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Factors shaping intersectoral action in primary health care services

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Abstract

Objective: To examine case studies of good practice in intersectoral action for health as one part of evaluating comprehensive primary health care in six sites in South Australia and the Northern Territory.

Methods: Interviews with primary health care workers, collaborating agency staff, and service users (Total N=33); augmented by relevant documents from the services and collaborating partners.

Results: The value of intersectoral action for health and the importance of partner relationships to primary health care services were both strongly endorsed. Factors facilitating intersectoral action included sufficient human and financial resources, diverse backgrounds and skills, and the personal rewards that sustain commitment. Key constraining factors were financial and time limitations and a political and policy context which has become less supportive of intersectoral action; including changes to primary health care.

Conclusions: While intersectoral action is an effective way for primary health care services to address social determinants of health, commitment to social justice and to adopting a social view of health are constrained by a broader health service now largely reinforcing a biomedical model.

Implications: Effective organisational practices and policies are needed to address social determinants of health in primary health care and to provide a supportive context for workers engaging in intersectoral action.

Introduction

The complexity of social determinants of health (SDH) makes it impossible for the health sector alone to address these. It must collaborate with other government sectors, non-government organisations (NGOs) and society to address the factors that influence health and well-being. Primary health care (PHC) is an important part of the health system and is well placed to advance intersectoral action for health at a local level. The term intersectoral action for health (IAH) is used to capture such collaboration, and is defined as:

> *a recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or*

intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone. (4)

The terms collaborative action, IAH and intersectoral collaboration are often used synonymously, with intersectoral collaboration described as 'the joint *action* [emphasis added] among health and other groups to improve health outcomes'. (7) Health promotion work is described as using 'an intersectoral and collaborative approach to develop or advocate for healthy public policy'. (8) This paper will use the term most appropriate to related literature context, and IAH elsewhere to maintain consistency.

An extensive literature on IAH and intersectoral collaboration spans description of local projects and analysis of the relationships between health and economic and social development, (8, 11) with global health reports contextualising IAH across a broad spectrum of approaches (see Box 1).

Box 1: Intersectoral Action for Health (IAH)

Intersectoral Action for Health (IAH) is:
- described as enabling healthy public policy in the Ottawa Charter for Health Promotion (1)
- an important component of the Global Strategy for Health For All by the Year 2000 (2)
- a component of the 2006 Health in All Policies (HiAP)directive (3)
- reflected in the South Australian Health in All Policies approach (5, 6)
- part of the Helsinki Declaration on HiAP (2013)(9)
- implicit within the UN Millennium Development Goals. (10)

One definition of collaboration is:

…a mutually beneficial and well-defined relationship entered into by two or more organisations to achieve common goals… (12)

Gray, however, states that common goals are insufficient, as much lower-level and less resource intense, or time-limited 'cooperation', may suffice for achieving these: (13) and that collaboration

should be reserved to describe instances of time and resource-intensive efforts on problems for which no one sector alone has the mandate or capacities to resolve.

There is some evidence that collaboration on health issues can lead to 'positive intermediate changes in people's knowledge, attitudes, behaviour, and the environment'. (14 p 5) Focusing on health improvements alone without measuring these intermediate outcomes understates collaborative effectiveness. (15, 16) Collaboration can lead to increased access to resources, shared risk, efficiency, and shared learning; underpinned by a pragmatic imperative. This is recognising that collaborations can tackle issues that would otherwise not be addressed. (17) Collaboration produces a *synergy* in which combining the skills, resources and perspectives of a group of people or organisations can lead to greater actions than the sum of the members' individual efforts. (18) This particular feature is hypothesised as the means by which collaborations gain an advantage over acting alone.

Although improvements in indicators of population-level health and social determinants would be the best measures of collaborative effectiveness, these outcomes are hard to measure due to often incomplete implementation, design issues, time taken to detect changes, and difficulties in attribution. (19) Research has found that successful intersectoral collaboration is also facilitated by clear agreement on outcomes, and getting early 'runs on the board'. (20) Effective intersectoral action relies on the capacity to devote meaningful resources to a project, (21) and partners appreciating others' perspectives while also feeling that their needs are being met through the relationship. (22) Collaborators need common or converging values and objectives, or acceptable trade-offs if faced with unavoidable and conflicting interests. (23)

The literature on potential barriers to collaboration suggests that these include political differences, financial constraints, organisational rigidities, professional rivalries and contested planning priorities. (24) Different organisational histories and foci are others, based on formal structures, organisational cultures, professional attitudes and behaviours, (25) and the difficulties of shared decision-making and power. (26) Political leaders are critical for driving and sustaining IAH, as most collaborations address political issues. (27) Broader structural challenges affecting IAH lie in dominant neoliberal economic and political theories that have led to reduced public funding, greater labour market insecurity, increasing privatisation of public goods and services, and an ideology of individualism and

personal responsibility. Increased sectoral competition for reduced levels of public financing and a dominant discourse of individualism and entrepreneurial competition constrain IAH.

Objectives

There is little documentation in Australia or overseas on how IAH on health determinants operates through PHC services which are those functions of health systems that aim to provide:

> …socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. (28)

One of few studies evaluating good practice in PHC concluded that intersectoral collaboration was one of eight broad strategies which appeared to have contributed to positive outcomes in the cases studied. (29).This paper sets out to augment the literature and answer the research question: What factors facilitate and constrain IAH in PHC services?

Methods

This research was part of a five year NHMRC project (2009-2013) to evaluate the effectiveness of comprehensive PHC at six PHC sites – five in South Australia and one in the Northern Territory. These included an Aboriginal community controlled organisation, Central Australian Aboriginal Congress, a non-government agency, the Sexual Health information networking and education SA Inc (SHine SA), and four South Australian state government managed services anonymised as Services A, C, D, and E (30). Service B withdrew from the study prior to the research reported here and was replaced by Service E. Such turnover was expected as the project spanned five years at a time of considerable change and reorganisation of PHC within Australia. Service labels were maintained for consistency across the project research papers.

The research employed a wide range of quantitative and qualitative methods and data sources. This paper reports on one element: descriptive case studies of IAH. Purposeful sampling (31) identified examples of good practice from participating sites concerning collaborations with sectors other than health that addressed one or more social determinants. Services submitted suggestions, and the

final focus was decided jointly by participating sites and the research team, based on potential richness of data and feasibility. The case studies examined how and why IAH was taken, and the outcomes and benefits as well as challenges and barriers. Services and collaborating partners provided relevant supporting documentation, including annual and other reports, policy documents, media releases and promotional material to help comprehend the context, actions and partners. Between four and seven semi-structured informant interviews were undertaken for each case study (total N = 33), including PHC workers (n= 13), NGOs, local and state government collaborating partners (n=13) and service users (n=7). Informants were identified by the research team, the PHC services and collaborating partners. Ethics approval was granted by the Southern Adelaide Clinical, SA Health, the Aboriginal Health (South Australian) Human Research, and Department for Education and Child Development Ethics Committees.

Interview schedules were developed by the research team and piloted on a PHC worker. An abridged schedule was developed for community members and service users. Interviews were conducted at participants' worksites between August 2012 and March 2013, and were audio-taped, transcribed and de-identified. Thematic analysis was employed using Nvivo 10 software, with codes and themes discussed and refined by team members, and findings fed back to participants. This paper draws on the interviews and document analysis to examine the role of intersectoral work within PHC services.

Results

The IAH focus / goal of each service, the PHC service, collaborating partners, and overview of findings from each case study are included in Table 1. Overall key findings that follow include universal endorsement of IAH as beneficial to partners, the importance of partner relationships to PHC services, and the factors facilitating and constraining IAH, contextualised by each study.

Insert Table 1 here

Endorsing an IAH approach

Respondents unanimously endorsed IAH as a comprehensive approach to address health and social issues, with broad consensus that the work could not have been undertaken by the PHC service alone. Respondents' positive views were explained in terms of the greater capacity IAH creates to influence governments, that it enables the use of wide expertise and evidence, strengthens

advocacy, avoids duplication, builds relationships, and pools resources. Other perceived benefits included improving the efficacy of working with a shared client group, fostering community engagement, and promoting community strengths. Interview participants believed that IAH has led to some positive program outcomes as noted in Table 1; for example, increasing the number of schools adopting sexual health and relationships education within target areas (SHine SA); operationalising a new Aboriginal Learning Centre offering culturally specific resources and courses (Service D); and empowering women leaving violent relationships, facilitated by community based approaches (Service E). One PHC worker in the living skills collaboration stated that when groups and organisations work in isolation:

> They are all falling over one another in one respect while the people [mutual clients] remain completely impoverished.

A Central Australian Aboriginal Congress worker and member of the alcohol coalition stated that IAH facilitates:

> stronger advocacy, more depth to the coalition, better information, better knowledge, more networks, more capacity, more capability... That really, in my experience, it's the best way to achieve social change and policy change.

Partner relationships

Another key finding was the importance of partner relationships to PHC services; how they potentially enable and constrain IAH, and are affected by organisational policies and practices. Establishing positive working relationships was described as a means to IAH and also as important to future work by laying the groundwork for effective future action. Consistent with the literature respondents stated that successful collaboration relies on partners feeling that their needs are met through their relationships; and that this is fostered by the shared values needed for promoting PHC aims, and by expending the necessary time and effort. Building strong inter-organisational relationships allows collaborations to survive even if individual workers change, with strong inter-personal relationships also important:

> Because we have good [personal] relationships we know we're still going to get along regardless of the issue... we work together and we know each other and we're going to get past it anyway, whatever barrier it might be. (collaborating partner, domestic violence network)

Challenges to partner relationships included dealing with legislative and contractual constraints, the potential for personality conflicts, differing agendas, unreal expectations, and negotiating different models of care:

> …[there are] people who are working from a medical model versus people who are working from a development model - there have been differences of opinion over time about how we provide what we do, the different frameworks that we work out of, depending on the organisation you're working with, so there have been challenges along the way. (collaborating partner, Supported Residential Facilities collaboration)

A partner in the living skills collaboration stated that strong partner relationships benefitted the PHC service by allowing more than a biomedical approach:

> In terms of health what it does offer is those community development activities and preventative activity that health can't actually fund itself any more, and so I think in that sense it's a really great partnership because you have health often doing chronic disease management but then you have another service which is on site and offering the components that we know interact with that.

A PHC worker in the domestic violence network highlighted how important relationships are within the PHC service context:

> You have to build relationships with people and to me that's one of the main ways that doing community based and collaborative work really links in with doing individual work. It's that both of them are really underpinned by good relationships.

A common thread across the different initiatives was:

> It's always about the three 'Rs', relationships, relationships, relationships… If you haven't got a good relationship you're not going to have good outcome. (collaborating partner, Supported Residential Facilities collaboration)

While partner relationships were understood as critical to IAH within PHC services, other important facilitating and impeding factors were identified.

Factors facilitating IAH

Major factors facilitating and sustaining IAH were having sufficient human and financial resources, accessing diverse backgrounds and skills, and getting a 'payoff' for effort; including from early rewards. Others were management support to attend meetings, having formal and transparent accountability structures including reference groups, steering committees, a facilitating Memorandum of Understanding, policies and procedures, program logic models, regular meetings, and new information technologies. Respondents also noted personal factors enabling IAH with the

PHC context, including shared values, passion for and commitment to the issue or people affected by it, reciprocation amongst partners, and engagement in reflexive practice: that is thinking about and analysing decision-making by drawing on theory and relating it to practice.

Human and financial resources

Organisational commitment to human and financial resources was critical to IAH, bolstered by the collaborative advantage of the synergy effect of working as a group. Human resources were considered necessary for functional capacity. While financial sufficiency is critical to IAH, some achievements can be made with limited financial outlay. As a PHC worker in the domestic violence network claimed, *'especially with community based work, you can do a great deal on not very much money as long as you've got the staff to do it'*. Both resource sufficiency and funding context are important. One Central Australian Aboriginal Congress worker, speaking about the alcohol coalition, argued that sourcing independent funding from charitable donations and small non-government grants facilitates greater autonomy over strategic IAH directions when political advocacy for policy change is the collaborative focus:

> *… we're not beholden to funding bodies…the little bit of money we've got is not from government and we're not constrained. The members aren't constrained in their views…*

Diverse backgrounds and skills

Diversity in backgrounds and skills of individuals from collaborating organisations was regarded as a key advantage to IAH. These enabled the collaborators in the different studies to address health more comprehensively. A Central Australian Aboriginal Congress worker explained that diversity provides a broad knowledge base drawing on multifaceted evidence and sources to assist in analysing wide-ranging and often complex information and legislation, developing strategies, and accessing a wider range of networks and opportunities:

> *We've had lawyers and the legal fraternity and we've had doctors and we've had religious people. People have got different skills, different power, different ways of understanding the problem, different ideas about how to solve the problem, but also different networks…and also different opportunities to get donations and money.*

No specific skills were prioritised across the different IAH initiatives; instead the value of diversity was context-specific. For example, a key collaborator's program management skills were critical for developing the Aboriginal Learning Centre in concert with the Aboriginal Health Teams and others.

Cooking skills, including practical demonstrations using ingredients sourced from the co-located vegetable garden, were an important component of the living skills collaboration. One respondent, a service user and volunteer in this garden and a member of a newly emerging community group that was one of the collaborative partners, engaged with the initiative to address negative health impacts from dietary changes since arriving in Australia:

> *… the food we used here got us problem like to be fat. She [his wife] was here to help the problem of cholesterol…*

Another important skill was interpreting provided by a senior member of this community group. A PHC worker explained how critical this was for both the PHC service and the broader IAH initiative:

> *… the man [interpreter] who had quite a senior role in the [Eastern African] Government prior to the war said "It's good that people have had the opportunity to talk about their experiences here because these people had very many difficult things happen in their lives"… I think for all of us that were sitting in that room that day it was a major education in what it means to be a refugee.*

A link was also made between access to diverse skills and the ability to adopt the evidence-based approach necessary to *'being able to dispel some of the myths and get people thinking about real solutions'* (PHC worker, Central Australian Aboriginal Congress). A collaborating partner in the domestic violence network contextualised the need to draw upon a PHC service's evidence-based knowledge to help evaluate:

> *What was the work we did? how do we know that it's effective?…how do we know that the resource that we're using now will make a difference?... One of the things domestic violence services tend to be is to remain a crisis end…It's the combination of skills that makes this network very rich.*

Two IAH initiatives had also called upon external skills to enhance their goals: decisions that may be understood as strategically expanding the immediate collaborative context for either the shorter or longer term. One was the PHC service in the living skills initiative that worked with SA Police and local residents on a 'one off' targeted campaign to improve street amenity. By accessing gardening tools, lawnmowers and other implements from the PHC service's community tool library, police and local residents worked together in ways that facilitated community development, helped mediate existing tensions, and greatly reduced the number of police call-outs for anti-social behaviour. Another example was a social inclusion program within the Supported Residential Facilities collaboration. Linking up with a well-known interstate street choir comprising homeless and disadvantaged people fostered an award-winning local community-based choir including residents from Supported Residential Facilities. As a collaborating partner explained:

I can't remember how we got connected with [the choirmaster]…that goes back a way. [The local choir] sang at his government reception… So we kind of have connections with him and then he came out doing workshops for people, vulnerable people, and he always invites our guys along, so we've formed a collaboration with him as well.

Getting a 'payoff'

Consistent with the literature on the importance of gaining early 'runs on the board' (20) to help sustain IAH, a PHC worker in the domestic violence network contended:

I think it is really important to do things that you can see will be effective fairly quickly… so not having things that are so long-term that you can't enjoy as you go along. You need to do things that you can see the impact, you can see that relationships are building, you can see that community members are benefitting, you can see that changes are happening.

Early rewards for the Aboriginal Learning Centre collaboration were the successful recruitment of, and positive feedback from, service users and the training providers for initial short courses; including first aid, defensive driving and personal development. Success in this start-up phase was critical to increasing the participation of Aboriginal people studying for health-related careers under a planned expansion of the IAH initiative involving government, non-government and tertiary education sectors.

Getting a 'payoff' for another initiative followed long-term negotiations with a major hospital to use a tailored patient discharge form including critical information necessary to assist vulnerable clients returning to private Supported Residential Facilities that offer varying levels of support:

We've been gradually getting that payoff with the hospital transfer form… the next step will be looking at using it for all contact with the acute sector from the SRF and then letting others know about it. (PHC worker, Supported Residential Facility collaboration)

For another respondent IAH was facilitated by the reward of positive change:

People get involved, see change happening as a result of the work we do and that's its own reward. People want to stay involved then because they see that it is working. (PHC worker, alcohol coalition)

Factors constraining IAH

Key factors impeding IAH were funding and time constraints and the impact of governments through the wider political and policy context; especially through ongoing reviews of the health sector and

changes to PHC. Other challenges specific to collaborative context included negotiating different models of care under contractual and legislative constraints (Supported Residential Facilities collaboration), and office space restrictions that hindered activity levels (living skills collaboration). Workplace restructuring and staff turnover in partner agencies, and difficulties associated with ideological blockers imposed by conservative political and community forces opposed to provision of sexual health and relationships education (sexual health collaboration); and the potential to feel overwhelmed by the enormity of the problems faced (alcohol coalition) were other challenges.

Financial and time constraints

A common theme was funding and associated time constraints, including the limitations of short-term employment contracts, and short-term and inflexible forms of funding or 'one off' grants. These constraining factors all impact negatively on the duration and/or scope of IAH, or discretion over how best to direct available funds. Respondents noted that this is especially likely in PHC services; citing long waiting lists and curative demands. There are also implications for trust and community engagement and constraints to collaborative vision when programs are curtailed or stopped. One respondent highlighted constraints to the living skills initiative within a climate of austerity and uncertainty. This program had been developed under a patchwork of government and non-government funding augmented by public donations, as well as short-term Federal Government funding (about to expire) for a part-time co-ordinator located at a partner agency. A PHC worker reflected on the need to focus on providing training in the community for usable and transferable skills under this program, and to commit to an appropriate level of funding, but noted financial limitations:

> We set up a program but there's no money in it. So [named partner] hasn't got any money to contribute to it. Our service won't contribute any money to it and that would be one of my criticisms is we're establishing this fantastic intersectoral collaboration but actually we're not putting our money where our mouth is.

The importance of, but constraints to, sustainability for IAH was highlighted by a partner in the Supported Residential Facilities collaboration:

> Other agencies we've been working with and the health sector have got very short-term contracts [and] the funding goes, the person goes, and the project just falls in a hole.

Informants' responses often noted that collaborative action was sustained despite the reality of financial constraints. As a community development worker in the alcohol coalition explained:

> *[The alcohol coalition] hasn't had any sort of regular funding which must be frustrating … in that they don't know just where long-term funding is going to come from. I think [the coalition] does remarkably well on the small amount of money that they do get.*

Another informant stated:

> *I could stretch and be creative with the small amount of money which is what you have to do in the community sector so often.* (community development worker Supported Residential Facilities collaboration)

Wider political and policy context

Respondents highlighted how governments influence IAH initiatives through the wider political and policy context. One noted the shift to a more populist approach to dealing with alcohol-related issues following a change of Northern Territory Government; citing negative outcomes from winding back earlier reforms including a Banned Drinkers Register and a 'Smart Court' that sanctioned non-custodial penalties:

> *At the moment we are in a tricky position where the government is winding back measures before they are evaluated. They're taking a more populist approach to alcohol. So trying to please the masses rather than using the evidence to make their decisions.* (collaborating partner, alcohol coalition)

A consistent theme across the government-managed PHC services was the impact of restructuring and reviews of the roles of PHC services. A social view of health embedded in a social justice framework appears to now be a more contested paradigm. While workplace strategic plans or job descriptions still acknowledge comprehensive PHC objectives, respondents stated that in reality work is becoming more prescriptive. For example, short courses focused on lifestyle issues are replacing longer-term objectives for community engagement. Respondents also spoke of the burden of accountability structures, including key performance indicators under which benefits of community development work and IAH within PHC are hard to demonstrate and measure. Structural changes and the changing face of PHC limit the ability to address health determinants. As a PHC worker explained:

> *Now it's about managing, managing staff and making sure risk is looked into, plans are done and stats are done after. If you went for a job years ago you'd have to know about primary health care and mediating, and advocating, and the Ottawa Charter. They would not be brought up these days.* *(asked for service anonymity)

The changing ethos within PHC was noted by workers from both government-funded and independent PHC services. A PHC worker in the Supported Residential Facilities collaboration argued:

> They're so focussed on the individual that I think we've almost forgotten that they actually sit within the community and wider structures.

A Central Australian Aboriginal Congress worker in the alcohol coalition stated:

> In our own sector there's been a loss of the understanding that comprehensive primary health care… is not just about treating sick people and making them well, it's about advocacy to address the underlying determinants of health and there's too many people coming to work doing the immediate things …

While respondents in the different initiatives articulated a range of constraints to IAH, this worker argued that it is important to commit to addressing social determinants despite the changing PHC service environment:

> People say they're too busy running their services, well I think you've got to find time; people have got to find ways of making time for this work.

Discussion

Overall this research revealed unanimous endorsement of IAH, (29, 32) citing a range of outcomes supporting PHC aims. It reiterated how important partner relationships and getting 'runs on the board' were to sustaining commitment to IAH from a PHC lens. (20)It showed how collaborators' diverse backgrounds and skills enabled IAH within a range of PHC contexts. It also highlighted the significant challenges and barriers to IAH due to the scope of resource limitations; especially time and financial constraints that often reflected a changing political and policy context.

This research contributed to a better understanding of factors facilitating and constraining IAH within PHC by including the views of both PHC workers and co-collaborators across six different IAH contexts. These initiatives were mainly based on interpersonal links with limited organisational support, which contrasts with another example of intersectoral action in South Australia, the Health in All Policies initiative which receives institutional support from both the Department of Premier and Cabinet and SA Health. (5) Both the Supported Residential Facilities and Sexual Health initiatives were underpinned by the requirements of a Memorandum of Administrative Agreement with the Department for Communities and Social Inclusion and a Memorandum of Understanding with the

Department of Education and Children's Services respectively. Respondents found that, depending on the initiative, these contractual structures could be either enabling or constraining.

While all of the cases addressed important social determinants of health the ability of the actors to do so was affected by their different organisational contexts. The two services with independent boards of management, SHine SA and Central Australian Aboriginal Congress, were part of a broader advocacy movement for comprehensive PHC. In contrast, workers in state-managed services were taking IAH within less supportive organisational environment, and the constraints to their political agency from their role as public servants had increased as the priorities of the Department of Health had shifted away from health promotion.(30) This research offers a largely historical review as health promotion work has recently largely been removed from South Australian health services.

Implications

Implications are the need for effective organisational and policy support, including an enabling management environment that allows workers greater scope to act on social determinants. (30, 33). While respondents in the different initiatives cited a range of champions who inspired commitment, relying on interpersonal relationships alone is unlikely to be sustainable. There is an imperative for all sectors to take a longer-term outlook on health; one that views IAH as an investment rather than a cost. (34) Even though supportive environments for planning and implementing policies and programs are important, attempts to address health inequities still experience some success even within less stable and facilitative environments. (34) Contextual factors throw up obstacles but can also stimulate innovative opportunities. (34) A further implication is therefore the need to engage in reflexive practice; (35)especially for identifying and acting upon opportunities for IAH at the interpersonal level within a PHC context under prevailing policy constraints.

Conclusion

While respondents universally endorsed IAH as an effective way for PHC services to address social determinants, the commitment to social justice and to adopting a social view of health underpinning comprehensive PHC is being constrained by a broader health service now largely reinforcing a biomedical model. The space to act on social determinants is narrowing in state-managed services, with current priorities suggesting a blunting of earlier promoted aims. (36) (37) Individual clinical

work appears to be prioritised over more collaborative activities within health services that had forged historical partnerships outside the health sector.

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Table 1: Focus of IAH

Short title	IAH context and goal	Collaborating partners and service users interviewed	Positive outcomes and negative factors
Alcohol coalition (Central Australian Aboriginal Congress)	Addressing negative alcohol impacts on Aboriginal people through organisations forming an alcohol action coalition	Six collaborating partners: • three Central Australian Aboriginal Congress workers • staff member of alcohol coalition • Central Land Council member • community member	**Positive outcomes** • Correlation between declining alcohol consumption, declining need for ICU beds for alcohol-related disease and hospital admissions for violence-related injuries • Achieving a floor price on alcohol • Achieving positive high public profile **Negative factors** • Impact of new Northern Territory Government's alcohol policies • Potential for feeling overwhelmed by the problem • Potential for victim blaming • Need for greater focus on social determinants
Sexual health collaboration (SHine SA)	Supporting sexual health and relationships education in Focus Schools and 'Closing the Gap' in Aboriginal Focus Schools: a collaboration between SHine SA, Department of Education and Child Development (DECD) and teaching staff	Five collaborating partners: • three SHine SA workers • DECD worker • former departmental worker (Teaching staff were invited to participate but none accepted)	**Positive outcomes** • High uptake of Focus Schools program • Benefits to DECD from SHine SA's expertise • Maintaining SHine SA's credibility and legitimacy under historical ideological and political constraints • Invitation for SHine SA to contribute to an undergraduate teacher training curriculum • SHine SA's ability to meet changing community needs

			Negative factors • Time and workload constraints • Workplace restructuring and staff turnover in partner agencies • Potential for ideological blockers • Potential strain on Aboriginal Focus Schools
Living skills collaboration (Service A)	Supporting disadvantaged people through a collaboration between the PHC service, local government, an NGO, the housing sector, and an association representing a newly emerging migrant community	Seven collaborating partners and service users: • PHC worker • local government community development worker • NGO community development worker • housing worker • three NGO service users	**Positive outcomes** • Recruitment of volunteers • Increased community engagement • Improved literacy and financial planning skills • Strengthened partner relationships **Negative factors** • Precarious funding for part-time coordinator position • Limitations of short-term program funding • Insecure accommodation and space restrictions • Concerns over changes to PHC
Supported Residential Facilities collaboration (Service C)	Assisting vulnerable clients with high and complex needs in Supported Residential Facilities: a collaboration between the PHC service, local and state governments and NGOs	Four collaborating partners: • two PHC workers • state government worker • local government community development worker	**Positive outcomes** • Linking vulnerable people back into the community through a community based choir • Progress on an obesity project and a hospital discharge plan • Demand for social work student placements in a collaborating agency **Negative factors**

			• Changing face of PHC • Negotiating different care models (developmental vs medical) • Contractual and legislative constraints • Negotiating within a private for-profit service model • Short-term funding
Aboriginal Learning Centre collaboration (Service D)	Supporting Aboriginal education and employment through tailored programs, services and service providers at an Aboriginal Learning Centre co-located with a PHC service	Six collaborating partners and service users: • two PHC program workers • Aboriginal health agency worker • three service users	**Positive outcomes** • Operationalising a new Aboriginal Learning Centre with expansion plans **Negative factors** • Funding threats under the Review of Non-Hospital Based Services • Cumulative legacy of ongoing health service reviews • Difficulties in attaining consensus on needs of Aboriginal people
Domestic violence network (Service E)	Supporting women and children experiencing domestic violence through community-based approaches: a collaboration between the PHC service, local government and a domestic violence service	Five collaborating partners: • Two PHC workers • Two local government community development workers • Domestic violence agency worker	**Positive outcomes** • Increased confidence and creativity in women who have experienced domestic violence • Less demand for medical attention • Improved relationships between women and their children • Collaborators' successful joint grant application for community capacity building • Links forged with housing services **Negative factors** • Lack of resources and inflexible funding

			- Time constraints due to increased focus on clinical work - Tension between collaborating partners' aims to assist women and children, and lack of practical pathways outside the role of dedicated services