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Interim findings from a mixed methods evaluation of a social and emotional wellbeing model of service pilot in Western Australian Aboriginal community-controlled health services

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ABSTRACT

Objectives To evaluate the establishment and early implementation phases of a pilot of the Aboriginal Health Council of Western Australia's Aboriginal Community Controlled Health Services (ACCHS) social and emotional well-being (SEWB) model of service.

Design A mixed-methods study framed by an Aboriginal Participatory Action Research lens. This entails Aboriginal leadership and governance; capacity building; and researcher reflexive practice.

Setting Five Aboriginal Community Controlled Health Services across Western Australia's South West, Mid West, Kimberley, Goldfields and Pilbara regions.

Participants Using purposive sampling, 19 SEWB team members; 6 key knowledge holders involved in pilot implementation and governance; 15 clients; and 6 representatives for collaborating and referring teams and agencies were recruited.

Results SEWB teams across each pilot site have made strong contributions to strengthening the SEWB of their clients and communities through a range of activities and services offered. By leveraging cultural and community knowledge, and lived experience, SEWB teams have been able to effectively engage with community, advocate and connect clients to relevant services and supports, and provide culturally appropriate counselling in flexible and responsive ways. It was also evident from the Social and Emotional Wellbeing Systems Assessment Tool discussions that developing and codifying systems, processes and governance of SEWB services is an emerging priority for the ACCHS sector.

Conclusions SEWB has been embedded as an essential paradigm within key policy frameworks that support the health and well-being of Aboriginal and Torres Strait Islander people and communities. Preliminary findings demonstrate the importance of programmes and services that strengthen the SEWB of Aboriginal and Torres Strait Islander people and communities, and address social, cultural and political determinants of health and well-being. The findings from this research also highlight the key areas relevant to SEWB service delivery and workforce that require further investment and development.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Recognising the diversity of Aboriginal people and communities, policy environments, and place-based considerations in the delivery of services, the findings may not be generalisable.
⇒ All participating pilot sites contributed to the evaluation, capturing a diversity of contexts and a comprehensive picture of the initiative.
⇒ Data was collected by a non-Aboriginal male researcher, this complicated data collection and may have impacted the relationship between the researcher and participants.
⇒ There was strong Aboriginal governance established in both the pilot and evaluation team.

The Aboriginal and Torres Strait Islander concept of social and emotional wellbeing (SEWB) model is a multi-dimensional holistic conception of Indigenous health and well-being. It reflects Aboriginal and Torres Strait Islander knowledges and recognises the social, cultural, political and historical contexts that determine well-being outcomes for people and communities. Indigenous conceptions of well-being, such as SEWB, are essential for addressing significant health inequities experienced by Indigenous people and communities experiencing the ongoing impacts of colonisation.[1] The model has been influential in shaping research and informing the development of Aboriginal and Torres Strait Islander health and well-being policies across government jurisdictions.[2–5] However, further understanding of how SEWB is translated from theory and policy into practice is needed.[6]

Aboriginal Community Controlled Health Services (ACCHS) have been a key site for much SEWB translational activity. Their holistic, self-determined and community-led model of primary healthcare makes them ideal settings for programmes and services that seek to strengthen SEWB. A

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recent survey by the National Aboriginal Community Controlled Health Organisation, an advocacy and representative body for the sector, indicates that most of their member services provide some form of SEWB service or support.[7] SEWB service delivery within ACCHS encompasses a range of activities, including community development; casework and advocacy; psychosocial support and education; counselling and therapeutic care.[7] Importantly, coordination between supports and services is a key element of effective service delivery[8 9] and requires integration within the organisational ecosystem.[8] Integration, foremost, requires shared understandings across an organisational ecosystem. SEWB can still be misunderstood and is often equated to mental health rather than a multi-dimensional construct of health and wellbeing.[10] Strong SEWB frameworks are essential to enable shared understandings, and appropriate shared tools and infrastructure can also support an integrated SEWB approach.[11] Within the ACCHS sector, there have been recent efforts to develop models of service that provide a framework for integrated and coordinated SEWB service delivery and provide a foundation for the development of systems and processes.

The Aboriginal Health Council of Western Australia's (AHCWA) ACCHS model of service is one example of SEWB translation approaches. AHCWA is the representative organisation for Western Australian (WA) ACCHS and developed the model of service through extensive consultation with its member services. This consultation included mapping existing SEWB service delivery across the sector and identifying approaches, gaps and needs.[12] The WA Mental Health Commission (MHC) worked with AHCWA to pilot the ACCHS Model of Service (Pilot). The Pilot was funded by the WA and commenced in 2022 and includes the establishment of SEWB teams across five WA ACCHS. The model of service articulates a framework for culturally centred and strengths-based SEWB service delivery that is flexible and allows for the recognition of place-based needs and the diversity of Aboriginal people and communities. Within the model, SEWB service delivery activities are described across a four-pillar approach: culturally secure community development, psychosocial support, targeted interventions and supported coordinated care. Further details of this approach can be seen in table 1. A range of activities sit under each pillar, with specific activities delivered depending on ACCHS and community needs.

The model proposes an interdisciplinary SEWB team to undertake service delivery through this four-pillar approach. An ideal team would include a range of Aboriginal SEWB roles, health and social support professionals, and others that may be important to the client.[13] Interdisciplinary teams provide important benefits for clients, carers and families, healthcare professionals and health delivery systems. These benefits include better service coordination, empowering clients as active participants in their care, improved cultural safety, holistic care, and more effective and efficient health service delivery.[13] The proposed model requires a minimum SEWB team to consist of an Aboriginal Cultural Lead, a Clinical Lead, an Aboriginal male and female SEWB worker, a male and female counsellor, and a Care Coordinator/Administration role.[12] Aboriginal identified positions reflect the importance for clients engaging with health and mental health services of receiving support from an Aboriginal workforce.[14] Male and female reflect gender-based considerations towards comfort and cultural appropriateness for Aboriginal and Torres Strait Islander people when using health and well-being services.[15]

This paper shares the preliminary findings from data collected as part of an interim evaluation[16] of the AHCWA WA ACCHS Model of Service Pilot. These findings relate to the establishment and early implementation phases of the Pilot, documented from December 2022 up to August 2023, and provide emerging insights towards the development of processes and systems; and SEWB service delivery impact, enablers and challenges.

METHODS

Setting

The Pilot sites are located in five of WA's regions: Derby Aboriginal Health Service in the Kimberley region; Wirraka Maya Health Service Aboriginal Corporation in the Pilbara region; Geraldton Regional Aboriginal Medical Service in the Mid-West region; Bega Garnbirringu Health Service in the Goldfields region; and South West Aboriginal Medical Service in the South West region. Pilot funding is managed and disbursed by AHCWA, who also provided support to all sites, and facilitated the Pilot governance committee. All sites except one had existing funding contracts to provide some SEWB services, and all sites except one had participated in the original consultations that informed the development of the model of service. Relationships with Pilot site staff had already been established through ongoing participation in the Pilot governance committee, and earlier site visits accompanied by a senior Aboriginal consultant with significant expertise in the ACCHS sector.

Research design

As outlined in the study protocol paper,[17] the evaluation used a mixed-methods approach framed by an Aboriginal Participatory Action Research[18] lens that privileges Aboriginal and Torres Strait Islander knowledge systems, ethics and methodologies. The approach does this by centring Aboriginal and Torres Strait Islander voices and recognises people as experts-by-experience. Additionally, the approach entails practices that enable culturally secure ways of researching alongside Aboriginal and Torres Strait Islander people and communities, through ensuring Indigenous leadership and governance, capacity building, and team members engaging in ongoing reflexive practices.[19]

Data collection

Data was collected through multiple sources, including document analysis, qualitative interviewing, field

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Table 1 Four-pillar approach to the delivery of social and emotional wellbeing (SEWB) services

Pillar 1: Culturally secure community development	Intended service impact	Example Pilot activities
► Psychosocial education, health promotion education/resources, healing days, awareness campaigns, life promotion	► Aboriginal people are more aware of their SEWB and mental health and have the knowledge and skills to seek help from appropriate services ► Enhanced opportunities for individual and collective empowerment, building resilience and healing	► Suicide prevention training ► Psychosocial education programmes in schools and community ► Educational radio advertisements ► Community events around topics such as self-care and family and domestic violence ► Participation in community events such as for National Aboriginal and Islander Day Observance Committee (NAIDOC) week ► Self-care workshops ► Post-vention support in schools
Pillar 2: psychosocial support	**Intended service impact**	**Example Pilot activities**
► Information, advocacy, referrals and case management for individuals and/or families centred on the successful resolution of challenges to their SEWB (non-clinical)	► Improved social determinants of health (eg, housing, employment, environmental health) ► Enhanced connection to culture through access to programmes, support and linkage with Elders/cultural advocates	► Collating relevant psychosocial resources relating to topics such as mental health, suicide prevention and family and domestic violence ► Development of own culturally appropriate resources ► Advocacy to support clients engaging with mental health services, Centrelink, court system, doctors, National Disability Insurance Scheme (NDIS), housing ► Referrals to financial counselling, emergency relief, NDIS, housing and homelessness services ► Counselling using multiple modalities such as tapping, cognitive–behavioural therapy, narrative therapy, art therapy ► Yarning
Pillar 3: targeted interventions	**Intended service impact**	**Example Pilot activities**
► Culturally secure assessments, referral and support responding to issues such as family violence, alcohol and other drugs, trauma, mental health ► Traditional healing and intensive cultural support (return to Country programmes, etc) ► Follow-up with specialist mental health and acute services	► Appropriate mechanisms to screen Aboriginal people's risks and resilience ► Improved systems for brief intervention and provision of psychological therapeutic support	► Targeted referrals to services relating to alcohol and other drug use and rehabilitation, acute mental health support, family and domestic violence ► Connecting with traditional healing programme embedded at the Aboriginal Community Controlled Health Services (ACCHS) ► On Country trips with Elders or men's and women's groups ► Knowledge exchange with local communities (eg, bush medicine, bush tucker) ► Drawing on lived experience to provide targeted and culturally secure support ► Exploration and use of culturally validated screening tools (eg, Aboriginal and Islander Mental Health Initiative Stay Strong app, Strong Souls, Here and Now Aboriginal Assessment)
Pillar 4: supported coordinated care	**Intended service impact**	**Example Pilot activities**
► Coordination (step up/step down) between primary health, SEWB and acute services. Provision of culturally appropriate wellness initiatives to support and strengthen mental healthcare plans	► Integrated care pathways ► Enhanced throughcare and aftercare protocols and processes ► Streamlined approaches to shared care and simplified referral processes	► Meetings with acute mental health services to improve processes ► Meetings with other teams within the ACCHS to improve processes ► Informal processes to coordinate with other teams and agencies (including psychologists based at the ACCHS) ► Culturally appropriate wellness initiatives and groups (eg, women's health, yarning drop-in, art therapy activities)

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observations and group discussions with SEWB teams at each Pilot site. A non-Aboriginal member of the evaluation team (RPA-I) undertook the data collection.

Document analysis

Key documents related to the delivery of SEWB services and the implementation of the Pilot, MHC Key Performance Indicator (KPI) reporting, as well as new resources and tools created to support workforces and SEWB service delivery have been collected and reviewed in a document analysis. Documents were related to governance, systems and processes, reporting, and tools.

Ongoing engagement and observation

Members of the evaluation team also undertook ongoing engagement and observation with Pilot site teams across initial consultation Pilot site visits and the initial data collection Pilot site visit. They also participated in governance forums and the Pilot SEWB teams community of practice and have ongoing ad hoc engagement with Pilot sites and key stakeholders. Data consists of meeting minutes, and fieldwork notes informed by salient topics arising from interviews and SEWB-SAT components.

Qualitative interviews

Semi-structured interviews were conducted with key knowledge holders including project officers, managers, executives, board members, cultural advisors, SEWB staff and other key staff from stakeholder organisations that are involved in governance, implementation or operations of the Pilot; Pilot site SEWB team members; and other staff from the Pilot site or external agencies that collaborate with the SEWB team. Culturally appropriate yarning interviews[20] were also held with clients to elicit their experiences of receiving support through the SEWB team. Clients were excluded if they were under the age of 18. Interviewees external to the SEWB team and governance committee, including clients and collaborators from other teams and external agencies, were identified and recruited by members of the SEWB team. Interviews lasted approximately 30–60 min, and were audio recorded and transcribed. Clients had the option not to be recorded and instead have written notes taken by the interviewer. Clients participating in the interview were also given the option for a member of the SEWB team to join, and two clients opted for this. All interviews took place in a location that was found acceptable for participants, this usually included an office or meeting room in the ACCHS building, or for one client, out in the community. Prior to interviews, participant information forms were provided and verbally explained in plain language, and informed consent was sought. Participating clients were given a $50 gift voucher to compensate for their time.

Social and Emotional Wellbeing Systems Assessment Tool

The Social and Emotional Wellbeing Systems Assessment Tool (SEWB-SAT) is a resource to guide facilitated discussion with SEWB teams (online supplemental appendix 1), where key systems components for SEWB service delivery are collectively reflected on and assessed, supporting teams to identify both strengths and areas for further development. The SEWB-SAT was created for this evaluation by authors EC and RPA-I and was adapted from the Menzies Health Systems Assessment Tool for health services.[21] The SEWB-SAT items reflect the AHCWA ACCHS Model of Service, and are additionally informed by the Kimberley Aboriginal Health Planning Forum Cultural Security Framework.[22] Key components are workforce, service delivery, client access, community linkages, and organisational influence and integration.

Data analysis

Qualitative interview data was thematically analysed through a structured analytic framework.[23] The framework was derived through categories relating to components and dimensions outlined within the SEWB-SAT, and relating to client experiences, client outcomes, tools and resources, service gaps, evidence of delivery guided by the Service Model pillars and evidence of SEWB domains being strengthened. Inductive coding was also undertaken to enable new themes to be identified in the data.

Emerging findings were shared back to individual SEWB teams and the Pilot governance committee to ensure accuracy. Feedback sessions were also an opportunity for reflection, discussion and the refinement of the analysis.

Patient and public involvement

As part of the APAR framed methodology, ongoing engagement with stakeholders through Indigenous-led governance structures has informed research design.

FINDINGS

The preliminary findings draw on data collected during data collection site visits from May to August 2023 (see table 2). Further data was collected through the evaluations of participation and engagement across initial relational site visits, Pilot planning workshops facilitated by AHCWA, governance committee meetings, community of practice meetings, and meetings and conversations with stakeholders as they arose. These additional points of data were captured in meeting minutes and fieldwork notes.

SEWB service delivery impact, enablers and challenges

This section of the preliminary findings presents SEWB service delivery impact, enablers and challenges as they relate to the four-pillar approach. Findings in this section are informed by qualitative interviews with team members, clients and other stakeholders; the SEWB-SAT discussions; observations and ongoing stakeholder engagement; and a review of sites' KPI reporting to the WA MHC.

Culturally secure community development

Most sites were confident and actively delivering a range of programmes and activities. One site that had experienced

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Table 2 Data collection across Pilot sites

	SWAMS	GRAMS	DAHS	BGHS	WMHSAC	Other stakeholders	Total
Visit dates	3–5 May 2023	22–26 May 2023	26–29 June 2023	21–24 August 2023	28–30 August 2023	–	–
SEWB-SAT discussion participants	3	7	5	–	4	–	19
KKH interviews	1	–	1	–	1	3	6
Client interviews	2	2	2	4	5	–	15
SEWB team interviews	2	2	2	2	2	–	10
Other teams/ agencies interviews	1	1	2	1	1	–	6
Total	9	12	12	7	13	3	56

BGHS, Bega Garnbirringu Health Service; DAHS, Derby Aboriginal Health Service; GRAMS, Geraldton Regional Aboriginal Medical Service; SEWB, social and emotional well-being; SEWB-SAT, Social and Emotional Well-being Systems Assessment Tool; SWAMS, South West Aboriginal Medical Service; WMHSAC, Wirraka Maya Health Service Aboriginal Corporation.

turnover in key roles and difficulty recruiting reported that this was a barrier for them to develop and deliver programmes and activities; however, they had plans in place for once the roles were recruited. SEWB team staff shared examples of being able to connect with people in the community and build their knowledge, awareness and understanding of SEWB and key topics such as consent and healthy relationships:

> I run a number of various presentations based on what the need is at the school. Like bullying, drugs and alcohol, risky behaviours, consent, and healthy relationships. I work mostly with young boys through the school here. Lately there was this one young boy in year 9 that stood out to me the most. He is a popular kid in his class and what he does reflects on his mates, during our Consent and Healthy Relationships presentation, this young man was really engaged and asked a lot of good questions. He left the presentation telling me he [understood] consent and realised it was a thing for men and women—he described it as "going both ways". Last week he came up to me outside the shops and wanted to talk some more. I can see how these young boys are growing up on the internet where consent is not asked. Being able to talk this stuff through and build their healthy behaviours is so important for our young people and their SEWB. (Aboriginal SEWB Worker, male)

Pilot sites shared that they were both initiators and collaborators with community and other organisations in delivering culturally secure community development. Collaboration was an important element across service delivery and was occurring with community, within ACHHS as well as with other external services and organisations.

Events within the community were described as important for prevention, and a soft entry point for clients to engage with SEWB services alongside other services. It was noted by sites that this enables holistic service delivery and removes barriers to access for clients that may not otherwise engage with service providers.

Some sites noted that there were challenges between allocating staff time to developing and delivering culturally secure community development events and activities and providing individual psychosocial support to clients. One site that had identified the need to provide outreach to other communities in the region also identified specific barriers, such as the distance required to travel to those communities.

Psychosocial support

Most sites reported that they were providing psychosocial education and sharing resources with clients that were engaging in one-on-one SEWB support. Many sites also shared that it was important to develop tailored resources that were culturally appropriate, relevant and accessible to their clients and community. All sites reported client advocacy and case management were central to the SEWB support they provided to their clients. This involved a strong knowledge of referral pathways to relevant agencies and services. In providing this support, SEWB teams were able to draw on their cultural and community knowledge, lived experience and/or strong relationships with external agencies to get positive outcomes towards resolving non-clinical SEWB needs of Aboriginal clients. The quote below from a client participant shows the important role of SEWB workers empowering clients by supporting them to access other help services:

> [I've learnt] there's help out there, and without these guys giving me their knowledge I wouldn't know that.

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> I've heard about [help service]. I never knew what it was about. And they took me to get a voucher from the [another help service] … I didn't know any of these things did that … So they open your eyes to a lot of other organisations … Without them, I wouldn't have even approached the places that they have. (client, Aboriginal man, older adult)

Many clients and team members across Pilot sites also shared that they valued the flexibility within SEWB service delivery. It was felt that it was important not to be constrained by time when advocating for clients to resolve immediate challenges they were facing, when building rapport and trust, or hearing a client's story. As one client shared, contrasting her experience with the current SEWB team with a previous help-seeking experience:

> I remember one day I was talking about why I'm there and all that, sharing my story and then a phone call came in reception and there's the other client waiting for her. So we quickly had to close my visit and move on. So I found after that, I sort of lost interest in that, so I didn't go back. (client, Aboriginal woman, older adult)

One barrier that was identified by some staff and clients at Pilot sites was the entry pathway to accessing SEWB services. Initial engagement with a GP or reception within the clinic was a barrier for some clients to engaging with the SEWB service. This included availability of GPs, having to engage at multiple points before being connected to the SEWB team, having to wait publicly in a clinic reception before receiving support, or reception staff not having sufficient training to triage and engage with clients in distress:

> You have to see a doctor first, and a doctor has to refer you over. And a lot of the time you might need help then and there or … that overwhelming feeling of wanting to see somebody, [to] make that step at that time. But you have to go through the process of seeing a doctor, waiting for that doctor, and that doctor might not be available for like weeks at a time sometimes. (client, Aboriginal woman, young adult)

While some sites shared that advocacy and case management were the main support they were providing clients, many sites were providing ongoing counselling services to clients. SEWB counsellors worked within a range of modalities such as tapping, cognitive–behavioural therapy, narrative therapy and art therapy. Cultural safety within the therapeutic support given to clients was seen as important by both Aboriginal and non-Aboriginal counsellors, and many counsellors spoke about bringing together an understanding of Western psychological knowledge and Aboriginal cultural ways. In the quote below, a client speaks of the counselling support she received, which drew on Western modalities but also respected and valued her Aboriginal culture and identity:

> I feel like it … was changing my way of thinking … without me losing my identity as an Aboriginal person and balanced it [with] my cultural upbringing … (client, Aboriginal woman, older adult)

Psychosocial support activities were positively viewed by clients who reported: further awareness of how to access support and knowledge of what support is available; resolution of issues relating to social determinants of health; being equipped with psychological tools and strategies to face and cope with challenges in life; and feeling more confident, valued, more connected and happier since they had engaged with the service:

> I think myself personally, I've come a long way since coming here, in dealing with matters now, like unbelievable the person I was like a year ago. With anger, all that anger, anxiety. It's not good for you, especially getting on in age too. (client, Aboriginal woman, older adult)

Targeted interventions

The use of culturally secure screening and assessment tools across sites reflected the knowledge and training with specific tools that individual practitioners brought to the team, or that other staff at the ACCHS possess. While many culturally appropriate tools were being explored, none had yet been integrated as routine service delivery.

Cultural or traditional healing and culturally responsive healing modalities were recognised, valued and seen as an important part of Aboriginal health and well-being by all teams. Though, the way this was translated into service delivery varied across sites and was dependent on organisational and community contexts. Most teams, however, had organised activities to facilitate cultural connections on Country, including on Country trips and camping for men's and women's group, for Elders and to connect young people with Elders. Clients felt that these were important well-being activities:

> … there's this perception that "you mob just pack up your Toyotas and you go bush and you go fishing and you're just having a good time". But it's not. It's about the conversations that you're having, about feeling safe in the space that you're having that conversation. Because of a lot of our mob don't like sitting inside of a room having a conversation. So it's about … saying to people from a Western background, "You might think we're out there doing nothing, sitting on country, but really we're having the real conversations about how do we deal with the things that are going on in our life". (key knowledge holder)

Most teams also reported that referrals to services relating to targeted issues such as alcohol and other drug use, family and domestic violence, trauma and acute mental health issues were either becoming part of routine practice, or already established as an effective and routine part of their service delivery. Most sites shared they had a good

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knowledge of referral pathways to these services and would provide warm referrals. However, many sites also noted barriers relating to the availability of services within the community, barriers to access faced by clients and inability to establish strong relationships with some external agencies. Supporting clients to overcome these barriers was a strong part of the advocacy support teams engaged in.

Supported coordinated care

Some teams noted that warm referrals to targeted support services and advocacy to navigate tertiary mental health services were an emerging role; and that clients that have been discharged from services are often referred back. Teams also noted that stronger relationships and mechanisms for communication with relevant services need to be established for stepped care to be more effective and part of routine practice. It was noted that teams felt that a clinical lead or SEWB manager was necessary to

Table 3 SEWB-SAT aggregated findings

Service delivery	
Service delivery processes and resources	Sites were in developmental stages for record keeping and governance processes. Client outcome monitoring processes were still being developed, with discussions underway to create a suitable monitoring tool. Teams generally had baseline resources for SEWB service delivery, but additional needs, such as cars and office spaces were noted
Workforce	
Team development	SEWB teams reported not having specific SEWB and Service Model onboarding information. Professional development was seen as important, but there were some challenges to accessibility, and a formal training needs assessment had yet to be undertaken
Leadership	There were challenges in hiring or retention for Clinical Lead roles. There were different team leadership configurations at each site, with an emphasis on clinical knowledge. Cultural Lead roles had recruitment and role structure challenges
Cultural security	Majority of team members were Aboriginal; staff with clinical qualifications were often non-Aboriginal. Cultural security was understood but not always reflected in policies and procedures
Occupational health and safety	SEWB delivery specific occupational health and safety (OHS) processes were not established, requiring development in priority areas. Psychosocial OHS was crucial, with teams seeking more organisational support, including psychosocial care initiatives. Clinical and cultural supervision was identified as important, but access and appropriate forms varied among sites
Client access	
Physical infrastructure considerations	Teams had varied workspaces, each with its unique challenges and advantages. Location inside the clinic building provided opportunities for better integration and stronger safety protocols but offered a less therapeutic environment and had implications for privacy. Locations external to the clinic could be more private with designated therapeutic rooms and supported trauma informed approaches, but could impact informal contact with other clinic services, and clients may feel shame if seen accessing the service
SEWB staffing	Aboriginal staff often served as the initial point of contact for clients, enhancing cultural security and client access. Teams had a mix of male and female staff, facilitating client access. Diverse staff age ranges were observed and valued for engaging different client demographics, especially young people. Most sites had difficulties recruiting and retaining roles for the Pilot SEWB team. This posed an additional challenge towards establishing systems and processes
Flexibility and responsiveness of SEWB service	Flexibility and responsiveness were strengths, operating on a ‘no wrong door’ principle, ensuring all clients received support or warm referrals. SEWB teams delivered support outside the office setting, including homes, community spaces or transporting clients. After-hours support was offered by some sites, but processes needed formalisation, and recognition for after-hours work was lacking in some cases
External linkages and internal integration	
Recognition and perceived importance of SEWB within ACCHS environment	Recognition and understanding of SEWB teams within ACCHS were increasing, with positive outcomes from promotional efforts and referrals from GPs. SEWB service delivery filled critical gaps in healthcare delivery, expanding the scope beyond mental health
Linkages within the community	Emerging interdisciplinary and step-up step-down care with tertiary mental health services were observed in some sites. Teams collaborated with other services and participated in network meetings, but integration with existing SEWB services at sites faced challenges

ACCHS, Aboriginal Community Controlled Health Services; SEWB, social and emotional well-being; SEWB-SAT, Social and Emotional Well-being Systems Assessment Tool.

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be able to develop relationships with other agencies. Staff from external agencies also spoke about the role the SEWB team played in working with other agencies in the community:

> The respect that [the SEWB manager] and [their] team have curated in the community has been noted I think. [They're] respected and respect in [this community] goes a long way, so that has made it easier to actually work with [them], because when we need something, [they] know where to shake the trees and also that knowledge of place. [This community] is very transient. So, when you have someone that knows the region, knows the place and was willing to share that information willingly it's, it's invaluable. (non-Aboriginal service provider from external agency)

Coordination within the ACCHS mostly consisted of informal communication rather than formal processes for shared care. Some sites shared that co-location with relevant services made coordination much easier, as these informal discussions relating to client care were more regular, as was attendance to team meetings by other service providers at the ACCHS.

For many teams, a significant portion of their clients were referred from GPs in the clinic; however, teams also shared that more knowledge and awareness of SEWB and the SEWB service could be developed within the clinic. This was a barrier towards coordination between both primary health, and social support services within an ACCHS:

> [The ACCHS] in itself need a really good outline of what the role of the SEWB team is. No different to any other new programme coming on. Because what I have seen is … Or what I hear is "ohh, just give it to SEWB. They can do it". And it's not actually … their role. (non-Aboriginal other service provider at ACCHS)

Summary of SEWB-SAT aggregated findings

Table 3 provides a high-level aggregated summary of the SEWB-SAT findings across the sites. These findings relate to other key systems and processes for SEWB service delivery within the ACCHS context.

DISCUSSION

The SEWB teams across each Pilot site have made strong contributions to strengthening the SEWB of their clients and communities across a range of activities and services offered. By leveraging cultural and community knowledge, and lived experience, SEWB teams have been able to effectively engage with community, advocate and connect clients to relevant services and supports, and provide culturally appropriate counselling in flexible and responsive ways. It was also evident from the SEWB-SAT discussions that developing and codifying systems, processes and governance of SEWB services is an emerging priority for the ACCHS sector. This reflects a history of ad hoc, inconsistent, and often poorly funded SEWB services and high levels of SEWB staff turnover. Despite these challenges, there are many examples of

Box 1 Recommendations for maintaining, strengthening and developing SEWB systems and processes

Maintain

⇒ Scope and spread of community development activities and initiatives within a wide range of community settings and community partnerships.
⇒ Client advocacy and case management services.
⇒ Existing service provider relationships and representation on interagency committees.
⇒ High numbers of Aboriginal SEWB team members, inclusive of male and female staff across a range of ages.
⇒ 'No wrong door' and warm referral approach to SEWB service delivery.
⇒ Service responsivity and flexibility, including a range of cultural and therapeutic services.

Strengthen

⇒ Professional capacity of SEWB teams through resource sharing and identification of relevant upskilling relating to brief intervention, psychosocial education, and culturally secure screening and assessments.
⇒ Internal pathways and processes to support clients to be referred to SEWB services from clinical services. This includes ensuring SEWB and mental healthcare are integrated within primary healthcare enquiries and processes; alignment of reporting processes to clinical governance standards; and enhanced systems for client record keeping.
⇒ Capacity (physical and human) of SEWB teams to facilitate more on-Country and cultural initiatives.
⇒ Ensure leadership of SEWB teams recognises and responds to the cultural and clinical dimensions of interdisciplinary, coordinated and stepped care.
⇒ Consider SEWB location challenges (within clinical building or external) and develop place-based strategies to enhance enablers and mitigate challenges.

Develop

⇒ SEWB orientation and induction processes and align to professional development opportunities.
⇒ Supports for ACCHS sector to learn more about traditional healing through informal and formal knowledge exchange.
⇒ Integrated care, throughcare and aftercare pathways and referral processes related to interdisciplinary, coordinated and stepped care activities with internal and external stakeholders.
⇒ Supports for identification of therapeutic outcomes across events, activities and services delivered by SEWB teams; and develop Pilot wide client outcome monitoring processes that are meaningful, easily administered, reflective of breadth of SEWB service delivery and acceptable to SEWB teams and clients.
⇒ Organisational occupational health and safety processes that include SEWB-specific policies, that is, staff safety, after-hours work, psychosocial support and staff well-being, and supervision arrangements.
⇒ Further staff recruitment and retention strategies and initiatives.

ACCHS, Aboriginal Community Controlled Health Services; SEWB, social and emotional wellbeing.

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emerging SEWB outcomes for clients and community which are indicative of the depth of knowledge, experience and existing relationships with agencies and communities that exist within SEWB teams. The need for well-established strong systems and processes is necessary for service delivery in primary health contexts such as the ACCHS sector.[24 25] SEWB sector strengthening and capacity building are required to support initiatives such as the Pilot to meet their full potential, and for SEWB workforces to feel adequately equipped. To achieve this requires sustainable, long-term funding and appropriate human resources.

A strong workforce is a key enabler of effective health service delivery,[24 25] and identified as key priorities for the improvement of Aboriginal and Torres Strait Islander primary healthcare services.[26–28] Key strategies for strong, supported and safe workforces include increasing role clarity,[14 29] policies and procedures for safe work environments[30] that reflect the breadth of the SEWB specific contexts, activities and ways of working; managing psychosocial hazards such as vicarious trauma and lack of cultural safety that can have negative impacts on SEWB and result in workforce burnout. Burnout is a key exacerbating factor for poor workforce retention.[31] For much of the Aboriginal and Torres Strait Islander workforce, this can be compounded by family and community responsibilities and being approached to provide support outside of a work context.[14] Staff need to be supported to cope with the stressors they may face in their roles.[32] The accessibility of clinical and cultural supervision for staff can better address some of the specific psychosocial hazards faced by the SEWB workforce and provide the necessary support to mitigate burnout.[33 34]

Within SEWB service delivery, in addition to strong clinical governance, and the systems and processes that support this, strong cultural governance and leadership are also required. This is essential for both the provision of culturally safe and appropriate care, and experiences of cultural safety within the workforce.[8 26 29 33] Culture is a central component of SEWB service delivery, and its centrality is needed for good SEWB outcomes.[9] Undervaluing cultural skills and knowledge in the workplace and the dominance of biomedical models are key barriers for a strong and effective Aboriginal workforce,[29] while recognising strengths and value of culture and ways of knowing has positive outcomes for employee well-being.[14 31]

To establish integrated and robust systems and processes, a foundation of a supported and well-resourced workforce is needed, and the time to develop the organisational capacity and knowledge required to drive and sustain these changes. This requires sustainable long-term funding, with collaborative and flexible approaches to commissioning, and streamlined reporting processes.[30 35 36] Poor staff retention emerged as a key issue faced by the ACCHS sector, a limited SEWB workforce poses significant barriers to establishing strong systems and processes, and without strong systems and processes, the SEWB workforce, in turn, is at risk of burnout.[7 30 33]

Implications

SEWB has been embedded as an essential paradigm within key policy frameworks to support the health and well-being of Aboriginal and Torres Strait Islander people and communities.[2] Preliminary findings from the Pilot contribute to the literature that demonstrates the importance of programmes and services that strengthen the SEWB of Aboriginal and Torres Strait Islander people and communities, and address social, cultural and political determinants of health and well-being.[37 38] The findings from this research also highlight the key areas relevant to SEWB service delivery and workforce, that require further investment and development. Box 1 highlights recommendations to guide current and future SEWB service design and planning.

Limitations

Recognising the diversity of Aboriginal people and communities, differing policy environments, and the salience of place-based considerations in the delivery of services, the findings may not be generalisable to SEWB services delivered in other contexts. All participating Pilot sites contributed to the evaluation, capturing a diversity of contexts and a comprehensive picture of the initiative. A limitation of the research is that data was collected by a non-Aboriginal male researcher, this complicated data collection and may have impacted the relationship between the researcher and participants. Overall, the findings from this research provide important insight into the key focus areas that support implementation.

Future research

These preliminary findings were taken from the early stages of a multi-year evaluation. The findings have been shared with key stakeholders within the Pilot and have informed the support and advocacy provided by AHCWA, as well as the service planning undertaken by SEWB teams at each Pilot site. In addition to documenting impacts and emerging outcomes of the Pilot, further data collected during the final evaluation activities, including follow-up sessions with the SEWB-SAT, will show actions that have been undertaken in response to these early findings and recommendations, and their impacts on the SEWB service delivery. The final evaluation report will be completed in June 2025 and will be informed by a second round of data collection site visits near the end of the Pilot, and ongoing engagement with Pilot site teams and stakeholders.

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Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants. This research aligns with the National Health and Medical Research Council Guidelines on Ethical Conduct in Aboriginal and Torres Strait Islander health research. The research received support from relevant Aboriginal Health Planning Forums across each region prior to receiving ethical approval from the Western Australian Aboriginal Health Ethics Committee (HREC1204). Participants gave informed consent to participate in the study before taking part.

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REFERENCES

1 Gee G, Dudgeon P, Schultz C, *et al*. Aboriginal and torres strait islander social and emotional wellbeing. In: Dudgeon P, Milroy H, Walker R, eds. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Commonwealth of Australia, 2014.
2 Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. Aboriginal and torres strait islander suicide prevention policy concordance. University of Western Australia; 2019. Available: https://www.gayaadhuwi.org.au/wp-content/uploads/2023/01/Australian_Indigenous_Suicide_Prevention_Concordance.pdf [Accessed 08 Aug 2024].
3 Transforming Indigenous Mental Heal. Social and Emotional Wellbeing Gathering 2 Report: 26th-28th October 2021. The University of Western Australia, 2021.
4 Transforming Indigenous Mental Health and Wellbeing Project. Social and Emotional Wellbeing Gathering 3 Report: 6th-8th September 2022. The University of Western Australia, 2022.
5 Transforming Indigenous Mental Health and Wellbeing Project. Social and Emotional Wellbeing Gathering 4 Report: 31st July-2nd August 2023. The University of Western Australia, 2023.
6 Dudgeon P, Walker R, Bray A, *et al*. Social and Emotional Wellbeing: A Review.
7 National Aboriginal Community Controlled Health Organisation. Social and Emotional Wellbeing Consultation Survey Results: NACCHO Members and Affiliates April 2023. NACCHO, 2023.
8 Coombes J, Cullen P, Bennett-Brook K, *et al*. Culturally Safe and Integrated Primary Health Care: A Case Study of Yerin Eleanor Duncan Aboriginal Health Services' Holistic Model. *Aihjournal* 2022;3:1–9.
9 Page IS, Leitch E, Gossip K, *et al*. Modelling mental health service needs of Aboriginal and Torres Strait Islander peoples: a review of existing evidence and expert consensus. *Aust N Z J Public Health* 2022;46:177–85.
10 Coe G. Decolonising mental illness: Aboriginal and Torres Strait Islander peoples' Social and Emotional Wellbeing and the persistence of colonial discourses in policy. *Aust J Social Issues* 2021;56:503–21.
11 Carlin E, Cox Z, Orazi K, *et al*. Exploring Mental Health Presentations in Remote Aboriginal Community Controlled Health Services in the Kimberley Region of Western Australia Using an Audit and File Reviews. *Int J Environ Res Public Health* 2022;19:1743.
12 Aboriginal Health Council of Western Australia (AHCWA). ACCHS social and emotional wellbeing service model. AHCWA; 2021. Available: https://timhwb.org.au/wp-content/uploads/2021/05/AHCWA_SEWBReport_JAN21.pdf [Accessed 08 Aug 2024].
13 Schultz C, Walker R, Bessarab DC, *et al*. Interdisciplinary care to enhance mental health and social and emotional wellbeing. In: Dudgeon P, Milroy H, Walker R, eds. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Commonwealth of Australia, 2014.
14 Cox Z, Carlin E, Derry K, *et al*. 'It's Us, Or Maybe No One': Yarning With Aboriginal Social and Emotional Wellbeing Workers From the Kimberley Region of Western Australia. *Aihjournal* 2023;4:1–22.
15 Canuto K, Wittert G, Harfield S, *et al*. "I feel more comfortable speaking to a male": Aboriginal and Torres Strait Islander men's discourse on utilizing primary health care services. *Int J Equity Health* 2018;17:185.
16 Dudgeon P, Carlin E, Agung-Igusti R. Evaluation of the Aboriginal Health Council of Western Australia's ACCHS Social and Emotional Wellbeing Service Model: Summary – Interim Evaluation Report 2023. University of Western Australia, 2023.
17 Dudgeon P, Carlin E, Derry K, *et al*. Evaluating a social and emotional well-being model of service piloted in Aboriginal Community Controlled Health Services in Western Australia: an Aboriginal Participatory Action Research approach. *BMJ Open* 2023;13:e075260.
18 Dudgeon P, Bray A, Darlaston-Jones D, *et al*. Aboriginal Participatory Action Research: An Indigenous Research Methodology Strengthening Decolonisation and Social and Emotional Wellbeing. The Lowitja Institute, 2020.
19 Walker R, Schultz C, Sonn C. Cultural competence –transforming policy, services, programs and practice. In: Dudgeon P, Milroy H, Walker R, eds. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Commonwealth of Australia, 2014.
20 Bessarab D, Ng'andu B. Yarning About Yarning as a Legitimate Method in Indigenous Research. *IJCIS* 2010;3:37–50.
21 One21seventy. Menzies School of Health Research.2012. Available: https://www.menzies.edu.au/page/Resources/Systems_Assessment_Tool_SAT/
22 Kimberley Aboriginal Health Planning Forum [KAHPF]. A cultural security framework. KAHPF; 2023. Available: https://static1.squarespace.com/static/5b5fbd5b9772ae6ed988525c/t/5f598017654f8b4023763ca3/1599701035315/KAHPF+Cultural+Security+Framework.pdf [Accessed 21 Feb 2023].
23 Gale NK, Heath G, Cameron E, *et al*. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodol* 2013;13:1–8.
24 KPMG. Organisational enablers for the aboriginal community controlled health services sector: department of health final report. 2020.
25 World Health Organisation, UNICEF. Operational framework for primary health care: transforming vision into action. 2020.
26 Carlisle K, Matthews (Quandamooka) V, Redman-MacLaren M, *et al*. A qualitative exploration of priorities for quality improvement amongst Aboriginal and Torres Strait Islander primary health care services. *BMC Health Serv Res* 2021;21.
27 Commonwealth of Australia Department of Health. National aboriginal and torres strait islander health workforce strategic framework and implementation plan 2021-2031. Commonwealth of Australia; 2022. Available: https://www.health.gov.au/sites/default/files/documents/2022/03/national-aboriginal-and-torres-strait-islander-health-workforce-strategic-framework-and-implementation-plan-2021-2031.pdf [accessed 08 Aug 2024]
28 South Australian Health and Medical Research Institute (SAHMRI). Aboriginal community controlled health organisations in practice:

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sharing ways of working from the accho sector. Wardliparingga Aboriginal Health Equity Theme, South Australian Health and Medical Research Institute; 2020. Available: https://create.sahmri.org/wp-content/uploads/2020/02/ACCHO_Interactive_Resource2020.pdf
29 Bailey J, Blignault I, Renata P, *et al*. Barriers and enablers to Aboriginal and Torres Strait Islander careers in health: A qualitative, multisector study in western New South Wales. *Aust J Rural Health* 2021;29:896–908.
30 The Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange [CREATE]. Aboriginal community controlled health organisations in practice: sharing ways of working from the accho sector. Wardliparingga Aboriginal Health Equity Theme, South Australian Health and Medical Research Institute; 2020. Available: https://create.sahmri.org/wp-content/uploads/2020/02/ACCHO_Interactive_Resource2020.pdf
31 Upton P, Ford L, Wallace R, *et al*. Improving Indigenous Mental Health Outcomes with an Indigenous Mental Health Workforce. Australian Government Australian Institute of Health and Welfare, 2021.
32 Matthews V, Bailie J, Laycock A, *et al*. Aboriginal and torres strait islander mental health and wellbeing care: final report, esp project. Menzies School of Health Research; 2016.
33 Deroy S, Schütze H. Factors supporting retention of health and wellbeing staff in Aboriginal health services: a strength-based case study. *Hum Resour Health* 2021;19:35.
34 McCalman J, Campbell S, Jongen C, *et al*. Working well: a systematic scoping review of the Indigenous primary healthcare workforce development literature. *BMC Health Serv Res* 2019;19:767.
35 Bulloch H, Forgarty W, Bellchambers K. Aboriginal health and wellbeing services: putting community-driven, strengths-based approaches into practice. The Lowitja Institute; 2019.
36 Dawson AP, Warrior E, Pearson O, *et al*. Exploring self-determined solutions to service and system challenges to promote social and emotional wellbeing in Aboriginal and Torres Strait Islander people: a qualitative study. *Front Public Health* 2023;11:1206371.
37 Gupta H, Tari-Keresztes N, Stephens D, *et al*. A scoping review about social and emotional wellbeing programs and services targeting Aboriginal and Torres Strait Islander young people in Australia: understanding the principles guiding promising practice. *BMC Public Health* 2020;20:1625.
38 Murrup-stewart C, Searle AK, Jobson L, *et al*. Aboriginal perceptions of social and emotional wellbeing programs: A systematic review of literature assessing social and emotional wellbeing programs for Aboriginal and Torres Strait Islander Australians perspectives. *Aust Psychol* 2019;54:171–86.

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