# Holding Space for the Modern Matriarchy

## A Barossa Hills Fleurieu Local Health Network Model for Keeping Families Healthy Together

Government of South Australia
Health
Barossa Hills Fleurieu
Local Health Network

# Because of her, we can

## We honour all Aboriginal and Torres Strait Islander women

'She' – our founding mothers, the first women who have walked this land for millennia and have birthed and nurtured centuries of our people into existence.

'She' – who has carried our stories and knowledge, so we hold in our hands today our societal values of intergenerational learning, care and responsibility for our land, our families and communities.

Embedded within these values are intrinsic lessons of our complex kinship structures and cultural practices. These teach us about collective leadership, collaborative and inclusive decision-making, negotiation and cooperation, the reciprocal sharing of resources, lifelong education, and the foundational understanding that an individual's health and wellbeing is intimately connected to the health of our Country, our surrounding environments, and our families and communities.

**June Oscar, Aboriginal and Torres Strait Islander Social Justice Commissioner, 2018**

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First published July 2025

ISBN 978-1-7641734-4-5

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**Publisher** Karabena Publishing

**Suggested citation**
Schmid, J., Nielsen, R., Bromley-Harvey, N., Kimlin, R., Gulbin, M., Arabena, K. 2025, *Holding Space for the Modern Matriarchy: A Barossa Hills Fleurieu Local Health Network Model for Keeping Families Healthy Together*, Karabena Consulting, Melbourne.

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**Acknowledgements**
We acknowledge the Traditional Owners of the Lands on which we live, work and play. As is our culture, we pay our respects to Elders past and present. We extend thanks to Aboriginal and Torres Strait Islander peoples everywhere for your strength, courage and resilience. We also acknowledge our friends, families and allies for giving true value and meaning to the words 'our fellow Australians'. We are all the richer for our relationships.

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# Foreword

The Barossa Hills Fleurieu Local Health Network (BHFLHN) is proud to present *Holding Space for the Modern Matriarchy*, a reflection on the enduring work, relationships and community-led transformation that have shaped our Keeping Families Health Together model.

This report stands as a testament to the strength, leadership, and cultural authority of Aboriginal women – our Elders, mothers, aunties and grandmothers – who have guided us across more than fifteen years of relational practice. Their wisdom has shaped our services, challenged our systems, and grounded our shared efforts in care, trust, and accountability.

We acknowledge the past contributions of those who stood in the early years of this journey: families who opened their homes, communities who held space, staff who committed to walking alongside, and partners who chose to follow the lead of culture rather than command from the centre. This report honours their legacy.

What is captured in these pages is not just a model of care. It is a way of working – rooted in kinship, driven by connection, and held together by a deep commitment to self-determination and cultural safety. This model has taught us that real change is neither rapid nor imposed. It is grown in relationship, sustained in community, and affirmed through trust. We are proud of what has been achieved through this culturally grounded, relational approach.

We are especially proud that the *Keeping Families Healthy Together* model has enabled a complete transformation in how child protection and health services engage with Aboriginal families in our region. It has shown that when systems make space for cultural governance, and when Aboriginal women lead, families are not only kept together – they are strengthened, celebrated, and affirmed.

BHFLHN remains committed to supporting and embedding this model across our regions. As we expand this work into Gawler and beyond, we carry with us lessons of the past, the voices of community, and the conviction that Aboriginal-led, culturally informed care is essential to the future of equitable and effective service delivery.

We thank all those who continue to walk this path with us – with humility, courage, and deep respect.

On behalf of the Executive,

**Bronwyn Masters**
Chief Executive Officer
Barossa Hills Fleurieu Local Health Network

19 June 2025

# Acknowledgements

We acknowledge the deep cultural, relational and intellectual contributions of all those involved in the development, implementation and documentation of the *Keeping Families Healthy Together* model. We are grateful for the opportunity of evaluating this innovative model and of sharing its insights with a wider audience.

We begin by honouring the **Aboriginal and Torres Strait Islander women, families, Elders and communities** of the Barossa Hills Fleurieu Local Health Network (BHFLHN). Your knowledge, leadership and cultural authority are the heart of this model. It is your stories, your care and your unwavering commitment to children, kinship and Country that have shaped every element of this work. We pay respect to the matriarchs, past, present and emerging, whose governance, resilience and nurturing form the backbone of community wellbeing.

To the **young parents, grandparents and great-grandparents** who generously shared their experiences, thank you. Your trust, honesty and strength have made visible the impact of a culturally grounded, relationship-centred system of care. Your voices are not just testimonies; they are blueprints for transformation.

We acknowledge the tireless efforts of the **Aboriginal Health Workers, midwives, social workers, nurses, cultural support workers and administrative staff** within the BHFLHN and Gawler Health Service. Many of you have walked alongside families for more than a decade, often going above and beyond formal roles to uphold cultural safety, continuity of care and relational integrity. Your practice exemplifies compassion, humility and steadfast commitment to community-led care.

We recognise the **non-Indigenous women allies and advocates** in leadership, management and frontline service roles. Your reconciliatory solidarity – expressed through presence, shared decision-making and structural advocacy – has been vital in creating spaces where Aboriginal women's leadership can flourish without compromise.

We thank the **BHFLHN Governing Board and executive leadership** for creating an authorising environment in which Indigenous methodologies, co-design, cultural safety and truth-telling are recognised and respected. Your support has enabled innovation to flourish where others may have defaulted to risk management.

Our deep appreciation extends to the **community researchers** who participated in training, data collection and analysis. Your cultural insight and methodological rigour ensured that this evaluation of the *Keeping Families Healthy Together* model honoured both story and structure.

Finally, we express gratitude to the **children and young people** whose presence and futures are at the centre of this work. This model exists to ensure you are raised strong, safe, loved and connected to culture, family and Country.

This report represents a collective effort. It is not owned by any single organisation, author or department, but is held in trust by a community of women whose care, leadership and authenticity have deeply shaped this initiative. May this work continue to honour the people and principles that brought it into being.

# Glossary of Terms

| Term | Definition |
|---|---|
| **Aboriginal women-led practice** | A care approach grounded in the cultural authority and kinship responsibilities of Aboriginal women, especially grandmothers, mothers and aunties, whose leadership forms the backbone of child and family wellbeing and systems transformation. |
| **Adaptive allyship** | A reflexive, evolving practice by non-Indigenous people to adjust their behaviours and assumptions in alignment with Aboriginal leadership and values, involving cultural humility and ongoing decolonisation. |
| **Allyship** | A relational and accountable form of support that includes active listening, cultural safety and rejecting saviourism. It entails humility and consistency from non-Indigenous practitioners. |
| **Allyship Community of Practice** | A structured, relational learning space where non-Indigenous staff reflect on their role as allies, engage in unlearning, and commit to culturally safe and accountable practice. |
| **Applied reconciliation** | Structural change enacted through embedding cultural authority, shifting power dynamics and resourcing Aboriginal leadership. It goes beyond statements to practical transformation. |
| **Authorising environment** | The cultural, relational and organisational conditions that allow matriarchal and culturally led innovations to thrive. These environments are intentionally created by and for Aboriginal women. |
| **#Blakout Campaign** | A governance initiative where Aboriginal staff take full control of organisational leadership for a set period, shifting power and demonstrating Aboriginal-led decision-making in practice. |
| **Child Protection** | Refers to the statutory systems and services responsible for responding to allegations of child abuse, neglect and harm, including mandated interventions by authorities such as the Department of Child Protection. This includes legal processes, risk assessments, removals, and case management of children and families under state care. In this report, capitalisation is used to distinguish the formal, legislated system of Child Protection from broader, preventive approaches. |
| **Child protection lens** | A preventive, adaptive and relational approach embedded in health and community services that prioritises support, trust and cultural safety over surveillance and punitive oversight. This lens shifts the focus from identifying risk to strengthening protective factors, thereby helping families remain safely together. It emphasises early intervention, relational continuity, and respect for cultural authority, especially in Aboriginal and Torres Strait Islander communities. |

| Term | Definition |
|---|---|
| **Co-design** | A collaborative process in which Aboriginal people are equal partners in shaping services, grounded in lived experience, cultural authority and relational accountability from design to evaluation. |
| **Co-design (as cultural governance)** | A process distinct from mainstream definitions, based on yarning, kinship structures and cultural leadership, ensuring services are designed through continuous negotiation and co-leadership. |
| **Collective accountability** | Shared responsibility among families, practitioners and systems to maintain cultural safety, respectful engagement and outcomes aligned with community expectations. |
| **Collective impact** | A coordinated, cross-sector approach to improving outcomes for Aboriginal communities, driven by trust, cultural legitimacy and shared goals, not institutional authority. |
| **Community-led model** | A governance model where Aboriginal people, particularly Elders and matriarchs, set service priorities, lead decisions, and hold systems to account. This is distinct from consultation or representation. |
| **Cultural authority** | The community-recognised legitimacy of Aboriginal leaders, particularly Elders and aunties, is vital for guiding care, decision-making, and boundaries. Non-Indigenous staff are encouraged to defer to this authority. |
| **Cultural determinants of health** | Spiritual, kinship, language, land, and cultural identity influences underpin Aboriginal health and wellbeing. These are essential to holistic care frameworks. |
| **Cultural leadership** | Leadership expressed through Aboriginal values, ways of knowing and kinship governance is often exercised collectively and legitimised through community rather than hierarchy. |
| **Cultural safety** | An outcome defined by Aboriginal people in which services are experienced as respectful, non-racist and affirming of cultural identity, kinship and parenting practices. |
| **Culture-led practice** | A service model where Aboriginal culture shapes the logic, structure and delivery of care, prioritising intergenerational responsibility, community healing and relational governance. |
| **Decolonising practice** | A commitment to dismantling the impacts of colonisation in health and social systems by privileging Aboriginal knowledge systems and confronting racism. |
| **Dismantling professional hierarchies** | An intentional shift away from status-based authority in favour of relational, cultural and experiential knowledge, creating space for equitable and culturally safe practice. |
| **Emotional labour** | The often-invisible work done by Aboriginal staff to hold space, educate colleagues and navigate racism while delivering care. This needs to be acknowledged and supported in the workplace. |
| **Intergenerational strength** | The transmission of cultural knowledge, care and resilience across generations, especially through grandmothers and aunties, which keeps families strong through trauma and change. |

| Term | Definition |
|---|---|
| **Listening without defence** | The practice of receiving feedback, especially regarding racism or harm, without minimising or deflecting. This is essential for trust and relational accountability. |
| **Matriarchal governance** | Leadership grounded in the caregiving, cultural and kinship responsibilities of Aboriginal women. It prioritises collective wellbeing and cultural legitimacy over hierarchy. |
| **Modern matriarchy** | A contemporary expression of Aboriginal women's cultural authority and leadership in systems of care, characterised by relational governance and community-validated decision-making. |
| **Non-hierarchical access** | Service design that dismantles power imbalances, allowing equal participation from community members and staff. It values lived experience and relationships over titles. |
| **Organisational culture** | The behaviours, norms and values that shape practice within a workplace. In this model, culture is intentionally equity-focused, trauma-informed and non-hierarchical. |
| **Racism acknowledged and challenged** | A foundational commitment to naming and confronting racism in all its forms. This includes validating Aboriginal people's experiences and ensuring non-Indigenous accountability. |
| **Reconciliatory solidarity** | Sustained, ethical partnership with Aboriginal communities, including truth-telling, sharing power and creating space for Aboriginal leadership to flourish. |
| **Relational accountability** | A core principle in Aboriginal-led work where relationships, not tasks, define success. This requires consistent, respectful engagement and trust-building over time. |
| **Relational authority** | Leadership earned through trust, care and community validation, rather than positional power. This is central to Aboriginal women-led service models. |
| **Safe conditions for truth-telling** | Environments where Aboriginal staff and clients can speak openly about harm without fear. This requires allyship, cultural supervision and structural safety. |
| **Safe service boundary** | The negotiated cultural and physical protection of clinics and healing spaces from statutory overreach, ensuring care environments are defined by trust and not surveillance. |
| **Service responsiveness** | The ability of services to adapt to the needs and contexts of Aboriginal families through flexible appointments, assertive outreach and meaningful cultural support. |
| **Shared governance** | A decision-making model that distributes authority across Aboriginal staff, community members and teams, enhancing transparency, trust and cultural accountability. |
| **Strengths-based practice** | A method of care that focuses on community strengths, cultural assets and inherent capabilities, countering deficit discourses and affirming dignity. |

| Term | Definition |
|---|---|
| **Systemic trust** | Long-term confidence in services, earned through consistent, respectful and culturally safe behaviour. This is essential for Aboriginal family engagement. |
| **Transformational opportunity** | Moments or initiatives, like the #Blakout Campaign, that enable deep shifts in power, structure and practice through the assertion of Aboriginal cultural leadership. |
| **Trauma-informed and culture-held healing** | A healing model grounded in cultural continuity, safe relationships and everyday practices (like yarning, holding, gifting and meals) that affirm identity and repair harm. |
| **Trust infrastructure** | The protocols, behaviours, relationships and agreements that build and sustain trust between services and Aboriginal families over time. |
| **Unlearning** | The process through which non-Indigenous staff let go of colonial assumptions and dominant professional norms to become culturally sustainable practitioners. |
| **Wrap-around support** | Holistic, culturally responsive support that addresses family, health, emotional and material needs framed through empowerment, not surveillance or containment. |
| **Yarning (in practice)** | A culturally embedded communication practice centred on deep listening, story-sharing and relational connection. This is essential for healing, co-design and ethical engagement. |

## Acronyms

| | |
|---|---|
| **BHFLHN** | Barossa Hills Fleurieu Local Health Network |
| **CEO** | Chief Executive Officer |
| **DCP** | Department for Child Protection (Government of South Australia) |
| **LHN** | Local Health Network |
| **SEWB** | Social and Emotional Wellbeing |

# Executive Summary

This report is an evaluation of the *Keeping Families Healthy Together* model, its key insights, strategies and outcomes. An Aboriginal women-led model of care developed within the Barossa Hills Fleurieu Local Health Network (BHFLHN), with a particular focus on the Gawler region of South Australia, the model is grounded in Indigenous knowledge systems, cultural governance and relational accountability. In a policy and service landscape often shaped by risk aversion and statutory intervention, *Keeping Families Healthy Together* redefines the role of health services in child protection by placing relational governance, cultural authority and Aboriginal matriarchal leadership at the centre of care.

Rather than treating health and child protection as separate domains, this model demonstrates how culturally grounded health care can act as a protective factor. It strengthens families, keeps children safe and supports community continuity, particularly during pre-pregnancy, pregnancy, birth and the early years of a child's life.

## 1 Foundations of transformation: Trust, culture, and relational care

At the heart of this model lies trust – built slowly and intentionally through sustained, culturally safe relationships. Trust is nurtured through continuity of care, presence, non-judgemental support and cultural responsiveness. It is not transactional.

Many of the health professionals involved, particularly Aboriginal women, operate beyond the roles of mandated notifiers or institutional gatekeepers. Instead, they are seen and see themselves as relational companions, walking alongside families through care journeys grounded in respect and reciprocity.

This approach challenges mainstream care models that often marginalise Aboriginal women and diminish the value of their caregiving and cultural authority. Here, care is not only a clinical function – it is a form of governance. Matriarchy becomes a deliberate and powerful design principle, shaping the system itself. Rather than imposing externally defined structures, this model elevates community-defined wisdom, positioning cultural authority as the foundation for systems transformation.

## 2 Core features of the model

### A Cultural legitimacy and kinship leadership

The model recognises Aboriginal parenting styles and kinship-based caregiving as essential, not peripheral. The caregiving roles of grandmothers, aunties and extended kin are honoured as legitimate and culturally authoritative. These family members are integrated into family group conferencing and decision-making processes, their wisdom respected and their presence seen as protective. Kinship care is a placement option of last resort but is regarded as the preferred, default context for child-rearing and intergenerational continuity.

### B Culturally responsive, wrap-around support

Multidisciplinary care teams, including midwives, social workers and Aboriginal Health Workers, provide coordinated support across physical, emotional and cultural domains. Services are flexible, relational and place-based. Staff visit homes, respond to urgent needs outside of hours and deliver ongoing support in the community. From facilitating access to care connection points to meeting the consumers where they are on their journey, the care model activates all areas of departmental and community services to provide a whole-of-government response to care.

Importantly, when the South Australian Government Department for Child Protection (DCP) engagement is required, health workers continue to walk alongside families, acting as cultural interpreters, trauma buffers and advocates. Their presence mitigates institutional harm and upholds a culturally safe experience for families navigating complex systems.

### C Co-design as cultural governance

Co-design is embedded as a cultural governance practice, rather than merely consultative. Families are not invited to comment after a service model is built. Instead, they co-author care responses in real time. This includes shaping what support looks like, who is involved and how decisions are made. Lived experience, kinship dynamics and cultural knowledge form the blueprint for care delivery through every moment of interaction.

### D Reconciliatory solidarity

A defining element of this model is reconciliatory solidarity: a relational ethic whereby non-Indigenous women working in the health system consciously make space for Aboriginal women's leadership. These professionals – often midwives, social workers, or program leaders – do not dominate but accompany; they enable rather than impose.

This solidarity is enacted through practices such as standing with families in DCP meetings, embedding Aboriginal knowledge into service design and being accountable to community expectations. Grounded in truth-telling and a commitment to decolonising professional practice, reconciliatory solidarity supports mutual trust, cultural safety and shared authority, all of which are key tenets of this modern matriarchy.

### E Trauma-informed and culture-held healing

Healing is not confined to therapeutic settings but is rather embedded in the everyday practices of the service. Symbolic gestures – such as giving flowers post-birth, the provision of Nunga lunches and the consistent presence of familiar staff – enable emotional safety. These practices humanise care and reinforce cultural identity, particularly for families recovering from trauma, violence, or previous statutory involvement. Such experiences contrast with bureaucratic and compliance-driven models by prioritising dignity, compassion and cultural recognition instead.

### F Authorising environment: Facilitated by women, for women

At the heart of this model lies an authorising environment shaped and sustained by Aboriginal and non-Indigenous women who collectively create the conditions for care, leadership and innovation to flourish. Rather than relying on hierarchical structures, this environment is characterised by mutual respect, lateral decision-making and shared accountability. It honours emotional intelligence and relational authority as legitimate sources of leadership. Women in key positions, whether within health services, community organisations, or government agencies, model this approach by using their institutional power to create space for others, especially Aboriginal women, to lead.

This authorising environment is the full expression of reconciliatory solidarity in action. It reflects a cultural and professional ecosystem where flexibility is valued, innovation is tolerated and care systems evolve in response to lived realities, not abstract policy. It includes non-Indigenous women acting as partners in system reform, by not only supporting but deferring to Aboriginal-led decision-making when it comes to families, kin and care.

Policies and protocols are developed in ways that recognise the nuances of community knowledge and the complexities of intergenerational trauma. Professional supervision incorporates cultural reflection and peer accountability. Staff meetings often resemble collaborative circles more than directive briefings. Through this, a new organisational culture has emerged, one that is deeply human and both culturally and emotionally literate.

The authorising environment also serves as a protective space allowing the work of keeping families together to take root and expand beyond individual efforts. It safeguards the cultural and gendered nature of this leadership by embedding it in practice frameworks, staffing decisions and program design. In doing so, it moves beyond symbolic inclusion and establishes enduring structures of support for Aboriginal women's leadership across all levels of service delivery.

## 3 Outcomes that matter

The strongest evidence of impact is family preservation. Parents report being free from statutory oversight, while aunties, grandparents and great-grandparents describe safe, dignified arrangements in which children remain with kin. Children grow up within culture and on Country, not removed or relocated. Secondary outcomes include:

- improved mental health and emotional regulation
- stronger attachments between parents and children
- increased engagement with services due to trust
- enhanced self-confidence and parenting capacity.

These outcomes cannot be separated from the model's values of cultural legitimacy, relational care and the centring of Aboriginal women's leadership.

## 4 Addressing access barriers

Despite strong outcomes, geographic inequities remain. Families living outside Gawler – particularly in Victor Harbour, Kangaroo Island and other remote communities – face difficulties accessing consistent support. Many have expressed a desire for the model to be replicated or adapted at other sites, accompanied by the same foundational values.

In addition, there is a strong call for cultural connection between DCP and SA Department of Health and Wellbeing to help embed cultural safety more consistently across statutory settings. This involves working alongside and hearing the voices of consumers through shared decision-making and engagement. Moving beyond relational practice requires embedding this as clinical care; a place where services connect, grow and learn.

## 5 Learnings for systemic change

This is not a program, pilot or time-limited innovation, but rather a living systems transformation. Learnings include:

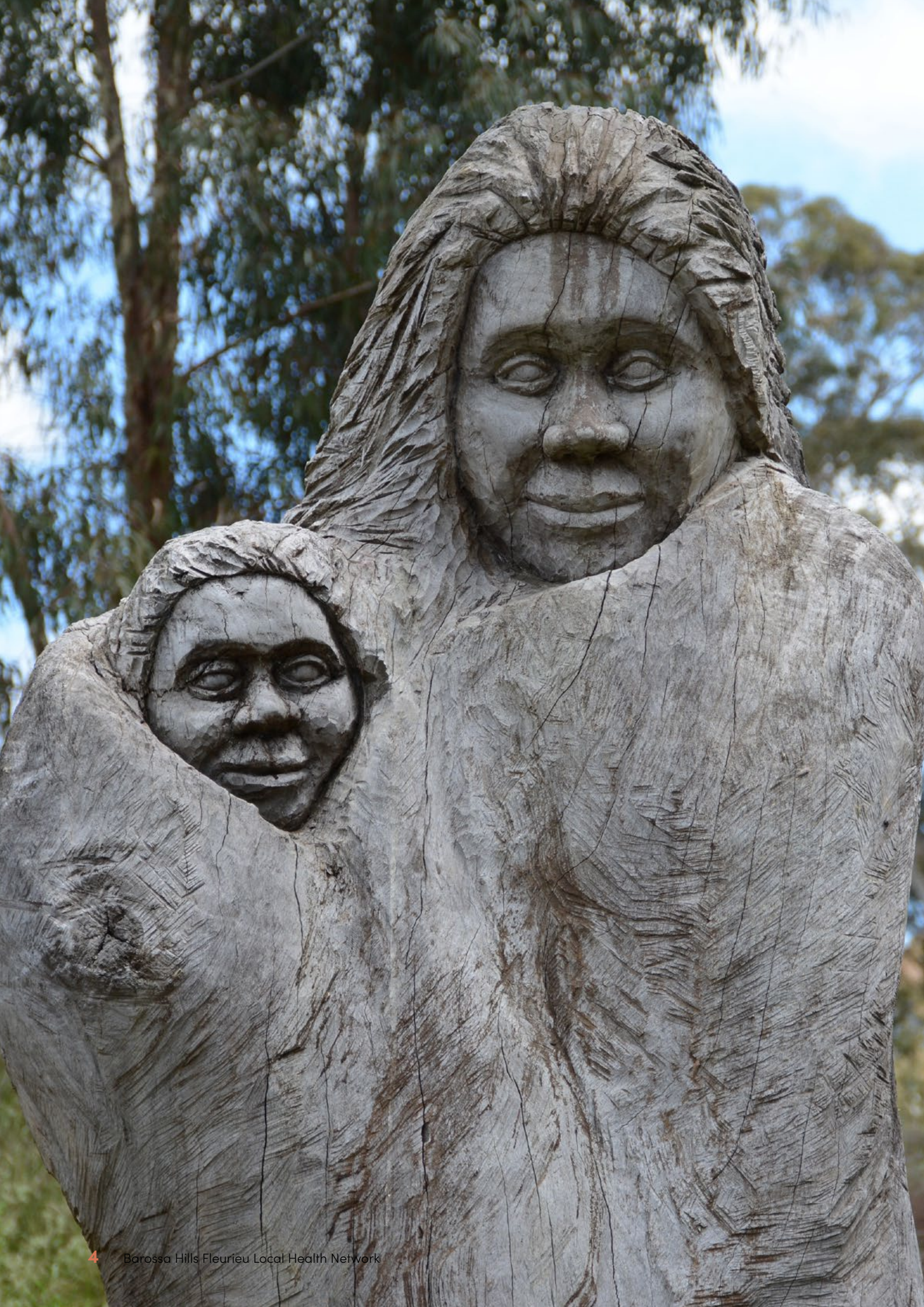
- **Trust is the architecture**: Built slowly, and maintained relationally, it is essential for engagement.
- **Culture is the driver**: Not an add-on element, but the central organising principle for care, governance and healing.
- **Leadership is gendered and local**: Aboriginal women's leadership is not incidental; it is foundational and ought to be structurally supported.
- **Care is political**: In a climate of post-Referendum racial tensions and growing systemic mistrust, this model provides a counter-narrative rooted in justice, relational repair and cultural sovereignty.

## 6 Concluding reflections: Modern matriarchy in action

The *Keeping Families Healthy Together* model reveals the possibility and the power of reorienting care systems around Aboriginal women's leadership and cultural ways of being. It shows that healing, safety and systemic trust emerge not from rigid procedures, but from presence, cultural fluency and relationships. This is the embodiment of a modern matriarchy: an intergenerational, place-based system of care that centres cultural authority, emotional safety and collective responsibility. As one participant reflected:

> It wasn't just all talk. If I said something, it got acted on.

This model transforms risk into opportunity, surveillance into support and statutory fear into cultural strength. It offers a blueprint for a just, responsive and relationally governed care system, one that recognises that true care requires trust, and trust requires time, presence and the leadership of women.



# 1 Introduction and Context

## 1.1 The Barossa Hills Fleurieu Local Health Network

The BHFLHN is responsible for the delivery of publicly funded hospital and community-based health services across the Barossa Hills and Fleurieu region of South Australia. As a government-designated Local Health Network, BHFLHN plays a key role in developing and implementing health and wellbeing strategies that respond to the needs of diverse populations, including Aboriginal and Torres Strait Islander families.

The Network provides a broad range of health services, including acute hospital care, aged care, mental health services, maternal and child health and other community-based initiatives. A Governing Board provides oversight across performance, budget, clinical governance, safety, quality and risk. This Board reports directly to the South Australian Minister for Health and Wellbeing and is responsible for meeting the statutory and operational obligations of the network.

BHFLHN has publicly committed to improving cultural safety and health equity for Aboriginal and Torres Strait Islander communities. This commitment is reflected in the *Reflect Reconciliation Action Plan 2024–2025*, which sets out a strategic agenda for strengthening relationships, respect and opportunities across all areas of health care. The principles outlined in that plan align closely with the values embedded in the *Keeping Families Healthy Together* model.

In recent years, BHFLHN has demonstrated transparency through the publication of annual reports that document service performance and strategic progress from 2019 onwards. Its support for the development of the *Keeping Families Healthy Together* model includes both strategic leadership and operational backing. This has enabled the use of Indigenous methodologies, community researcher engagement and co-designed approaches that underpin the cultural safety and effectiveness of the model.

## 1.2 Child protection outcomes in the Gawler Region

BHFLHN staff in the Barossa Valley and Gawler region in South Australia have witnessed a transformative and community-led shift in child protection outcomes. Central to this achievement, they believe, is an Aboriginal women-led, culturally grounded model of care that has changed the way DCP notifications are raised. This highlights that the clinician's role goes beyond raising a notification; it is about open and transparent sharing with parents while holding strength in family. This has led to notifications becoming a relational connection between DCP, SA Health and the families involved, which has enabled them to grow, learn and share together, thereby decreasing the fear of engagement. This outcome, unprecedented in many parts of Australia, demonstrates the strength of an approach that prioritises relationship-based practice, cultural legitimacy and Aboriginal authority, particularly as exercised through matriarchal leadership.

The model is built on more than a decade of sustained relationship-building between health practitioners, Aboriginal women, Elders and families. It prioritises cultural authority, matriarchal leadership and relational trust. Health services have shifted from primarily reactive and statutory roles to a proactive approach that supports family wellbeing through early engagement, cultural safety and continuity of care.

Practitioners have emphasised that these results reflect not only programmatic changes but also a systemic shift in how services relate to Aboriginal families. Trust has been established through consistent, culturally respectful practice and genuine alignment with community priorities. This has enabled services to intervene earlier and more effectively, reducing the likelihood of statutory involvement.

The outcomes in Gawler demonstrate the potential of health services to act as protective and culturally legitimate institutions when guided by Aboriginal leadership and grounded in local relationships, emphasising the importance of embedding culturally governed, relationship-based models within broader service systems.

## 1.3 Redefining the role of health services in child protection work

The *Keeping Families Healthy Together* model reframes the role of health services within the Child Protection system. Traditionally, health practitioners were positioned as peripheral to statutory DCP processes, with their role largely limited to identifying and reporting risk. Under this model, health services become central participants in preventing child removal and promoting family wellbeing, particularly during pregnancy, birth and early parenting.

Through the implementation of culturally responsive practice and Aboriginal leadership, health services, most notably at Gawler, have become sites of early intervention and trusted engagement. Aboriginal families describe these services as places where they can seek support without fear, supported by culturally safe, consistent care and strong relationships with Aboriginal staff. This means families engage proactively with services rather than avoid them.

Community-based initiatives such as 'Nunga Lunch' provide informal opportunities for social and cultural connection and improve access to support. These gatherings reduce isolation and enhance service engagement. Families report that relational continuity with culturally competent practitioners and Aboriginal Health Workers supports trauma recovery, parenting confidence and service navigation.

Although highly effective, the model has not reached all families. Some remain disengaged or at risk of exclusion, highlighting the importance of sustained investment in outreach, relational infrastructure and culturally embedded engagement strategies.

This model presents an integrated, culturally informed and relationship-centred approach to child and family health and wellbeing. It recognises that health services have a vital role beyond clinical care; they are essential partners in supporting Aboriginal children to grow up safe, healthy and strong in their identities, connected to family, community and culture.

By embedding cultural authority, relational trust and continuity of care, the model responds directly to systemic issues that have historically undermined Aboriginal families. It aligns with the *National Agreement on Closing the Gap*, particularly:

| | |
|---|---|
| **Priority Reform 1**<br>**Formal partnerships and shared decision-making** | The model is built on deep partnerships with Aboriginal communities, led by Aboriginal women and Elders who bring lived experience, cultural governance and local authority into service design and delivery. |
| **Priority Reform 3**<br>**Transforming government organisations** | Health services are reoriented to function as culturally safe and responsive institutions, where Aboriginal ways of knowing, being and doing shape not only care delivery but also leadership, accountability and workforce practice. |
| **Priority Reform 4**<br>**Shared access to data and information at a regional level** | Through place-based design and culturally governed evaluation, the model enables communities to access, interpret and act on data that is locally meaningful and underpinned by Indigenous data sovereignty principles. |

In doing so, the model activates structural transformation and creates conditions for long-term, intergenerational wellbeing for Aboriginal families.

## 1.4 Turning child protection engagement into positive experiences

The model supports intergenerational outcomes. Grandmothers caring for their great-grandchildren are supported through kinship care and family conferencing. Young women facing homelessness, domestic violence, or mental health crises are met with compassion and culturally safe practical support. From care connection points or meeting consumers where they are on their journey to birthing and early parenting, services promote holistic wellbeing grounded in Aboriginal knowledge systems.

**Aboriginal women's leadership is present in every phase of system design, service delivery and accountability. Their cultural authority shapes responses to domestic violence, perinatal care and child wellbeing through practices that centre on relationships and community responsibility. This contemporary form of matriarchal leadership offers a culturally anchored alternative to dominant child protection models.**

## 1.5 What cannot be fully captured in this model

While this report describes the structure, principles and implementation of the *Keeping Families Healthy Together* model, it is important to acknowledge that not all aspects of the model can be fully documented or transferred. Much of its effectiveness depends on relational work that sits outside formal program descriptions. It is difficult to codify culturally informed practice that is underpinned by trust-building and sustained engagement.

Across BHFLHN, mostly female staff have worked with Aboriginal families in ways that extend beyond conventional service roles. Their decisions to practise differently are often shaped by personal values, cultural knowledge and a long-standing commitment to equity and justice. These staff bring consistency, cultural humility and a capacity to engage meaningfully with complexity, attributes that are not easily standardised and cannot be embedded through policy alone.

This report offers a detailed account of the model's design, including program components, engagement strategies and leadership roles. However, it is not a toolkit that can be directly replicated without attention to local context, relationships and cultural governance. The model depends on the right people, in the right roles, operating within culturally safe and community-led structures.

The evidence and insights presented here draw on interviews, program documentation, and the experiences of Aboriginal families and service providers. The model has shifted service responses away from surveillance and statutory threat towards relational accountability and cultural care. These shifts rely on the presence of trust, legitimacy and ongoing collaboration within specific local contexts.

Adopting similar approaches elsewhere will require a commitment to building relationships, supporting Aboriginal leadership and working within culturally governed structures. The model's success depends not only on its principles but also on the capacity and trust that enable those principles to be enacted.

# 2 Methodology

This evaluation employed a culturally grounded, community-led methodology that upheld Aboriginal ways of knowing, being and doing. At its core, the approach was designed to be inclusive, relational and accountable to the Aboriginal families, staff and community members involved in and impacted by the program.

## 2.1 Community researcher training and capacity-building

A key component of this methodology was recruiting and training BHFLHN Aboriginal staff as researchers. These staff participated in a two-day workshop – delivered by Karabena Consulting, a Torres Strait Islander woman-led firm with experience in research, evaluation and training – which included roleplays, yarning techniques, co-design principles and trauma-informed approaches, all of which ensured cultural and psychological safety for researchers and participants. This built local capability while embedding Indigenous methodologies and leadership into the research process.

## 2.2 Co-design as a principle and practice

The methodology was underpinned by co-design as both a principle and a practice. Power and control over the knowledge-generation process were intentionally located within the community. Aboriginal leadership led the decision-making around research questions, interview protocols and reporting. Co-design extended to the development of all research tools and processes, thereby ensuring cultural appropriateness and alignment with community values.

## 2.3 Development of ethical and culturally safe research tools

The team developed Participant Information Sheets, consent forms and semi-structured interview guides that adhered to the principles of Indigenous data sovereignty. All tools were reviewed with community researchers to ensure cultural relevance and sensitivity. Participants were offered community payments in recognition of their time and expertise, in line with ethical best practice.

## 2.4 Mixed methods data collection

The evaluation utilised multiple data collection strategies including in-depth interviews with Aboriginal families who had experienced the program, staff interviews conducted by the external consultant and focus groups with program implementation teams led by community researchers. Observational methods, such as participation in community lunch settings, were also employed to observe relational dynamics, service engagement and cultural safety in practice.

## 2.5 Site visits and immersive practice

Site visits were conducted both win the Barossa Valley and Gawler regions to engage with local contexts, build rapport and observe service delivery environments. These visits provided a nuanced understanding of the local health and social support ecosystems, and how trust-based and culturally responsive approaches were embedded in services.

## 2.6 Participatory knowledge exchange and co-authorship

Following data collection and initial analysis, preliminary findings were presented to staff and the community for review and validation to ensure accurate representation. Staff were then invited to co-author the final evaluation report so that their voices and contributions could be formally acknowledged. Mechanisms were also established for knowledge translation, including future workshops, staff briefings and community dissemination events.

## 2.7 Responsive to contractual and emergent needs

In line with contractual obligations, the methodology allowed for follow-up interviews and additional data collection as needed. The research team remained responsive to the needs of staff and the community, adapting tools and timelines to maintain the integrity of the process and the safety of all involved.

# 3 Aboriginal Women's Leadership and Systemic Allyship

Across the Barossa Valley and beyond, a powerful and often overlooked force has shaped the success of service transformation: the leadership of Aboriginal women. This Section explores the distinct contributions of Aboriginal women in care, governance and service redesign, acknowledging their leadership as a foundational logic for effective mainstream models rather than as an addendum. From matriarchs coordinating multigenerational care to young mothers navigating systems with strategic resolve, Aboriginal women are leading through kinship obligations and responsibilities and culturally informed relational authority.

Their leadership is also being held, amplified and protected by a growing cohort of allies, particularly women in health and human services, who are willing to step outside traditional power structures and stand beside Aboriginal leaders. This form of allyship is defined by support, not control, with allies walking alongside Aboriginal women to strengthen and uphold their leadership.

## 3.1 Beyond Aboriginal-led

In contemporary service reform, the term Aboriginal-led is often used as shorthand for both cultural authority and community engagement that promotes self-determination. Yet, within this term, a significant and enduring form of leadership is too often hidden: the specific, grounded and gendered leadership of Aboriginal women. This work, which is deeply relational, strategically wise and culturally legitimate, has long underpinned the wellbeing of Aboriginal families and communities. However, its visibility is cloaked by frameworks that assume a singular Aboriginal voice or leadership type. What is frequently described as 'Aboriginal-led' is, in practice, Aboriginal women-led, and thus shaped by matriarchal governance, kinship obligations and intergenerational forms of care and protection.

To leave this distinction unnamed is to erase the specific emotional labour, expertise and leadership of women who have consistently carried communities through experiences of trauma, systemic failures and cultural resurgence. This report challenges the flattening of Aboriginal leadership and reactivates the rightful place of women's leadership in care systems, co-design and community governance. It repositions Aboriginal women from hidden figures within a generic notion of leadership to central architects of change, operating through a lineage of matriarchy that continues to sustain life, law and legacy.

The *Keeping Families Healthy Together* model emerges from a deep lineage of Aboriginal women's leadership. For tens of thousands of years, Aboriginal matriarchs have sustained complex social, ecological and spiritual systems across the southern continent. From the red ochres of the northern Flinders to the riverine systems of the Murray, Aboriginal women have held responsibility for teaching, caring, decision-making and protecting Country. These were not acts of service alone but of governance, strategy and innovation.

This strength has endured despite centuries of imposed disruption. Since colonisation, Aboriginal women in South Australia have navigated dispossession, protectionist policies and the forced removal of children, often being cast in public narratives as passive victims or 'carers of last resort'. However, these are the women who have continued to hold communities together through crises, to transmit culture and to build new, informal institutions when state systems have fallen short.

The *Keeping Families Healthy Together* model responds to this history. It repositions Aboriginal women as leaders of place-based, culturally grounded service models. These women operate within a matriarchal paradigm, where care is governance and keeping families together is a political, cultural and practical act of self-determination.

In Gawler, this model grew from the strength of community leadership and the deep cultural knowledge that health services – when grounded in trust, relationships and cultural authority – can keep families strong and together. It offers a powerful, community-led response that focuses on early support, healing, safety and connection across generations. Rather than being borrowed from elsewhere, this approach is rooted in local wisdom and shaped by the strengths and priorities of the region.

Aboriginal men and women bring unique and complementary ways of knowing, being and doing. Their cultural knowledge continues to guide strong, resilient families and communities. Supporting the wellbeing of Aboriginal women means building on these strengths and investing in systems that:

- celebrate matrilineal leadership and cultural authority
- back locally designed and co-created models of care
- centre healing through community-led approaches
- support Aboriginal women's aspirations for self, family and Country

Informed by Aboriginal concepts of wellbeing, the Gawler model expands leadership beyond positions of power. It defines leadership as the ability to protect, teach, organise, advocate and heal. It sees women as strategists designing interventions that draw from kinship systems, cultural law and personal lived experience.

**Here, asserting contemporary matriarchy is not an abstract concept; it is embedded in every home visit, every multidisciplinary care meeting, and every act of advocacy that centres mothers and grandmothers as the rightful architects of their children's futures.**

## 3.2 Grounding the model: Country, continuity and contemporary matriarchy

Long before colonial intervention, Aboriginal women played central roles in maintaining health and wellbeing through custodianship of Country, ceremonial leadership, and responsibilities for nurturing family and community. These matriarchal systems ensured food security, ecological balance and cultural continuity, and were also systems of governance grounded in reciprocity.

Colonisation violently disrupted these systems. Despite more than 65,000 years of cultural continuity, the legal doctrine of Terra Nullius denied Aboriginal sovereignty and erased the legitimacy of Aboriginal lore, culture, and governance structures. The federation of the Australian nation-state in 1901 built on the dispossession of First Nations people, and further entrenched policies of forced removals, exclusion and marginalisation. Subsequent assimilation policies have left enduring legacies, visible today in the disproportionate removal of Aboriginal children from their families, the overrepresentation of Aboriginal people in custodial and child protection systems and the intergenerational burden of poor health.

In this context, Aboriginal women have led community responses to systemic harm, reasserting their roles as cultural authorities and protectors of community wellbeing. Their leadership is not new; it is a continuation of roles shaped by Country, storylines and responsibility. The *Keeping Families Healthy Together* model is a contemporary expression of this matriarchal leadership. It demonstrates how trust, cultural safety and community-led health care can address the structural causes of family separation and facilitate healing.

Health and wellbeing, as defined by Aboriginal people, is holistic. It encompasses spiritual, emotional, social and cultural wellbeing for the whole community, not just the individual. This whole-of-life approach reaffirms that when women are supported to lead from within their cultural systems, entire families and communities benefit. Aboriginal women's leadership is central to this transformation. It restores the integrity of community life and connects past, present and future through action that is grounded in relational responsibility. This form of modern matriarchy anchors the model's success in Gawler and provides a blueprint for systems change more broadly.

## 3.3 Reclaiming space: The convergence of matriarchal and reconciliatory leadership

The success of the *Keeping Families Healthy Together* model is not solely the outcome of Aboriginal women's leadership in isolation; it is also the result of deliberate and sustained support from women in positions of systemic influence who recognised the need to do things differently. This modern matriarchy has been nourished by a broader ecosystem of allyship: one in which women within bureaucracies, health systems and policy circles have created space for Aboriginal women to lead, shape and enact care on their own terms.

Feminist frameworks, when grounded in truth-telling and reconciliation, have made room for the emergence of diverse forms of leadership. These frameworks have helped to question singular models of power and productivity, and instead value relational authority, cultural knowledge and intergenerational wisdom. Feminism, when practised through an ethic of presence and accountability, becomes a mechanism for enabling Aboriginal women to step into governance on their own terms and contribute to the transformation of existing systems.

Crucially, this shift has required flexibility within systems; a willingness to make room for non-linear pathways, cultural obligations and care-based leadership that sits outside conventional employment frameworks. These spaces, held open by women committed to cultural and human rights justice, have allowed matriarchal governance to develop, strengthen and take hold.

What we see in Gawler is a coalescence of leadership forms: the deep, enduring strength of Aboriginal matriarchs and the strategic support of women committed to reconciliation and system transformation. This convergence has provided the safety and legitimacy necessary for a new paradigm of child and family wellbeing to emerge, one that is community led, culturally secure and fundamentally gendered in the most powerful sense. Together, these leaders illuminate a path forward, one whereby keeping families together is not only possible, but inevitable, when care is governance and matriarchy is policy.

## 3.4 Co-design as a cultural practice

In the *Keeping Families Healthy Together* model, co-design is a culturally grounded practice embedded in the everyday functioning of the service, relationships with families and decision-making across teams. In this context, co-design is less about technique and more about cultural practice: a relational, embodied and community-led way of working that reflects the values, governance structures and aspirations of Aboriginal peoples.

### Reclaiming the definition of co-design: From consultation to cultural authority

Mainstream service systems often treat co-design as a bounded process facilitated through a series of stakeholder engagements or time-limited workshops. In contrast, BHFLHN embeds co-design within the long arc of relational accountability. Here, Aboriginal families are not 'participants' in a co-design process; they are active designers of their own care journeys, guided by kinship systems, cultural laws and lived experience.

> They [DCP] are not the authors of the story. They're participants. The family is the author. We just hold the space.
>
> **Practitioner**

This reframing shifts the locus of power from service-led models of care to community-held and family-led decision-making. It positions Aboriginal women and Elders as central to the governance of family wellbeing and ensures that service delivery is not imposed, but emerges in response to what families know, want and need.

### Relationship first: The architecture of trust

The co-design approach within BHFLHN is built on a foundation of long-term relational investment. Practitioners are encouraged to spend time listening, showing up consistently and respecting the rhythms of community life. Rather than extracting feedback or 'consulting' with families to justify programs, this model listens deeply, adjusts iteratively, and respects silence and storytelling as design forms in themselves.

> The outcomes that we've had could absolutely not be done in silo. And by virtue of that, they probably have been co-designed in nature. But it's also the trust and respect we have for one another.
>
> **Practitioner**

Trust is not a by-product, but the infrastructure. It is through relationships that co-design becomes possible, and it is through those same relationships that the model remains accountable.

### Enacting sovereignty: 'We didn't ask for permission'

Co-design in this setting is also a form of decolonial practice. Rather than waiting for bureaucratic permission or policy alignment, staff acted in accordance with what is right for families, especially when cultural care and safety are at stake. This is enabled by strong internal leadership, an authorising environment that centres Aboriginal governance, and a shared organisational ethic of responsibility rather than deferral. Moving beyond a story of systems improvement, this is a story of systems resistance, where communities reclaim the right to design, adapt and hold services in accordance with their own cultural laws and priorities.

### Co-design as ethical relationality

The model also recognises that allyship is central to co-design. Aboriginal and non-Indigenous women work together across disciplines to co-create spaces of belonging, healing and learning. Staff are encouraged to engage with cultural humility, admit when they don't know and learn through doing.

> If I can't step into a space, I know someone else will hold that narrative and vice versa.
>
> **Practitioner**

This model of co-design does not rely on a fixed facilitation plan or externally imposed timelines, but instead draws on Aboriginal cultural logics of reciprocity, obligation and collective responsibility. In so doing, it foregrounds values such as:

- **Consent and agency**: Families decide who is at the table and what is shared.
- **Kinship and continuity**: Design is informed by intergenerational not organisational roles.
- **Respect for silence and story**: Yarning is not a precursor to the work – it is the work.
- **Reflection as action**: Learning is iterative and grounded in cultural humility.

### Applied cultural governance: Co-design in action

Across BHFLHN, co-design is evident in the structure and style of service delivery. Examples include:

- **Roundtable care planning** that includes extended family and cultural carers, not just biological parents.
- **Family-led meetings** where DCP and other agencies are invited as participants, not directors.
- **Flexible care protocols** that allow for care to be provided in homes, on Country and alongside community leaders.
- **Continuous staff reflection** processes to revisit care plans and adjust them based on family feedback.

These practices have been made possible not through formal frameworks but through the cultivation of a culturally safe, flexible and responsive system where the values of Aboriginal governance take precedence over compliance requirements.

### Shifting the gaze: Co-designing as a cultural practice

Within the *Keeping Families Healthy Together* model, co-design is a cultural practice that actively reshapes the gaze through which Aboriginal women are seen and understood. Co-design invites a collective reimagining of how Aboriginal women are perceived, moving beyond externally imposed lenses that fragment, diminish, or stereotype.

To co-design in this context is to co-create the very gaze through which the work is done. It means rejecting deficit-based, pathologising frames and instead embracing a gaze rooted in cultural authority, relational accountability and deep listening. This practice allows women to be seen through more than the eyes of policymakers or statutory systems, but through the shared lens of community, Eldership, story and place.

### Reframing the gaze: From fragmentation to wholeness

Too often, Aboriginal women are subject to colonial and institutional gazes that fragment their identities and experiences. Too often, this leads to them being seen as:

- **vulnerable** – rather than as women experiencing vulnerability due to violence, poverty, racism, or structural neglect
- **impoverished** – rather than as women navigating economic exclusion while holding families together through cultural and relational wealth
- **dysregulated** – rather than as women embodying trauma responses from intergenerational harm, including changes that occur at the cellular and epigenetic level during pregnancy.

These gazes come from multiple sources: social workers, police, hospital staff, intimate partners, the general public, politicians and even from within community contexts. They define what is 'visible' to systems: who gets help, who is believed and who is deemed a risk. In a co-designed, culturally grounded practice, the gaze itself becomes a site of intervention.

> I still get the sweats... but no one made me feel bad for it there. Other places, they thought I was on drugs. But it's trauma. PTSD. I couldn't even say the word.
>
> **Young mother, Gawler region**

Co-design here becomes a political and cultural act; a collective agreement to see Aboriginal women in their entirety, not in fragments. It is about turning away from the harsh gaze of judgement and towards one of kinship and care.

### Co-designing with, not for, women

Rather than asking Aboriginal women to adjust to systems that cannot see them, the *Keeping Families Healthy Together* model invites those systems to adjust their gaze. In doing so, it elevates Aboriginal women's knowledge, agency and leadership in shaping the very terms of their engagement. The process draws on long-held cultural practices: decision-making through yarning, collective witnessing and holding space for story and silence.

> We could just say it without shame. We didn't have to explain ourselves over and over; they already knew us.
>
> **A parent reflecting on the cultural safety of the clinic**

Co-design here is not a consultation, a focus group, or a set of discrete actions; it is a cultural relationship. The gaze is co-created through the spaces women trust: the lunch table, the birth suite, the drop-in clinic, the moment of eye contact during a panic attack. It is designed by who is in the room, who holds power, who is believed and who is prepared to do the deep listening.

### Embodied and intergenerational gazes

This co-designed gaze also honours the embodied and intergenerational realities of Aboriginal women's lives. Women carry trauma and strength through their memory, bodies, pregnancies, and attachment to their children. The gaze, therefore, holds space both for the immediate and the ancestral, for the daily struggle and the long arc of cultural survival.

Children, too, look to their mothers with their own gaze, seeking safety, regulation and connection. The co-designed model acknowledges the circular nature of this gaze: when women feel safe and seen, their children become calm, confident and connected. This is not incidental; it is an outcome of relational design.

> I think he's such a calm baby because we are calm.
>
> **Parent, reflecting on life after leaving an abusive relationship**

**Table 1**

## Co-designing the gaze

| Traditional gaze | Co-designed gaze |
|---|---|
| **Vulnerable woman** | Woman experiencing vulnerability in the context of strength and survival |
| **Impoverished mother** | Matriarch managing multiple responsibilities with resilience |
| **Problem patient** | Trauma survivor in need of relational and culturally responsive care |
| **Risk to children** | Central caregiver, protector and cultural educator |
| **Passive recipient** | Active co-designer, knowledge holder and relational leader |

### Co-design as cultural sovereignty

Co-design, when grounded in Aboriginal worldviews, is an act of cultural sovereignty. It challenges colonising perspectives and centres Aboriginal women's right to define themselves, their families and their communities. Within this model, service provision becomes a means of seeing differently, of recognising and validating the labour, leadership and cultural authority that women bring to family and community life. Each act of care reflects a deeper commitment to cultural logics, kinship, story and accountability. Through this lens, the *Keeping Families Healthy Together* model positions co-design as a mechanism for cultural authority and structural redefinition; a place where a truthful voice can be heard and held.

### Measuring success through cultural accountability

The model defines success through culturally informed accountability. Instead of relying solely on conventional service metrics, it draws on questions shaped by community priorities and values, including:

- Were families heard and respected?
- Did the child remain safely connected to culture and kin?
- Did the grandmother's role and authority receive recognition?
- Was the care team consistent, trustworthy and responsive?
- Were Aboriginal staff empowered to lead?

These questions position families and communities as interpreters of impact, embedding evaluation within relational processes shaped by the same cultural logics that guide care.

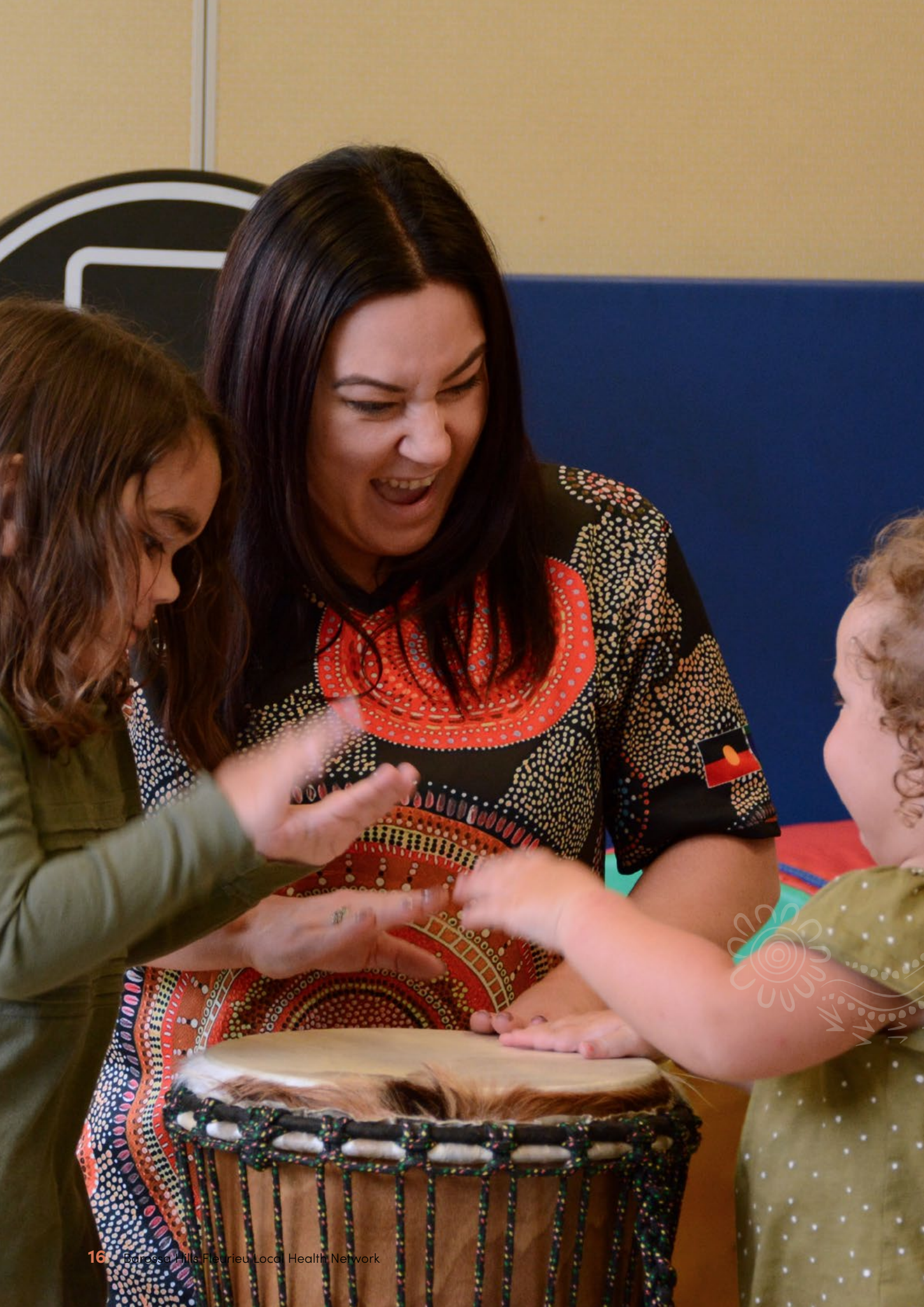
## 3.5 Concluding comments

In this context, co-design is a cultural practice that shapes how care is given and received. It is grounded in community values, sustained through relational trust, and led by Aboriginal women whose authority is anchored in kinship and culture. The model supports an adaptive, locally authored and culturally grounded approach that builds healing and strength while enabling systems to shift in response to community-defined priorities.

**Table 2**

Co-design as cultural practice

| Dimension | Co-design as method | Co-design as cultural practice |
|---|---|---|
| **Authorising power** | Service-led | Community-led |
| **Focus** | Delivering programs | Building relationships and responses |
| **Process** | Linear phases (plan, consult, deliver) | Relational, adaptive (real time) |
| **Leadership** | Project teams or external consultants | Aboriginal women and allies |
| **Timeframe** | Short term, time-bound | Ongoing and evolving |
| **Cultural legitimacy** | Often secondary | Foundational |
| **Role of families** | Consulted or surveyed | Authors of their own story |
| **Emotional tone** | Professional and formal | Trusting, relational, honest |
| **Outcome** | Documented service improvements | Family-held, culturally embedded change |



# 4 Centring Lived Experience: Trust, Connection and Cultural Authority

The BHFLHN model is built on foundational trust, developed over 15 years, between community members and Aboriginal health system staff. This trust is relational, enduring and embedded in a culturally safe framework. It has emerged through consistent support, cultural integrity and an unbroken presence, all of which have created the conditions for young women to maintain custody, strengthen their confidence as parents, and engage with services in non-judgemental, strengths-based ways. As one young mother reflected:

> When I was pregnant, I thought I was going to have an abortion. I was 16 weeks, and Mum called them back and said, 'She doesn't want to do it.' And they supported me, even though I was young... they helped me find programs, housing, all of that. They didn't judge me. They just helped.

Support grounded in cultural safety and relational care offered immediate relief while also creating the conditions for long-term resilience. The model's strength comes from its continuity – of people, place and sustained commitment. Another young mother, reflecting on her relationship with the service over more than a decade, spoke of how these enduring relationships held her family through grief, parenting challenges and systemic barriers:

> Yeah, we struggled, but we did always keep it together, always stick together and strong.

She described her connection to the Gawler health team in terms of kinship and belonging:

> The service has been like family... and seeing loved ones we used to catch up and have lunch with at Gawler Health, just seeing that all disappear, kind of thing, yeah... it's been a while with the health team.

This sense of relational care extended far beyond clinical care. It was also felt through spontaneous check-ins, shared meals and the emotional labour of staff who stayed connected even outside their formal roles. When asked who stood by her during difficult times, her answer was immediate and heartfelt:

> Yeah... second year; Dr Jody. She's been a great listener... Georgia is deadly too. She's great to talk to.

This young woman viewed these staff as part of the family structure that surrounded and supported her. Their presence built a bridge between clinical systems and cultural safety, where listening was prioritised and judgement suspended in favour of understanding.

In this way, trust within the BHFLHN model is deeply embodied and constantly enacted. It manifests in who turns up, who stays, who listens and who continues to check in long after other systems have disengaged. It is this trust – earned, relational and grounded in cultural integrity – that continues to keep families strong, together and safe.

## 4.1 Relational accountability and continuity of care

Families consistently described the BHFLHN model as wrap-around care led by Aboriginal women with deep roots in both community and service structures. Care was characterised by relational accountability, with staff regarded as kin rather than external professionals. Long-term relationships were central to the model, offering families a depth of trust and familiarity.

> They've been with me for 14 years. That's more than a service; that's family.

This framing reflects a fundamentally different approach to care than that provided by conventional service systems, which families often experienced as impersonal and lacking continuity. Participants repeatedly named staff whom they recognised for their presence, patience and personal commitment. These 'deadly' women remained in families' lives across critical moments, including pregnancy, grief, mental health challenges, housing instability and DCP involvement. Their sustained relationships fostered trust, which in turn created the conditions for safety. Families shared that they could express themselves without fear of judgement or misunderstanding:

> I'm a very open person, but I wasn't open until you guys. You just took me in. I felt supported by the whole team, like we were under your wing.

> We could let anything out. If we needed to say anything that's bothering us, you could just say it. That's why we still travel three hours round trip to Gawler. It's not just a clinic; it's family.

The model's continuity of care, both cultural and relational, meant families would travel long distances to engage with trusted staff, even when more geographically convenient options were available:

> There's literally a clinic just there at the shopping centre, but we just don't go there. It's not the same connection. We're coming back to mob who know our story.

> Now when we go to different clinics, it's like, 'Nah, we need to go back to the Gawler one.' This is not right.

Returning to a place where their history was known and where their children were remembered offered more than clinical care: it offered cultural safety, emotional recognition and intergenerational continuity.

These long-standing relationships were actively maintained. The clinic was a place where people felt known, respected and safe. As one participant put it:

> I could talk to them like family. They knew me, knew my mum, knew my whole story. I never had to explain anything twice. That's what made me feel safe.

Importantly, this trust extended across time and through life transitions. Even when families moved or experienced service gaps, the memory and impact of culturally safe care remained, and people returned not out of obligation, but because they knew they would be treated with care and consistency.

> Even when I wasn't in a good place, they didn't give up on me. That's what made the difference.

> It's just like going to someone's house, and it's just family. You know it's a service, but it doesn't feel like one.

This commitment to relational practice over procedural delivery meant that families did not feel alone or judged. Rather, they were welcomed, celebrated and supported in ways that enabled healing and strengthened their capacity as parents, caregivers and kin. In this model, relational continuity is cultural safety, and it is the reason that many families remain together.

## 4.2 Women's leadership and cultural governance

The BHFLHN model stands as an exemplar of Aboriginal women-led governance. Throughout the consultations, grandmothers, aunties and young mothers were consistently described as the driving force behind family wellbeing, cultural continuity and decision-making. Their leadership was defined by community legitimacy, kinship responsibility and cultural authority: there was no mistaking that these women were central to service design, case planning and care delivery.

> They were going to take the kids, but I said, 'No, I'll take them.' I've already got one with me. It's difficult on my own mental health, but I'd do anything for them.

> We're not just babysitting. We're teaching, protecting, and loving these kids the way our mob always have.

Such expressions of kinship responsibility illustrate how Aboriginal women enact leadership through deep intergenerational care. These roles were recognised and actively supported by the service, with cultural governance embedded, not merely invited, into family support frameworks. Services ensured that kinship care arrangements were respected and that grandmother-led homes were resourced and included in decision-making processes from the outset.

This model also highlighted the leadership of young mothers, many of whom faced complex and compounded challenges, including stigma, housing instability, financial and food insecurity and health risks. What set this program apart was its strengths-based approach: non-punitive, affirming and emotionally responsive. Young women were treated as capable, loving mothers and decision-makers in their own right.

> When I said something, they listened. And they didn't just listen. They did something about it. It wasn't all talk.

Women described being celebrated at milestones, such as the birth of a child, receiving consistent emotional support, and being met with compassion rather than surveillance. One young mother, who had initially considered terminating her pregnancy due to overwhelming circumstances, recalled the support she received:

> When I was pregnant with my baby, the staff were always just checking up. No judgement. Just helping.

In that moment, her leadership emerged, not only in choosing to parent but in navigating care for her family amid systemic and personal challenges. Her leadership was supported, not suppressed. When asked what helped her feel safe as a parent, she responded:

> Just them listening... when they didn't have to.

She also spoke openly about the stigma surrounding mental health, identifying it as a barrier that often pushes Aboriginal parents away from support systems:

> You don't want to be judged... you don't want to be looked down on just for having struggles. Especially when you've got kids.

> Mental health is number one. Some people turn away and don't get help and end up in the grave. Or go inside. Or do drugs.

These reflections reinforce the BHFLHN model's emphasis on early, non-judgemental support. They show that strengths-based approaches do not ignore vulnerability; they respond to it with care, respect and cultural understanding. Emotional resilience was recognised as a community resource to be cultivated.

Leadership within this model also extended to collaborative processes. Roundtable planning brought together Aboriginal Health Workers, social workers, midwives and, when necessary, DCP representatives. These gatherings upheld cultural safety and de-escalated adversarial dynamics by centring trust and transparency.

> I was scared when they said DCP was coming to the meeting. But I trusted the team. They sat next to me, not across from me. They helped me speak up.

Families described these meetings as spaces of safety and solidarity, where decision-making was shared rather than imposed. In this model, the act of walking with families through risk was the norm. Risk was not a reason for removal; it was a prompt for creativity, prevention and co-designed pathways forward.

Through these approaches, Aboriginal women across generations – young mothers, aunties and Elders – were recognised and supported as the cultural and structural backbone of the system. The BHFLHN model affirmed that keeping families together means supporting the women (and men) who hold them. It resourced not only their survival but also their leadership.

## 4.3 Embedded cultural practice and family-centred connection

A defining feature of the BHFLHN model is its seamless integration of culture into all aspects of service delivery. For families, care was not restricted to clinic appointments or formal case management; it extended into daily life through shared meals, yarning circles, school pick-ups, home visits and spontaneous check-ins by familiar Aboriginal staff. Culture formed the foundation of how the service operated, from governance to language to lunch.

> The Nunga lunch... deadly. Sit with mob, yarn, eat, laugh. That's when you feel strong.

These gatherings were cultural infrastructure; they built trust, reduced isolation and strengthened collective identity. Their absence, when staffing or programs changed, was deeply felt.

> Seeing the loved ones we used to catch up and have lunch with... just seeing that all disappear... yeah.

Such reflections highlight how cultural connection operates as both a protective factor and a healing practice. Informal spaces like the Nunga lunch provided emotional nourishment, community cohesion, and opportunities to share knowledge and experience. They also created space for humour, celebration and grieving – functions often excluded from clinical or bureaucratic models of care.

The importance of these cultural touchpoints was mirrored in the role of Aboriginal outreach staff, who acted as consistent, trusted figures across time and space. One participant shared her distress at the absence of Joan, a worker with whom her family had previously maintained close ties:

> She used to come out and check how you're going... I don't get that now.

This disruption of cultural continuity, caused by staff changes, resource gaps, or service restructuring, was experienced as a form of cultural dislocation. These women weren't just losing a worker; they were losing connection to a known and trusted system of care.

This loss was compounded by structural hardship. Housing instability, poor living conditions and inadequate public infrastructure all magnified the stress carried by Aboriginal families. One participant clearly described the daily impacts of this:

> Housing doesn't meet your needs. You feel neglected... especially when kids get sick and you're in and out of hospital.

> I have to go to the park to get water because the water from the tap tastes chemical.

Such conditions are core to understanding how environmental injustice, poverty and intergenerational inequality intersect with health and wellbeing. The BHFLHN model did not ignore these issues; instead, it created culturally safe spaces where families could disclose them, be believed and receive support without shame or surveillance.

This ethos of relational honesty extended into the clinic's response to any involvement by the DCP. When families were at risk of statutory intervention, the team leaned in to help de-escalate fear, hold space for difficult conversations and push back on punitive responses. They also offered truthful, supportive dialogue and advocated fiercely, when necessary, by reminding the external systems of the importance of centring the child's connection to family, culture and Country as a non-negotiable aspect of wellbeing.

> You told me the truth, even when it was hard. But you also helped me change. That's why I still have [my child]. Because you didn't give up on me.

Ultimately, the impact of this culturally embedded model was evidenced in shifts to family dynamics, improved communication and stronger kinship ties:

> We talk more now. We sit down and yarn properly. We sort things out before they blow up. That's not how we were before. That's what this clinic did for us.

Families consistently reported that this model of care kept them together, reduced involvement by the DCP in their lives, and strengthened relationships between parents, children and extended kin. These outcomes are not incidental; they are the direct result of a service model that is led by Aboriginal women, grounded in culture, and delivered with integrity, consistency and deep respect.

## 4.4 What services need to know

Families who engaged with the BHFLHN model shared not only their own experiences but also their insights into what distinguishes culturally safe, effective services from those that continue to cause harm. One of the strongest messages to emerge was the need for services to operate from a foundation of relational care that is based on trust and cultural understanding. Participants emphasised the importance of genuine human connection over procedural compliance, calling for culturally informed responses instead of a narrow focus on forms, referrals or risk frameworks.

As one mother explained:

> Have an ear out. I know it's just a job, but sometimes it becomes like family.

She acknowledged that while service providers operate within systems, the relationships they build, especially with young parents, can be transformative. Her plea was simple yet powerful:

> Don't judge us. Just check in. Sometimes we don't feel okay, but that doesn't mean we're failing as parents.

This reflection points to a central flaw in many mainstream services: the tendency to respond to distress with surveillance rather than support. In contrast, the BHFLHN model is grounded in compassion and a belief in families' capacity to thrive. Staff saw each family as whole – shaped by histories, cultural obligations and kinship ties – not as problems to be fixed. As one Elder framed it:

> Use your heart more than your mind... think about the family reaching out, not just your job.

In Gawler, families felt seen in their entirety. Grandmothers, aunties and other kinship carers were treated as essential to a child's wellbeing. Their knowledge was sought, their caregiving acknowledged, and their leadership included in planning and decision-making.

## She felt her role as a Nana was seen and respected by the Gawler team.

This stood in sharp contrast to experiences with other services, where kinship care was often ignored or actively devalued.

## Other places don't understand kinship. They judge us from a textbook.

Participants made clear that for services to be truly effective, they need to honour Aboriginal ways of raising children, where care is shared across generations and healing is collective. As one grandmother said:

## More and more grandparents are raising kids. Services need to support us too. Aunties, Nanas, all of us.

This is not only a cultural truth but a practical reality for many Aboriginal families navigating Child Protection systems, poverty and intergenerational trauma. To walk with these families, services need to move beyond deficit-based assessments and focus instead on strengths, stories and relationships.

For systems and practitioners looking to offer better support to Aboriginal families, these voices give a clear directive: listen deeply, honour kinship, lead with heart.

### 4.5 Concluding comments

The BHFLHN model demonstrates what is possible when services are designed and delivered under the cultural authority and leadership of Aboriginal women. Across every element of the service – whether clinical care, social support, or governance – women's leadership has shaped an environment in which trust became the foundation of family engagement.

This model recognises and centres kinship structures, honouring the role of grandmothers, aunties, siblings, and community carers in raising and protecting children. Decisions were made with families, not for them. Emotional and practical support was offered together, grounded in cultural safety and an unwavering belief in each family's capacity for strength and change.

What stood out most was the model's consistency. Families knew they could rely on staff to walk alongside them over time. There was no revolving door, no shifting expectations. Staff continuity and presence built families' confidence, reduced risk and kept children at home. Community events, shared meals and informal yarning spaces were all central to reducing isolation and reinforcing collective care. Families came together not only in crisis but in moments of celebration, reflection and growth.

What unfolded through this approach was not simply a reduction in Child Protection notifications; it was a strengthening of families themselves. Culture was embraced as a protective force, and care was shared across roles and relationships. The result? Children were not removed because communities were resourced and respected in keeping them safe.

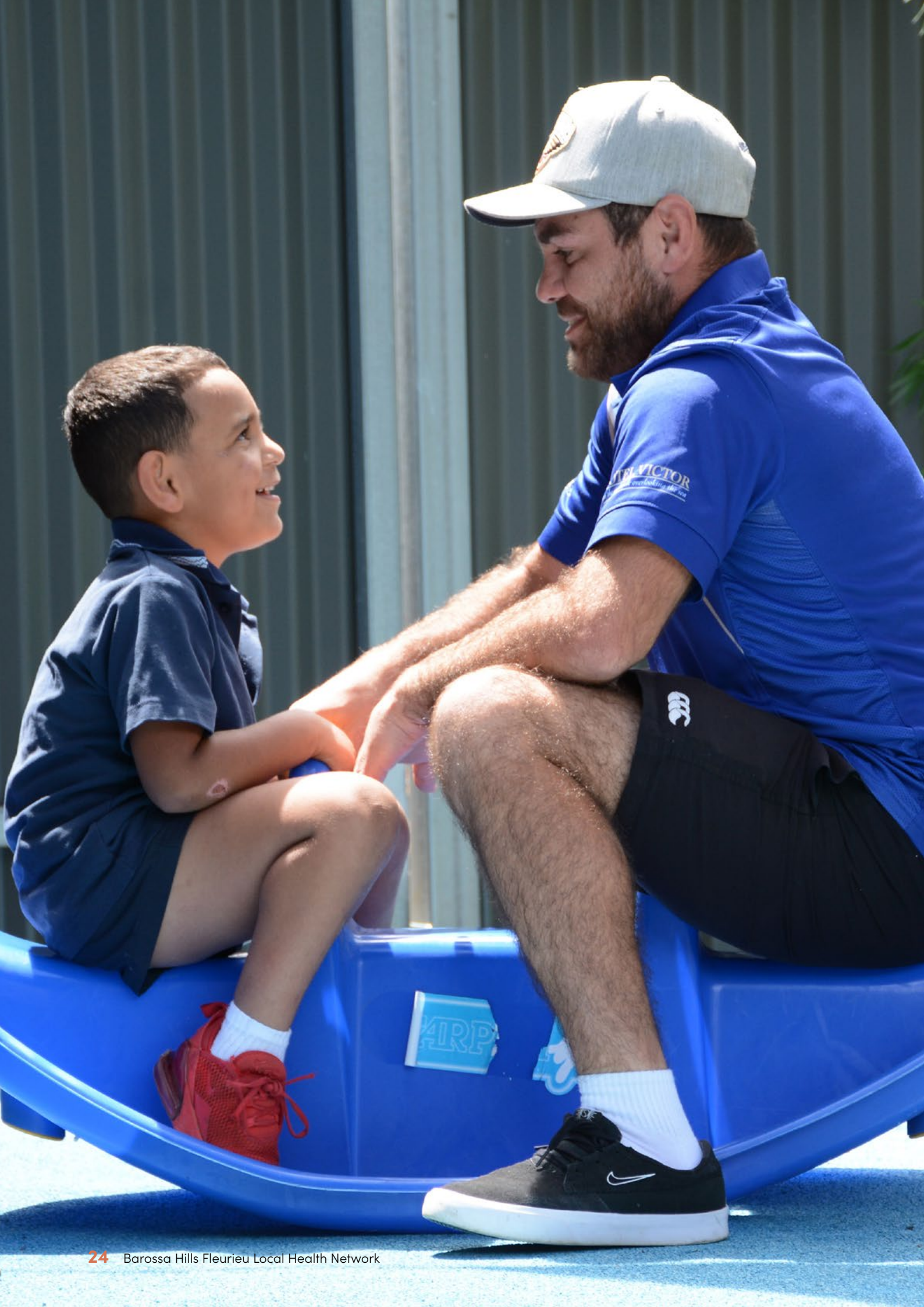
> Children were not viewed through a statutory lens, but recognised as active voices; individuals deserving of dignity, respect and genuine collaboration to ensure their safety and wellbeing.

Aboriginal women-led practice in this context is a way of working, relating and governing that transforms how we understand accountability, safety and service. It is grounded in cultural legitimacy, built through trust, and sustained by those who live the responsibility of care every day. This model is not only successful; it is essential. And it offers a powerful insight into what systems can become when they walk behind community leadership, not in front of it.

**Table 3**

Summary of key insights from the BHFLHN model

| Theme | Key features of the model | Lived experience reflections | Implications for services |
|---|---|---|---|
| **4.1**<br>**Relational accountability and continuity of care** | • Long-term relationships with Aboriginal staff<br>• Staff viewed as kin, not professionals<br>• Care built on trust and familiarity | 'They've been with me for 14 years. That's more than a service – that's family.'<br>'I never had to explain anything twice.' | • Prioritise relational, long-term staff continuity<br>• Build culturally safe environments of trust |
| **4.2**<br>**Women's leadership and cultural governance** | • Elders, aunties and young mums as leaders<br>• Kinship roles embedded in service delivery<br>• Strengths-based support for parenting | 'We're not just babysitting. We're protecting and teaching like we always have.'<br>'They listened and did something about it.' | • Recognise Aboriginal women's leadership<br>• Include kin in care plans from the outset<br>• Resource kinship carers appropriately |
| **4.3**<br>**Embedded cultural practice and family-centred connection** | • Culture embedded in all service aspects<br>• Shared meals, yarning, home visits<br>• Advocacy during DCP involvement | 'The Nunga lunch – deadly… that's when you feel strong.'<br>'We drive hours to come back… they know our story' | • Embed cultural practice in day-to-day work<br>• Provide informal spaces for community connection<br>• Use advocacy to reduce punitive system responses |
| **4.4**<br>**What services need to know** | • Families value empathy over procedure<br>• Kinship care must be respected<br>• Relational over transactional engagement | 'Don't judge us. Just check in.'<br>'Use your heart more than your mind.'<br>'Other places judge us from a textbook.' | • Honour kinship as central to care<br>• Lead with compassion, not compliance<br>• Support intergenerational carers (grandmothers, aunties) |



# 5 Findings from Gawler-based Health Professionals

## 5.1 The role of women allies in health settings: A professional standpoint

Within the BHFLHN, the strength and influence of women allies have emerged as a defining feature of the service's ability to innovate and transform in response to child protection concerns. Women in leadership, operational and community-facing roles have enabled a shift in practice from risk-driven statutory responses to compassionate, culturally anchored and family-centred approaches. This service innovation is largely due to a working culture shaped by women committed to walking alongside families, bearing witness to their experiences, and advocating for outcomes aligned with dignity, cultural legitimacy and community aspiration.

### Shared professional values

These shifts in practice are grounded in a shared set of professional values that shape how care is understood, delivered and sustained across the BHFLHN. These values are enacted daily through the decisions, relationships and advocacy work of staff. What follows is a synthesis of the values most frequently named by practitioners during co-reflection activities, each contributing to a professional culture rooted in cultural humility, relational accountability and justice-oriented leadership.

**Non-hierarchical accessibility:** The leadership team includes senior staff and executive management, all of whom are approachable and deeply embedded in team dynamics. They are known not by title but by relational proximity and cultural trust. Staff feel safe to bring up difficult issues with them because they are discussed with humility, curiosity and care. One worker shared, *'You don't have to book a meeting to talk about something hard. You walk down the hallway. That's what trust looks like in here.'*

**Truth-telling and transparency:** Women in both executive and clinical roles have modelled what it means to hold space for stories of pain, racism and structural neglect. This is evident in the frank discussions about the legacy of the Child Protection system and in the refusal to sanitise or excuse poor behaviour or discriminatory practice. In the words of a clinical lead, *'We don't pretend everything's okay. We talk about racism. About harm. That's the only way we get better.'*

**Social justice as governance logic:** As one executive noted, *'Wherever there is bias, racism, disadvantage, poor outcomes, you triple your effort.'* This equity-based model of governance reframes leadership as a tool for redressing injustice. Staff understand governance not just as structure but as an ethical orientation.

**Walking alongside, not ahead:** Health workers, particularly Aboriginal women and their allies, describe their practice as deeply relational: they co-construct solutions with families, supporting autonomy and recognising the family's expertise in their own lives. The relational nature of care is described as *'not doing things for families, or to them, but with them'.* This co-created approach shifts accountability away from institutions and towards community-defined care.

**Powerful advocacy within and beyond the system:** Whether negotiating with Child Protection services or pushing back against hospital protocols that undermine family safety, staff act as boundary riders defending cultural safety and recalibrating risk within a framework of strength. Several staff describe advocating fiercely for families, especially when institutional processes conflict with cultural safety. As one midwife noted, *'Sometimes we're the only ones saying, "That's not safe. That's not respectful." And we don't back down.'*

**Adaptive leadership and emotional resonance:** Leadership team members are attuned to the emotional toll of the work and model vulnerability, openness and adaptability. This cultural humility creates an environment where learning, growth and experimentation are permissible and even encouraged. Vulnerability and responsiveness are regarded as leadership strengths. Teams model a culture of emotional honesty, where learning and growth are constant and expected.

**Organisational culture shaped by matriarchal values:** The sustained presence of strong Aboriginal and non-Indigenous women over more than a decade has cultivated a culture of nourishment, not punishment. Staff talk openly about the 'divine feminine energy' and of workplaces that focus on love, strength and responsibility. This is a counterpoint to the masculinised, compliance-oriented health bureaucracy that exists elsewhere.

## 5.2 Practising allyship, women-centred relational leadership

Staff frame allyship as active, embodied and political: a commitment to ethical responsibility, historical accountability and the pursuit of systemic change. This orientation shapes both individual actions and broader organisational culture. At its core is a refusal to remain neutral within systems that have historically caused harm.

In the *Keeping Families Healthy Together* model practised in Gawler, non-Indigenous women demonstrate how relational and culturally responsive leadership can reshape the role of health services in child protection. Their actions create environments defined by cultural safety, shared decision-making, and consistent support through complex and vulnerable experiences.

The Allyship Community of Practice reflects this ethos. Described by one leader as a place *'where non-Aboriginal people learn how not to be assholes',* it is a tangible expression of cultural humility and collective accountability. Racism is addressed directly, and dialogue is used as a mechanism for cultural safety and growth.

### Holding space: Women's allyship and the response to Aboriginal women's leadership

'Holding space' emerges as a defining element of the practice environment, which is quite distinct from service provision or case management. Holding space refers to the ability of professionals, particularly non-Indigenous women in health leadership and frontline roles, to sustain environments of cultural safety, emotional regulation and relational integrity in which Aboriginal women's leadership can emerge, evolve and be enacted without disruption or appropriation.

This 'holding' is deeply active as it involves the conscious deferral of power, the willingness to be transformed, and the prioritisation of Aboriginal ways of knowing, being and doing. Non-Indigenous women in the system describe their allyship not as speaking for, but rather as listening with:

> I just think that if that's the only power I have, then that's how I'm going to use it.

What this means in practice is making room for Aboriginal women to take the lead, without imposition, in processes of care planning, community engagement, risk assessment and advocacy. This model actively rejects deficit-based paradigms and reframes Aboriginal women as cultural authorities navigating complex systems while maintaining their roles as carers, matriarchs and leaders. One of the strongest indicators of this responsive allyship is the way non-Indigenous women describe their readiness to be held accountable by the communities they serve:

> We're not walking in their shoes. So if someone says to me, "This is racism", then I believe them. Full stop.

The model supports Aboriginal women's leadership through mechanisms such as:

- Handing over decision-making power, as seen in the #Blakout Campaign, where governance is transferred to Aboriginal staff.
- Succession planning that prioritises Aboriginal women in leadership pipelines and safeguards their authority across service layers.
- Reframing risk not as a deficit to be managed but as an opportunity for innovation in partnership with Aboriginal women.
- Creating time for conversations, cultural care and complex decision-making rather than imposing rigid timelines or externally imposed outputs.

The respect for Aboriginal women's leadership is also evident in the structuring of family-led meetings and culturally governed engagement practices. These are substantive spaces where Aboriginal perspectives shape the narrative, define priorities and guide implementation:

> We are not the authors of these families' stories. DCP are not the authors. The families are.

In this context, allyship means refusing to rush, refusing to fix and refusing to centre non-Indigenous knowledge systems. It means trusting the leadership of Aboriginal women, even (and especially) when it requires structural change, emotional labour, or confronting entrenched racism.

> I was allowed to make mistakes because the space was safe. That's what our Aboriginal colleagues gave us: the chance to grow without shame.

This experience of mutuality, of being shaped by the leadership of others, marks the distinction between performative allyship and enacted, accountable solidarity. It is this relational infrastructure that allows the system to adapt, respond and ultimately reduce DCP notifications to near zero; not through compliance, but through care-based leadership and cultural honouring.

**Embodied leadership and the work of going above and beyond**

Staff and leaders frequently described going 'above and beyond' standard protocols. This included emotional labour, after-hours engagement, and a refusal to allow rigid policy settings to override relational and cultural imperatives. The commitment to care was enacted through countless small, responsive acts, with health workers across Gawler consistently going beyond their formal job descriptions. They offer care rooted in kinship, responsibility and justice, which they implement by: providing after-hours check-ins; protecting cultural staff during recruitment freezes; refusing to allow the DCP on-site without consultation; and backing families through systems that otherwise exclude them.

One nurse shared:

> I'll drive an hour out to check in on a mum if I know she won't come back in. Not because it's in my KPIs. Because it's what's needed.

Yet this ethic of care also brings costs. Staff spoke of burnout, dependency on key individuals, and the emotional labour of maintaining safe spaces in a post-Referendum climate of rising public racism:

> People started saying things out loud that they used to whisper. And we were the ones holding the line.

The leadership team acknowledged these pressures and responded with adaptive rostering, increased cultural supervision and investment in staff wellbeing. Still, the demand far exceeds the resources.

> You're not welcome on our hospital site unless you engage first. Because that's not a safe practice... and families don't come back if they feel unsafe.

This is systemic compassion in action, made possible by women who hold themselves, their colleagues and their institutions to a higher standard of justice.

**Qualities of women leaders in health settings**

## Across all consultations, a clear pattern emerged regarding the attributes of effective women leaders working in allyship with Aboriginal families:

Relational authority over positional power

Vulnerability and openness to critique

Deep cultural humility

Adaptive practice in complex, ambiguous situations

Commitment to team integrity through flexible rostering, succession planning and acknowledgment of emotional labour

Values-based leadership grounded in social justice

This commitment to cultural safety and equity extends to the executive level, with the CEO of BHFLHN describing her work as an extension of a legacy she inherited and now consciously upholds:

> There is an honest and genuine commitment to improving things for First Nations people... we don't have all the answers, but oh my goodness, we have to do better.

Such leadership is grounded in humility, discomfort and truth-telling:

> My discomfort is nothing like the discomfort or pain of being subject to racism. So I say, we're all in this together, and we're not perfect. Let's roll around in the discomfort.

The BHFLHN model embeds allyship as a cultural logic. What emerges is a form of institutional kinship, sustained by women whose leadership is enacted through relational authority, emotional labour and everyday acts of resistance against bureaucratic norms. These practices do not seek to dismantle systems through confrontation alone, but through the creation of parallel spaces where alternative values – care, accountability and cultural legitimacy – govern decision-making.

In doing so, the model enacts a matriarchal ethic that challenges dominant paradigms of risk and authority, offering a lived demonstration of what system transformation can look like when led from within and held by those most attuned to the consequences of failure.

## 5.3 Enacting system change through relational infrastructure

The practice of allyship within the BHFLHN has not remained at the level of interpersonal ethics or leadership style. It has taken root in organisational structures, governance practices and everyday decision-making. This system change has occurred through a relational infrastructure grounded in trust, cultural authority and shared responsibility.

Staff described a shift in how power is distributed, particularly through mechanisms such as the #Blakout Campaign, which gives Aboriginal staff control over executive agendas, strategic priorities and internal communications. These shared governance models influence how care is delivered, how risk is interpreted and how families engage with services. The model advances a view of leadership as inherently collaborative and culturally located. Through these structures, Aboriginal staff are positioned as drivers of organisational direction.

Relational trust is central to how these changes have been sustained. Long-standing relationships across teams, communities and families have enabled difficult conversations, supported collaborative decision-making and reduced fear around statutory interventions. Families spoke of feeling known, not surveilled. Staff described a practice culture where decisions, particularly DCP notifications, are made in dialogue with families. These ways of working have created the conditions in which trust can act both as a protective factor and as a catalyst for change.

These strengths, however, exist within a broader social and political context that remains volatile. While the model has led to demonstrable improvements, such as increased family engagement and reduced notifications, it has not reached all communities equally. Families who have moved away from the Gawler region reported a lack of culturally safe alternatives. Staff spoke of the additional pressures placed on the service in the wake of the Referendum, citing an increase in overt racism and the emotional toll of holding safe spaces in hostile environments.

Despite these pressures, the commitment to equity has remained a defining feature. Leaders described a deliberate intensification of effort wherever structural barriers persist. The service's approach to governance, trust-building and continuity of care reflects a belief that system change is achieved through long-term investment in relationships, cultural legitimacy and community governance.

## Co-design and non-hierarchical access

A significant theme emerging from the interviews was the dismantling of professional hierarchies to enable collaborative and culturally grounded responses. The use of shared governance models, like the #Blakout Campaign, which hands decision-making power to Aboriginal staff for a full month, demonstrates an applied commitment to cultural leadership:

> During #Blakout, First Nations staff controlled the Board agenda, executive priorities, and internal and external communications. It's not just about reconciliation. It's about celebration and coming from a strengths base.

This reframing of leadership as shared rather than delegated has created powerful opportunities for Aboriginal staff to drive meaningful change.

### Trust and continuity of care

What distinguishes this model is its unwavering commitment to invest in trust. This enables deep conversations, even in statutory Child Protection contexts, without invoking fear or betrayal:

> If we do need to make a notification, it's done with the family. We exhaust every opportunity first. We ask: Have I done everything I can do for this family?

This relational, trauma-informed approach has enabled notifications to drop to zero in some regions.

### Responding to systemic challenges

While the model represents a beacon of best practice, respondents also acknowledged that it is not universally accessible. One Aboriginal mother expressed gratitude for the support she received from the Gawler clinic, yet noted:

> We live so far [away] now... [but] we just don't go [to other clinics] because they don't know us. We travelled three hours just to come back here.

Another staff member reflected on the post-Referendum landscape, describing the rise in racism and the challenges it poses for their workforce and clients:

> It's like something cracked open. People felt emboldened to be racist out loud. We had to double down on our anti-racism work.

The service's equity governance model, described as *'tripling our effort wherever there's racism, bias, or disadvantage',* has been crucial in this climate. However, the broader impact of racism, failed political processes and community division continues to affect Aboriginal families' access to care.

## 5.4 Concluding comments

This Section has examined the integral role of women, particularly non-Indigenous allies, in shaping a culturally grounded, justice-oriented model of care. Their leadership does not rely on hierarchy or procedural mandates but on relational commitment, cultural humility, and an ethic of accountability to Aboriginal families and colleagues. These are not soft skills; they are structural capacities essential to the effectiveness of the BHFLHN model.

What emerges is a living system, sustained through trust, emotional labour and long-term investment. It is a model upheld not by compliance mechanisms but by women, Aboriginal and non-Indigenous, who show up with courage, clarity and care. These individuals honour culture, challenge injustice and uphold relational accountability even in the face of overwhelming structural pressure.

At the same time, this work requires protection. It cannot depend indefinitely on extraordinary individuals or ad hoc leadership. Without structural reinforcement – formal investment in relational infrastructure, cultural governance and workforce wellbeing – the sustainability of the model is at risk.

> You can't codify love. But you can build a system that makes it possible.
>
> **Staff member**

These tensions raise critical questions: How can systems formalise and protect the relational infrastructure that makes this model possible? What does it mean to scale a framework that resists standardisation? And how can policy account for care that is enacted in relationships rather than imposed through policy?

The *Keeping Families Healthy Together* model responds to these questions by offering a structured, values-based articulation of the practices, conditions and cultural logics that have made transformation possible. It is a cultural architecture that charts a path forward, one in which Aboriginal families are not only safe but sovereign; not managed, but respected; not marginalised, but leading.

# 6 Operationalising the Keeping Families Healthy Together Model

This Section explains how the *Keeping Families Healthy Together* model is practically enacted across systems, services and relationships. Rather than introducing a new initiative, it codifies what has already been built by Aboriginal women, their communities and trusted allies over many years of cultural, clinical and relational work. What follows articulates the vision, principles, objectives and core actions that make the model work on the ground. It provides a cultural infrastructure within which the child protection and health systems can align to honour the local, place-based and kinship-governed practices that keep families strong and together.

## 6.1 Vision

> To uphold the right of Aboriginal families to remain strong, healthy, connected and together.

This vision recognises the enduring leadership of Aboriginal women, whose cultural authority is located in kinship, caregiving, and the responsibilities that come with holding families and communities through hardship and healing. Health services become places of connection and early support, rooted in cultural safety and built on trust. Care begins with dignity, not deficit. This model meets families where they are at, affirms their strength, and restores the relational and cultural systems that have protected children for generations.

## 6.2 Objectives

The objectives of this model, listed here, strengthen Aboriginal family life through care that is early, culturally anchored and family led. Each objective reflects a commitment to structural transformation, not just to service adaptation.

- Prevent child removal through early, voluntary and culturally secure engagement.
- Strengthen family capacity and cultural identity.
- Redefine the role of health services in protective care.
- Create a trust infrastructure within health and community services.
- Embed matriarchal and allied women's leadership.
- Support trauma-informed and culture-held healing.
- Ensure continuity of care across generations and geographies.
- Elevate Aboriginal women's leadership in health and social services.
- Co-create safe spaces for meaningful engagement.
- Foster gender equity and structural inclusion.
- Promote economic independence and cultural entrepreneurship.
- Establish an Allyship Community of Practice for learning and legacy.

Where child removal is necessary, guarantee a strong voice for families and children in the context of their worlds, supporting them through growth and collaborative efforts.

## 6.3 Principles

The BFHLHN model is held together by principles that centre women's leadership, cultural governance and relational accountability. These are the ethical and operational foundations that keep the model true to its community roots while making space for institutional change.

| Principle | Description |
|---|---|
| **Cultural respect** | Affirms Aboriginal women's knowledge, roles and responsibilities across care and governance. |
| **Cultural recognition** | Centres women's artistic, ceremonial and familial obligations in service design. |
| **Relational authority** | Authority is earned through consistent, respectful relationships, not role or title. |
| **Cultural safety and identity** | Embeds Aboriginal worldviews, languages and kinship systems in service delivery. |
| **Family-led decision making** | Supports families to lead their own care journeys through kinship-based governance. |
| **Empowerment** | Enables Aboriginal women to make choices that reflect their aspirations, identity and obligations. |
| **Non-judgemental support** | Offers care without shame, surveillance, or coercion. |
| **Accessibility and continuity** | Provides care that is responsive to geography, mobility and intergenerational needs. |
| **Community control and participation** | Positions Elders, aunties and extended families as core to service governance. |
| **Celebration and achievement** | Creates space for pride, visibility, and recognition of women's leadership and cultural practice. |
| **Collective accountability** | Embeds accountability in relationships and community legitimacy, not just reporting lines. |
| **Cultural legitimacy over statutory threat** | Builds services that families trust because they are culturally governed and relationally grounded. |
| **Modern matriarchy** | Recognises Aboriginal women as healers, protectors and institutional leaders. |

## 6.4 Operationalising cultural governance

This model is made real through daily practices that uphold cultural legitimacy and protect the leadership of Aboriginal women. These actions are not step-by-step processes; they are cyclical, relational and grounded in place.

| Action | Description |
|---|---|
| **Reframe child protection as cultural care** | Strengths-based, kinship-informed support replaces punitive responses. |
| **Pre-engagement with Elders and mentors** | Trust is built through cultural orientation and community endorsement. |
| **Cultural leadership and identity strengthening** | Women reconnect with culture, reflect on roles and grow as community leaders. |
| **Narrative ownership and healing** | Women reclaim their stories, language, and truth as acts of agency and resistance. |
| **Proactive, wrap-around support** | Transport, housing, peer support and cultural programming are offered early and consistently. |
| **Relational engagement and continuity** | Care is built on presence, consistency and long-term connection. |
| **Shared decision-making through roundtables** | Families lead care planning with support from trusted cultural and clinical allies. |
| **Culturally embedded practice** | Practice reflects Aboriginal parenting, communication and community obligations. |
| **Elders and kinship carers as core participants** | Grandmothers and aunties hold decision-making and cultural leadership roles. |

## 6.5 Relational conditions for change

Transformative practice within the *Keeping Families Healthy Together* model is driven by the cultural and relational conditions that enable trust, innovation and family leadership.

**Risk** is understood as a shared cultural responsibility. It is not imposed through institutional surveillance but redefined through the strength of kinship care and community knowledge. Safety is co-created with families who determine what support is needed and when. Plans reflect lived realities, not bureaucratic assumptions. Innovation arises through deep listening, cultural humility, and the willingness of practitioners to walk alongside rather than direct.

**Family-led practice** is foundational. Families are not positioned as passive recipients of care but as decision-makers. Their cultural authority shapes the structure and intent of roundtable meetings, where care plans are developed through kinship protocols, community logic and collective knowledge. Practitioners are accountable to these cultural frameworks, not just to organisational policies.

**Relational casework** enables long-term support grounded in trust and continuity. Practitioners stay present across time, life stages and service transitions. This sustained engagement strengthens cultural connection and reduces the risk of fragmented care.

**Several enabling conditions make this work possible.**

**Time** is critical. Relationships that hold cultural authority cannot be accelerated to meet funding cycles. Trust is built over years, not months.

**Cultural safety** is enacted in the everyday. It is shown through respectful, consistent behaviour, not claimed through certificates or declarations.

**Allyship** requires humility, reliability and a deep commitment to relational practice. Non-Indigenous practitioners and leaders must actively support cultural authority, not override it.

**Kinship** is the governance model. It determines who leads, how care is structured and what accountability looks like. Recognising kinship as both a care system and a leadership structure ensures that services remain culturally grounded and responsive to the realities of Aboriginal family life.

Together, these elements form the relational infrastructure that enables meaningful change, where care is not delivered to families but created with them in ways that uphold dignity, trust and cultural sovereignty.

## 6.6 Resource allocation and workforce sustainability

The *Keeping Families Healthy Together* model is built on deep relationships, cultural governance and sustained presence. These are not incidental features; they are the conditions that make the model work. As the model grows and is considered for implementation beyond the Barossa Hills Fleurieu Local Health Network, it is critical to acknowledge that its success depends on roles that are already operating beyond capacity.

The current demands placed on practitioners, particularly those in culturally embedded and relational roles, far exceed existing resourcing. As consumer needs grow more complex – across mental health, housing, intergenerational trauma and family violence – so too does the need for consistent, high-quality clinical and cultural care. Without increased investment, the ability of the model to deliver proactive rather than reactive support is at risk. This is especially true in the Gawler region, where demand continues to outpace capacity and where additional social and emotional wellbeing (SEWB) workers, Aboriginal Maternal Infant Care positions and allied staff are needed to meet the scale of family needs in the context of health and wellbeing.

The BHFLHN team includes unique and critical roles such as the Advanced Clinical Lead – Women, Child and Family Safety, whose expertise spans policy, clinical governance and cultural accountability. These roles are not easily replicable; they require strategic investment, long-term capability-building, and a deep understanding of place-based and culturally specific practice. If other LHNs are to implement this model with integrity, they ought to commit to resourcing these positions appropriately rather than assuming existing structures can absorb the work.

Additional funding would strengthen multiple aspects of the model, including:

- more frequent and sustained engagement with families through outreach, accompaniment and cultural programming
- stronger integration with external services, allowing for coordinated care across health, housing, mental health, and child and family services
- greater capacity to implement and evaluate innovative practices, including cultural supervision, narrative-based healing and kinship governance mechanisms
- enhanced workforce development through mentoring, supervision, training and allied leadership roles across the region.

Investment in these areas is not only clinically sound, it is financially strategic. Early, culturally safe, community-based support reduces the demand for high-cost, acute interventions and enables families to remain together, safe and connected.

Critically, this model ought not (cannot) be lifted and dropped into other contexts without care. Cultural legitimacy, matriarchal leadership and sustained community relationships cannot be replicated without deliberate investment in the roles that hold them. This is not a scalable program; it is a place-based, culturally governed practice that demands equally serious commitments from any service system seeking to adopt it.

## 6.7 Implementation of the model: Cultural conditions, relational actions

The *Keeping Families Healthy Together* model is not sustained by policy instruments or program logic alone. Its strength lies in the deep and enduring commitments made by those enacting it. The following foundational commitments are not ancillary to the model; they are its operational heart.

- **Kinship-centred care:** The model draws its structure and relational logic from Aboriginal kinship systems. Grandmothers, aunties and extended kin are recognised not as informal supports but as leaders, cultural authorities and the backbone of family care.
- **Cultural leadership:** Aboriginal women lead with integrity, relational depth and cultural legitimacy. Their leadership shapes service logic, team dynamics and family engagement. This is not leadership by designation but by relational presence and community trust.
- **Relational continuity:** Trust is built through consistency. Staff remain present over time, through joy and trauma, creating a foundation of safety that formal systems alone cannot deliver.
- **Cultural fluency in practice:** Staff are supported to learn, reflect and act with cultural humility. This is not about completing training but about cultivating ethical sensibility, relational awareness and readiness to be changed.
- **Responsive care systems:** Services adjust to family-defined needs and rhythms. Practitioners listen, adapt and walk alongside families across life stages, not only in crisis.
- **Narrative-based accountability:** Evaluation is grounded in lived experience, cultural indicators and the relational effects of care. Families and communities shape how success is defined and how learning occurs.

These commitments, which provide the architecture through which transformation occurs, are interwoven practices shaped by Country, culture and community leadership. Sections 7 and 8 build on these foundations to identify critical considerations for those seeking to apply the model elsewhere.

# 7 Evaluating the Keeping Families Healthy Together Model

This evaluation report has been designed to track the implementation and impact of the *Keeping Families Healthy Together* model in ways that are meaningful to Aboriginal families and communities, not just measurable by systems. Thus, it includes outcomes and indicators that reflect family wellbeing, trust in health services and cultural integrity, as well as process measures that assess how key features of the model are sustained over time.

The evaluation has been treated as a culturally safe, community-led practice that upholds sovereignty, dignity and justice, and not simply as a technical exercise. Aboriginal women's leadership, cultural governance and relational care are both the focus of this evaluation and the method by which it is conducted. As such, the report challenges conventional compliance models and offers an approach grounded in accountability to the community.

## 7.1 Monitoring and evaluation principles

To ensure that the evaluation remained community-led, culturally safe and based on Indigenous ways of knowing, the following foundational principles guided the work:

- **community-led** evaluation is designed, led and governed by Aboriginal communities and Elders
- **narrative-based** storytelling and lived experience are primary forms of evidence
- **culturally defined indicators** measure success through cultural safety, trust, kinship integrity and relational outcomes
- **iterative and reflexive** learning cycles enable adaptation and community feedback
- **data sovereignty** ensures all data is co-owned and governed by community protocols.

## 7.2 Evaluation outcomes and impact measures

The outcomes in this report reflect a shift from deficit-based assessments to culturally defined measures of strength, safety and connection. These outcomes prioritise what matters to Aboriginal families and track whether the health system operates as a site of care rather than one of control.

## 7.3 Distinctive features to be monitored

To evaluate the *Keeping Families Healthy Together* model in a meaningful way, we found that standard evaluation indicators were insufficient. We needed indicators that reflect the values and practices of the model through the following features:

**Aboriginal-led and Aboriginal women-led practice:**

- Examining how leadership is held and enacted by Aboriginal women and their allies through decision-making authority, governance roles and relational influence across the service system.

**Organisational culture that nurtures female allyship and adaptive leadership:**

- Exploring how the organisation cultivates a workplace culture that values the leadership of Aboriginal women and fosters allyship among colleagues.
- Highlighting systems and behaviours that promote innovation, cultural safety and flexibility, such as responsive decision-making processes, support for cultural responsibilities, and a commitment to listening and acting on feedback.
- Identifying how these elements create conditions for culturally grounded, gender-responsive service transformation.

Table 4

From deficit to strength: Culturally relevant indicators of family and system change

| Domain | Outcome | Indicators | Methods |
|---|---|---|---|
| **Child safety** | Reduction in statutory intervention | Significantly reduced DCP notifications or where notifications are raised the family are involved where possible | Administrative data review, case audit |
| **Family wellbeing** | Improved family mental health, confidence in parenting and cultural connection | Self-reported improvements in parenting confidence, mental health, cultural participation | Yarning interviews, wellbeing surveys, family story capture |
| **Child development** | Secure attachment and cultural identity in children | Increased connection to kinship, cultural identity markers, stable care environments | Practitioner and family observations, narrative assessments |
| **Service transformation** | Health services become trusted sites of care | Increased service access, reduced fear of statutory involvement | Client feedback, trust indicators, narrative inquiry |
| **Cultural safety and integrity** | Embedding cultural governance across service delivery | Elders engaged in care planning, cultural supervision implemented, kinship governance frameworks operational | Staff reflections, cultural audits, governance documentation |

**Cultural governance and co-design of the evaluative 'lens':**

- Assessing the extent to which Aboriginal cultural logics shape the outcomes as well as the evaluative process itself.
- Prioritising ongoing governance and community-led meaning-making over compliance-driven consultation.

**Trust as a system value:**

- Attending to the presence of relational integrity across families, staff and service touchpoints; this may be evidenced through repeated feedback loops, yarning sessions and observed continuity of care.

**Relational continuity:**

- Tracking whether families experience consistent and culturally safe relationships over time.
- Focusing on stories that reflect stability, trust, and a sense of being known and held across life stages and transitions.

**Modern matriarchy in action:**

- Documenting stories and evidence of Aboriginal women leading with cultural authority, governing services, shaping care, and enacting protective kinship in ways that resist bureaucratic reduction.

This approach privileges narrative, legitimacy and responsibility over standardised outputs. It asks: who holds the power, whose voices shape meaning, and what does care feel like to those who receive and deliver it?

## 7.4 Implementation: Relational processes and structural commitment

The integrity of this model rests on the lived processes that govern how relationships are built, decisions are shared, and safety is made real for families and staff. Implementation needs to honour Aboriginal systems of care and community-defined ethics. The following process areas offer ways to reflect on how the model is taking root.

- **Relationship mapping and listening:** Track the early work of building trust – who initiates engagement, how relationships are formed and what networks emerge over time. Visual mapping and reflective journaling can illuminate where relational authority sits and how it grows.
- **Cultural supervision for staff:** Prioritise staff wellbeing and cultural integrity through regular, story-based supervision. Reflection journals, supervision notes and narrative review processes help to ensure practitioners are supported, grounded and accountable in their roles.
- **Flexible systems design:** Examine whether policies and procedures enable or restrict culturally responsive practice. Record adaptations, case examples and local innovations that emerge in response to family-defined needs.
- **Kinship governance in operations:** Analyse how service operations reflect kinship structures. This includes hiring Aboriginal staff into culturally legitimate roles, allocating resources in ways that honour family and community leadership, and maintaining data sovereignty agreements that protect Indigenous knowledge.
- **Investment in safe spaces:** Consider what safety looks and feels like both for families and staff. Audit the presence and use of culturally safe spaces such as yarning rooms, communal areas and flexible engagement zones. Gather stories of satisfaction, discomfort and cultural affirmation.

## 7.5 Sustaining the model: Workforce considerations

Delivering this model with integrity requires ongoing attention to the workforce structures that support it. Staff carry significant cultural, relational and clinical responsibilities, often extending beyond the scope of their formal roles. The model's success depends on relationships built over time, continuity of care, and the presence of trusted professionals who are culturally embedded and community connected. Several areas have emerged as important in supporting the long-term sustainability of the work.

**Social and emotional wellbeing support:** Community-embedded SEWB practitioners, particularly those with qualifications in Aboriginal health or social work, play a key role in maintaining relational care and supporting families through complex circumstances.

**Clinical leadership and cultural governance:** Senior roles that bring together clinical oversight and Aboriginal-led governance contribute to continuity, mentoring and integrated practice. These roles help uphold cultural integrity across service delivery.

**Aboriginal maternal and child health workforce:** The presence of Aboriginal workers in maternal, infant and child health has proven critical to cultural safety, continuity of care and trust. Expansion in this area strengthens early intervention and prevention outcomes.

**Allyship and non-Indigenous leadership:** Non-Indigenous staff in leadership roles can actively support matriarchal governance by creating space, listening deeply and enacting culturally informed allyship. This relational work is essential to sustaining the values of the model.

**Cultural supervision and reflective practice:** Cultural supervision and reflective practice are foundational, not ancillary. These processes support ethical care, prevent burnout, and enable staff to work in ways that are relationally and culturally accountable.

Workforce sustainability is not just a matter of resourcing; it is central to the cultural, protective and relational fabric of this approach. The model thrives when care is held within community-defined relationships, not imposed by systems. Recognising the depth and scope of carried by staff is part of honouring the trust that has made this work possible.

## 7.6 Concluding comments

The *Keeping Families Healthy Together* model is not a compliance framework to be operationalised through metrics alone. It is a culturally anchored system of care built through lived relationships, kinship authority and Aboriginal women's leadership. Its power lies in how it reshapes institutional time, decision-making and definitions of safety. This model does not ask systems to absorb Indigenous knowledge; it requires them to be reconstituted by it.

Transformation occurs when health services become sites of cultural accountability, when non-Indigenous allies hold space without control and when Aboriginal governance is enacted as everyday practice. These shifts are not the result of policy adoption but of deep, relational labour carried over time.

This model is a living cultural archive. It tells us what becomes possible when Country, culture and care structure the logic of service delivery. The challenge now is whether existing systems are willing to be changed by what it reveals.

# 8 Considerations for Broader Implementation

Scaling or adapting the *Keeping Families Healthy Together* model requires more than replication. It calls for a grounded understanding of the cultural, relational and governance commitments that enable it to thrive. These prompts are designed to help systems reflect on their readiness to engage with the model's principles.

- **Cultural legitimacy as a precondition:** Adaptation should begin with Aboriginal leadership and kinship-based governance. If this foundation is missing, the conditions for cultural safety will not hold.
- **Relational investment as strategy:** Systems need to commit to building trust over time. This means long-term staffing, continuity of care, and organisational patience to grow relationships before measuring impact.
- **Contextual specificity matters:** The model is rooted in Country, community and historical relationships. Implementation elsewhere must be locally led, culturally negotiated and never lifted wholesale.
- **Governance must carry authority:** Cultural governance structures, such as roundtables and Elder engagement, are not advisory groups. They are decision-making bodies with cultural legitimacy that ought to be operationalised in practice.
- **Sustained and targeted resourcing:** Implementation will fail without investment in the roles and relationships that sustain the model: namely, an Aboriginal workforce, cultural supervision, peer support, community-led monitoring and kinship carers.
- **Allyship as ongoing practice:** Non-Indigenous practitioners need to hold space with humility, act with institutional courage, and be willing to share power and to be changed by the process.
- **Evaluation shaped by community priorities:** Impact ought to be defined by families, not institutions. Indicators like trust, cultural connection and safety must take precedence over compliance and throughput.
- **Support systems must be transformed, not supplemented:** This is not about adding cultural care to existing frameworks. It is about unsettling dominant logics of risk, authority and control to centre relational and cultural accountability.
- **Matriarchal leadership is the architecture:** The leadership of Aboriginal women is not a component of the model; it is the model. Systems need to protect and elevate this leadership in structure, not just sentiment.
- **Flexibility and cultural responsiveness:** Families move across geographies, life stages and support needs. Rigidity will fail them. Implementation must preserve responsiveness, autonomy and care that aligns with lived realities.

# 9 Matriarchy as Method: Redefining Systems through Cultural Care

This evaluation report offers a rare and deeply grounded account of how modern matriarchy operates in practice among Aboriginal women in the Barossa Hills Fleurieu region of South Australia. It reframes matriarchy not as a mirror image of patriarchal power but as a culturally legitimate system of authority rooted in kinship, care and community-defined responsibility.

## 9.1 Matriarchy as cultural governance

The BHFLHN *Keeping Families Healthy Together* model reveals that Aboriginal women do not hold power through institutional titles or hierarchical structures. Instead, their authority emerges through cultural legitimacy, continuity of presence and sustained relational accountability. Grandmothers, aunties and young mothers enact leadership by holding families together, making decisions in times of crisis and transmitting knowledge across generations. Their leadership is not an intervention; it is the architecture of daily life.

As the report demonstrates, cultural governance is not symbolic. It shows up in roundtable meetings where grandmothers assert kinship rights to care for children, in service planning led by Aboriginal women, and in the quiet, consistent presence of Aboriginal Health Workers who function as relational anchors over decades. This is an example of embedded governance that holds community and culture together.

## 9.2 Relational authority over procedural power

The modern matriarchy evident in this model privileges relational authority over bureaucratic mandate. Women are trusted precisely because they stay, listen, remember and act without judgement. As families attest, what made the difference was not clinical expertise but emotional availability, cultural knowledge and the ability to hold complexity without retreating.

This disrupts the Western bias toward individualised professional practice; instead, it presents a model where collective memory, intergenerational ties and relational continuity are the true indicators of authority. It highlights a distinctly Indigenous logic of power, where who you are in relation to others is more important than your title.

## 9.3 Matriarchy as systemic resistance

This model of care resists the assumptions embedded in dominant child protection and health care frameworks. The Aboriginal women leading this work do not simply soften the blow of harmful systems; they redefine what care and protection mean. Risk is reframed as an opportunity for culturally responsive intervention. Leadership is enacted through walking with, listening deeply and refusing to abandon families in crisis.

This form of matriarchy is subversive in the best sense. It does not seek to reproduce state systems in culturally adapted forms. Instead, it insists that cultural forms – such as yarning, shared meals and kinship networks – *are* the system. When services align with these practices, they become safe. When they do not, they remain sites of harm.

## 9.4 Matriarchy in motion: Care as governance

Crucially, this report positions care itself as a mode of governance. Aboriginal women are more than care providers; they are political actors stewarding community safety, cultural survival and intergenerational stability through their everyday practices. This is matriarchy in motion – responsive, grounded and accountable.

It is work practised in the clinic, the home, the car and the park, and through food, language, memory and laughter. It is both intimate and structural. As such, it holds valuable insights for service systems, policymakers and researchers seeking to understand how care, authority and justice can be enacted outside Western institutional norms.

This report offers a clear and compelling account of Indigenous matriarchal governance. It is grounded in kinship, expressed through care and sustained by cultural legitimacy. It holds families together through continuity, cultural safety and deep relational trust.

# Appendix 1: BHFLHN Model – Lived Experience Findings

| | Issue | Summary of key issues and systemic implications |
|---|---|---|
| 1 | **Fragmented services** | Mainstream models rely on short-term or rotating staff. Families described having to retell their stories repeatedly, thereby eroding trust. The BHFLHN model offers stability through long-term Aboriginal staff relationships. |
| 2 | **Lack of relational care** | Conventional services often feel clinical and transactional. Gawler was described as 'like family', reflecting a need to reframe care as relational and community led. |
| 3 | **Stigma towards young mothers** | Young Aboriginal mothers face compounded stigma – about age, parenting capacity and mental health. BHFLHN's strengths-based, non-punitive approach fostered empowerment and trust. |
| 4 | **Kinship structures overlooked** | Grandmothers and aunties often provide primary care but are excluded from formal decision-making. The model recognises cultural governance and kinship as being central to child wellbeing. |
| 5 | **Mental health and judgement** | Fear of child removal deters families from seeking mental health support. Families emphasised the need for compassionate, non-judgemental responses from services. |
| 6 | **Unsafe housing and basic needs** | Substandard housing (e.g., lack of clean water) undermines family stability. Families want advocacy from health services on broader social determinants. |
| 7 | **Loss of cultural spaces** | Informal cultural infrastructure initiatives – like Nunga Lunches and outreach visits – were highly valued. Their loss due to resourcing gaps caused distress and disconnection. |
| 8 | **Child Protection fear** | DCP involvement was experienced as threatening in other settings. At Gawler, roundtables were described as protective, respectful and collaborative. |
| 9 | **Exclusion from planning** | Families felt 'judged from a textbook' elsewhere. In contrast, Gawler staff respected lived knowledge and centred community voices in planning. |
| 10 | **Access barriers and travel** | Families travelled hours to access culturally safe care, and bypassing local clinics that didn't 'know their story'. This highlights a need to replicate culturally secure models regionally. |

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Publishing