mainstream partnership in New Zealand suggest focusing on outcomes rather than investigating organizational effectiveness can create limitations (21). It is perhaps for these reasons that the World Health Organization (WHO) supports measuring partnerships in terms of process and coordination, rather than product (8). A tiered evaluation approach where the client, the staff and the partnership itself are included as outcome measures may assist services to not only work more effectively together, but also build transparency and trust.

With Continuous Quality Improvement (CQI) an increasingly important aspect of reputable health service practice in Australia, developing tools that can assist services to measure the health of their partnerships in process may offer important input for CQI practices. Although no current process assessment tool exists specifically for Aboriginal and mainstream partnerships, a useful starting point for services may be to explore existing instruments-particularly those that are focused on enhancing the relational aspects of a partnership. The New York Partnership Self-Assessment Tool (PSAT) which has received acclaim for focus on partnership 'synergy' rather than product (51) is one possibility. Further, Lasker Weiss and Miller provide a useful framework for assessing partnerships by identifying the practical operational aspects of a partnership necessary to work synergistically (12). The VicHealth partnership analysis tool, which helps to reflect on health promotion activities within established partnerships, may also be useful for monitoring effectiveness of collaborations with multiple actors across different health settings (52). More recently, the Wilder Collaboration Factors Inventory developed by Mattesich et al uses the factors identified in their literature review to lead people to think about relationships with collaborating partners as well as in their own organisations (1).

System-wide shifts and alignment of the policy climate

Mattesich and colleagues' review highlighted the importance of a favorable and socio-politically supportive environment in a successful partnership (1). Since the December 2007 Council of Australian Government's (COAG) agreement and development of targets, the

reforms announced suggest the socio-political climate for Aboriginal-mainstream collaborative relationships may never have been better. The COAG Aboriginal Reform National Partnership Agreements focussing on deliverable primary health care services and improving the patient's journey highlight the attention that will be increasingly driven towards inter-agency service arrangements. Developing and supporting a workforce to deliver these reforms is also receiving concerted focus, with the professionalization of the Aboriginal staff a key component. As Fuller highlights, when partnerships align with the wider policy environment, there is greater potential for increased flow of resources to initiatives (28). The reforms and initiatives projected to be supported through the COAG agenda suggest that there may be greater opportunities for Aboriginal-mainstream health service partnerships to be more adequately resourced.

In a recent study, the reliance of mainstream on Aboriginal partners in their knowledge of community and how to communicate effectively, and a resulting deep respect was identified (9). Undoubtedly, an increasing movement for Aboriginal autonomy has seen Aboriginal health staff emerge as primary service providers (23). With the current Australian policy climate favoring Aboriginal-led initiatives, there may very well be a shift of power and an unprecedented opportunity for Aboriginal leadership in health service delivery.

Limitations

In the context of the history of Aboriginal-non-Aboriginal race relationships and the movement for Aboriginal community control of health service delivery, there are many partnership experiences –both successful and attempted - that will not have been documented. While parties involved in a successful partnership may not have thought to document their experiences, the response following an attempt at an ultimately unsuccessful Aboriginal-mainstream partnership is usually to move on and forget, rather than to interrogate the experience for future learning. In unsuccessful partnership ventures, frank disclosure may also be impossible and the learning's 'censored' for a variety of reasons - at least in terms of documenting the experience. Outcomes may be sanitized, with the true challenges unmentioned or glossed over. In such retrospective analyses, there is also the question of who writes about the experience - and in what position they sit. Assessments also generally reflect on the state of a partnership at a specific point in time, and given the potential fragility of partnerships, reported findings may not be sustained in the long term.

Conclusion

Strong partnerships between Aboriginal and mainstream services clearly offer multiple benefits for improving the capacity of health service delivery and can help to address the underlying determinants of Aboriginal health, improving financial and emotional costs to the wider community (22, 28, 39). Given the current environment which favors partnerships to deliver culturally appropriate health services and improve Aboriginal outcomes, it is propitious to understand the factors that support Aboriginal-mainstream collaboration.

Mattesich et al provide an extremely useful framework to guide collaborations, which offers important transferability to Aboriginal-mainstream partnerships (Figure 2). Further to this list, our study suggests that in terms of contributing to success, Aboriginal-mainstream partnerships must also consider developing trusting relationships over time; building a partnership based on needs that are community-identified; and committing to work through issues associated with different perspectives on health and service delivery. Particular attention needs to be taken of the historical legacy that overshadows Aboriginal/non-Aboriginal relationships in Australia, with careful attention to power sharing and reflective staff practices and opportunities to build relationships of trust with partners over time without the pressures of unrealistic and imposed funding cycles. Failure to do this may cause such partnerships to be unsuccessful, and consequently inflame a sensitive socio-political environment, polarizing the Aboriginal-mainstream service community. Such outcomes have negative ramifications, ultimately impacting on client choice and service. Aligning Aboriginal autonomy in health delivery through successful partnerships with mainstream services provides an important contribution to the wider movement for reconciliation (53, 54).

Competing Interests

There are no competing interests.

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Figure 1: Factors Affecting Effective Collaboration

Factors related to the **Environment**

- History of collaboration or cooperation in the community
- Collaborative group seen as a legitimate leader in the community
- Favorable political and social climate

Factors related to **Membership Characteristics**

- Mutual respect, understanding and trust
- Appropriate cross-section of members
- Members see collaboration as in their self-interest
- Ability to compromise

Factors related to **Process /Structure**

- Members share a stake in both process and outcome
- Multiple layers of participation
- Flexibility
- Development of clear roles and policy guidelines
- Adaptability
- Appropriate pace of development

Factors related to **Communication**

- Open and frequent communication
- Established informal relationships and communication links

Factors related to **Purpose**

- Concrete, attainable goals and objectives
- Shared vision
- Unique purpose

Factors related to **Resources**

- Sufficient funds, staff, materials, and time
- Skilled leadership

Source: Mattesich, Murray-Close & Monsey, 2001.

Research Question	Key themes identified *(listed in descending order of frequency)*
Benefits of Aboriginal - mainstream health service partnerships	• Builds cultural safety of mainstream staff & services, thus improving access for Aboriginal clients • Builds clinical capacity in Aboriginal staff • Broadens services available to Aboriginal people & capacity to deal with social determinants • Helps break down institutional racism
Challenges facing Aboriginal-mainstream health service partnerships	• Poor understanding of each others' roles & resulting lack of confidence in partners • Emphasis of mainstream 'time-line' projects incompatible with Aboriginal preferences for developing trusting relationships slowly • Not having adequate resources to support the arrangement • Determining objectives & measuring success within the partnership when operating with different understandings of health & culture • Staff continuity and turnover • Devoting insufficient attention on core relational process • Historical legacy causing Aboriginal mistrust of mainstream service providers • Poor linkage structures at the level of service delivery & poor understanding of the partnership process • Aboriginal staff balancing demands of responding to community with clinical/training requirements • Traditional leadership role and control of mainstream service having to change to supportive role • Paying insufficient attention to developing clinical skills of Aboriginal health staff • Differences in pay, training and position between mainstream and Aboriginal staff • Internal politics of Aboriginal organizations • Aboriginal staff not having a detailed understanding of the whole health system
Improving partnerships between Aboriginal and mainstream health services: what has been learnt?	• Ensure partnership services are developed in response to needs articulated by the Aboriginal community • Honor Aboriginal ways of building relationships and allowing development of trust over time • Ensure meetings are held regularly & staff have opportunity to interact & build relationships • Need for motivated individuals (partnership champions), commitment of senior staff, leadership & vision • Ensure there is equal participation in planning & power

	sharing • Give the partnership service an Aboriginal name & ensure there are suitable promotion/ materials • Position staff at partner organization (staff exchanges) • Develop linkage processes, including formal documentation of partnership service structure; clarification of roles & clear lines of who troubleshoots • Use a facilitator to openly negotiate historical baggage & different approaches to health/ culture. Have a commitment to work through issues using problem solving processes • Ensure partnership is built on realistic resource capacity to support development of partnership and execution • Be consistent with meetings; use innovative communication technologies where necessary to maintain contact • Set targets, develop reliable data collection to simple monitoring and outcome indicators • Dedicate time for a development period to build mutually respectful relationships • Ensure the project that is visible to local community & get them engaged • Ensure non-Aboriginal staff have cultural awareness training & Aboriginal staff have opportunities for professional development • Use innovative power sharing methods, such as changes in chairing of meetings, place of meetings etc

Table 2. Collation of key themes