

# Consulting in remote Indigenous health—how effective is it?

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## Abstract

There are many reasons why organisations and groups employ external consultants. The major two reasons are that the organisation wants a specific task done and doesn't have the capacity to do it, or the organisation doesn't know what it wants and needs someone to assist them with a process of clarification and progression. There are a small number of consultants in Australia who specifically consult on rural and remote health workforce education, evaluation and service planning. Our various reports often contain numerous well intentioned recommendations and strategies to progress these issues. This collaborative paper will examine the key activity of consultation with consumers and communities by reflecting through the lens of a number of these consultants. It will explore the issues of consulting with remote and Indigenous groups to achieve successful outcomes. The paper will address: (i) the complexities of the 'outsider' consulting with Indigenous groups and how one seeks effective engagement, establishes trust and avoids 'consultation exhaustion'; and (ii) how to overcome the barriers to successful consultation processes.

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I would like to acknowledge the traditional owners of the land that we stand on here today, the land where I did most of my own growing up as a child and where my family still live today. I would like to thank the elders and the peoples of this land for their enduring patience as we work through the great health challenges that they face daily.

This paper is a little different from the other papers you will hear at this conference this week. It is not a paper based on any great theory from someone else. It is not a paper that uses a PowerPoint presentation to demonstrate the great ways in which we do things. It is also not a paper that provides you with any answers at all really. It is more a reflective piece about how we do things as three consultants who work extensively in remote and rural communities throughout Australia in the provision of independent consulting services to health departments, universities, Aboriginal community controlled health organisations, government, non government and not for profit organisations.

So consulting in remote Indigenous health—How effective is it? I suppose we could have written a one liner saying—not very, probably, but do we really know?

In this paper today you are going to hear from three of us who often work together. First I am going to talk to you about the experiences I have had in consulting about remote Indigenous health as someone who runs their own consulting company, imaginatively named RhED Consulting, where in the past 5 years I have conducted around 35 consultancies and where about half of my work has been in the Northern Territory, where I also lived for 11 years in the '80s. I largely provide consulting services to develop education programs to help prepare health professionals to work in remote and Indigenous communities; and I evaluate programs and organisations to assist them to improve. In this paper I will reflect about the challenges that we often face as 'outsiders' coming in, with our often brutal timelines set by someone else

based our white ways of thinking and doing. I will then discuss some principles that I developed with two Indigenous academics to assist students and health professionals to work more effectively with Aboriginal and Torres Strait Islander peoples.

I will then introduce you to Dr Kristine Battye. Kris also has her own national consulting business, unimaginatively named Kristine Battye Consulting. Now while Kris started her life as an 'Aggie' as she would call herself, which involved doing terrible things to sheep's ovaries, today she is a very well respected health services planner who also works nationally and like me does a lot of work in the northern Australia. Kris is quite famous for the North West Queensland Primary Health Care model that she developed for allied health professionals, which has resulted in one of the best rural and remote workforce retention rates in the country. Kris is going to provide some examples of consulting in remote Indigenous communities and her reflections and learning's that result.

I will also introduce Dr Louise Loufeil who is a psychologist consultant who works with Kris in her consulting business; and yes, I admit, has been known to occasionally provide us both with some free counselling. Louise is one of those people with the most enormous capacity for work, she is also a fantastic and fast writer, and one of the best listeners I have ever met. Louise has contributed to this paper and our thinking around it.


Let me tell you two stories. The stories are the same but they are seen through 2 different lenses—a black lens and a white lens—hence they provide a different picture and a different perspective of the same situation.

## White lens

When consulting for governments and service providers there are particular challenges that we face as consultant. And it always pays, I think, to identify why it is that this group has employed a consultant in the first place? Usually I find that there are two major reasons. The first is that the organisation wants a specific task done and doesn't have the capacity to do it, or secondly, that the organisation doesn't know what it wants and needs someone to assist them with a process of clarification and progression. Both of these reasons often result in a project with an unrealistic timeline, an unrealistic budget and a lack of information about the stakeholders that they want consulted. The remote Indigenous context adds another layer of complexity because the timeline, budget, terms of reference and stakeholders list is usually based on white expectations, contacts, reporting mechanisms.

We then enter into an agreement, based on these white ways of knowing and doing, and have to find our way through the system to endeavour to find and consult with the right people, do so in a respectful way that observes the required protocols for consulting with Aboriginal people, and then interpret the often conflicting and diverse information 'as it was intended' into a report with recommendations that reflects the needs of the people.

One of the things I am always very aware of when trying to consult with Aboriginal and Torres Strait Islander people, is what I term 'consultation exhaustion'. I have been in multiple situations where I am trying to find a representative for a committee, where there was an expectation that this person will speak with expertise about 'everything Aboriginal'; for all communities everywhere; and be happy to attend all meetings as the only Aboriginal person. And this person will operate like the rest of us on the committee, while they also fulfil the requirements of their own full time job and look after their family and the associated commitments in the meantime. If they don't turn up or respond to our urgent and of course extremely important emails, then that is their fault, not ours.



There are a limited number of Aboriginal people in Australia in total, and a limited number who do this type of work. So the pool to draw from is small. These busy people also often teach into the multitude of cultural awareness programs, are on every conceivable committee going, and they and their families also suffer the health statistics that we read and write about daily. Hence these reps are often younger or older and sicker than everyone else on the committee. I am ashamed to admit that I have developed remote Indigenous programs that had one or two Indigenous reps on them, who rarely attended the meetings, or had any input and then published the report. Yet I included their names on the list of members of the advisory group. I suppose I have done this because I know of the incredible demands on these peoples time, the different priorities they often have, and all for a piece of paper that may or may not have any impact on the health of the people, because it is about teaching the largely white workforce how to do its thing.

Respecting these priorities is critical for success. As consultants visiting remote communities we are also very aware of this when we might arrive to discuss 'our' important issue with the community and arrive on the 8am flight for a whole day and find that a funeral is going on, sorry business or the person we thought we had confirmed the meeting with via email, as we always do, was on the 9am flight going into town for another meeting. Our priorities are not the priorities of people living in remote Indigenous communities, most of whom don't have ready access to email or phone and who often suffer from consultation exhaustion, from 'another consultant' trying to rapidly find out their views. As someone once told me do you really think someone who is struggling to feed their kids, looking after their extended family, trying to keep their kids out of jail, while working at the women's refuge, really gives a shit about your bit of paper?

Alternatively when we ask who to contact regarding this particular issue in a remote community, we are often referred to the white person in the community, who will often 'speak for' the community despite the fact they may have only lived there a short time—this somehow gives them an immediate level of expertise about everything about the community.

## The black lens

I often think that consulting in remote Indigenous communities is a bit like playing that game of secret whispers...you know, when someone sends a message up the line and by the time it gets to the last person it has changed significantly.

So let's have a look through a different lens. 2007 saw the results of an extensive consultation process turned into a multi-million dollar government intervention that did not implement one of the 96 recommendations made in the report—*the little children are sacred report*. Last year I attended a seminar in Canberra, the most remote community in Australia, where Pat Anderson the co-author of the report spoke. She talked about her dismay and frustration at the end of a long consultation process. She said that the first recommendation was that all aspects of the implementation of the report should be done in partnership with Aboriginal people and that this was not done. She said 'mainstream Australia does not see Aboriginal expertise' and that Aboriginal people are not often 'intellectually engaged' in these processes. 'We are still in the demountable out the back when decisions are made and we can't get in' she said. Pat also said that there was nothing new in this report, nothing that has not been said before. So the example of secret whispers has once again hit a novice in the field, who was horrified by what he found. The novice in this instance happened to be the Minister, who reacted in the only way he knew how from his white framework for thinking and doing—bring in the police and the military. A prime example of how he did not know how to intellectually engage with Aboriginal people, respect, nor trust the processes that they wanted to put into place to deal with this issues and do so from their framework for thinking and doing.

One of the things I think we get wrong in our multitude of cultural awareness programs is the lack of understanding that we have about the differences in priorities of the two groups when it comes to the different hierarchical structures for decision making. In the white world we set up our list of key stakeholders—these are the king pins in an organisation or group, with whom we will consult. Through a remote Indigenous lens there is a different social and hierarchical structure where only certain groups or people can speak on behalf of the community. The king pins are the elders and community leaders, who most likely are not based at the health centre, certainly don't have email contact lists and whose agenda is most certainly not the same as the one that we were going there to consult with them about, so the standard questionnaire probably won't work. I would now like to ask Kris to provide us with a couple of examples from her own experiences where she will emphasise these issues.

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The consulting that I do is usually for the purpose of health service planning and service development. So the effectiveness of the consulting is probably best assessed in the outcome.

This afternoon I want to talk about some of the factors that I have found that can make consultation process, and the end result effective or not. There are a couple of projects that I will draw on to highlight these.

The first project is one that some of you will have heard me bang on about before. But I think it is an important project because it has had a very good outcome in terms of delivering primary health care services on a sustainable basis.

We are now seven years down the track since the establishment of the North West Queensland Allied Health Service, which is auspiced by North and Western Queensland Primary Health Care. In developing the service model to cater to both the Indigenous and non-Indigenous populations, there was extensive consultation across the communities of the North West. One of these communities is a remote Indigenous DOGIT community up in the Gulf of Carpentaria; others are predominantly small Aboriginal towns, as well as a couple of larger mixed townships and several pastoral communities out along the Flinders Highway.

I would also like to draw on some work recently undertaken in East Arnhem Land. From these two projects I can distil out about five key features that appear to be important to a good consultation outcome.

The first feature is that consultation is broad not only to cover the diversity of the communities, but also broader than just the health sector. So in the developing the North West Queensland Allied Health Service (which services the whole population) we talked with the white service providers in the health centres and hospitals, the schools, shires, Aboriginal corporations, child care services, aged care. We talked a lot with non-Indigenous community members that were identified through various strategies like the shire councillors, local Community groups, and people with kids with disabilities.

The second feature, which enabled the breadth of consultation with Aboriginal people across the North West, was the opportunity to work with an Aboriginal man, Frank Shepherd. Whilst Frank was not from the region he had strong connections to Mt Isa. We talked with local Aboriginal people, not only those working as health service providers, but also were able to work through the local health workers and Frank's connections to have some small and very effective community meetings.

In the East Arnhem project, we were able to have a very effective meeting on a Homeland to develop a very sophisticated governance model, by linking up with Laynhapuy Homelands Resource Centre who organised the meeting, and brought community members from other outstations to meet with us in



Gangan. We would never have had this opportunity to hear from people across the Homelands without their assistance.

So the second feature was the opportunity to work with and through someone with good connections into the Aboriginal communities.

The third key feature becomes pretty evident when we get into community meetings. We need to frame our questions and our discussions to the world view and experience of the people we are talking with—not your own. This doesn't apply only to consulting in Aboriginal communities; I think it is relevant across the board. It's a very good lesson for a brand new consultant to learn.

The fourth feature is about the role of the consultant and our responsibility to package the information we gather from the consultation process into language/ models that “work” for the communities *and* the health service managers, bureaucrats and funders.

Health service modelling and service development often requires re-engineering of the way services are currently provided (and may well have been provided that way for years) if we are seeking to improve access to, and utilisation of them by Aboriginal people. If we are serious about consultation, whether it's with Aboriginal people, people living in rural and remote communities, or people living in western Sydney, we have to listen to what is said and not dismiss it because it doesn't fit into our box about how services should be delivered, or because it doesn't “fit the guidelines”.

So the fourth feature is to foster the relationships and take advantage of the opportunity to walk the middle line to get a good outcome.

The fifth and final feature that became evident in the North West Queensland Project was the diligence that North West Queensland Primary Health Care exhibited in checking with communities that the service was being rolled out in a way that they would use them. This was initially undertaken prior to finalising the model and funding proposal where we invited key people that were identified to review our proposed model. We tweaked it a bit, and that was the model we put to the feds for funding.

This checking back with communities continued in the form of a community panel, which met initially quarterly and then half yearly over the first 3-4 years to continue to get community views about service change, expansion, what was working well, what could be done differently.

So I think the important message is that consulting in Indigenous health is more effective if it is not a once off but there is a mechanism for ongoing involvement in how things are done, which is what Community participation, community engagement, community control is all about. And this may well extend beyond the life of a consulting contract, but clearly something that is built into the service model.

## Summary

So how effective are we? And how do we measure our success? They ask us back but is that because we are great at what we do, or that we are the best of a limited number of a bad bunch. I suppose after 20ish years of doing this stuff all I can say is how little I feel I really know and how much I have to learn.

There is an old saying in remote—if you have seen one remote community then you have seen one remote community. This speaks of the enormous differences between these communities, which is emphasised in the very remote context. I believe to work effectively in this context we need to be able to stand back, listen, hear, we are not the expert in this context and we never will be, we need to be respectful of the different frameworks we work from, think from and understand. Critical is being able to do

this with an open heart and be prepared to laugh at ourselves, with Indigenous people who I have found are extraordinarily generous with their time and patience. I also think that we must remember that the people we are consulting with, and the families that they go home to every night, are living with the statistics that we recite daily. So we need to be cognisant of the impact that this may have on not only their day, but their lives. We however work for two masters so we must then try to translate the information that we are so privileged to be provided with into a report, while maintaining its integrity; and do so in the hope that it can in some small way contribute to improving the health of Aboriginal and Torres Strait Islander Australians.

Thank you and any questions.