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

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

Patricia Dudgeon,[1] Emma Carlin ,[2] Kate Derry,[1] Joanna Alexi,[1] Michael Mitchell,[1] Rama Putu Agung-Igusti [1]

To cite: 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. doi:10.1136/bmjopen-2023-075260

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2023-075260).

Received 02 May 2023
Accepted 13 September 2023

[1]School of Indigenous Studies, The University of Western Australia, Perth, Western Australia, Australia
[2]Rural Clinic School, University of Western Australia, Broome, Western Australia, Australia

Correspondence to
Dr Rama Putu Agung-Igusti; rama.agung-igusti@uwa.edu.au

ABSTRACT

Introduction The delivery of services to improve Aboriginal health and well-being must centre culture and integrate a social and emotional well-being understanding and approaches. These approaches are essential in increasing access to, and engagement with, health services, as well as ensuring culturally safe, person-centred and community-centred care. This study will evaluate the Aboriginal Health Council of Western Australia's social and emotional well-being model of service being piloted in five Aboriginal Community Controlled Health Services across five of Western Australia's regions. The model of service includes the establishment of interdisciplinary social and emotional well-being teams and a four-pillar approach to service delivery.

Methods and analysis An Aboriginal Participatory Action Research methodology will be undertaken which calls for Indigenous leadership and governance, capacity-building of community co-researchers and engagement in reflexive practice. The evaluation will take a mixed-methods approach to data collection, including at each pilot site, yarns with up to five clients engaging with social and emotional well-being services; qualitative interviews with up to five service providers at each site, and up to five key knowledge holders from stakeholders including funders and commissioning bodies; the collection of clinical data; facilitated discussion using the social and emotional well-being Systems Assessment Tool; and document analysis and cost-estimation. Analysis will be guided by a client journey mapping framework, and data will be collectively analysed through a socioecological framework to understand the connections and inter-relatedness between client outcomes and experiences, social and emotional well-being team and service provider experiences, service systems and governance structures.

Ethics and dissemination This evaluation was approved by the Western Australian Aboriginal Health Ethics Committee (HREC1204). The findings will be disseminated through the production of an evaluation report and academic publications and presentations. Findings will also be disseminated through community forums and plain language summaries. These outputs will detail evaluation findings and recommendations, the process of evaluation through an Aboriginal Participatory Action Research approach and the collaborative stakeholder relationship-building that underpinned the project.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The evaluation will take an Aboriginal Participatory Action Research approach, which supports self-determination and centres on Indigenous ways of knowing, being and doing.
⇒ The evaluation's mixed-methods design represents the complexity of the pilot and aligns with an ecological and systems approach to examine multiple levels of analysis.
⇒ The Social and Emotional Well-being Systems Assessment Tool is a useful tool for assessing systems and processes for social and emotional well-being service delivery within Aboriginal Community Controlled Health Services.
⇒ A limitation of the evaluation is that it will not capture longer-term social and emotional well-being outcomes for the clients and community.

INTRODUCTION

A holistic and culturally grounded understanding of health and well-being is essential in improving health outcomes for Aboriginal and Torres Strait Islander people.[1] This understanding must be articulated by Aboriginal and Torres Strait Islander people and account for their social, cultural, political and historical contexts. Social and emotional well-being (SEWB) is a holistic framework that recognises these contexts as key determinants towards health and well-being, and the mediating role of social structures and

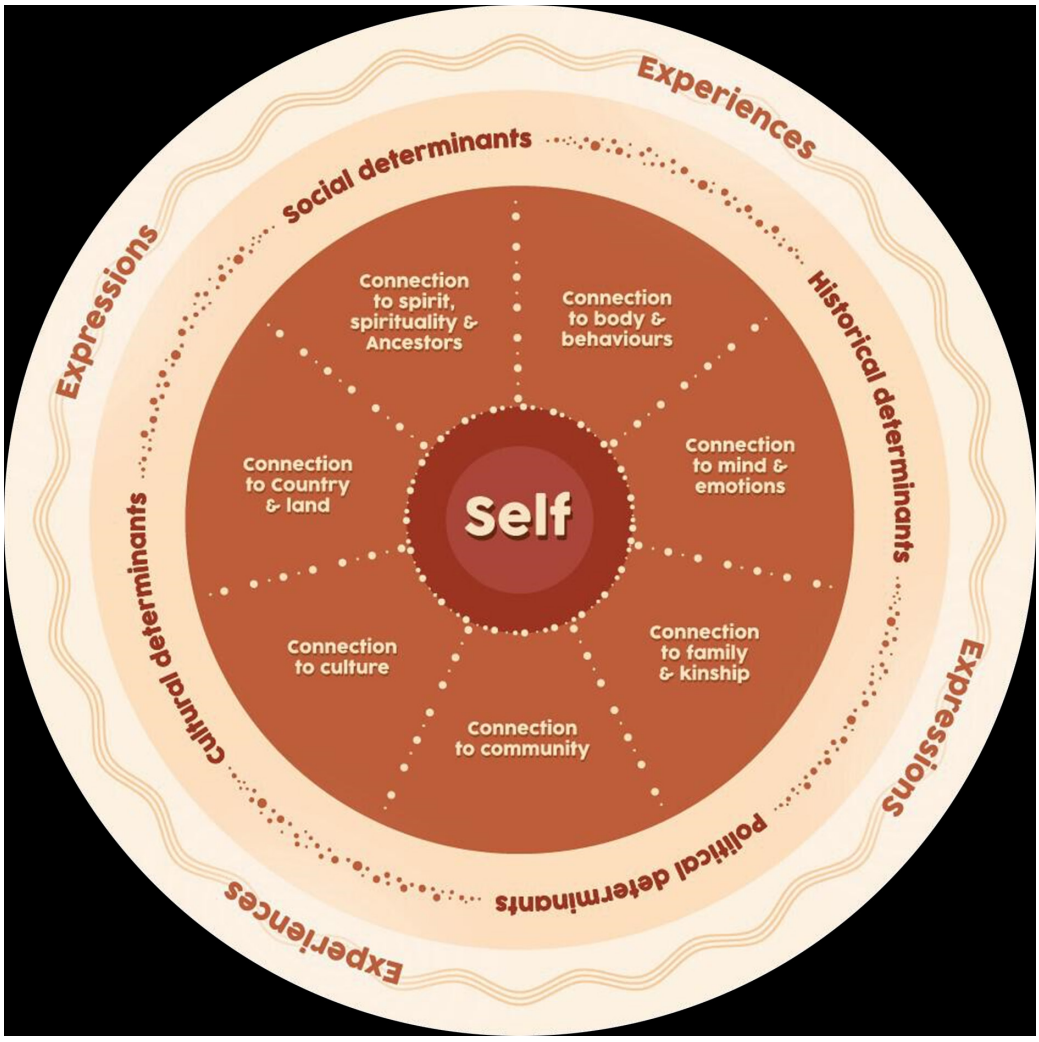

Figure 1 Social and emotional well-being (SEWB) domains. SEWB diagram adapted from Gee *et al*.[2]

conditions, legacies of colonisation, cultural systems and knowledge, and laws and policies that have contributed to loss of land, sovereignty and the ability to self-determine. It aligns to Aboriginal and Torres Strait Islander people's ways of being, doing and knowing. The SEWB framework encompasses multiple domains including connection to spirit, spirituality and ancestors; connection to body and behaviours; connection to mind and emotions; connection to family and kinship; connection to community; connection to culture; and connection to country and land.[2] These domains are centred around an Indigenous concept of self which is connected and related to these domains through diverse expressions and experiences across time and place reflecting the diversity of cultures and histories among Aboriginal people and communities (figure 1).

The concept of SEWB has been adopted by Australian governments, at all levels, to direct and shape policy relating to Aboriginal and Torres Strait Islander people.[3–6] Explicit within these policy frameworks is that the delivery of services to improve Aboriginal health and well-being must centre on culture and integrate with an SEWB understanding and approaches. Research has shown that these approaches are essential in increasing access to, and engagement with, health services, as well as ensuring culturally safe care.[7–11] Several government agencies have funded dedicated SEWB services, many of which are embedded in Aboriginal Community Controlled Health Services (ACCHSs).

ACCHSs emerged in the 1970s as a community-led response to the systemic racism evident within mainstream health services and the poor health outcomes experienced by Aboriginal and Torres Strait Islander people.[12] Key characteristic of ACCHSs is that they are governed by a local Aboriginal and/or Torres Strait Islander Board of Directors as a mechanism to ensure community control. ACCHSs progress self-determination and empowerment for their communities by centring the cultural understanding of health within approaches to service delivery. Further, they are committed to developing a culturally competent and skilled workforce to provide accessible and flexible services.[13–15] SEWB services delivered within ACCHSs aim to complement the delivery of holistic health by delivering community development; social support; casework and advocacy; psychosocial support; therapeutic care and/or support; and psychiatric care or

liaison/care integration.[10 16] SEWB services are often key in providing or brokering access to traditional healing services, return to country programmes or Aboriginal and Torres Strait Islander-developed and facilitated psychosocial education programmes such as the Kimberley Empowerment and Healing Program and the National Empowerment Project's Cultural, Social and Emotional Wellbeing Program.[17 18]

Despite strong commitment to the delivery of SEWB services, a recent survey of ACCHSs identified ongoing SEWB service gaps requiring additional SEWB service development and resources.[19 20] One key area for development is the establishment of translational frameworks that clearly define and operationalise the SEWB model within SEWB service delivery. Without such frameworks, there is a risk that SEWB service delivery will not meet the place-based needs of an ACCHS or Aboriginal and Torres Strait Islander communities.[20 21] Additionally, establishing clear frameworks contributes to the fidelity of SEWB service delivery approaches, which enables better valuation of what factors have most impact, and supports reproducibility across contexts.

SEWB model of service pilot

The Aboriginal Health Council of Western Australia (AHCWA) is a peak body for Western Australian (WA) ACCHSs. In this representative role, AHCWA engages in sector development, and provides support, advocacy and capacity-building for its 23 independent member ACCHSs.[22] In 2018, AHCWA commissioned work to explore the development of an SEWB service model through consultation with its member ACCHSs. The consultations sought to describe and define existing SEWB services; provide conceptual clarity regarding services; and map existing services, delivery gaps, funding and implementation challenges, and opportunities for workforce development and evaluation.[16]

One of the findings from the consultation was that all the participating ACCHSs offered programmes and services that fell under the category of SEWB, even if not named and funded as such. Almost all the ACCHSs also delivered programmes and services through named SEWB teams, and received funding specifically identified for the delivery of SEWB services.[16] For ACCHSs, this represents a context of multiple funders across levels of government involved in service delivery, which shape what existing SEWB service delivery looks like across sites.[23]

Drawing on the consultation findings, AHCWA and its member ACCHSs collaborated to develop the ACCHS SEWB service model (the Model) and secured $17.6 million in funding from the WA government's Mental Health Commission (MHC) to pilot the Model across five WA ACCHSs selected by AHCWA from its members (the Pilot). Each of these sites is located across 5 of WA's 10 regions, which include Derby Aboriginal Health Service (Kimberley), Wirraka Maya Health Service Aboriginal Corporation (Pilbara), Bega Garnbirringu Health Service (BGHS; Goldfields), Geraldton Regional Aboriginal Medical Service (Mid-West) and South West Aboriginal Medical Service (South West). Each of these sites, except for BGHS, had participated in the original consultations. A map of the site locations across WA's regions can be seen in figure 2. The funding would be distributed among the Pilot sites to develop dedicated SEWB teams to deliver SEWB services as outlined in the model. A portion of the funding was also allocated to AHCWA to provide support and manage the Pilot contract. Evaluation was funded separately through the WA MHC.

ACCHS SEWB service model

While many ACCHSs already provide SEWB services, the Model is a framework that translates the SEWB domains and principles into a four-pillar approach to guide and support service delivery (see figure 3 for examples of service responses and impacts). The four-pillar approach entails *culturally secure community development* through activities such as psychosocial education, health promotion education and resources, healing days and awareness campaigns; *psychosocial support*, such as advocacy, provision of information, and referrals and case management for individuals and/or families; *targeted interventions*, such as culturally secure assessments, referrals within ACCHS and to external services to provide support for issues relating to social determinants of health, culturally centred healing and support such as traditional healers, and follow-up with specialist and acute services; and *supported coordinated care*, which involves stepped care between services, and provision of culturally appropriate wellness initiatives. While these broad pillars characterise the Model and an integrated approach to SEWB service delivery, these examples of services and activities are dependent on the contexts and needs of each ACCHS reflecting a place-based approach.[21]

The need for a trained workforce that can deliver services within the four-pillar approach is a key component of the Model which calls for recruitment of a flexible interdisciplinary SEWB team with cultural, therapeutic and clinical expertise. An SEWB team could consist of a range of allied health workers as well as elders, traditional healers and cultural connectors,[24] but at a minimum the following positions would need to be funded under the Model: clinical lead (mental health clinician) to provide clinical governance; cultural lead (50D position (50D refers to an Aboriginal or Torres Strait Islander-identified position where an employer may indicate a role be filled only by an Aboriginal or Torres Strait Islander; identified positions address employment inequities experienced by specific groups who are structurally disadvantaged[25])) who may be an elder, community leader, cultural advisor, cultural connector or cultural mentor who can provide cultural advice and guidance; SEWB workers (one male, one female (this reflects gender-based considerations towards comfort and cultural appropriateness for Aboriginal and Torres Strait Islander people when using health and well-being services[26]), 50D positions) who provide

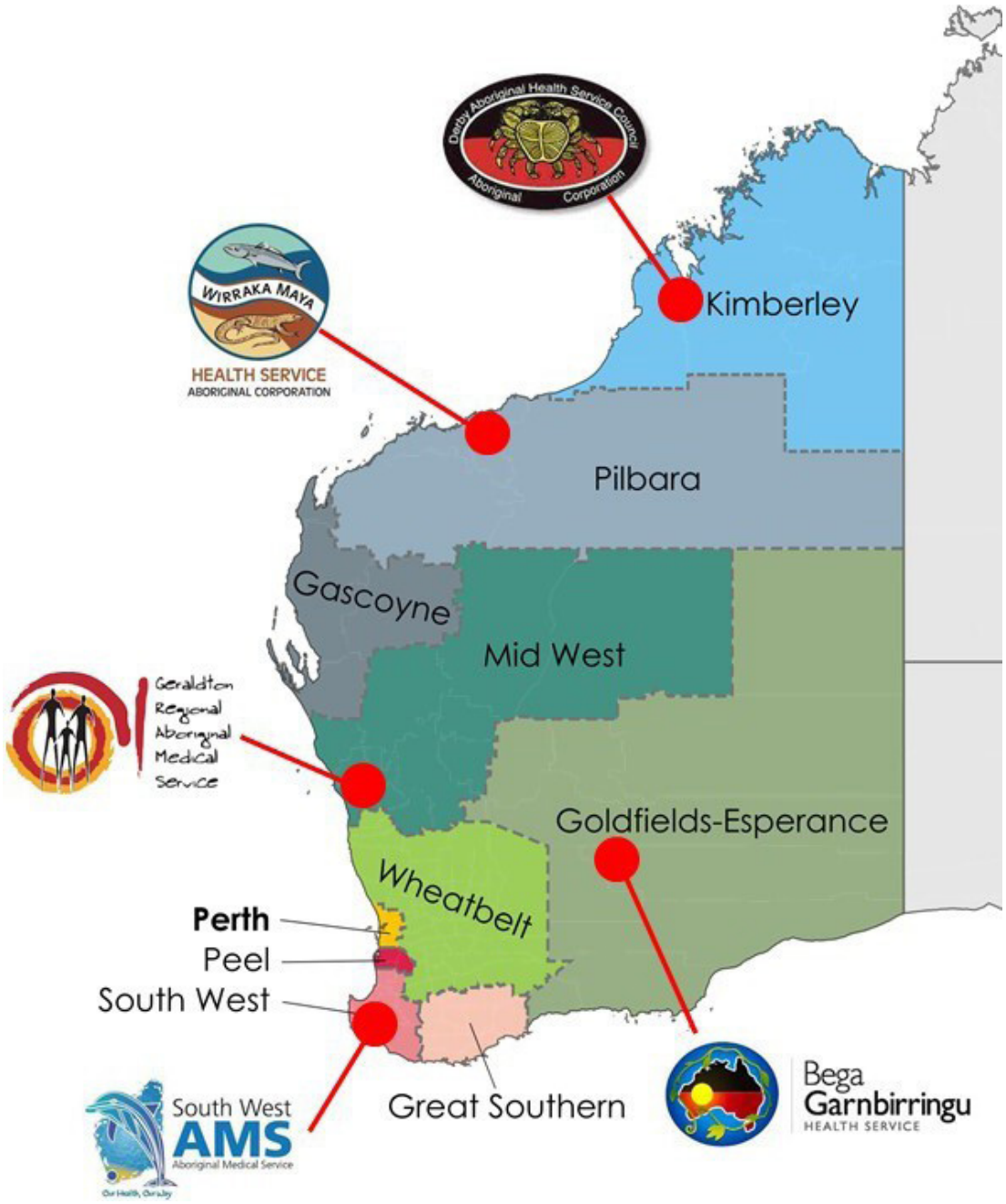

Figure 2 Pilot site locations across Western Australia's regions.

advocacy, case management and support to strengthen SEWB, for example, by connecting clients to health services or culturally appropriate activities; qualified counsellors (one male, one female); and care coordinators/administrators. Employment and development of Aboriginal staff is a key feature of the Model.[21] Each site will identify how best to implement the Model's SEWB teams in relation to existing staff who have been delivering SEWB services.

AIMS AND OBJECTIVES

There is a need to contribute to the growing evidence of how SEWB services and programmes can strengthen SEWB outcomes for Aboriginal and Torres Strait Islander people and communities.[10 27] This study aims to evaluate the formative development of the Pilot, and the processes, impacts and emerging outcomes related to implementation of the Model.

STUDY DESIGN

This study will be principle driven[28] and engage an Aboriginal Participatory Action Research (APAR) methodology[29] that supports best practice approaches to evaluation with and for Indigenous organisations and communities.[30 31] APAR is a participatory research paradigm that adopts an Indigenous standpoint theory. As an

Pillar	Service Response examples	Service Impact
Culturally secure community development	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.
Psychosocial support	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 (e.g. housing, employment, environmental health). Enhanced connection to culture through access to programs, support and linkage with Elders/cultural advocates.
Targeted interventions	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 programs 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.
Supported co-ordinated care	Coordination (step up/step down) between primary health, SEWB and acute services. Provision of culturally appropriate wellness initiatives to support and strengthen mental health care plans.	Integrated care pathways. Enhanced throughcare and aftercare protocols and processes. Streamlined approaches to shared care and simplified referral processes.

Figure 3 AHCWA SEWB service model's four-pillar approach.[21] AHCWA, Aboriginal Health Council of Western Australia; SEWB, social and emotional well-being.

approach to research, it privileges Aboriginal and Torres Strait Islander knowledge systems, ethics and methodologies; centres Aboriginal and Torres Strait Islander voices; recognises Aboriginal and Torres Strait Islander people and communities as experts-by-experience; and promotes decolonising practices that unsettle harmful and extractive forms of research.[29] An APAR approach will entail establishing Indigenous leadership and governance, capacity-building community co-researchers and engaging in reflexive practices.

Indigenous leadership and governance

Indigenous governance and leadership are central to both the implementation of the Pilot and the approach to evaluation. The evaluation team will be led by a senior Aboriginal researcher (PD) and supported by a senior cultural consultant (MM), both with extensive cultural and content knowledge. The research team will also participate in a monthly Pilot governance group established by AHCWA and consisting of leadership from each Pilot site; and a bimonthly governance group consisting of the research team, AHCWA and MHC. Indigenous leadership is present across both governance groups which serve as important advisory bodies to shape the evaluation focus and design, and ensure usefulness of evaluation outcomes for the ACCHS sector, and Aboriginal and Torres Strait Islander people and communities. Within these forums, evaluation methodology and methods will be shared with an invitation for input, and regular progress updates will be given.

Community co-researchers

The study will seek to strengthen the capacity of locally based community co-researchers to support with data

collection and analysis; these will be existing staff within the Pilot services. The capacity strengthening will occur through the delivery of site-specific, remote and face-to-face training modules. The training will be delivered by the evaluation team and will include topics such as an introduction to research and evaluation, ethics and data collections methods, and data analysis (online supplemental appendix 1). The engagement and development of community co-researchers in APAR ensure that Aboriginal and Torres Strait Islander peoples are involved within the research and evaluation process in meaningful ways. It will also provide opportunities for mutual learning as community co-researchers apply their lived experience and deep cultural and community knowledge, strengthening processes of data collection and analysis.

Reflexive practice

It will be important for the team, and especially non-Indigenous researchers (EC, KD, JA, RPA-I), to engage in ongoing reflexive practice.[32] This begins by considering our various social locations and identities, how this shapes our relationships and the knowledge we produce. Other practices include creating spaces for dialogue within the research team to unpack experiences and perspectives, share knowledge and have a reflexive diary throughout the evaluation process.

DATA COLLECTION

A mixed-methods approach will be taken to evaluate the Pilot.[33] Multiple sources of data better represent the complexity of a programme, service or setting and align with an ecological and systems approach that examines multiple levels of analysis.[34] This allows for data triangulation which in turn strengthens the research findings.[35] All participants will be over 18 years of age, Indigenous and non-Indigenous, and of varying genders. The planned time frame of the evaluation will be from December 2022 to March 2025.

Stakeholder engagement

In line with the APAR approach, the evaluation team will have ongoing engagement with key stakeholders including AHCWA, the MHC and the five Pilot sites; relevant governance committees are a key forum where this will occur, as well as a monthly community of practice for the Pilot site teams that will be facilitated by AHCWA. Initial site visits will be an integral component of the engagement and will be undertaken by a non-Aboriginal researcher within the evaluation team, accompanied by an Aboriginal consultant or local community co-researcher. These will occur at the beginning of the evaluation to inform design, and at each point of data collection. Informal observations will occur as part of the stakeholder engagement and will include meeting minutes and researcher reflections.

Key knowledge holder interviews

The evaluation will include semistructured interviews with up to five key knowledge holders from across the stakeholder organisations who can offer relevant insights towards the Pilot's formation and its process, impact and emerging outcomes (online supplemental appendix 2). Key knowledge holders are defined as 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. Key knowledge holders will be known to the evaluation team and already familiar with the evaluation and will be recruited through these existing relationships. Key knowledge holders will be interviewed up to three times during the evaluation to share their perspectives at the point of the Pilot's development, initial implementation and completion. Key knowledge holders will provide point-of-time contextual information across the pilot so continuity of staff will not be necessary.

Client journey mapping

Client journey mapping is a useful approach to documenting clients' engagements with a service, and to understand both the client experience and service processes.[36] The evaluation will adapt existing client journey mapping approaches that have been used in Indigenous health research,[36 37] to develop a tool that will capture the client's journey in relation to SEWB outcomes and the SEWB service model (online supplemental appendix 3). Client yarns, service provider interviews (online supplemental appendix 4) and clinical data will be the data sources that will contribute to client journey mapping.

Client yarns

Up to five clients, at two points of data collection, will be recruited by the Pilot sites to participate in a 30–60 min culturally appropriate yarning interview[38] about their experience of engaging with SEWB services. Client yarns will be conducted in a comfortable setting chosen by the participants and an interpreter will be organised if required. Participating clients will be able to select whether they are interviewed by a community co-researcher, a member of the evaluation team or both, depending on their preference. Gender will be a consideration when recruiting community co-researchers so that interview participants will be able to opt for a same-gender interviewer.

Service provider interviews

Up to three service providers who have been involved in delivering services to the participating clients will be asked to take part in a 30–60 min interview. The service providers will be identified by the Pilot sites when engaging clients to participate. These service providers may include members of SEWB teams as well primary healthcare services at each Pilot site. Participating service providers will be interviewed on the Pilot site premises by a member of the evaluation team. The participants will be asked to share their experience of providing services to the clients participating in the client journey mapping.

These interviews will be points of data triangulation to provide deeper context and understanding to the stories shared by clients.

Clinical data

With consent from participating clients and the Pilot site, clinical data and case notes will be collected. Strengthening SEWB requires integration, coordination and collaboration across both SEWB and clinic services. Including clinical data and case notes in the client journey mapping will help demonstrate the interaction between primary healthcare and SEWB services in caring for clients' SEWB. Information related to SEWB engagements, screening assessments, interdisciplinary coordination meetings and service feedback will be sought.

SEWB Systems Assessment Tool

Implementing the SEWB service model requires significant systems changes within each Pilot site, and it is anticipated that these changes will occur gradually over the course of the Pilot. To assess systems changes, the Menzies Health Systems Assessment Tool (SAT) for health services[39] has been modified to focus on SEWB service systems and further incorporate items related to cultural security informed by the Kimberley Aboriginal Health Planning Forum Cultural Security Framework[40] (online supplemental appendix 5). This tool will be administered via facilitated discussions with SEWB teams at each Pilot site at the beginning and end of the Pilot to systematically assess systems and processes and how they have been impacted by the SEWB service model. The tool requires teams to discuss and rate their progress across the following components: workforce, service delivery, client access, linkages, and organisational influence and integration. Changes in these component scores and scores for each item will be tracked over the course of the Pilot. The evaluation team will take notes during the discussions and collect the completed SEWB-SAT for further analysis. The SEWB-SAT will be administered prior to scheduled interviews with key knowledge holders and service providers and will inform additional questions related to the emerging findings from the tool.

Document analysis

Key documents related to the delivery of SEWB services and the implementation of the Pilot, as well as new resources and tools created to support the workforce and SEWB service delivery, will be reviewed. These will deepen understanding of systems and process changes. Documents will be related to governance (eg, annual reports, frameworks for service delivery, terms of reference for committees and advisory groups), systems and processes (eg, position descriptions, accountability flows, referral pathways, protocols and guidelines), resources (fact sheets and flyers, social media posts, staff onboarding documents), reporting (eg, funder Key Performance Indicator (KPI) reporting, compliance reporting) and tools (eg, screening and assessment, brief interventions).

Cost-estimation templates

To understand the economic costs of delivering SEWB services, an optional cost-estimation template, which was adapted from an existing estimation tool,[41] will be provided for the Pilot sites during the last 6 months of the Pilot for self-completion. Categories include the added labour costs of involving/hiring new staff for the Pilot involvement; additional labour costs of involving existing staff in the Pilot activities; new set-up or fixed costs; products and services carried over from existing services; and additional running costs to keep the project resourced.

Drawing on completed client journey maps, the evaluation team will also work with the Pilot sites to develop baseline cost estimates for items related to the delivery of services for an individual client. This will include labour, facilities, tools and resources costs which can then be attributed to an individual case study, while also accounting for regional differences in costs.

DATA ANALYSIS

The adapted client journey mapping approach provides an interpretive frame to analyse a client's experiences of engaging with SEWB services. This frame will allow the evaluation team to represent how the SEWB service model shapes this experience, and what domains and determinants of SEWB are affected through their engagement.

The analysis process entails transcription of client yarns, and the creation of a narrative summary from the transcriptions.[42] The evaluation team will then work collaboratively with community co-researchers to undertake thematic analysis of the client narratives through a structured analytical framework. This approach involves the development of an analytical framework to guide analysis of data, and allows for both inductive and deductive coding. The approach has strong utility within qualitative health research and towards organising large datasets in ways that are accessible for lay researchers.[43] The client journey mapping tool will guide analysis, providing conceptual categories such as client experiences, client outcomes, tools and resources, service gaps, evidence of delivery guided by the Model pillars and evidence of SEWB domains being strengthened. A coding book will be used to clearly define each conceptual category, emerging codes and clear examples to ensure consistency among analysts.

A member of the evaluation team will also undertake a thematic analysis of service provider and key knowledge holders' interviews, using both deductive coding guided by the client journey mapping tool, SEWB-SAT components and inductive coding to enable novel themes to emerge from the data. Emergent findings will be integrated into client journey maps, along with clinical data, and individual case cost-estimation to provide further context to each client journey.

SEWB-SAT ratings for individual sites will be mapped onto a spider graph comparing overall scores for each core component at each point of administration. This

will provide a visual representation of perceived systems change across the life span of the Pilot and guide analysts in identifying salient themes when analysing interview transcripts. Documents collected during the evaluation and observational notes will provide further context to the findings generated through the above analytical approaches and serve as point of data triangulation.

Analysis of each data source will contribute to a series of case studies of each Pilot site. These case studies will provide contextual and place-based insights towards how the Pilot was implemented, the impacts and emerging outcomes. The analysis of these data sources will be done through a socioecological lens[44] to understand the connections and inter-relatedness between client outcomes and experiences, SEWB team and service provider experiences, service systems and governance structures. This approach to analysis will provide an in-depth understanding of key impacts and outcomes for clients and SEWB teams, while also situating these impacts and outcomes within the context of service systems and governance structures. Recurring themes will then be analysed across all cases to develop insights about the broader SEWB service model and the overarching governance structures that supported implementation.

Throughout the analysis process, researchers will engage in team debriefs and the comparison of interpretations of codes and themes, ensuring alignment on approaches to coding and emerging themes. Summaries of preliminary analytical interpretations will also be provided to participants as member checking[45]; this will allow participants to ensure they have not been misinterpreted and that they are comfortable as to how they have been represented. Importantly, Aboriginal researchers will participate in the analysis and their voices prioritised in the analytical process.

PATIENT AND PUBLIC INVOLVEMENT

As part of the APAR methodology, ongoing engagement with stakeholders through Indigenous-led governance structures has informed research design. Community co-researchers will also undergo capacity-building to support in data collection and analysis.

ETHICS AND DISSEMINATION

Ethics

The protocol was developed through consultation and regular engagement with all stakeholders. The protocol has approval from the Western Australian Aboriginal Health Ethics Committee (ethics approval no: HREC1204).

All participants will be subject to informed consent. Given some clients participating in yarns may know the community co-researchers, participants will be able to choose if they would prefer to be interviewed by a community co-researcher, a member of the evaluation team or both. If participants experience distress or discomfort during the interview, the interview will be terminated immediately, and the participant will be connected to relevant and appropriate support.

Data collected from interviews, client yarns and observation notes will be de-identified to ensure confidentiality. This will include the use of pseudonyms and removal of identifying details such as place and organisation names. It will be made clear to participants that in describing a specific setting, there are limits to confidentiality. To mitigate this, participants will be provided their interview transcripts and given the opportunity to notify the evaluation team if they are uncomfortable with any parts being included as data. Participants will have the right to withdraw their data prior to analysis of the data. For the duration of the project, raw data with participant identities preserved will be maintained and will only be accessible to the research team in a secure shared drive. The data will be stored for a minimum of 7 years, or as required by institutional data storage standards, in an electronic, secure, password-protected drive, only accessible to the evaluation team.

Dissemination

The findings will be disseminated through an evaluation report; plain language summaries, reports and resources; and academic publications and presentations. A community forum will also be held to report the findings back to all stakeholders involved in the Pilot, including the Pilot sites, and AHCWA member services. This will be an opportunity for knowledge sharing and dialogue. Dissemination of final material will occur with consultation with AHCWA and each Pilot site. Throughout dissemination activities, the contributions of Aboriginal and Torres Strait Islander peoples and communities will be recognised through coauthorship and acknowledgements where appropriate.

Acknowledgements We would like to acknowledge all the stakeholders involved in the implementation and evaluation of the Pilot, and their contribution of community and cultural knowledge and professional expertise towards the development of the protocol. This includes the Aboriginal Health Council of Western Australia, the Mental Health Commission, and most importantly the leadership and SEWB teams at each of the Pilot sites.

Contributors PD is the principal investigator and provides supervision and Indigenous knowledge and governance. PD, EC, KD, JA and RPA-I conceived the initial evaluation framework. MM and RPA-I undertook consultations with the Pilot sites to inform the protocol development. PD, EC and RPA-I further developed the evaluation protocol. RPA and EC were involved in drafting the manuscript. PD, RPA-I and EC provided feedback and reviewed drafts of the manuscript. All authors approved the final version.

Funding Funding for the evaluation was received from the Western Australian Mental Health Commission (MHC2022-111).

Map disclaimer The depiction of boundaries on the map(s) in this article does not imply the expression of any opinion whatsoever on the part of BMJ (or any member of its group) concerning the legal status of any country, territory, jurisdiction or area or of its authorities. The map(s) are provided without any warranty of any kind, either express or implied.

Competing interests None declared.

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 Patient and public involvement section for further details.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

ORCID iDs
Emma Carlin http://orcid.org/0000-0002-1003-1981
Rama Putu Agung-Igusti http://orcid.org/0000-0002-3375-1279

REFERENCES

1 Swan P, Raphael B. *Ways Forward": National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health (no.13*. Canberra, Australian Capital Territory: Australian Government Publishing Service, 1995.
2 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*. Canberra, Australia: Commonwealth of Australia, 2014: 55–68.
3 Department of Health and Ageing. *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. Canberra, Australian Capital Territory: Commonwealth of Australia, 2013. Available: https://www.health.gov.au/sites/default/files/documents/2021/05/national-aboriginal-and-torres-strait-islander-suicide-prevention-strategy.pdf
4 Intergovernmental Committee on Drugs. Commonwealth of Australia; National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019: A sub-strategy of the National Drug Strategy 2010-2015, . 2014Available: https://www.health.gov.au/sites/default/files/national-aboriginal-and-torres-strait-islander-peoples-drug-strategy-2014-2019_0.pdf
5 Department of Health. Commonwealth of Australia; Implementation plan for the national Aboriginal and Torres Strait Islander Health Plan 2013-2023, . 2015Available: https://www.health.gov.au/sites/default/files/documents/2020/12/implementation-plan-for-the-national-aboriginal-and-torres-strait-islander-health-plan-2013-2023.pdf
6 Commonwealth of Australia. Department of the Prime Minister and Cabinet; National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing, . 2017Available: https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf
7 Austin C. The impact of social determinants of health of Australian indigenous women on access and engagement in maternal child health services. *J Adv Nurs* 2023;79:1815–29.
8 Brickley B, Burzacott J, Naren T. Enhancing person-centred care and access to primary care for aboriginal and Torres Strait Islander peoples. *Aust Health Rev* 2022;47:13–5.
9 Bulloch H, Forgarty W, Bellchambers K. *Aboriginal Health and Wellbeing Services: Putting community-driven, strengths-based approaches into practice*. Melbourne, Victoria: The Lowitja Institute, 2019.
10 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. *Australian Psychologist* 2019;54:171–86. 10.1111/ap.12367 Available: https://doi.org/10.1111/ap.12367
11 Warwick S, LeLievre M, Seear K, *et al*. Above and beyond: fashioning an accessible health service for aboriginal youth in remote Western Australia. *Prog Community Health Partnersh* 2021;15:463–73.
12 National Aboriginal Community Controlled Health Organisation [NACCHO]. Aboriginal Controlled Community Health Organisations. Canberra, Australian Capital Territory: NACCHO; c2002. n.d. Available: https://www.naccho.org.au/acchos/
13 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. Adelaide, South Australia; Wardliparingga Aboriginal Health Equity Theme, South Australian Health and Medical Research Institute, . 2020Available: https://create.sahmri.org/wp-content/uploads/2020/02/ACCHO_Interactive_Resource2020.pdf
14 Harfield S, Pearson O, Morey K, *et al*. Assessing the quality of health research from an indigenous perspective: the aboriginal and Torres Strait Islander quality appraisal tool. *BMC Med Res Methodol* 2020;20:1–9.
15 on behalf of the Leadership Group guiding the Centre for Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE), Pearson O, Schwartzkopff K, *et al*. Aboriginal community controlled health organisations address health equity through action on the social determinants of health of aboriginal and Torres Strait Islander peoples in Australia. *BMC Public Health* 2020;20:1–13.
16 AHCWA. *An Aboriginal Community Controlled Health Service Social and Emotional Wellbeing Service Model for Western Australia*. Highgate, Western Australia: AHCWA, 2019.
17 Mia T, Dudgeon P, Mascall C, *et al*. An evaluation of the National empowerment project cultural, social, and emotional wellbeing program. *J Indig Wellbeing* 2017;2:33–48.
18 Carlin E, Seear K, Spry E, *et al*. *Evaluation of the Kimberley Empowerment Healing and Leadership Program*. Broome, Western Australia: Rural Clinical School University of Western Australia, University of Western Australia, 2020. Available: http://kams.org.au/wp-content/uploads/2021/02/KEHLP-evaluation-report-2020-final.pdf
19 NACCHO. *National SEWB Survey: Understanding the SEWB landscape*. Canberra, Australian Capital Territory: NACCHO, 2022.
20 Transforming indigenous mental health and wellbeing project. social and emotional wellbeing gathering 3 report: 6Th-8Th September 2022. Perth, WA The University of Western Australia; 2022.
21 AHCWA. Western Australia: AHCWA. Social and Emotional Wellbeing Service Model Highgate, Available: https://timhwb.org.au/wp-content/uploads/2021/05/AHCWA_SEWBReport_JAN21.pdf
22 AHCWA. Western Australia: AHCWA; About us highgate, . 2022Available: https://www.ahcwa.org.au/about-us/
23 Dwyer JM, Lavoie J, O'Donnell K, *et al*. Contracting for indigenous health care: towards mutual accountability. *Australian Journal of Public Administration* 2011;70:34–46.
24 Schultz C, Walker R, Bessarab DC, *et al*. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Canberra, Australian Capital Territory: Commonwealth of Australia, 2014: 221–42.
25 Australian Human Rights. Sydney, New South Wales: AHRC. Identified positions, Available: https://humanrights.gov.au/quick-guide/12047 [Accessed 21 Feb 2023].
26 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.
27 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.
28 Farnbach S, Eades A-M, Gwynn JD, *et al*. The conduct of Australian indigenous primary health care research focusing on social and emotional wellbeing: a systematic review. *Public Health Res Pract* 2018;28:27451704.
29 Dudgeon P, Bray A, Darlaston-Jones D, *et al*. *Aboriginal participatory action research: an indigenous research methodology strengthening decolonisation and social and emotional wellbeing*. Melbourne, Victoria: The Lowitja Institute, 2020.
30 Dudgeon P, Milroy J, Calma T, *et al*. *Solutions that Work: What the Evidence and Our People Tell Us*. Crawley, Western Australia: University of Western Australia, 2016.
31 Kelaher M, Luke J, Ferdinand A, *et al*. *An evaluation framework to improve Aboriginal and Torres Strait Islander health*. Melbourne, Victoria: Lowitja Institute, 2018.
32 Walker R, Schultz C, Sonn C. Working together: aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. In: Dudgeon P, Milroy H, Walker R, eds. *Cultural competence –Transforming policy, services, programs and practice*. Canberra, Australian Capital Territory: Commonwealth of Australia, 2014: 95–220.

33 Anguera MT, Blanco-Villaseñor A, Losada JL, *et al*. Revisiting the difference between mixed methods and multimethods: is it all in the name *Qual Quant* 2018;52:2757–70.
34 Kagan C, Burton M, Duckett P, *et al*. Critical community psychology. In: *Critical community psychology: Critical action and social change*. Routledge, 2019.
35 Flick U. Triangulation in qualitative research. A companion to qualitative research. 2004;3:178–83.
36 Kelly J, Dwyer J, Pekarsky B, *et al*. *Managing Two Worlds Together: Stage 2 – Patient Journey Mapping Tools*. Bedford Park, South Australia: Flinders University, 2012.
37 Fraser S, Mackean T, Grant J, *et al*. Patient journey mapping to investigate quality and cultural safety in burn care for aboriginal and Torres Strait Islander children and families - development, application and implications. *BMC Health Serv Res* 2022;22:1428.
38 Bessarab D, Ng'andu B. Yarning about Yarning as a legitimate method in indigenous research. *IJCIS* 2010;3:37–50.
39 One21seventy. Menzies School of Health Research; Facilitators guide to the systems assessment tool, . 2012Available: https://www.menzies.edu.au/page/Resources/Systems_Assessment_Tool_SAT/
40 Kimberley Aboriginal Health Planning. KAHPF. A cultural security framework, Available: https://static1.squarespace.com/static/5b5fbd5b9772ae6ed988525c/t/5f598017654f8b4023763ca3/1599701035315/KAHPF+Cultural+Security+Framework.pdf [Accessed 21 Feb 2023].
41 RAND Europe, Ernst and Young LLP. National evaluation of the department of health's integrated care pilots. RAND Europe, Ernst and Young LLP, . 2012Available: www.rand.org/content/dam/rand/pubs/technical_reports/2012/ RAND_TR1164.pdf
42 Emden C. Conducting a narrative anlysis. *Collegian* 1998;5:34–9.
43 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;13:117.
44 Rappaport J, Seidman E. Handbook of community psychology. In: Rappaport J, Seidman E, eds. *Understanding and changing social systems: An ecological view*. Boston, MA: Springer, 2000: 133–59.
45 Lincoln YS, Guba EG, Pilotta JJ. Naturalistic inquiry. *International Journal of Intercultural Relations* 1985;9:438–9.