

“Listen with your ears and eyes and heart and your minds and your soul”: Implications for decolonising consultation and occupational therapy from case studies on “Closing the Gap” policy implementation

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Abstract

Background: Including Aboriginal and Torres Strait Islander people and communities through consultation has been a key feature of policy implementation throughout the Australian Government’s “Closing the Gap” (CTG) strategy. However, consultation often reinforces power imbalances between government and local community and can undervalue or marginalise Indigenous knowledge and leadership. Occupational therapy has a short history of examining colonial power structures within the profession, but there has been limited progress to decolonise consultation and practice.

Methods: Drawing on decolonising research methodology and positioned at the interface of knowledge, comparative case studies were used to understand policy implementation in two regions. In Shepparton, Victoria, CTG policy was implemented predominately through an Aboriginal Community Controlled Health Organisation, and in Southern Adelaide, South Australia, CTG policy was implemented through mainstream state government and non-government providers in the absence of a local Aboriginal-controlled organisation. Findings were examined critically to identify implications for occupational therapy.

Results: Our case studies showed that policy stakeholders perceived consultation to be tokenistic and partnerships were viewed differently by Aboriginal and non-Indigenous participants. Participants identified the need to move beyond a rhetoric of “working with” Aboriginal and Torres Strait Islander people, to promote Aboriginal leadership and really listen to community so that policy can respond to local need. The findings of this research show that Aboriginal-controlled services are best positioned to conduct and respond to community consultation.

[Correction added on 6 June 2024, after first online publication: Affiliation has been removed from the third author.]

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Conclusion: A decolonising approach to consultation would shift the status quo in policy implementation in ways that realign power away from colonial structures towards collaboration with Indigenous leadership and the promotion of Aboriginal-controlled services. There are lessons for occupational therapy from this research on policy implementation on authentic, decolonised consultation as a key feature of policy implementation. Shifting power imbalances through prioritising Indigenous leadership and honouring what is shared can drive change in CTG policy implementation processes and outcomes.

PLAIN LANGUAGE SUMMARY

Aboriginal and Torres Strait Islander people are often asked to give advice or share ideas on how health and education services are provided to community. We asked people in Southern Adelaide what this was like when the Closing the Gap strategy was first introduced in the region. People explained that Aboriginal leaders were not really listened to, and even when there are meant to be partnerships, it often does not work out as planned. There are lessons we can take from this for occupational therapy so that we stop making the same mistakes over and over. Health and education services need to really listen and respond appropriately, so that services are safer for Aboriginal and Torres Strait Islander people and communities. Aboriginal leadership must be valued and respected if we are to close the gaps in health and education. This is important for the future of occupational therapy.

KEYWORDS

Aboriginal and Torres Strait Islander Health, Closing the Gap, consultation, decolonisation, policy implementation

1 | INTRODUCTION

Policy implementation is an integral part of the policy process that is negotiated or modified depending on the influence of key stakeholders (Barrett, 2004). This means that institutions that provide structure for policy implementation, and policy actors who influence decision making, and the ideas held by both institutions and people within, will influence the unfolding and outcomes of policy processes (Howlett et al., 2009). In 2007, the Council of Australian Government (COAG), together with Indigenous health bodies and the Aboriginal and Torres Strait Islander Social Justice Commissioner, committed to “closing the gap” in life expectancy between Indigenous and non-Indigenous Australians (Pholi et al., 2009). As outlined by the Australian Human Rights Commission (2020), the strategy was a response to the “Close the Gap” campaign, led by Australian Indigenous and non-Indigenous health bodies, non-government organisations and human rights organisations to advocate for closing the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous

Key Points for Occupational Therapy

- Australian policy has been implemented through colonial structures that disempower Aboriginal and Torres Strait Islander leadership.
- Decolonising consultation requires moving beyond tokenistic approaches and addressing power imbalances.
- Occupational therapy can and must drive change for both the profession and the wider health system.

Australians within a generation. Since its inception, the CTG strategy has received bipartisan government support and remains a high priority for Commonwealth, state, and territory governments.

Many examples in the literature show how Indigenous peoples have been included in policy implementation process through consultation, collaboration,

community engagement, partnership, or participation (Australian Institute of Health and Welfare, 2016; Bishop et al., 2009; Kelaheer et al., 2015; Meo-Sewabu & Walsh-Tapiata, 2012; Robertson et al., 2012; Ronald & Koea, 2013; Sullivan, 2011; Thomas, 2014; Victorian Council of Social Service, 2016). However, consultation is often described as a primarily Western and tokenistic approach to Indigenous involvement (Black & McBean, 2016; Kelaheer et al., 2015). Klein (2015) argued that consultation has been “more to convince local people of the merit of preconceived policies and principles than to inform the policies themselves and allow deliberation and community participation” (p. 7). Even when collaboration and consultation with Indigenous people is mentioned in policy, the quality of this engagement is often found to be inconsistent and continues to isolate or marginalise the very people targeted for consultation (Black & McBean, 2016; George et al., 2019; Klein, 2015; Lavoie, 2014).

The overall purpose of this research was to contribute to understandings of how government policy can work more effectively to address the social determinants of health, so as to improve health and promote the fair distribution of health in society (Baum & Friel, 2017). This study contributes to a collection of research on policy implementation and cultural safety in public policy (Fisher, Harris, et al., 2021; Fisher, Mackean, et al., 2021). The findings of this research have implications for occupational therapy delivering services to Aboriginal and Torres Strait Islander people and for policy actors who can influence policy implementation.

Zeldenryk and Yalmambirra (2006) provided a viewpoint for the Australian Occupational Therapy Journal, whereby the impact of assimilation policies was described as occupational deprivation. The authors called occupational therapists to action to understand social justice issues, including the impact of past policies on Aboriginal and Torres Strait Islander Peoples' health and wellbeing. Following this in February 2011, the Australian Occupational Therapy Journal released a special issue titled “Indigenous health, wellbeing, social and economic inclusion closing the gaps.” Within this edition, the profession was asked to consider how occupational therapy can respond to the challenge to close the gap? (Wronski et al., 2011). Considerations raised included maximising occupational therapy practice to meet the needs of Aboriginal and Torres Strait Islander clients; promoting practice standards that provide cultural safety; guidelines for occupational therapy programmes to ensure graduates have proper training to meet these standards; and the need to support the growth of Aboriginal and Torres Strait Islander occupational therapists with an vision to impact national health policy (Wronski et al., 2011). The

journal asked questions of the profession at a time when the answers were not easily known, and the profession was not necessarily ready to answer.

At that point in time, literature from Aboriginal and Torres Strait Islander and other Indigenous occupational therapists was beginning to emerge (Emery-Whittington & Te Maro, 2018; Gibson, 2020; Gibson et al., 2015; Ramugondo, 2015). The work of these occupational therapists continues to provide direction, learnings, and leadership on decolonising occupational therapy. Gibson et al. (2015) encouraged the use of a human rights-based approach, which incorporates the principles stated by the United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007) in occupational therapy. Included in the article are six self-reflective questions that encourage occupational therapists to critically self-reflect on personal, political, professional, historical, and environmental factors and contexts when engaging with Aboriginal and Torres Strait Islander Peoples (Gibson et al., 2015). One of the questions specifically encourages occupational therapists to reflect on consultation and engagement processes in service delivery, policy development, and curriculum design to ensure appropriate and meaningful processes. Gibson (2020) further highlighted the work of Indigenous occupational therapy leadership on decolonising occupations and breaking down barriers that prevent Indigenous peoples from participating. In this work, six strength-based dimensions to guide decolonisation are outlined and prioritise building genuine relationships that are not focussed on empowerment, but on sharing power and working together to break down systemic barriers.

Beyond the Australian context, Emery-Whittington and Te Maro (2018) from Aotearoa New Zealand conceptualised decolonisation in occupational therapy by highlighting the way in which colonisation permeates the profession and impacts on Indigenous occupational therapists. They convey that although there is some understanding in how Indigenous peoples have been disadvantaged by colonisation, there is little understanding in how it advantages colonial settlers and the approaches needed to redress these inequities. This further highlights the value of Indigenous occupational therapists who are positioned to appreciate, understand, and reveal what decolonised occupation could be. An even broader perspective from Ramugondo (2015) in South Africa speaks to occupational consciousness theory, which challenges colonialism and colonial practices, and highlights the ways in which colonialism permeates spaces of culture, labour, and knowledge production. The calls to decolonise occupational therapy continued to rise in 2021, as demonstrated by Rudman et al. (2021) who asked the

profession “how prepared is Australian occupational therapy to decolonise its practice?” Findings from their study align with commitment to change; however, there was still a strong sense that the profession felt unprepared.

1.1 | Positionality

The authors of this paper bring together a shared understanding of policy and implementation from both non-Indigenous and Aboriginal standpoints, and public health and occupational therapy perspectives. The lead author (George) is a non-Indigenous occupational therapist who completed the initial analysis for this paper as part of their PhD on policy implementation in public health. She is the fifth generation of her family born in Australia and lives on Kurna country in southern Adelaide. In an in-depth reflection on her standpoint as a non-Indigenous researcher, she outlined the importance of decolonising transformational unlearning by unravelling from dominant colonial ways of thinking and embracing opportunities for learning from and with Indigenous knowledge and people (George, 2023). In this reflection and throughout the research, George acknowledged that colonisation continues to exclude Aboriginal ways of knowing being and doing (Sherwood et al., 2015) and that too often research results in limited change for Aboriginal communities that are often overresearched without improvements in health status (Bainbridge et al., 2015). Partnership with Indigenous colleagues and communities is essential, and the strongest research projects prioritise Indigenous leadership (George, 2023). Authors Ritchie and Ryan provided oversight of secondary analysis and application of the research findings to occupational therapy practice from an Aboriginal perspective. In addition, Ritchie offered peer mentoring during the lead author's PhD project. The three final authors (Fisher, Baum, and Mackean) provided supervision of the PhD project. Guidance from the final author (Mackean) as an Aboriginal public health researcher and leader supported the lead author to reflect on the challenge to engaging with Indigenous knowledge and adopting decolonising methodology. During the PhD and secondary analysis reported in this paper, we considered policy, history, and knowledge from an Indigenous perspective and considered how this should inform political and social actions (George, 2023). As a team, we argue that policy and policy implementation matter for occupational therapy and occupational therapists. Without appropriate consultation as demonstrated through engagement, Indigenous leadership, and respect for Indigenous knowledge, health inequities will continue to be reproduced

and small to no progress will be made under the CTG banner.

We acknowledge the existing contributions of occupational therapy researchers who have grappled with the interface of culture, colonisation, and practice (Gibson et al., 2015; Hammell, 2019; Iwama et al., 2006; Nelson, 2007) and seek to continue the work through a focus on policy implementation. In this paper, we extend a critique of two case studies (George, 2023) to unpack the context and challenges of consultation in policy implementation. Our research answers the following question: How does the implementation of the CTG strategy compare in Shepparton (Victoria) and Southern Adelaide (South Australia)? Differing experiences of consultation on policy and implementation emerged as a key theme from the results and are explored through secondary analysis in depth in this paper.

2 | METHODS

This research is founded on an understanding of and respect for Indigenous knowledge, described by Durie (2005) as dynamic and based on collective and holistic principles, rather than individual or reductionist perspectives. According to Sherwood (2010), Aboriginal people in Australia have made many attempts to share knowledge, and that while some non-Indigenous people have listened, many have not. Grieves (2009) explained that “mainstream” society has historically been resistant to accepting Indigenous knowledge and solutions that promote health and wellbeing. This resistance continues despite growing awareness of the significance of Indigenous knowledge in improving health and educational outcomes for Aboriginal and Torres Strait Islander people (Bessarab, 2015). Sherwood (2010) argues that a “mainstream” failure to value Indigenous knowledge contributes to ongoing oppression and marginalisation, and to the current poor health status of Aboriginal people. Different ways of knowing, in combination can provide richer and more diverse understanding of policy, and health and wellbeing (Semali & Kincheloe, 1999; Sherwood, 2010). This approach was adopted by the lead author to guide data collection, data analysis and dissemination in their PhD.

Ethics approval for this case study research was granted by three separate ethics committees. The project was approved by the Flinders University Social and Behavioural Research Ethics Committee (project number 6786). Following this, the project was approved by the Aboriginal Health Research Ethics Committee, a subcommittee of the Aboriginal Health Council of South Australia Inc (project number 04-16-697), and by the

Ethics Committee from Goulburn Valley Health (project number GV39/16). In the reporting of case study findings, every effort has been made to protect the anonymity of participants. Following feedback from the Aboriginal Health Council of South Australia, detailed descriptions of participants are not provided, and quotes used in publications are not associated to any identifying feature other than Aboriginality when needed to emphasise Indigenous perspectives and protect anonymity of participants. The planning and completion of this research is consistent with the AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research (AIATSIS, 2020). Author 1 conducted analysis of original data. In a secondary analysis of findings to determine implications for occupational therapy, two Aboriginal occupational therapist authors (Authors 2 and 3) guided a review of PhD research processes against the Aboriginal and Torres Strait Islander Quality Appraisal Tool (Harfield et al., 2020), and a summary is included as supplementary material to evidence of the integrity of the research.

2.1 | Case studies

We adopted a case study model because it is appropriate to answer research questions on *how* and *why* policy has been implemented in certain ways (Liamputtong, 2013; Yin, 2009). Cases were purposefully chosen to be compared, in order to provide an in-depth understanding of policy implementation as it occurred within a defined place and community.

1. Shepparton, Victoria

Shepparton is a regional town in the state of Victoria. The Yorta Yorta and Bangerang people are the traditional owners of this area in the Goulburn Valley. The Rumbalara Aboriginal Cooperative (Rumbalara) is an Aboriginal-controlled organisation providing health and community services and is one of the largest providers catering to the needs of Aboriginal and Torres Strait Islander people in the region, and it is influential in the implementation of the CTG strategy. Rumbalara was a formal partner in the research project.

2. Southern Adelaide, South Australia

Southern Adelaide is a metropolitan regional area in South Australia. The Kurna people are the traditional owners of the Adelaide plains, including Southern Adelaide. In this case study, the CTG strategy was implemented through mainstream (Government) health and

education services. There is no local Aboriginal-controlled organisation within the Southern Adelaide region.

Participants in this study were policy actors who had a role in and/or knowledge of the implementation of CTG by local, state, and national governments, and it also included service providers responsible for implementing policy on the ground. Some community members also participated as they had experience in CTG strategy consultation processes and advisory roles in service provision.

Sixteen people in Shepparton (11 identified as Aboriginal or Torres Strait Islander) participated in semi-structured, in-depth interviews, and 16 people in Southern Adelaide (nine identified as Aboriginal or Torres Strait Islander) participated in semi-structured, in-depth interviews. All interviews were audio recorded and transcribed verbatim. Transcripts were analysed using NVivo 11 software to search for repeated themes as well as differences. Workshops with participants were conducted in both case studies to review key themes as they emerged from the data and to seek feedback and input from research participants and partners on the findings. A member of the research team took detailed notes at each workshop. In both Shepparton and Southern Adelaide, the team recorded new insights and reflected on the contributions of all participants, which informed the primary thematic analysis.

2.2 | Occupational nature of community engagement

Community engagement in both case studies was pursued and prioritised in the early stages of the project. Nayar and Stanley (2015) explained that researchers must demonstrate sensitivity when entering communities and that sustained engagement and discussion with cultural advisors supports cultural safety. In addition, community engagement provides opportunities to build mutual respect and acts of reciprocity, consistent with principles of research at the interface of knowledge systems (Durie, 2005). In this project, community engagement began under supervision and through personal introductions, so that relationships were fostered as advice was sought from key leaders. As a result, community engagement was appropriately tailored for each case study to reflect the differing communities and contexts of Shepparton and Southern Adelaide (George, 2020).

2.3 | Critical analysis of research findings

Following the completion of the study and presentation on decolonising consultation and power imbalances at

the 29th Occupational Therapy Australia National Conference and Exhibition (George et al., 2021), the three occupational therapy authors (Author 1, 2, and 3) reviewed the findings and conducted a secondary analysis to further identify implications for occupational therapy as a profession and in relation to practice standards. This was guided by the Aboriginal occupational therapists (Author 2 and 3) who contributed Indigenous perspectives and positioned the discussion at an interface of public health knowledge and occupational therapy.

3 | FINDINGS

The CTG strategy was implemented through multiple mechanisms (George, 2020). In both case studies, participants described consultation as a feature of policy implementation that was limited by tokenistic approaches, different perspectives on partnership, or a narrative of “working with” the community that often lacked action. Participants advocated for a change in the status quo where power could be shared, to promote Aboriginal leadership, and for policy implementation to respond local need.

3.1 | Tokenistic consultation

Participants in Southern Adelaide expressed frustration with the process of consultation, as well as underlying assumptions or intentions of government consulting with community. Consultation was deemed inflexible, which limited community engagement. One participant explained “they want the voice of Aboriginal people who don’t work. They want unemployed Aboriginal people to make decisions on everybody because all consultations are nine to five.” Another participant stated that even when the broader community are able to participate in consultation, it is “a bit like paying lip service and it’s like ‘we’ve heard you and so we’ve done consultation’.” They went on to explain that when community participate in consultation, they expect a response. However, in Southern Adelaide, the consensus was that the government would push ahead regardless of the information gleaned from consultations.

These experiences of consultation were described as “tokenistic.” An Aboriginal participant explained that consultation “does seem like a tick box thing, like we talked to the community and so we’re done with consultation.” Both non-Indigenous and Aboriginal participants agreed the tokenistic nature of consultation was reinforced when community was informed of policy implementation rather than implementation occurring in

response to community input. For example, “they ask us about things which they’ve already decided what they’re going to do, so it’s kind of like you’re consulting but you’re not, because you’re going to go ahead to do what you’re going to do anyway, even if we give you a different viewpoint.” Half of the participants in Southern Adelaide described governments as “not really listening” during consultation. One Aboriginal participant described a “very white centric” approach to consultation which limits the influence or presence of Indigenous knowledge in policy implementation. They explained “they’re not considering Aboriginal knowledges and ways of being, knowing and doing which can actually be effective in helping Aboriginal people ... top-down approaches crush this knowledge.”

One of the barriers identified by participants was the lack of conversation with community about the causes of health inequity, particularly “dispossession and oppression and what’s happened to Aboriginal people in this country.” Participants suggested that really getting to root causes of health inequities requires more than just “sitting around a big table.” They contended that governments have a responsibility to “actually listen with your ears and eyes and heart and your minds and your soul.”

The experience of consultation in Southern Adelaide was particularly difficult for the Aboriginal participants who helped to facilitate consultation. One participant explained “as Aboriginal workers when we go out and consult, that’s hard for us because we know that our sphere of influence is only so big, and what you can change is so limited.” These participants described the weight of expectation to be an advocate for the Aboriginal community, but when “they’re giving their voice and they’re telling you [what they need] but then they don’t see it change,” it can be a very difficult burden to bear.

3.2 | Partnerships in policy implementation

In Shepparton, different views on partnerships emerged in relation to the rhetoric of “working with” Aboriginal people. For example, one non-Indigenous participant from a non-government community-based organisation stated “we’re going to stop doing things *to* Aboriginal people, we’re going to do things *with* Aboriginal people. I think that’s a sensible reframing and that’s something that we should’ve been doing all along” (emphasis added). Another non-Indigenous participant from within the government sector suggested that partnerships need to be more than an agreement on a piece of paper. They identified that commitments needed to have actions associated with the promises of working together.

However, Aboriginal participants described having to repeatedly exercise tolerance and patience with non-Indigenous policy actors claiming to want to work in partnership but positioning community-controlled organisations as instrumentally useful to government policy goals, rather than engaging in a genuine, two-way partnership. One participant in Shepparton compared partnerships to an ongoing master–servant relationship and that the government plays the role of “puppet masters directing what’s being said and where money goes,” reflecting a significant power imbalance. The non-Indigenous narrative of “working with” Aboriginal and Torres Strait Islander people and communities was not considered by Aboriginal participants to be a new approach, and partnerships were seen to be more performative than substantive. These Aboriginal participants were sceptical of how such relationships would facilitate policy implementation.

3.2.1 | The role of Aboriginal-controlled services in policy implementation

In both case studies, the role of Aboriginal-controlled services was seen as vital to implementing the CTG strategy in both consultation processes and service delivery. In Shepparton, Rumbalara was seen as much more than just a service provider. One participant said, “it’s important that Rumbalara exists, to help connect people to their culture and the history not only of Rumbalara but the history of Aboriginal people in general.” This history and connection were seen as a source of strength by participants. “There can’t be a strong Shepparton without a strong Aboriginal community and a strong Rumbalara.” The connection between Rumbalara, culture and identity were described as inseparable. Another participant stated that “Rumbalara in itself is culture ... we never want to lose our cultural identity, ever, so we always make sure that whatever we do, it always has, you know, us as part of it.” The importance of culture as a determinant of health and that sense of belonging to Rumbalara was identified as something unique for Rumbalara that other services in the region could not replicate. Rumbalara was described as “a gathering place, a meeting place, you know, connection.”

In contrast, the absence of an Aboriginal-controlled organisation in Southern Adelaide meant that services for Aboriginal people were “absorbed” within the “mainstream.” All participants agreed that policy implementation that specifically endorsed Aboriginal services within the mainstream should support social determinants of Indigenous health, however, “if there is not that understanding, there can be misunderstanding,

miscommunication and possible disconnect.” The disconnect from Indigenous knowledge and culture results in policy being imposed on to a community, “rather than being from the community up.” One participant in Southern Adelaide explained that because of the way they were directed to implement policy by their state body, services were unable to respond flexibly to local community. They stated “the needs [of Southern Adelaide and Northern Adelaide] are different, and the communities are different ... We threw all this money at [the gap] and it hasn’t gone away.” Another participant explained that mainstreaming “doesn’t work because the leadership are non-Aboriginal. They see things through their eyes, in their image. If they don’t consult, if they don’t take note of how it is for Aboriginal people, they will miss the mark, like they have been doing for many, many years.”

3.3 | Advocating for a change in the status quo

Many of the Aboriginal participants reasoned that a commitment to truly collaborative policy that addresses underlying causes of inequity would result in “more pride in Aboriginal history, achievement” and “appropriate recognition of knowledges ... a melding, merging of the best of both worlds ... a much better reconciled system.” Participants recognised that this would require “a cultural shift [where] policy writers and policy makers would look at things differently,” because “more of the same won’t make any difference.” Participants advocated for Aboriginal leadership and control within long-term or recurrent funding. One participant in Southern Adelaide explained “if it’s working, make it stick. Let us take care of our families. They’re listening to us; we’re listening to them. We’re getting results, like how is that not worth noting?!” The investment in ongoing services was seen as crucial because “the community need to see you as a consistent service. One of the worst things you can do is start something and then stop. It’s start-stop. There’s no consistency so the community don’t have faith in any services and unfortunately, the system isn’t very good at making those types of things happen.”

Ultimately, participants in both case studies agreed that the CTG strategy should be implemented in ways that “move beyond racism and social injustice” and that healthier communities would be “happier” communities. One participant described a vision for health in which “people will enjoy life more ... You’re going to be more community involved, caring about what’s going on around you and having time to care about those things ... it could change dramatically and if our non-Aboriginal

counterparts were able to see and experience who Aboriginal people really are – the country would be in a much better place.”

4 | DISCUSSION

Hunt (2013) identified that effective engagement of Indigenous peoples in policy implementation requires an appreciation and valuing of Indigenous culture and knowledge, shared decision making, actions based on Indigenous aspirations and strengths, and clarity about processes and outcomes. In many of the CTG strategy reports, there is a repetitive narrative that “true gains are made when Aboriginal and Torres Strait Islander people are able to work with governments to set the agendas that impact their wellbeing” (Commonwealth of Australia, 2017a, p. 10), and “services need to be designed, developed and implemented in partnership with Aboriginal and Torres Strait Islander people” (Commonwealth of Australia, 2018, p. 8); however, this was inconsistent with policy implementation described in these case studies. Even when government reports clearly state that “when governments listen, collaboration puts Indigenous Australians at the centre of decision-making, builds capacity of individuals, organisations and communities, and enables people to make decisions to support their wellbeing” (Commonwealth of Australia, 2017a, p. 10), it does not mean that such approaches are implemented in local communities. Moran (2016) argued that “no matter how well policy is conceived, delivery on the ground is where it counts, and where it consistently fails” (p. 13). The findings from both case studies align with tokenistic approaches in policy implementation, characterised by a low levels of participation, where the real objective of engagement is not to enable participation but to educate or inform (Arnstein, 1969; Johnson et al., 2012; Talbot & Verrinder, 2014) and reinforce a colonial apparatus (Moreton-Robinson, 2007, 2015).

Tokenistic approaches were also seen in partnerships between government and non-government organisations as described by participants in Shepparton. Dwyer et al. (2014) explained that the relationship of funder and provider between government and Aboriginal community-controlled services is seen to offer security to a health-care system but that a significant gap remains regarding accountability and trust between key stakeholders. They noted that the Aboriginal health sector is funded through “a complex array of short-to-medium term funding contracts, a situation that contrasts with the mainstream health system, where essential basic care is either provided directly by government or funded

through long-term fee-for-service arrangements” (p. 1103). Similar to the concerns voiced by Aboriginal participants on the partnership rhetoric in Shepparton, Dwyer et al. (2014) argued that turning the rhetoric of “working with” into action will take time to enact at the local level.

Previous analysis of policy in early childhood identified that a fundamental flaw in the CTG strategy is the inconsistent recognition of Indigenous rights (George et al., 2023). Some policies such as the Indigenous Advancement Strategy (Commonwealth of Australia, 2017b) direct leadership away from Indigenous control, critiqued as an undermining of Indigenous rights. In this policy document, the structural causes of inequity and trauma of colonisation and the generations of advocacy by Aboriginal people are ignored (Fisher et al., 2018; George et al., 2023). In early childhood-specific policy such as the “Investing in the Early Years’ National Early Childhood Development Strategy” (Council of Australian Governments, 2009a), early life experiences are framed around a priority for future economic contribution with no consideration of self-determination. In many of the broader education-specific policies within the CTG strategy (Council of Australian Governments, 2008, 2009b, 2015, 2016), there is little evidence of alignment with Indigenous rights such as those to advance community-controlled services or promote culturally safe and responsive services (George et al., 2023). If the CTG strategy itself does not consistently prioritise the voice and leadership of Aboriginal and Torres Strait Islander communities, then we argue that tokenistic approaches in implementation are most likely to be inevitable.

In response, a decolonising approach should be adopted in policy and consultation should be reimagined to rearticulate power, enable change, and promote Indigenous knowledge. This would question and resist colonial notions of power that threaten Indigenous ways of being (Sium et al., 2012). To decolonise consultation, we must consider and address the power imbalances (Gray & Oprescue, 2016). Based on the findings from this research, policy implementation must move beyond the rhetoric of “working with” Aboriginal people and communities and build trust between governments, policy actors, implementers, and community. Key stakeholders have to keep “really listening” to one another, with the intent to learn and then respond. Without true partnerships that are mutually beneficial, the next era of the CTG strategy runs the risk of writing partnerships into policy documents that are not enacted as needed. Reciprocity is essential if partnerships are to be successful. This requires shared power, authority, responsibility, and accountability of policy actions (Gibson et al., 2015),

including the fair and equitable distribution of funding to Aboriginal-controlled organisations.

We have identified three key learnings for occupational therapy from this research that reimagine how the profession can operate and conduct decolonising consultation and policy implementation.

1. Decolonisation is an ongoing process

Policy actors must move beyond the rhetoric of “working with” Aboriginal people and communities and build trust between governments, policy actors, implementers, and community. Key stakeholders have to keep “really listening” to one another, with the intent to learn and respond. This is something that can only occur with intentional, long-term commitment for genuine consultation. Reflections on the findings highlight that it takes time to build trust and rapport with people, especially those who are sceptical of partnership, due to deficit narratives and ongoing colonisation. Yalmambirra (2000) explained that time is understood very differently from western and Indigenous perspectives. “White time” is focussed on the calendar and the clock where there is a time to go to sleep, to get up, to go to work, for dinner, for sport. However, Indigenous time began with the era of creation and is centred on seasonal movements, traditional practices, resources, the environment, and people. Yalmambirra (2000) presents the contrast in understandings of “black time” and “white time,” which is very difficult to weave together. Therefore, there is a responsibility to take the time to sit with people and in the word of one research participant, “really listen – with your ears and eyes and heart and your minds and your soul.”

We recommend that occupational therapy services connect with local Aboriginal groups, elders, and services to build sincere, in-depth partnerships. Relationships should be built with the intention of reciprocal benefit, and the relationship must be prioritised over immediate actions or outcomes and Aboriginal leadership prioritised at all stages of projects. We encourage occupational therapists to visit with Aboriginal leaders and, while being mindful of cultural load, have a *yarn* with people about their experience, their life, and seek their advice for working with the community. It is essential that activities for community engagement and liaison with Aboriginal leaders and Elders be appropriate for specific communities and note that our recommendations presented here must be considered as suggestions, based on our own knowledge and experiences working with Aboriginal people and communities. The diversity of cultural practices across communities must be acknowledged, and therefore our recommendations are not to be considered as a checklist for cultural competence.

Really listening to Aboriginal leaders requires occupational therapists to take time for this process and reflect on their own standpoint. Wilson’s model for reflexive practice guides researchers through stages to explore challenges, learnings, new levels of understanding, and changes in practice (Wilson, 2014). This model includes a series of questions to enable researchers to better understand their standpoint and bias. We recommend this model as a useful tool for reflection and a foundation for discussion and feedback from Indigenous team members. It is essential that reflection challenges pre-conceived ideas and enables ongoing learning and respect.

2. Honour what is shared

Hart (2020) outlined that when drawing on Indigenous knowledge in research, it is essential to honour what is shared. In this research, when participants shared their pain, trauma, and disappointment associated with policy, peer mentors and supervisors insisted that we engage with the injustices as they were revealed in order to fully understand the challenge of policy implementation and to give voice to Indigenous perspectives and experiences. It would be easier for non-Indigenous researchers to isolate participants’ pain and trauma and separate out stories solely as pieces of data, but alienating knowledge in that way would destroy the integrity of consultation, engagement, and partnership. Personal and professional barriers often impact an occupational therapist’s openness and willingness to engage with Aboriginal and Torres Strait Islander Peoples’ stories and experiences. It is, however, essential to move through these barriers and discomfort to be able to take necessary actions (Ryall et al., 2021). This also includes if conflict arises throughout the consultation process. Conflict, differences, and opposing worldviews should be expected; however, genuine partnerships built on trust will ensure these are resolved appropriately (Ryall et al., 2021). Furthermore, Rudman et al. (2021) argued that non-Indigenous occupational therapists must demonstrate humility, inquisitiveness, and openness to build meaningful and sustainable relationships.

To honour what is shared, we argue that occupational therapists must have processes for accountability in place (e.g., advisory bodies, steering committees, and peer mentoring). Feedback from Aboriginal stakeholders must be prioritised and acted on. Support and monitoring through an Indigenous perspective can hold occupational therapists accountable to ensure that they deliver on what they say they will do.

Decolonisation of policy and implementation is the responsibility of all stakeholders. Therefore, when addressing complex policy issues, robust debate must be

humbly welcomed. Responsibility for policy action and reform must not be deferred or placed solely on Aboriginal leadership. The occupational therapy profession must not abdicate the responsibility of leading change for decolonisation. This means that professional bodies, together with individual occupational therapists can and must advocate for Indigenous rights, as was seen in the position held by Occupational Therapy Australia in support of the referendum for an Indigenous voice to parliament (Occupational Therapy Australia, 2023). Support for decolonisation in policy and implementation processes (such as consultation) must continue despite the successes or failures of political campaigns, such as the rejection of the indigenous voice to parliament in 2023.

3. Indigenous leadership is essential

In both of the case studies critiqued in this paper, Aboriginal leaders described being positioned between government and community where they are answerable to both groups. Stewart and Warn (2016) described this as leading “between two worlds” (p. 3), one aligned to organisational reality and demands, and the other in community. This results in a process of constant interpretation and negotiation. Aboriginal participants in both case studies viewed their roles in leadership as a responsibility, and at times as a heavy burden, but always an important contribution to the community. The findings of this research show that Aboriginal-controlled services are best positioned to conduct and respond to community consultation. In occupational therapy, the same challenges identified by the study participants regarding consultation are prevalent. Tokenistic actions result in the same mistakes being repeated year after year. Partnerships can appear balanced from a non-Indigenous perspective but are entered into with caution and concern from Aboriginal and Torres Strait Islander people and communities. This requires phenomenal strength and resistance to a national history of dispossession, displacement, violence, and exploitation enforced on Indigenous people through colonisation (Yadeun-Antuñano & Vieira, 2020). For Indigenous communities, this resilience has systemic, collective, and communal dimensions (Kirmayer et al., 2011).

It is essential that as occupational therapy builds on previous work by Zeldenryk and Yalmambirra (2006), Wronski et al. (2011), and (Rudman et al., 2021), who highlighted the power imbalances and challenges for the profession, and learns from Gibson et al. (2015), Gibson (2020), and Ryall et al. (2021) to unlearn colonial approaches to policy and practice, so that Indigenous voices and leadership are privileged and followed. The

strength-based model proposed by Gibson (2020) serves as a guide for occupational therapy for decolonisation in practice and policy implementation. We argue that this strength-based model in action must avoid tokenistic approaches to consultation and policy implementation and begin to address power imbalances.

As a strategy for supporting Indigenous leadership, occupational therapists can learn from the important work of Indigenous Allied Health Australia (IAHA) by engaging with the association and completing the cultural responsiveness training modules (Indigenous Allied Health Australia, n.d.). In addition, universities and service providers can support pathways into practice for new occupational therapists, provide culturally safe working environments, and promote leadership opportunities for Aboriginal and Torres Strait Islander occupational therapists.

5 | CONCLUSION

Consultation during the first decade of the CTG strategy in Shepparton and Southern Adelaide was described by policy stakeholders as tokenistic and partnerships reflected power imbalances. Decolonising consultation is essential to move beyond the rhetoric of “working with” Aboriginal and Torres Strait Islander people as an important step to close the gap in health inequity. There are implications from this study for occupational therapy practice that can inform service provision and policy implementation. Learning to decolonise consultation processes, honouring what is shared by “really listening” and responding accordingly, and prioritising Indigenous leadership, are all key strategies for consultation now, and in the future.

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CONFLICT OF INTEREST STATEMENT

There are no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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