Sydney South West Area Health Service

Aboriginal Health Plan 2010 - 2014

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Principles for Progress

Terminology used within this report reflects the authors understanding of relevant NSW Government policy directives. The term "Aboriginal" is used in preference to "Aboriginal and Torres Strait Islander" in recognition that Aboriginal people are the original inhabitants of NSW (NSW Health Circular 2003/55). The term "Indigenous" has been avoided wherever possible as some Aboriginal people feel that the term diminishes their Aboriginality. The instances where it is used are on quotation from secondary documents which employ this terminology. The practice adopted is consistent with *Communicating positively – A guide to appropriate Aboriginal terminology*, NSW Health 2004.

Story behind the front cover art work:

The art work on the cover is the work of Susan Grant, a well renowned and respected Aboriginal artist. Susan commenced painting in 1991 and since that time has achieved many awards and recognition from her community in the greater western Sydney region. Susan is a descendant of the Wiradjiri people of south–west NSW. Susan's artwork has become more intense over time which she contributes to a special gift handed down by her Aboriginal ancestral.

Susan in her painting has captured the spiritual and cultural meaning inherent in the framework that underpins Aboriginal Health in Sydney South West Area Health Service.

The inner circle represents the camp fire, the giver of warmth that nourishes the family and community connecting the family and community to the earth. The family sitting around the fire are connected to each other by this secure base; this foundation that is important to our mothers and babies and families.

The middle circle represents traditional lore, men's business and women's business, the nurturing of babies by mothers and grandmothers and the passing of cultural knowledge through stories, music, dance and painting. This traditional lore with its spiritual guidance holds communities together and provides connection to land and people. It keeps Aboriginal people strong in body and mind.

Within the outer circle is an Aboriginal man who is disconnected; lost from his traditional way of life and spiritual connectedness. He is on the fringe looking inwards and can reenter with help from his people and services in the community.

This sense of disconnect, powerlessness and not belonging is a result of colonisation and breakdown of traditional life. The lines coming in from each corner represents chaos, those things that have made Aboriginal people unhealthy; racism, discrimination, tobacco, drugs, diseases, alcohol and domestic violence.

The blood is seen running from the camp fire; the blood of the lives of Aboriginal people who are much sicker and die much earlier than non Aboriginal people.

This magnificent artwork with vibrant earthy ochre colours gives us hope like the Aboriginal man looking in lost but able and wanting to become reconnected to land to community; the pink ochre significant for Aboriginal people and their journey back to health.

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Chief Executive's Message

" Our challenge for the future is to cross that bridge and, in so doing, to embrace a new partnership between Indigenous and non-Indigenous Australians …. the core of this partnership for the future is to close the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities.

We need a new beginning – a new beginning which contains real measures of policy success or failure; a new beginning, a new partnership, on closing the gap with sufficient flexibility not to insist on a one-size-fits-all approach …. but instead allowing flexible, tailored, local approaches …. a new beginning that draws intelligently on the experiences of new policy settings across the nation."

Extract from the speech on Apology to the Stolen Generations, 13 February 2008
The Hon Kevin Rudd MP, Prime Minister

During this historical broadcast on Feb 13th 2008, The Hon Kevin Rudd MP, Prime Minister, apologised on behalf of the Australian Government to members of the Stolen Generations. In his speech the Prime Minister pledged the Government to lead a national effort to close the gap between the life opportunities experienced by Indigenous and non Indigenous Australians. Closing the gap is one of the biggest challenges facing contemporary Australia and the health care system.

Sydney South West Area Health Service (SSWAHS) is committed to closing the gap and has a long history of working to improve Aboriginal Health. SSWAHS accords the highest priority to service developments which aim to help close the gap for local Indigenous communities. The challenge is most marked in the many communities within SSWAHS of high socioeconomic disadvantage. Aboriginal and Torres Strait Islander peoples of SSWAHS are disadvantaged across all socioeconomic markers. These differences directly contribute to the poor health outcomes and gap in life expectancy between Aboriginal and non Aboriginal people in SSWAHS.

This comprehensive, detailed and thought provoking plan will guide SSWAHS efforts to close the gap and requires commitment to action by all our services. It is equally responsive to the needs of highly urbanised inner city communities such as Redfern/Waterloo and to those communities on the urban fringe such as Camden. It recognises the impact that spiritual belief and social and cultural context have on access to and engagement with health services; and the importance of placing individuals, families and community at the centre of care. The art work on the cover of the documents dynamically depicts the values and principles within the cultural context of the plan.

The Plan builds on a number of innovative, ground-breaking and successful Aboriginal Health programs in SSWAHS. It is grounded in the cultural values and principles held by local Aboriginal communities, recognising that joint action across services and within communities is necessary to bring about improvements in health.

Aboriginal and Torres Strait Islander people will continue to be at the forefront in shaping SSWAHS services to meet the needs of their local communities. This occurs not only through acting on the advice of Aboriginal community organisations and partnering in service provision, but also through creating employment opportunities for Aboriginal people in the health workforce. SSWAHS is committed to expanding its Aboriginal workforce and to training and nurturing individuals to reach their potential. Aboriginal representation within our health services is the most tangible way to improve access, ensure cultural safety and engage with Aboriginal communities in health improvement. It also makes an important contribution to building the capacity of communities.

This Plan brings together the evidence base, principles of action and the prioritised strategies that are of prime relevance to local Aboriginal communities. It will provide the blue print for services to achieve long term sustainable outcomes in Aboriginal Health.

I thank all those who have contributed to the plan and look forward to a future where its implementation has contributed to closing the gap in our generation.

Mike Wallace
Chief Executive

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1. Preamble

The SSWAHS Aboriginal Health Plan is presented in four documents, including a summary in question and answer format; two supporting papers, covering firstly the population need, policy imperatives and service delivery responses to date and secondly the framework principles upon which services will be provided in the future reflecting community views; and a fourth core document outlining detailed future agendas for action. In total, all four documents provide the schema on how SSWAHS will proceed to improve Aboriginal health over the next five years and make inroads towards closing the gap within our generation.

The approach in providing separate documents reflects both practical considerations in providing accessible and focused exploration of the key health issues for the Aboriginal populations of SSWAHS; and recognition that the diverse target audience for the Plan, including SSWAHS Aboriginal communities, SSWAHS service providers and Aboriginal health workers, managers, policy and planning staff, researchers and those undertaking academic pursuits, may all focus on different aspects of the SSWAHS experience in Aboriginal health.

The Supporting Paper, *Policy and Practice*, surveys the policy environment that has been explored in Aboriginal Health, nationally, statewide and locally, and the impact of these policy directions on the Aboriginal Communities of SSWAHS. Demographic and health status data is presented to profile the characteristics of Aboriginal communities that impact on health. Available data is presented on mainstream services used by Aboriginal people and the range of targeted programs offered in Aboriginal Health is outlined. This Paper identifies the baseline state of play on which future action is built.

The Supporting Paper, *Principles for Progress*, outlines the way in which SSWAHS will proceed to address Aboriginal Health in the future. It reveals the views of Aboriginal communities on needs, gaps and priorities, the principles that will be observed as SSWAHS engages with these communities to improve health and the framework initiatives that will be applied across SSWAHS to ensure that closing the gap remains core organisational business. These initiatives seek to cut through the barriers created by geographic, clinical, craft group or agency silos to develop a shared agenda for progress. It also identifies the rationale for action in priority areas, both corporate and specific to health need. This paper outlines the enabling organisational framework on which future action is built.

The core activities for SSWAHS in closing the gap are outlined in *Agendas for Action* which identifies the specific actions SSWAHS will be taking to improve Aboriginal Health in the future. Building on the evidence presented in the Supporting Papers, it identifies specific initiatives to improve Aboriginal Health and explicitly links these to existing policy and best practice evidence. Lessons from history and the model of care proposed are clearly outlined along with areas of action, responsibilities of partners in action and the projected resources required. The domains for performance indicators and the mechanisms for monitoring and evaluation of programs are also identified. *Agendas for Action* provides the concrete strategies which will shape future action.

2. Community Views on Needs, Gaps, Priorities

For this planning process, the views of the Aboriginal communities of SSWAHS on their health care needs, gaps in service provision by SSWAHS and the priority areas for action have been gathered from a number of sources:

- involvement of the Aboriginal health worker staff of SSWAHS on the steering committee and the working groups established as part of the Plan;
- consultation processes undertaken by the Priority Area Working Groups (PAWG) established under this Plan;
- views expressed through established Partnership meetings with the Aboriginal communities of SSWAHS inc. the Partnership Arrangement with AMS' Redfern and Tharawal;
- consultations undertaken with Aboriginal communities in the context of other service planning activities in SSWAHS e.g. Aboriginal Men's health, HIV/AIDS and Related Programs, Maternity, Aged Care and Rehabilitation, Youth Health;
- Yarn-Up Forum canvassing Aboriginal Health issues of strengthening communities, holistic care, working in partnership and improving access.

The community viewpoints expressed in consultancy processes undertaken in developing Aboriginal Health Plans for the former SWSAHS and CSAHS also remain relevant.

The views and strategies suggested by the Aboriginal health worker staff of SSWAHS represented on the steering committee and the working groups are threaded throughout the Plan and have been the driving influence behind the initiatives identified.

The outcomes of consultative processes undertaken by the Priority Working Groups are reflected in the initiatives developed by these PAWGs. Aboriginal community perspectives on health needs for youth, older persons, those with disability, for carers and for those families affected by drug and alcohol use, were obtained through formal consultation processes undertaken to feed into both this Aboriginal health plan and broader planning processes underway covering service needs across the whole population of SSWAHS.

2.1 Consultations in the context of other planning activities

HIV/AIDS and Related Programs Strategic Framework 2008-2012

The views of the Aboriginal Community became apparent through consultations with SSWAHS service providers (some of whom were Aboriginal), an NGO Forum (including representation from service providers of significance to Aboriginal communities and Aboriginal people) and a focus group of Aboriginal community members, undertaken over March-June 2007.

The issues experienced by the community

- under-representation and lack of access at clinic based services;
- lack of cultural appropriateness of services, in terms of the physical environment, availability of AHWs and cultural awareness of staff;
- stigma, shame, need for confidentiality and anonymity of access;
- lack of information and understanding about disease transmission risks;
- difficulties in arranging transport to services;
- understanding of HCV among those injecting.

How SSWAHS could respond to these issues

- target information on STI/BBV transmission risks through NSPs;
- build the AHW workforce within HARP funded services;
- increasing cultural awareness training opportunities and address the cultural appropriateness of physical environments;
- expanded and on-going training for AHWs about STIs/BBVs;
- HARP services work with AHWs to reorient services to make them more attractive to Aboriginal clientele;
- provide outreach services to community events and gathering places, including education and testing;
- explore potential of increased outreach clinics;
- continue to support work and strategies arising from Aboriginal sexual health steering committee.

Older People, People with Disabilities and Carers

These consultations were held October-November 2007 at Punchbowl and Minto, to provide community input to a number of strategic plans being prepared in SSWAAHS, including this Aboriginal Health Plan and Plans for Aged Care and Rehabilitation, Carers Plan and Disability.

The issues experienced by the community

- lack of transport which is flexible, available in emergencies, able to cater for the family carers of older persons with a disability, available to respite service/day care centres – carers have tiring and lengthy trips to visit those in hospital;
- Lack of Aboriginal specific respite for older people and people with disabilities;
- isolation and loneliness of many older people and those with disabilities who are scattered across LGAs and hove no one to visit them and have a "yarn" – exacerbated by no clustering of Aboriginal housing, residential aged accommodation or residential respite facilities;
- health provider attitudes and communication – poor listening and consultation, little continuity of contact, judgemental attitudes, task not person focused, using jargon or not explaining the patient's problem properly, patients and carers having to act as advocates for other patients, rudeness;
- health service insensitivity to cultural nuances - reluctance to use the phone and reliance on families, pride and shame asking for help, reluctance to use general practitioners, association of hospitals with grief and death, poor health literacy and understanding of health jargon, lack of financial resources, men's and women's business.
- Poor discharge planning - no or late referrals to community/HACC;
- lack of coordination between HACC/community and health services;
- variations in health service availability – inconsistent availability of outreach and hospital liaison officers, inflexible opening hours;
- community unawareness of services available – lack of information, no directory, not listed in the phone book as Aboriginal, literacy constraints, lack of verbal information;
- carer issues - older people who are (hidden) carers of children, many patients are also carers, no services targeting Aboriginal carers, little follow-up back in community;
- lack of Aboriginal health workers – limited number of Liaison Officers, staff not always well supported or supervised, burning out and leaving, lack of continuity with staff turnover;
- difficulties accessing loan equipment due to hiring cost, waiting lists, unavailability;
- lack of general, practical help for general maintenance, costly home modifications, difficulties in getting old Housing Department stock modified;
- confidentiality – physical environments unsuitable for maintaining privacy of information and lack of sensitivity by staff;
- trialling services - raising expectations, encouraging dependency but not sustained over time;
- work practice OH&S requirements conflict with consumer expectations;
- lack of Aboriginal specific accommodation for rural patients and carers, what is available is too expensive;
- hesitation in complaining – don't know process, feeling complaints not heard;
- lack of knowledge about guardianship and consent legislation;
- long waiting lists, particularly for services like dental.

How SSWAHS could respond to these issues

- develop a non-professional home visiting scheme for isolated older and disabled people;
- develop an Aboriginal cluster in a residential aged care inc. respite opportunities;
- develop Aboriginal traineeships in aged care;
- expand outreach models e.g. ACATs to aged care respite centres, diabetes services to respite centres, outreach to community health centre one day a week;
- work and advocate with Department of Housing to better plan for client needs;
- advocate for flexible brokerage packages for older people and people with disabilities;
- expand day and flexible respite services for Aboriginal people, inc. transport;
- improve access to allied health through EPC items e.g. podiatry in day care centres;
- provide carer education on dementia and delirium;
- ensure staff understand how to handle patients with behavioural problems;
- ensure the community and service providers know how to access respite;
- develop an Aboriginal Carers network/forum;
- involve carers in the discharge planning process;
- develop carers support workers;
- provide carers' education using visual and auditory easy to understand information;
- provide referrals for patients and carers rather than giving them a number to ring;
- provide culturally appropriate accommodation for rural patients and families;

- take time and treat patients with respect, explain reasons for treatments or approaches being used, acknowledge and respond to family/carers role and needs;
- improve information provision – directory of services (covering all human service agencies) distributed to AMS', land councils, local press, yellow pages;
- develop a discharge information kit targeted at Aboriginal patients;
- seek funding to develop and maintain an Interagency Aboriginal Services Website;
- increase cultural sensitivity of services – job rotations, direct education/training - importance of "yarning" to develop trust, workers looking comfortable and language used - ensure cultural sensitivity is included in job descriptions;
- more flexible and consistent approaches to transport including use of cabcharges;
- increase employment of Aboriginal Liaison Officers in hospitals e.g. Braeside/ Fairfield - alternatively, ensure that Social Workers are aware of the admission and visit the Aboriginal patient and carer to determine their support needs;
- undertake a door knocking exercise to determine Aboriginal people's needs;
- support Aboriginal staff in their jobs through clinical supervision, etc;
- leadership from the top in relation to Aboriginal health;
- don't forget the needs of the many young Aboriginal people.

Drug Health

In the context of Aboriginal health planning and more broadly drug health planning, over 2007-08 consultations were undertaken to assess the health needs of Aboriginal people living in SSWAHS who have been affected by drug and alcohol use. The consultation process comprised focus groups with Aboriginal clients (2 groups), SSWAHS Aboriginal workers (2 groups) and with non-government and government stakeholders, as well as semi-structured interviews with key stakeholders and a staff survey of Drug Health Services & REPIDU. Questions and research methodology were granted ethics clearance by the Aboriginal Health and Medical Research Council.

The aim of these consultations was to assess the appropriateness, effectiveness and quality of services provided by SSWAHS Drug Health Services as well as gaining information on how services could be improved to better meet the needs of the Aboriginal community.

The issues experienced by the community

- there is a community view that CBT is not an appropriate form of intervention to use with either younger or older Aboriginal people;
- generally AHWs do not know much about DHS incl. McKinnon and Palm Court;
- Aboriginal clients need access to treatment and not to be turned away;
- high turnover of DHS staff is an issue;
- Aboriginal workers are often called in to deal with aggressive Aboriginal clients- this is thought to be inappropriate unless the worker knows the client;
- stereotyping of Aboriginal people "not all black people are drunk, doing drugs and involved in DV";
- client fear of DoCS involvement – removing babies, esp. at RPAH;
- more resources are needed in the South West including a group space like at RPAH;
- Aboriginal clients don't like going to Cooper's Cottage methadone clinic (South West);
- waiting lists and waiting times are too long;
- sometimes there is an unwillingness to take Aboriginal clients;
- access issues to drug health services particularly in the South West where public transport is problematic;
- confidentiality concerns;
- few Aboriginal clients have disclosed that they have an alcohol problem;
- loss of respect between elders and young people has impacted on Aboriginal communities and community cohesion
- young people need strong, positive role models
- perception of lack of support by D&A workers at Bankstown;
- Aboriginal clients at Cooper's Cottage need to go 7 days a week – there is no transport or takeaways - Tharawal is also closed on weekends therefore clients don't get dosed;
- mainstreaming Aboriginal services doesn't work;
- there is a concern Aboriginal designated positions are not being utilised properly;
- referral processes for clients are very time consuming and there is general lack of understanding of how to refer clients to services;
- services are not culturally appropriate;
- no support for women coming out of jail;
- there are gaps in services and in the continuity of care for Aboriginal clients;
- services operate in silos and are fragmented – there is a need to improve partnerships and collaboration between services;

- NSP has a high % of Aboriginal clients (Inner West);
- Of HIV clients, less than 1% identify as Aboriginal;
- there is a perception that DHS are medically focused;
- of HCV clients, few people identify as Aboriginal and there is a scarcity of information re HCV prevalence in Aboriginal communities;
- HCV Aboriginal nurse cadet works at Redfern AMS X2 days a week;
- D&A use is a major issue for young Aboriginal people, particularly, polydrug use, alcohol, cannabis and amphetamines;
- Community Health does not seem to attract many Aboriginal clients;
- injecting drug users are often seen as being "too chaotic and not suitable for HCV treatment", therefore they are not referred to HCV services;
- Tharawal is the key agency people refer Aboriginal clients to in the South West;
- little awareness of any alcohol or tobacco services available in DHS, though these would be very useful if they were made available.

How SSWAHS could respond to these issues

- training and employing more AHEOs and ALOs, particularly in Campbelltown;
- improve partnerships and collaboration with Aboriginal services/workers;
- promote DHS to the Aboriginal community; develop a services directory; use Aboriginal media e.g. radio, newspapers etc; provide more culturally appropriate Aboriginal specific information using lots of images and not too much writing; develop a campaign involving schools, camps, churches, police etc.; undertake D&A community forums; generally get out in the community more often;
- ensure services are more culturally appropriate, in particular the detoxification units;
- provide more outreach services to communities, including clinical outreach to the Block, consider use of an outreach bus;
- link in with AHWs to access communities - useful to tell the Aboriginal community about DHS through existing health workers;
- prioritise Aboriginal clients in DHS;
- cultural training and education needs to be made available to non-Aboriginal staff including management;
- employ Aboriginal clinicians (male and female);
- improve service functions such as the intake system, assessment process, flexibility of service provision including drop in services, identify clear clinical pathways, include Aboriginal staff more frequently in service planning and at clinical review meetings etc.;
- there is a need for youth specific services for Aboriginal young people, flexible and including cultural aspects;
- target young Aboriginal people and young Aboriginal women through child & family services;
- there needs to be a family & community focus;
- clarify with management what an Aboriginal Identified position actually means;
- ensure flexibility in service delivery;
- provide a more relaxed environment for Aboriginal clients;
- reduce stereotyping;
- the need for an Aboriginal detoxification unit & rehabilitation unit has been identified;
- more flexible admission processes are needed, for example into rehabilitation units;
- develop a simplified, flexible and shorter assessment process;
- separate NSP and treatment services – co-located services can be challenging for some Aboriginal clients receiving treatment;
- undertake more community development initiatives;
- develop better partnerships between Health and DoCS.

Maternity Services Plan 2008-2012

Four Aboriginal women's focus groups were held at Camperdown (2), Bonnyrigg and Campbelltown, over the period April-July 2007.

The issues experienced by the community

- hospital antenatal clinics - crowded, intimidating, long waiting times in poorly arranged waiting rooms, difficult when attending with children, sense of being "rushed';
- shared care arrangement with AMS easy to use, with understandable information provided;
- Aboriginal Home Visiting Service (Campbelltown) valued with personalised care, good communication and information and staff also assisted with emotional issues;
- Don't attend SSWAHS antenatal classes – not comfortable, no vacancies, not considered to be important – contrast with AMS where made to feel at ease and staff empathetic.
- difficulties with verbal information provided – explanations too clinical and complex, inability to understand advice, poor explanations of medications, vague information lacking detail;

- not encouraged or lacked the confidence to ask questions;
- useful information provided but not enough, literacy issues made signing paperwork problematic;
- not provided information about or inadequate explanations of different options for care;
- transport difficulties in south west, infrequent private bus service difficult to use with accompanying children and prams.
- during inpatient stays appreciative of gestures such as having their own room;
- negative interactions with staff - rudeness; breach of confidentiality, lack of assistance, discrimination, pressure to breastfeed without adequate instruction, lack of staff introduction at shift handover, lack of cultural awareness;
- postnatal home visits appreciated and valued, especially if they had other children.
- little use of Family Care services (Karitane, Tresillian) - lack of knowledge, rely on families or GPs for advice, difficulty contacting services when reliant on mobile phones.

How SSWAHS could respond to these issues

- provide home visits especially late in the pregnancy;
- ensure continuity of carer e.g. midwife led models and Aboriginal Home Visiting Service;
- shorten waiting times in the antenatal clinics;
- expand Aboriginal health staff numbers to provide care and a point of contact in the hospital;
- antenatal classes for Aboriginal women;
- provide a more personalised service;
- increase the number of Aboriginal staff in the antenatal clinic and child and mother friendly clinics;
- provide a designated Aboriginal space within antenatal clinics.
- allow additional time with staff to allow for adequate instruction, the provision of verbal information and explanation of the pamphlets given to read.
- allow a longer inpatient stay;
- assistance with transport home and hiring of capsules;
- increase the number of postnatal home visits and provide these earlier so that problems such as postnatal depression can be promptly addressed.
- use Aboriginal health workers for postnatal home visits to overcome embarrassment, shame and reluctance to admit to feeling depressed;
- mail out information;
- improve transport;
- provide assistance with shopping
- provide more information about children's services
- provide information about pap smears; ensure these are conducted by an Aboriginal worker.

Community Health Strategic Plan 2007-2012

A consultation forum was held on 19 September 2006, with Aboriginal and Torres Strait Islander People being one of nine target groups considered at the consultation forum. Aboriginal service consumers and service providers to Aboriginal communities contributed to small group discussions on the provision of community health services. The main themes arising from this consultation were that there needed to be flexibility in how services are provided, improved links with schools in education of children about health lifestyles and improvement in cultural awareness and understanding among the workforce of human services agencies. Some detailed observations recorded included the following.

The issues experienced by the community

- good housing is at the heart of good health, including the need for "safe houses";
- Aboriginal people are looked down on, with mainstream services not understanding the culture.
- lack of supported education for Aboriginal health workers to be trained to give specialist care e.g. nurses, podiatrists, occupational therapists.
- lack of identified Aboriginal medical centres and dental clinics (not just Tharawal and Aboriginal Medical Service);
- dental services used to provide outreach to Hoxton Park, but no longer operating;
- travel is a barrier for Aboriginal communities, public transport can be costly and transport to medical appointments can be difficult;
- much more needs to be done to get health messages to Aboriginal communities, including health education to kids, promoted via parents;
- financial difficulties for Aboriginal people with chronic health problems, spending a large proportion of their pension on medications, for podiatry etc;
- need more youth services, early childhood services, Aboriginal counsellors.
- sexuality and STIs are an issue in Aboriginal health, with a lack of services for the gay, lesbian, bisexual and transgender community;

- Fear of intimidation and lack of trust in using health services;
- Community Health is too quick to refer people to other centres where people live rather than where they want to use a service;
- mainstream services lack understanding of how to communicate with Aboriginal clients;
- some health services try to redirect clients to the AMS rather than encouraging use of local mainstream services;
- lack of understanding that literacy issues and lack of confidence make it difficult to make complaints in writing – need to ensure that feedback mechanisms are simple;
- mainstream services do not know much about Aboriginal people and they are not very inviting to the Aboriginal community.
- People don't always know what services are available, should advertise in Koori Mail and Koori radio;
- Mainstream health staff are not always respectful and even when aware may not be culturally competent;
- Boundary demarcations may mean that local practices are 'foreign' to services in adjoining areas;
- Ineffective use of crisis workers who only get called if there is an issue (not earlier);
- Health information in libraries.
- Insufficient number of Liaison staff in hospitals.

How SSWAHS could respond to these issues

- provide more educational sessions in community venues, ensure promotional literature needs uses Aboriginal faces, colours, design;
- employ more Aboriginal staff and outreach to where people live;
- develop protocols for working with Aboriginal people acknowledging beliefs and values;
- employ more Aboriginal Liaison officers at hospitals (particularly Bankstown) and address barriers for Aboriginal staff in accessing general wards;
- Ensure cultural awareness training for all staff to create a sense of trust and understanding and encourage compassion towards Aboriginal people and their related issues and family lives.
- involve the community on an ongoing basis, e.g. in planning and decision making;
- Have staff (preferably Aboriginal) talk to Aboriginal elders about specific health problems e.g. diabetes, oral health.
- Provide health information in libraries.
- facilitate linkages between community Elders groups as elders feel isolated from friends living in other areas and all Aboriginal people have a connection.
- ensure Aboriginal staff are supported to take a community development approach;
- ensure a culturally appropriate service;
- Provide education/prevention in schools on good health and wellbeing;
- Support Women's groups for Aboriginal people to share experiences and support one another, encourage courses to build confidence.
- Address the barriers between clinical services that limit provision of quality care;
- Build on successful projects that offer an opportunity to re-engage with community;
- Recognise that community development operates on a different time frame to client care which can take longer.
- Support an Aboriginal drug rehabilitation and detoxification clinic;
- Adopt a "healing" approach as some of the community, particularly women are very interested in "healing";
- Mentor Aboriginal Health Workers as role models to teach children;
- Ensure mainstream managers understand the wider boundaries for Aboriginal health staff in adopting an holistic approach to assessment and ongoing care;
- take a prevention/early intervention approach on issues of sexual assault/violence and the relationship to drug and alcohol issues;
- employ youth workers for Aboriginal kids.
- Effectively link with Department of Aboriginal Affairs "Two Ways Together initiatives;
- Ensure staff use cultural protocols to increase access by Aboriginal populations;
- Provide a crisis service after hours.

Obesity Prevention and Management Plan 2008-2012

In October 2007 consultations were held with the AMS' at Tharawal and Redfern about the issues experienced by Aboriginal communities in relation to obesity and how SSWAHS could support and/or work with the AMS' in addressing this problem.

The issues experienced by the community

- there are a few people in the community who are very overweight/obese;
- few young mothers or children are grossly overweight, although some have a few extra pounds and for children issues about food occur when they are started on solids (and older);

- there have been very few NSW Health resources developed targeting overweight and obesity in Aboriginal communities;
- many children and adults drink soft drinks and there is a need to reduce the availability of these beverages;
- there are a range of new drugs which are becoming available and can be used in primary care, however, the cost of these drugs would need to be lowered to enable widespread adoption;
- new Medicare items for those at risk of diabetes expected in 2008 may support Aboriginal people in accessing dieticians and exercise physiologists.
- Issues arise in ensuring patient compliance to treatment, maintenance, sustainability of programs, cost effectiveness, literacy and a need to ensure adequate time in sessions to explain care and treatment – often benefits of approaches work for a while (e.g. shopping trips) but then taper off.
- There is an issue in taking children out of school to attend a clinic when a community problem is ensuring that children actually attend school; there is a belief that weight should be managed at school and by parents.
- group treatment sessions tend not to work in Aboriginal communities, with young women preferring one on one interaction, although group cooking classes can work e.g. focusing on morning teas, etc;
- a high level of sugar and dietary intake across the communities;
- many people in the community smoke and when they quit smoking they put on weight;
- high cost of accessing general community services e.g. gyms, pools, events; limits access to healthy lifestyle options;

How SSWAHS could respond to these issues

- provide consultant expertise/program development/writing around how various AMS activity and diet programs could be tied together to support individuals who are overweight/obese;
- provide support to AMS' regarding overweight/obesity assessment and management, including management of gastric bands;
- provide training to AMS staff and community members in running group programs focused on overweight and obesity in children or adults;
- provide cultural training for SSWAHS health workers working with Aboriginal people;
- improve access to nutritionists/dieticians for AMS patients who are overweight and obese through targeted referral to SSWAHS services or outreach to AMS;
- ensure any opportunities for lower cost provision of pharmaceutical and dietary products achieved for SSWAHS patients are accessible by AMS patients;
- facilitate availability of information stalls/group activities on obesity prevention, health promotion and education at community events in association with AMS' e.g. at Nutrition Week;
- advocate with fast food outlets including those in local suburban shops to change nutrition and fat content;
- advocate for schools to take on a stronger role in management of diet and exercise e.g. through canteens etc.

Aboriginal Men's Health Implementation Plan (2008-2011)

A number of planning forums and consultations were conducted with Aboriginal men across SSWAHS in 2007 including with the Miller Aboriginal Men's Group, Redfern Aboriginal Men's Group, Babana Aboriginal Men's Group, Tharawal Aboriginal Men's Group and at an Aboriginal Men's Networking Day at Shark Island, Sydney Harbor. Around 190 Aboriginal men participated in these consultations and from the discussions common issues and themes emerged relating to:

- family violence;
- support for Aboriginal men;
- mental health problems;
- drug and Alcohol problems;
- unemployment concerns;
- chronic disease management;
- space for men to meet;
- crime prevention;
- counseling for men;
- support for Youth.

Transport for Health Plan 2007

This Plan reported on the transport related concerns raised in more general consultations with Aboriginal communities undertaken prior to release of the Plan, including:

- the time spent by SSWAHS Aboriginal Health staff providing transport for clients and patients reduces the time available for those staff to provide health programs;
- the impost that lack of private transport has for Aboriginal patients/clients who need to access health services, on a frequent and sometimes daily basis;
- the difficulty that rural Aboriginal patients experience when accommodation is distant from care providers;

- the lack of information about transport options available to rural and remote Aboriginal people when first arriving at Central Railway Station and Sydney Airport;
- demand on Aboriginal organisations for patient related transport; and
- inconsistencies in application by Aboriginal people to the IPTAAS Program.

2.2 Consultation on framework issues in Aboriginal Health

As part of this planning process a Yarn-up" workshop was held on 17th September 2007 with wide ranging representation from Aboriginal communities, including community members working within SSWAHS and AMS'. The workshop focussed on developing a shared understanding of how SSWAHS could progress in service development around themes of:

- Strengthening communities;
- Holistic care;
- Working in partnership; and
- Improving access.

It was recognised that these themes or similar are commonly referred to in Aboriginal Health documents, however, the implications for SSWAHS service development had not been explored with Aboriginal communities in a systematic way. The workshop aimed to tease out what was really meant by these terms, develop a sense of shared meaning, reconnect with why they are important or significant and think about how the themes can underpin the SSWAHS Aboriginal Health Plan.

A World-Café format was used to explore these issues, involving small group discussions enabling participants to discuss in depth each of the themes. A summary of the outcomes from small group discussions is at Table 2.1.

Table 2.1 Conceptual issues, barriers and actions identified at Yarn-up

Defining the concept	What is holding back progress	Actions to make progress
Strengthening Communities		
· Need to understand all of the needs of many different Aboriginal communities; · Strength across all population groups - elders, parents, youth, men, women etc.; · Working alongside & together, learning from and about each other; · building capacity not just in health but also in leadership, wealth, infrastructure, education, workforce, and community 'spirit'; · empowering and informing communities to become more independent.	· Lack of clarity on role of AHWs - increasing emphasis on clinical roles and less on capacity building, lack of understanding from line managers, difference in expectations between community members and the AHS, differentiation from the role of AMS workers; · High personal toll and burn-out for AHWs; · Continuing variation between sectors in ways of working; · time required to consult properly; · lack of appropriate community meeting places; · Politics, mutual mistrust and lack of understanding; · lack of aged care facilities for older Aboriginal people; · need to focus on strengthening through not only elders but also young people and adults.	· Area-wide community map and directory of support agency services; · inform the community about local services; · Identify the different needs of different communities; · Establish culturally appropriate meeting spaces e.g. for healing, youth friendly spaces; · Strengthen leadership in *all* the community inc. youth, young families and adults. · Confirm role parameters of AHWs, ensure management awareness and understanding, provide clear accountability and monitoring, increase recruitment; · Increase staff training and development initiatives; · Review equity and access, make Aboriginal health everybody's business; · Enhance health promotion strategies e.g. in-school, attendance at Koori community events, target sub-populations e.g. dads, · work in partnership inc. with existing community groups; · learn from other successful Indigenous programs; · raise the profile of urban Aboriginal health issues · ensure AHWs have a face in the community and community members a face in the AHS services.
Holistic Care		
· Involves the whole body and person – caring from head to toe; · Includes the family and the	· Lack of understanding of the term; · Not embraced in mainstream services, seen as only for AHWs;	· Increased focus on culturally appropriate approaches - cultural awareness and sensitivity of staff (could be compulsory), Aboriginal mentors for non-Aboriginal

Defining the concept	What is holding back progress	Actions to make progress
community surrounding the person; · Addresses emotional, physical, spiritual and financial aspects of health. · Focuses on the things that matter. · Looks at the whole picture. · Considers traditional and non-traditional treatment methods. · Engages a range of services matched to client needs and communicates between all those various services. · Works in partnership between mainstream and community.	· Not often provided by specialised services; · AHWs have difficulties providing holistic care - unrealistic expectations of AHS and communities, lack of flexibility or understanding from management, perception that builds dependence, prevailing view that people should come to the services, · High burnout and turnover of staff exacerbated by lack of resources and attention to addressing issues of cultural awareness /sensitivity; · Service delivery issues - not 'Aboriginal-friendly', unsustainable pilot programs, not enough continuity of care, lack of services on weekends, inflexibility e.g. on length of stay, poor transport and other support services; · Structural issues with silos of care, internal competition for funding, inconsistency in infrastructure and support availability; loss of staff empowerment and lack of input into decision making.	managers, partnering workers for on-the-job-training, documenting Aboriginal patient journeys; More work in partnership – increase in co-located services, involvement of the community in program development, multi service case review and discussion; · Strategies to improve access – outreach to clients, increased home visiting, improved provision of transport (working with other partners such as local councils), providing better information to communities on access, out-of-hours services, empowerment of young people; · Support AHWs - 'fast-tracking' recruitment processes, increase generalist Aboriginal designated positions and disease/illness specific positions, clarify roles (esp. for ALOs), improve management understanding of the need for flexibility, recognise the after-hours work undertaken, ensure a balanced approach to accountability and monitoring, improve retention through access to recognised external and on-the-job training, expand trainee positions (esp. for leadership positions); · Ensure Aboriginal Health is part of all service business plans.
Working in Partnership		
· Working together with the same goal, not solo; · Recognising many and varied relationships, between and within organisations, with and within communities; · Trying to achieve the best outcome for clients; · Understanding and having respect for different roles. · Building infrastructure and working towards communities becoming more independent; · Knowing what community needs are.	· Lack of understanding - from managers about the roles, complexity and demands on AHWs, from mainstream services about the community, from workers about how to operate within the system; · Lack of effective communication between - mainstream and Aboriginal managers, AHWs and AHS managers (esp. on reporting and accountability); · Navigating between different entities within SSWAHS – operational variations, competition and tension; · Differences in priorities e.g. policy and protocols vis a vis flexibility to adequately carry out the role; · Cultural variations within some communities; · Racial issues; · Lack of resources and competition for resources; · Politics; · Lack of follow through into action – need identified but unable to be acted on.	· Develop better internal partnerships within the AHS. · Compulsory cultural awareness training for all employees, including managers; · Develop mentorship arrangements; · Resources encouraging people to see the value of partnerships; · Support AHWs through education, clarity and transparency of roles, and flexibility in practice; · Inter-agency mapping of service availability across SSWAHS; · Develop clear picture of available resources for Aboriginal Health across SSWAHS; · Work with others to create culturally appropriate meeting spaces esp. for young people, and in Bankstown; · More community barbecues for communities to get to know SSWAHS staff; · Increased input from the community to program development; · resources and giveaways e.g. 'deadly bags'.
Improving Access		
· Focus on how services access the community not always on	· Lack of knowledge in communities on services	· Improve physical environments - warm and inviting, culturally welcoming, frontline

Defining the concept	What is holding back progress	Actions to make progress
the community visiting the service; · Think especially about those people who don't access services at all, or rarely; · Make sure what services offer is what the community wants, meets their needs and is culturally appropriate; · 'Keep it real' i.e. be realistic, put boundaries around what can be done within resources, find a balance; · Be reflective about whether services are really listening to the community; · Always keep equity at the forefront of access considerations; · Build the bridges between population target groups and services; · Look at *why* things haven't changed, despite access being mentioned in all key documents; · Transport as a critical issue in improving access; · Put effort into providing sustainable services, don't start services with an uncertain future; · Use the language of the community - simple and straightforward; · Distribute information through established community groups.	available; · Criteria for providing services is too narrow; · Lack of understanding of Aboriginal culture; · Community distrust of mainstream services; · Limited resources and staffing esp. men's health; · Lot of planning, not enough doing; · Time to develop trust and relationships can be at odds with need to produce statistical outcomes; · Lack of demonstrated commitment from senior managers; · Issues fall to AHWs to address, whereas it needs to be part of everyone's role; · Lack of Aboriginal staff in many services; · Lack of flexibility and innovation in service delivery; · Not taking responsibility for transport; · Transient populations; · Accommodation issues for people coming for care from rural areas; · Restructure impacts on ability to plan and fill positions; · Inequity in resource distribution across geography; · Lack of formal relationships with other services e.g. MOUs;	Aboriginal staff, visible Koori art; · Clarify AHW roles - task audit, well defined job descriptions, leadership to direct work within boundaries, facilitate skill development opportunities with backfill; · Increase the role of AHWs in helping other staff to facilitate access. · Reflective thought on how to tackle some issues differently e.g. transport; · Remove some existing barriers - consult with the community about their barriers to access, identify good practice in services that are well accessed and use as a model; · Develop accommodation options for clients and families attending services from rural areas e.g. hostels, supported by ALOs; · Transport - work in collaboration with other organisations to assign clear responsibility, quicker access to cars for AHWs visiting clients. · Be more flexible about the boundaries by providing choice for clients about which services they can attend. · Streamline referrals process; · Tailored approach to addressing waiting lists; · Better community information about services, e.g. maps distributed through schools and sporting clubs; · Cultural awareness and sensitivity training for all staff. · Increased health promotion activities - pubs and clubs, mothers whilst in hospital, Koori Arts programs, resources designed and developed by community members; · Opportunities for services in Campbelltown; · Improve access to palliative care; · Partnerships - more involvement of AMS on AHS committees, mainstream services delivering from within AMSs, mainstream speakers/services into Aboriginal groups. · Senior management encouragement – mainstream service focus on Aboriginal health, widespread consultation with the community and AHWs within SSWAHS.

Following the small group discussions a plenary session brought together all the participants to identify for each theme the main focus of discussions and make suggestions for overall actions that would help SSWAHS address these issues. Plenary discussions identified summary issues about each of the themes:

- **Strengthening communities** – need cultural centres and meeting places, develop partnerships within SSWAHS, explore 'old ways' solutions, review management perception of role of AHWs, capture data on all the work of AHWs, be mindful of distrust that stems from past experiences, take time for consultation with community groups and to build community participation, build the capacity of all individuals, work with other agencies, work across rural and urban together for a stronger voice;
- **Holistic care** – ensure health professionals recognise that people have more than one health issue, planning to link across all health issues, Aboriginal one-stop shops needed, understand the role of AHWs and collect statistics on all aspects, recognise the AMS is providing holistic care and comprehensive primary health care, clarify and articulate the differentiation in roles between the AMS and the AHS;
- **Working in partnership** – communication between the three levels of partnership i.e. MOU between the AMS and the AHS, middle management/staff and at the ground level, recognise that Individual workers develop their own partnerships which are at risk of collapsing when workers leave, maintain local partnerships, develop local working protocols on who does what, put Aboriginal health on the agenda of new players and partnerships in the game;

- **Improving access** – reorientate services, involve the community in planning, cultural sensitivity training for frontline staff, collaborative effort to address support issues for patients and their families from outside SSWAHS, address confusion about the roles of AHWs, need focus on *access* to services and not just on delivery of services to achieve equity of outcomes, need equity of access across all the geography of SSWAHS, be proactive to get people to come to services, leadership from management is required, Aboriginal health issues should be included in orientation for all workers.

The plenary session also identified overarching activities for SSWAHS that would help in addressing the issues raised in discussion of the themes. These included:

- Provide health promotion and health education in communities;
- Develop a public affairs strategy;
- Produce an events calendar;
- Progress recruitment of Aboriginal staff;
- Find venues for activities;
- Develop future Aboriginal leaders – identify and promote and support them;
- Increase communication between Elders and other groups and include Elders in planning;
- Increase ways of communicating with Aboriginal Community Controlled services;
- Hold more community social events such as barbecues and participate in community radio;
- Work at breaking down the barriers of geographical boundaries;
- Develop solutions to transport problems;
- Implement cultural awareness/safety programs using community educators –for all staff, including managers, in orientation programs, and included in all business plans;
- Clarify the roles of Aboriginal Health Workers;
- Provide all managers with an Aboriginal Health contact list.

Participants were also encouraged to provide their number one priority, message or action for SSWAHS to take forward from the day:

- Community participation – youth forum;
- Involvement from staff in planning days for action plans and staffing levels;
- Community venues;
- Mapping of social and human resources;
- Action ASAP – no more yarning;
- Education for the current Aboriginal Health Workers;
- A committed, educated and motivated Aboriginal workforce;
- Collaboration with Aboriginal people concerning their healthcare;
- Education of students in schools in 5/6 – promoting the positives and negatives in Aboriginal health;
- Good communication;
- Advocacy agenda for those issues where we need to influence other agencies;
- More training;
- Awareness;
- Cultural sensitivity program developed and implemented that targes the key services provided to the Aboriginal community – this should be ongoing;
- Cultural orientation;
- Staff development;
- We have enough plans in place – we need to deliver strategies and start collecting outcomes of our work;
- Aboriginal Health needs to be made THE priority health area within SSWAHS – from the top down to the bottom up. Aboriginal health is everyone's responsibility;
- Understanding of the culture;
- Manager reorientation training about Aboriginal issues;
- Helping people know what services are available and how to use them;
- Promotion through community interaction and more case management workers [home visiting;
- More workers;
- Follow Aboriginal Health plans already developed – commitment;
- Action, not talk;
- The ability to be able to do my job;
- Communication and resources;
- Prioritise and work on a couple of key issues – invest for 5-10 years;
- Communication;
- Maintain focus on commitment and working in partnership;
- Lets all work together for the community's needs, ensuring better outcomes for all.

3. Principles for Engaging with Aboriginal Communities to Improve Health

SSWAHS has developed some framework principles to guide the way that it undertakes its role in enhancing the health of Aboriginal communities and contributes to the process of closing the gap in health outcomes and addressing health disadvantage. These principles reflect the current understanding of the essential prerequisites that need to be in place to ensure that action on Aboriginal Health has the best chance of having a real impact on the health of the Aboriginal communities of SSWAHS. The principles are a synthesis of foundation principles of indigenous health identified internationally, nationally and in NSW (see Volume 1, Chapter 2) and the framework principles identified in the consultation with stakeholders representing the Aboriginal communities of SSWAHS (see Volume 2, Chapter 2).

The principles are:

- Provision of services within a holistic health paradigm;
- Demonstrating relationships between SSWAHS clinical services and with the services provided by other public funded human service agencies that are consistent with an integrated response to holistic health principles;
- Demonstrating partnerships with Aboriginal communities that reflect both involvement in the development of programs that reflect the communities' views of priority areas of need; and an intent to empower communities to increase their capacity to address health issues;
- Providing services that are complementary, supportive and non-duplicative of services best provided through Aboriginal Medical Services.

This chapter provides analysis on the rationale behind development of these principles and their importance in guiding service development in Aboriginal Health.

3.1 Holistic Health Paradigm

For at least two decades, policy frameworks for advancing Indigenous health internationally and Aboriginal and Torres Strait Islander Health within Australia have emphasised the need to provide health services within a holistic health paradigm. A definition of holistic health was developed by the National Aboriginal Health Strategy Working Party report 1989 and adopted within the National Aboriginal Health Strategy (NAHS) (Preface p. X):

> **"Aboriginal health"** means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life."

This concept has been further elaborated in subsequent documents to include other considerations within the holistic health paradigm e.g. as reported in the *Social and Emotional Wellbeing Framework — A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being (2004-2009)*, Commonwealth Department of Health and Ageing, Canberra, p. 7:

> "Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to well-being. This holistic concept does not merely refer to the "whole body" but is in fact steeped in the harmonised interrelations which constitute cultural well-being. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical."

It is now accepted that policy directions in Aboriginal health need to adopt an approach that is multifaceted and covers all aspects of people's lives, including housing, education, employment and social justice and that physical and symptomatic relief of disease will not in itself redress the burden of Aboriginal ill-health.

Income, education and employment are all interdependent variables that impact on health status. Socioeconomic disadvantage in childhood, inadequate nutrition, poor education, unemployment, and psychosocial factors (such as lack of self-esteem and social support, often associated with addictive behaviours) are causative of ill-health, and this can occur with or without access to good-quality medical care. A child raised in an affluent home is likely to succeed educationally, which in turn favours entry to more privileged sectors of the labour market, access to better working conditions and higher incomes with financial security in old age. A child from a disadvantaged home is likely to achieve few educational qualifications, leave school at the minimum age, and enter the unskilled labour market, where pay is low, the work often hazardous, and for those who live to old age this means reliance on the welfare system.

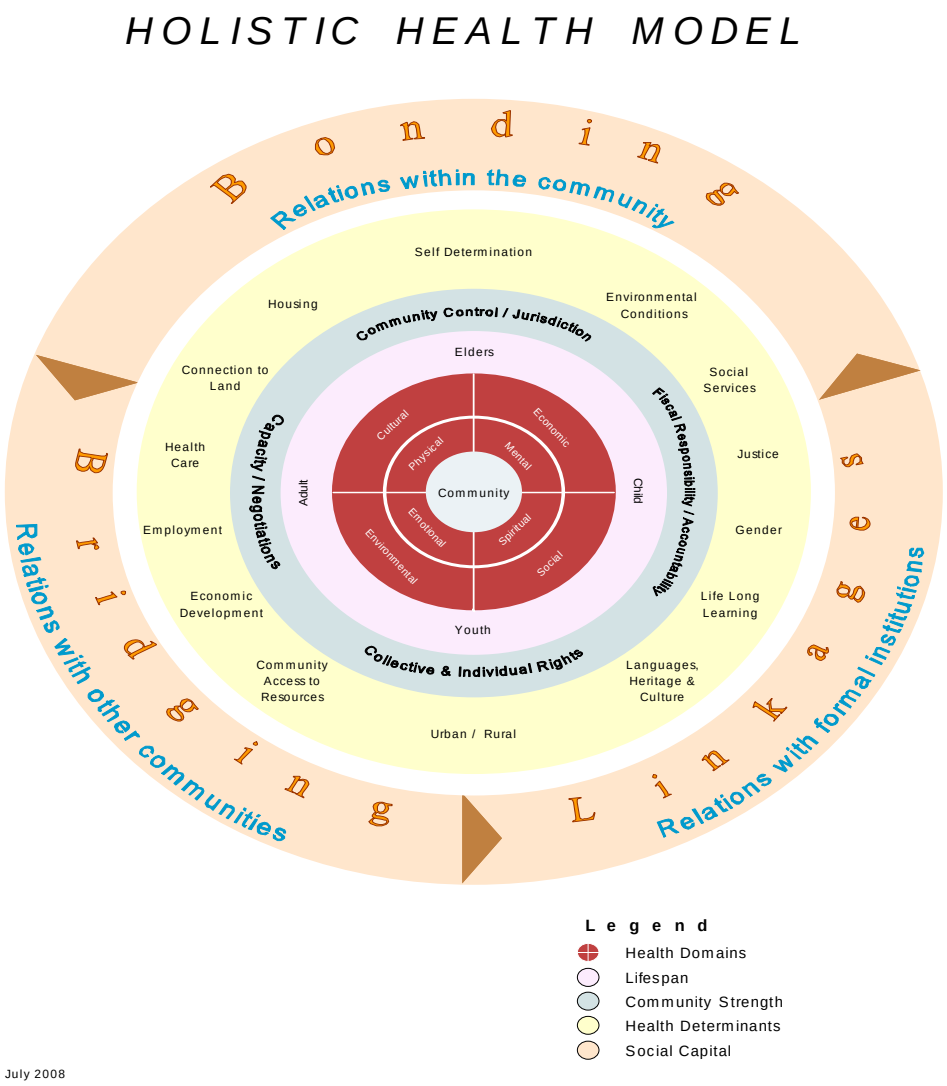
Education may lead to better health outcomes through increasing a person's health-related knowledge and information, or their ability to make efficient use of such information, increasing the likelihood of engaging in positive health behaviour (e.g. exercising, regular health check-ups), or alternatively not engaging in behaviour likely to be harmful (e.g. smoking).

Physiologically, it is considered that when biological stress response is activated too often and for too long, there are multiple health effects - depression, increased susceptibility to infection, glucose intolerance leading to diabetes, and high blood pressure and accumulation of cholesterol in blood vessel walls leading to heart attack and stroke. For Aboriginal communities issues of racism, prejudice and the generational impacts from the stolen generations and severance of connection from land, have cumulative effects in exacerbating feelings of grief, loss and stress levels. Marginalisation from aspects of social and community life has additional detrimental effects on health.

Therefore, to make a significant impact on closing the gap, Aboriginal health initiatives need to be provided through a model of care that also positively reinforces the multifaceted aspects of life experience that contribute to the well-being of Aboriginal communities. This includes concepts of identity, community, family, autonomy, culture, heritage and social justice.

There have been attempts to map the domains that are covered by a holistic health model. The Canadian Assembly of First Nations has developed a model of holistic health entitled the *First Nations Wholistic Policy and Planning Model*. This model was presented to the World Health Organisation Commission on social determinants of Health in 2007. The model is of relevance in outlining the domains that need to be considered in providing holistic health services.

Fig 3.1 Canadian First Nations Wholistic Policy and Planning Model



The key components of the model are:

- Community at the core;
- Components of Health (the Medicine Wheel) include the Spiritual, Physical, Emotional and Mental;
- Cycles of the lifespan (child, youth, adult, elder);
- Four key dimensions of social interaction (self-government/jurisdiction, fiscal
- Relationships & accountability, collective and individual rights, capacity/negotiations);
- Social determinants of health;
- Components of social capital (bonding, bridging, and linkage).

Note: some terminology within graphic adapted to Australian context.

Source: United Nations, Commission on the Social Determinants of Health, *Social determinants and Indigenous health: The International experience and its policy implications*, Report on specially prepared documents, presentations and discussion at the International Symposium on the Social Determinants of Indigenous Health, 2007, Adelaide, SA.

This model is also useful in placing holistic care within the context of the social capital owned by communities. Social capital has been defined as the networks, shared norms, values and understandings which are embedded in the social structure of societies, ensuring cooperation and coordination of action to achieve desired goals. Because social capital arises from trust, engagement, participation, social interaction and reciprocity between people it can be considered an attribute of families, groups and communities, but not individuals.

Generally, social capital is seen within three dimensions - bonding, bridging and linking:

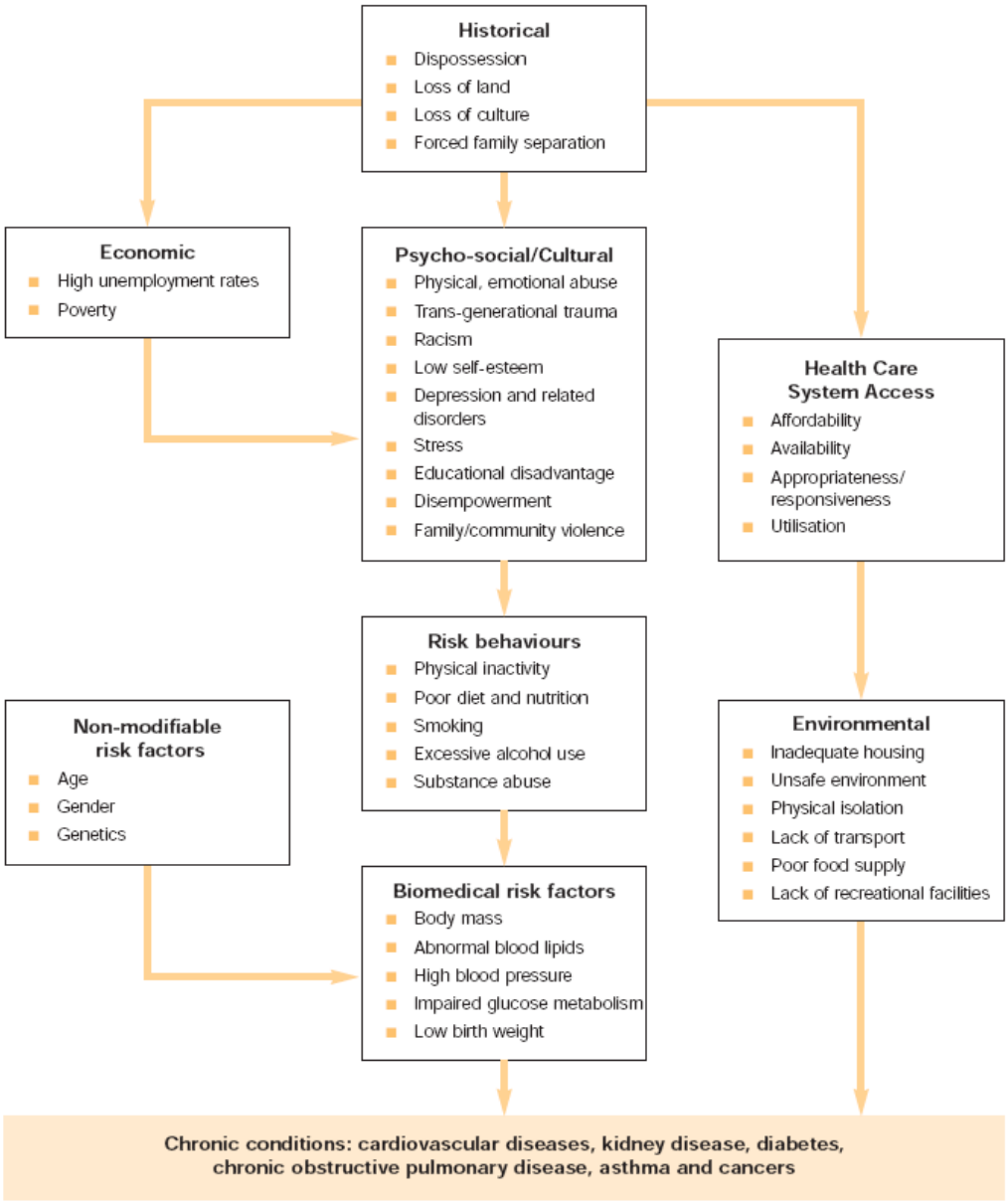
- **Bridging social capital** is about partnerships across different cultures and between socioeconomic groups which enable the marginalised and disadvantaged access to resources, expertise, opportunities for participation and exchange with wider social networks;
- **Linking social capital** is about access to external resources and support beyond local neighbourhoods through influence of the decision making of external institutions such as Government, the public sector, corporations and philanthropic bodies.
- **Bonding social capital** is about the ties between people in similar situations such as family, friends and neighbours which provide mutual support to aid day-to-day survival and is reflected in the strength of cultural identity, heritage, kinship and generational respect.

A holistic care paradigm takes account of all of the dimensions of social capital in health improvement strategies – the bonding characteristics that strengthen resilience, the bridging characteristics that facilitate beneficial access to mainstream resources and expertise locally and linking characteristics that advocate and influence the strategies employed, shape of services and models of care.

For service providers holistic care can be seen as being provided within and adding to the stock of social capital for Aboriginal community. By being cognisant of and working with the strengths of Aboriginal families and their local social connectiveness, bonding social capital is advanced. By addressing access, outreaching, consulting, respecting culture and forming strong partnerships, bridging social capital is advanced. Through advocacy, increasing employment opportunities for Aboriginal people within and without of the health sector, professional development and proactive policy, planning and funding acquisition to advance Aboriginal health, linking social capital is advanced.

In the Australian context, models of holistic care have been developed which outline the factors contributing to chronic health conditions in Aboriginal communities and illustrate the multilateral actions that are required to address the determinants of health among Aboriginal communities. For NSW, this has been most completely outlined in the work undertaken through the NSW Aboriginal Vascular Health Program Working Group and reflected in the NSW Aboriginal Chronic Conditions Area Health Service Standards.

Figure 3.2 Factors Contributing to Chronic Health Conditions in Aboriginal Communities



Source: NSW Aboriginal Chronic Conditions Area Health Service Standards – Cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer, NSW Department of Health (2005), p. 3.

3.2 Integrated Agency Responses

A key rationale of Two Ways Together is the coordination of agencies for a whole of government approach to the service of Aboriginal customers. Human service agencies working within Aboriginal communities report many referrals and multiple contacts across intake systems, suggesting that not all of a client's needs can be met by a single agency. Clients often have multiple or complex problems, requiring help from more than one agency. The longer term goal is to ensure that Aboriginal people will be able to access a wide range of services from the first agency contacted.

There are clearly many advantages for Aboriginal people in ensuring that their contact across human services agencies is streamlined and coordinated, including:

- avoiding the need to tell their story over and over again;
- not having to face multiple, uncoordinated human service providers;
- Experiencing lower levels of frustration.

More generally the community has a right to expect that human service agencies demonstrate:

- consistency in service design and protocols;

- sharing of information and collaborative action;
- complementary workforce structures;
- shared access to relevant, quality health and wellbeing resources outside their sector.

This concept of coordinated agency responses to need in disadvantaged communities has been referred to as a "whole of Government" or "joined-up Government" approach. The benefits of this approach have been described as:

> "Through this co-ordination it is hoped that a number of benefits can be achieved. First, situations in which different policies undermine each other can be eliminated. Second, better use can be made of scarce resources. Third, synergies may be created through the bringing together of different key stakeholders in a particular policy field or network. Fourth, it becomes possible to offer citizens seamless rather than fragmented access to a range of services."
> C. Pollitt 2003, 'Joined-up Government — A survey', *Political Studies Review*, vol. 1, pp. 34-49, p. 35.

There are whole of Government approaches underway with a view to streamlining the way human service agencies approach the task of providing multiple services consistent with a holistic health paradigm. This includes further development of the Human Services Network (HSNet) which through providing agencies with multiple tools to assist in service delivery, aims to:

- Improve the delivery of services to the community
- Assist human service agencies, government and non-government, to exchange information
- Foster networking and cooperation between agency staff
- Make accurate information about services easier to obtain
- Assist agencies to make faster, more accurate referrals for clients
- Protect the client's privacy in collecting, processing and recording information
- Improve the use of resources by agencies
- Identify and address gaps in services

HSNet resources include ServiceLink, an online directory of human services in NSW and ReferralLink, an electronic client referral system; enabling agency staff to quickly locate and refer clients to appropriate services. There is also potential to develop coordinated online communication through information exchange, publishing and sharing of documents and e-learning.

It is considered that an integrated electronic systems approach to data availability across human service agencies can provide:

- Cost-effective access to programs, tools and information
- Time saving through faster searching of human service information
- More accurate data through reduced duplication of data entry
- Time saving through faster, more accurate referrals
- Information exchange and online training programs resulting in savings in time and cost and less travel effort
- Productivity gains through easy access to professional development materials
- Resources to enhance service planning

However, there remain many barriers to improving inter-agency coordination that still need to be addressed, including:

- continued reluctance or structural inability to share information;
- lack of clarity about constraints of confidentiality;
- failure to include all those involved with clients in planning care;
- rigid demarcations;
- role boundary conflicts;
- unrealistic expectations of individual agencies capabilities/or what they were able to do or undertake;
- lack of understanding of the roles and responsibilities of different agencies; and
- inter-professional or inter-agency conflict of perspectives and varying degrees of commitment;
- perceived power differences between partners

Strategies to improve inter-agency coordination are being developed and implemented across NSW and SSWAHS participates in this process. Key system-wide developments include:

- multi-agency training to address training needs and sharing of perspectives;
- inter-agency agreements , normally broad, high-level documents that outline the basis of a new relationship and the agreed objectives between partners;

- inter-agency protocols, normally practical, hands-on documents that outline specific processes and procedures between service delivery agencies;
- multi-agency forums to monitor joint working protocols.
- whole of government, whole of community place-based approaches e.g. Redfern/Waterloo Partnership Project, Macquarie Fields; where interagency coordination is addressed through identifying a lead agency and setting cooperative agreements in place with other agencies

Further effort is required, however, in developing common assessment and referral tools and frameworks, to facilitate joint agency work and case coordination. There is need for more cross-agency pathways and protocols that are client-focused and holistic, and embedded in systems rather than being service-specific or place-specific.

3.3 Partnerships with Aboriginal Communities

One of the core premises that Two Ways Together is founded on is Aboriginal people working as equal partners with government, deciding what needs to be done at a local and regional level to improve lives, rather than government dictating from the top. This concept of working in partnership recognised that the issues arising in Aboriginal affairs were holistic and required an integrated approach, between government agencies and Aboriginal people and organisations, in order to achieve long term, sustainable change in people's lives.

The value of a community partnership approach has been well demonstrated internationally as a preferable way of addressing the health needs of disadvantaged communities, for both practical and philosophical reasons. Practically, many community problems are so complex and interrelated that no single service, organization, or sector can hope to address them alone. The broad array of knowledge, skills, and resources that are required to address the root causes of a community's health disadvantage and to develop locally effective solutions requires participation from an equally broad array of diverse, talented, and engaged community members. Also, philosophically, collaborative efforts offer a mechanism for giving people who have been excluded from community decision making a meaningful voice about the issues, policies, and services that affect them.

The partnership philosophy can be seen as being closely aligned with the imperatives of participative decision making, self-determination and mutual obligation. In practice, the application of these philosophies often occurs through:
- extensive consultations with Aboriginal people in the development, implementation and review stages of policies and programs;
- establishment of specific Aboriginal advisory groups formed for each policy or program.

However, to be truly effective partnership arrangements have to move beyond interaction and consultation to collaboration. To develop policy actions that are culturally appropriate and engage the community, partnerships need to address policy implementation as well as policy formation and assessment.

There are some prerequisites to developing enduring partnerships with Aboriginal communities. These include:
- the partnership should be based on equality, inclusiveness, trust and respect;
- the partnership should add value to both organisations;
- clear, transparent and achievable goals should be established for the life of the partnership;
- formal partnerships are more likely to be sustained than informal ones;
- leadership of the partnership should be undertaken by someone with skills to liaise with key stakeholders to maintain momentum and to provide the glue to keep the partnership together.

Partnerships with communities may be forged in different contexts. Some may be of smaller scale and project, place or service specific. Others may be more diffuse focusing on less tangible outcomes, such as capacity building, integration, co-ordination, and strategic planning.

SSWAHS and the previous CSAHS and SWSAHS have been actively involved in developing partnerships with Aboriginal communities at the local level for specific services/programs which exhibit the characteristics of practical partnerships identified above i.e. consultations on program development and review and in establishment of Aboriginal advisory groups e.g. sexual health, drug health, mental health. There has also been widespread consultation with Aboriginal communities in Area service planning activities such as for HIV/AIDS and Related Programs, Community Health, Maternity, Carers, Disability and Youth health.

A broader partnership has been established with the Aboriginal Medical Services at Redfern and Tharawal. This is in the form of a formal Partnership Arrangement that can be seen as the key mechanism through which SSWAHS partners with the key organisations representing the health interests of the Aboriginal communities of SSWAHS.

For SSWAHS, an important Aboriginal community is the community of staff who identify as Aboriginal. The principles of partnership equally apply to how SSWAHS interacts with its Aboriginal staff and these people represent the single most effective resource that is available to SSWAHS to make progress on closing the gap. They play the key role in consulting and engaging with, advocating and providing a voice for, and bringing the SSWAHS Aboriginal communities viewpoints into policy and program development. Many take on leadership positions of influence within their local Aboriginal communities.

Continuing support of an Aboriginal health worker network, provision of training and educational opportunities, commitment to Aboriginal workforce strategies and targets for employment, leadership and mentoring programs and inclusion of Aboriginal staff on key policy, management and governance committees are all tangible aspects of a SSWAHS partnership with its Aboriginal staff. This partnership commitment is an integral foundation to partnership arrangements with Aboriginal populations of SSWAHS.

3.4 Complementary and Supportive Services to those provided by ACCHS

Aboriginal Community Controlled Health Services (ACCHS), the generic term for Aboriginal Medical Services (AMS) have the leadership role in providing primary health care services to Aboriginal communities and in integrating service provision with those services only available through mainstream public funded services. This a broad role which, in addition to the provision of medical care through clinical services treating diseases and management of chronic illness, may include services such as environmental health, pharmaceuticals, counselling, preventive medicine, health education and promotion, rehabilitative services, antenatal and postnatal care, maternal and child care, programs and necessary support services to address the effects of sociosomatic illness and other services provided in a holistic context. This extends to a range of services included in the NACCHO definition for 'Aboriginal Health Related Services' as:

> "those services covered by the Aboriginal holistic definition of health including, but not restricted to, such services as health promotions and disease prevention services, substance misuse, men's and women's health, specialised services to children and the aged, services for people with disabilities, mental health services, dental care, clinical and hospital services and those services addressing, as well as seeking the amelioration of, poverty within Aboriginal communities."

The AHMRC has identified the range of services that are or potentially could be provided through an Aboriginal Medical Service. The extent to which an AMS provides these services is a reflection of funding availability, community priorities and the degree to which communities can adequately access appropriate services through the mainstream public health system. These services are outlined at Table 3.1.

Table 3.1 Range of Services that could be provided through ACCHS

Clinical Care
- Diagnostic and clinical care
- Treatment of illness/disease
- Management of chronic illness
- Referral to secondary health care (inpatient hospital and other health residential facility) and tertiary health care (specialist services and care) when not available at the ACCHS
- Dialysis services and endocrinology referral
- Collections for pathology testing and/or referral
- Radiology services or referral
- Sterilisation of equipment meeting Australian standards
- Respiratory disease testing, services and referral
- Cardiovascular testing, services and referral
- Outreach clinical health services to satellite clinics or communities without services
- Clinical health services to prisons and institutions
- Domiciliary health care
- Prescription of medication and drugs
- Pharmaceutical supplies.

Preventative Health
- Population health promotional program
- Early intervention
- Otitis Media examination and testing
- Immunisation
- Health education and promotion
- Socially communicable disease control, manuals and education programs
- Health protection supplies and distribution
- Antenatal instruction and classes
- Maternal and child care (0 – 5 years)
- Diabetic screening, testing and counselling
- Screening, individual and mass screening programs
- Vaccinations
- Infection control
- Injury/accident prevention education
- Outreach health promotional programs
- Dietary and nutrition education

Dental Care and Prevention
- Diagnostic and dental care
- Treatment of tooth decay/extraction
- Provision of dentures
- Orthodontic and specialist services
- Orthodontic and specialist services referral when not available at an ACCHS
- Sterilisation equipment meeting Australian standards
- Outreach dental services to satellite clinics or communities without dental services
- Dental health promotional program
- Early intervention
- Dental health education
- Dental health supplies and distribution.

Health Related and Community Support Services
- Psychiatric services and care
- Counselling and group activities
- 'Stolen Generations' counselling and Link-up services and support
- Cultural promotion activities
- Aboriginal traditional methods of healing
- Clinic usage as venue for visiting specialists
- Aged care services
- Paediatric Services
- Client follow-up and support
- Home and community care
- Assistance with surgical aids
- Podiatry services
- ENT Services
- Ophthalmology services
- Optometry services
- Advocacy work *e.g.* support letters for public housing issues

- Homelessness support and temporary shelter services
- Submission writing for community organisations
- Advocacy/interpreting services
- Community development work
- School based activities
- Transportation health services and Community bus activities
- Accommodation or assistance for visiting rural and remote patients
- Meeting of patients travelling long distance by public transport
- Deceased transportation and arrangements
- Funeral assistance
- Youth activities and counselling
- Satellite primary health services to remote outlying communities or towns
- without services
- Support services for people in custody
- Prison advocacy services
- Welfare services and food assistance
- Affordable and wholesome food provision
- Financial assistance for medical supplies or prescriptions
- Environmental health services
- Substance misuse counselling, education and promotions
- Detoxification services
- Needle exchange services
- Services for people with disabilities
- Men's and women's business services
- Family counselling services
- Crisis intervention services
- Audiometry services
- Audiology services
- Local or Regional Health Ethics Committee representation
- Community and ACCHS research and data analysis
- Formal in-service staff education and training
- Liaison with mainstream and private health sectors to assist in access and equity to secondary and tertiary health care services for Aboriginal people.
- Community, Shire Council, Regional Area Health Service, Hospital Board committee representation

Source: Primary, Secondary and Tertiary Health Care Services to Aboriginal Communities - Core Functions of Primary Health Care in Aboriginal Community Controlled Health Services (ACCHS), AH&MRC Monograph Series. Volume 1. Number I. 1999

The core primary healthcare services delivered by Aboriginal community controlled health services have also been delineated in NACCHO documents:

Clinical Services

- primary clinical care such as treatment of illness using standard treatment protocols, 24 hour emergency care, provision of essential drugs and management of chronic illness;
- population health/preventive care such as immunisation, antenatal care, appropriate screening and early intervention (including adult and child health checks and secondary prevention of complications of chronic disease), and communicable disease control;
- clinical support systems such as pharmaceutical supply system and comprehensive health information system (population registers, patient information recall systems, and systems for quality assurance).

Support Services internal to the health service

- staff training and support such as Aboriginal health worker training, cross cultural orientation, continuing education;
- management systems that are adequately resourced, financially accountable and include effective recruitment and termination practices;
- adequate infrastructure at the community level such as staff housing and clinical facilities, and functional transport facilities.

Support Services external to the health service

- systems for supporting visiting specialists and allied health professionals (including dental, mental health etc), medical evacuation or ambulance services; access to hospital facilities;
- training role for tertiary and other students.

Special Programs

- based on locally relevant priorities and the availability of funds for programs directed at rheumatic fever, substance misuse, nutrition, environmental health and for target groups such as youth, aged and disabled people, young mothers, school children etc.

Advocacy and policy development

- support for the community on local, state and federal issue

Source: Close the Gap, Solutions to the Indigenous Health Crisis facing Australia, A Policy Briefing Paper from the National Aboriginal Community Controlled Health Organisation and Oxfam Australia, April 2007, p.10.

As previously described, SSWAHS has developed Partnership Arrangements with the Aboriginal Medical Services at Redfern and Tharawal.

4. Framework Initiatives

The four principles for engaging with Aboriginal communities to improve health will need to be firmly embedded within the organisational framework of SSWAHS service provision for optimal impact to be achieved on closing the gap in health disadvantage. In this chapter, key initiatives are identified to strengthen the overarching framework across the clinical and corporate structures of SSWAHS within which health priority area specific activities can proceed. They will strengthen the focus of the organisation on Aboriginal Health and build the organisational capabilities to make an impact on closing the gap. This will be an essential prerequisite for success in the corporate-wide or health priority area specific initiatives, for which the rationale for action is outlined in Chapter 5 and 6 of this volume and the detailed Action Plans outlined in Volume 3.

These framework initiatives were developed with the active involvement of the SSWAHS Aboriginal Health Unit and the relevant Aboriginal Health Worker staff within SSWAHS. They are wholly consistent with the views expressed in the numerous consultations with Aboriginal communities outlined in Chapter 2.

Strategic focus of framework initiatives

From analysis of policy and reflecting the views of Aboriginal communities expressed in numerous consultations it was considered that the main strategic focus in developing framework initiatives should include:

- enhancing community and social capital;
- strengthening primary and community care;
- ensuring holistic care;
- strengthening partnerships with Aboriginal controlled health services and other Aboriginal controlled organisations;
- strengthening partnerships with general practice and other primary care services inc. community health;
- developing research, monitoring and evaluation frameworks addressing key health outcomes and performance indicators.

Rationale for Program Development

History has indicated that piecemeal approaches by organisations to lower the gap in health outcomes for Aboriginal communities have not been successful. Coordinated and integrated action is required if there is to be any prospect of a significant and sustained lowering of the gap. Action needs to be within the TWT framework principles of a coordinated approach across services/agencies, close involvement of Aboriginal communities in setting priorities for action and respect for the rights of Aboriginal communities to determine the direction of their social, economic and political development and maintain culture, language and identity.

SSWAHS initiatives to address Aboriginal Health need to be developed within a framework that ensures these principles are achieved in practice. Intention is not sufficient, rather enduring and sustainable structures need to be maintained to ensure progress. Framework initiatives provide the scaffolding to support more specific initiatives developed for each priority health area and the supporting infrastructure to ensure that progress can continue to be made over time.

Organisations are best placed to undertake program development within disadvantaged communities when there is a clear set of guiding principles as to how they conduct business. An example is NACCHO's guiding principles, which are based on the Ways Forward Report (Swan/Raphael 1995) and include:

- National Aboriginal Health Strategy definition of health;
- Concepts of health as holistic;
- The right to self determination;
- The impact of history in trauma and loss;
- The need for cultural understanding;
- The recognition of human rights;
- The impact of racism and stigma;
- Recognition of the centrality of kinship;
- Recognition of different communities and needs;
- Aboriginal strengths;
- Universal access to basic health care;
- High quality health care services; &
- Equitable funding for health care.

Source: National Aboriginal Community Controlled Health Organisation 2006/07 Overview and Action Plan, Aboriginal Peoples Making the Health System Equitable, 2006, Canberra, ACT, p.2.

With similar intent, the Australian Health Ministers' Advisory Council Standing Committee on Aboriginal and Torres Strait Islander Health has developed a *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004 – 2009* (AHMAC 2004). In this document, cultural respect is described as follows:

> *"Recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples. Cultural Respect is achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected. The goal of Cultural Respect is to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes"* (AHMAC 2004:7).

The Framework identifies guiding principles of:

- A holistic approach encompassing physical, spiritual, cultural, emotional and social wellbeing, community capacity and governance;
- Aboriginal health as a core responsibility and high priority for the whole of the health sector;
- Supporting the community controlled health sector;
- Working together across government, non-government and private organisations within and outside the health sector;
- Localised decision making through communities defining their health needs, priorities and culturally appropriate modes of service delivery;
- Health promotion and illness prevention as core activities;
- Building the capacities of health services and communities;
- Reciprocal accountability for outcomes.

These are the types of principles that any organisation operating with intent to improve Aboriginal Health should use continually to shape policy and develop programs in Aboriginal communities. However, to be effective framework structures need to be in place to ensure that the principles can be put into practice.

Principles for Progress

The four core principles underlying the actions SSWAHS will take to strengthen the organisation's focus on Aboriginal health and build the organisational capabilities to make an impact on closing the gap are outlined at Chapter 3. Consistent with and building on these principles SSWAHS will focus on 11 main areas of activity to strengthen the organisational framework within which action on corporate and health priority area initiatives can be undertaken. These areas of activity include:

F1	SSWAHS support of capacity building in Aboriginal communities;
F2	Shaping health promotion agendas to work within Aboriginal communities;
F3	Partnering with Aboriginal Community Controlled Organisations;
F4	Partnering with Primary Care Providers;
F5	Partnering with other Agencies in Whole of Government/Whole of Human Services activities;
F6	SSWAHS contribution to community renewal agendas;
F7	Working with clinicians on awareness raising of the principles of holistic care provision as it applies for SSWAHS Aboriginal communities;
F8	Developing an Area Charter of Commitment to Advancing Aboriginal Health through a salutogenic (strengthening of health-enhancing attributes) approach, recognising cultural identity and richness;
F9	Supporting Aboriginal communities in addressing "men's business" in health;
F10	Supporting Aboriginal communities in addressing "women's business" in health;
F11	Encouragement of research into issues of Aboriginal health of importance to the Aboriginal communities of SSWAHS.

In all the above areas SSWAHS has already been working within its capacities to make advances that will contribute to improvements in Aboriginal Health. There are already in place many examples of good practice programs and the following schedule outlines the history, good practice examples, strategic focus over the next five years and the partners SSWAHS will need to continue to work with in consolidating and strengthening this foundation supporting framework.

Table 4.1 Strategic Focus of Framework Initiatives

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
F1. SSWAHS support of capacity building in Aboriginal communities			
The Aboriginal Health Workforce of SSWAHS is actively involved in capacity building within their local communities, both within their role as AHWs and more broadly as community members. SSWAHS Aboriginal Employment strategy recognises that the health sector is a major employer of Aboriginal people and can expand employment opportunities not only in care giving occupations but also in trades, this enables advances in economic independence for Aboriginal communities; The research activities in Aboriginal communities in areas such as early childhood, ageing and vascular health all have capacity building as an explicit goal or expected benefit; SSWAHS clinical services are increasingly providing health information and advice to community groups to increase capacity to participate in preventative health activities e.g. presentations to men's groups, in-reach to Miller; Knowledge on how to access SSWAHS services is being addressed through production of Aboriginal specific TAGs. The SSWAHS Aboriginal Health Promotion Action Plan 2007-2011 has explicit goal of community capacity building. Bovis Lend lease arrangements.	Capacity building processes aim to help people manage their own affairs and work collectively to foster and sustain positive change. This can apply equally to individuals, groups and organisations and involves improvement in awareness, skills, knowledge, motivation, commitment and confidence. It goes beyond traditional top down approaches of enhancing skills and knowledge through training and the provision of technical advice. Ideally it focuses on enhancing genuine community engagement in all aspects of activities from planning to on-ground actions. In addition to the transfer of information and technical capability, capacity building should also foster social cohesion in communities, and build both human and social capital. Capacity building can be seen as developing strength across a number of elements: ▪ Human development – improving talents and expertise, having the information and guidelines, to address problems and seize opportunities in health, education and economic advancement; ▪ Institutional development – harnessing financial, cultural and human assets, deploying them intelligently and fairly, to create contexts (networks, norms and trust) in which skilled workers can function effectively; ▪ Leadership – shared awareness of problems, opportunities and workable solutions, capacity to plan and implement projects, ability to achieve change.	▪ Strengthening the capacity of AHWs to undertake a community development role within their communities; ▪ Providing culturally appropriate health information to increase community recognition of healthy lifestyles, adverse health behaviours and the precursors to ill health. ▪ Providing support in the development of community support groups. ▪ Increasing the capacity of communities to self manage chronic disease. ▪ Empowering the community to access mainstream health and social welfare services. ▪ Providing simpler, improved service directories and ensuring appropriate health information in community directories and working across agencies to develop holistic information; ▪ Assisting communities in developing economic independence. ▪ Ensuring maximum Aboriginal participation in all Health funded infrastructure development activities. ▪ Providing training and management development support for office-holders of Aboriginal community organisations.	The Aboriginal Health Workforce network within SSWAHS and Statewide. ACCHS Redfern and Tharawal. Land Councils. Community support groups in Aboriginal communities. NGOs working with Aboriginal communities Corporate services of SSWAHS including public relations, capital works, Centre for Education and Workforce Development, transport. Institutes, Foundations and Associations providing consumer health information and advice. The Clinical Streams of SSWAHS in priority areas for Aboriginal Health , including: ▪ Aged Care and Rehabilitation; ▪ Cardiovascular; ▪ Complex Care, General Practice and General Medicine; ▪ Drug Health; ▪ Gastroenterology and Liver; ▪ Mental Health; ▪ Oral Health; ▪ Paediatrics; ▪ Population Health ▪ Women's Health and Neonatology SSWAHS Community Health Other Government Human Service agencies providing services to Aboriginal communities of relevance to the determinants of health. Private sector organisations providing construction and infrastructure development services under tender to SSWAHS.

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
F2. Shaping health promotion agendas to work within Aboriginal communities			
NSW Health funds health promotion activities in Aboriginal communities targeting chronic disease. The SSWAHS Health Promotion Service has developed an Aboriginal Health Promotion Action Plan 2007-2011, aiming to contribute to: ▪ a reduction in the disparity between Aboriginal and non-Aboriginal health; ▪ minimisation/reduction of chronic disease in Aboriginal populations; ▪ improvements in the social determinants of health for Aboriginal people. Initiatives consolidate previous and current health promotion initiatives e.g.: Chronic disease prevention ▪ Increase level of physical activity and good nutrition; ▪ Reduce smoking prevalence and environment tobacco smoke Social determinants of health ▪ Increase access to services, food and transport ▪ Increase social connectedness through community development ▪ Promote and strengthen Aboriginal culture.	Generic good practice principles on health promotion are outlined in the *Ottawa Charter on Health Promotion*: 1 building health-related public policy 2 creating supportive environments 3 strengthening community action 4 developing personal skills 5 re-orienting health services. NSW Health supports the Sydney Consensus Statement of Principles for Better Practice in Aboriginal Health Promotion, which suggests health promotion programs should: ▪ acknowledge Aboriginal cultural influences and the historical, social and cultural context of communities; ▪ be based on available evidence; ▪ build the capacities of the community, government, service systems, organisations and the workforce, ensuring equitable resource allocation, cultural security and respect in the workplace; ▪ ensure ongoing community involvement and consultation; ▪ apply Aboriginal self-determination principles; ▪ adhere to the holistic definition of health and acknowledge that primary health care in Aboriginal communities incorporates Aboriginal health promotion; ▪ establish effective partnerships to address the determinants of health; ▪ aim to be sustainable and transferable; ▪ demonstrate transparency of operations and accountability.	▪ Secure resources to enable implementation of the SSWAHS Aboriginal Health Promotion Action Plan 2007-2011. ▪ Facilitate placement of Aboriginal Health Promotion Officers within Clinical Streams of highest relevance to closing the gap in health disadvantage. ▪ Continue to influence State agendas in Aboriginal Health Promotion through participation on and active engagement with State wide committees established by NSW Health. ▪ Identify and document best practice in Aboriginal Health Promotion Statewide, Nationally and Internationally for indigenous peoples; and facilitate adoption of good practice locally, including piloting of innovative approaches. ▪ Ensure the inclusion of Aboriginal perspectives in mainstream Health Promotion strategic and business planning, including use of AHIS process. ▪ Identify potential for Aboriginal specific modules within broader mainstream health promotion programs.	SSWAHS Health Promotion Service. The Clinical Streams of SSWAHS in priority areas for Aboriginal Health , including: ▪ Aged Care and Rehabilitation; ▪ Cardiovascular; ▪ Complex Care, General Practice and General Medicine; ▪ Drug Health; ▪ Gastroenterology and Liver; ▪ Mental Health; ▪ Oral Health; ▪ Paediatrics; ▪ Population Health ▪ Women's Health and Neonatology SSWAHS Community Health
F3. Partnering with Aboriginal Community Controlled Organisations			
The NSW Aboriginal Health Partnership Agreement 2008-13 (April 08), with AH&MRC, Minister for Health and DG NSW		▪ Consolidate existing Partnership arrangements with AMS' ensuring sustainable formal Partnership	ACCHS Redfern and Tharawal. The Clinical Streams of SSWAHS in priority

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
Health signatories, supports the development of Partnership agreements between ACCHS' and/or their Consortia and AHS', acknowledging that AHS' will consult and engage with a wide range of Aboriginal community organisation representatives and stakeholders. Former AHS' SWSAHS and CSAHS had established formal Partnership arrangements with AMS' Tharawal and Redfern. SSWAHS and AMS Tharawal entered into a formal Partnership in March 2006. Negotiations are underway with AMS Redfern to update and clarify Partnership arrangements that have continued to operate under auspices of the Partnership agreement with the former CSAHS. SSWAHS clinical services operate approx. 15 specialist service inreach and joint programs under service level agreements with the AMS'.		arrangements with each AMS. ▪ Expand the number of clinical service level agreements with AMS' to improve access of Aboriginal populations to specialist services and joint programs. ▪ Explore potential to undertake joint research projects, particularly on innovative service delivery models for Aboriginal populations.	areas for Aboriginal Health , including: ▪ Aged Care and Rehabilitation; ▪ Cardiovascular; ▪ Complex Care, General Practice and General Medicine; ▪ Drug Health; ▪ Gastroenterology and Liver; ▪ Mental Health; ▪ Oral Health; ▪ Paediatrics; ▪ Population Health ▪ Women's Health and Neonatology SSWAHS Community Health
F4. Partnering with Primary Care Providers			
The Divisions of General Practice in SSWAHS have participated in Commonwealth funded primary care initiatives addressing Aboriginal Health. The most recent initiative is through the OATSIH funded brokerage proposal (Marumali) that is being sponsored within the Macarthur Division.	Sydney South West Indigenous Community Health Brokerage Services (also known as Marumali), which aims to increase Aboriginal access and choice to culturally appropriate mainstream health services (public or private) and health equipment.	▪ Engage with and undertake joint projects with GP Divisions to build and strengthen relationships with primary care providers in private practice. ▪ Strengthen general practice links to targeted Aboriginal health programs operated within SSWAHS inc. Miller Clinic. ▪ Engage with GPs in the development and operation of chronic care prevention and management programs auspiced through SSWAHS. ▪ Engage with GPs in the development of Aboriginal targeted programs in chronic care self management. ▪ Work with GPs on development and expansion of the pilot diabetes prevention project within Aboriginal communities.	Divisions of General Practice ACCHS Redfern and Tharawal. SSWAHS Community Health

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
F5. Partnering with other Agencies in Whole of Government/Whole of Human Services activities			
Cross-agency work in regions is undertaken within the Premier's Department Regional Coordination Program (RCP) and overseen by Regional Coordination Management Groups (RCMG). High level coordination of human services cross- agency effort is overseen by the HS&JSOG (South West) and HS&JMSRN (Inner West) which address interagency collaboration, integrated planning and collaborative service arrangements. These groups have developed workplans (07-10 for South West; 08/09-11/12 for Inner West) which include some Aboriginal specific initiatives. TWT has inter-agency collaboration as one of the key tenets. There is cross agency representation at all levels of TWT coordination. At the State level, this includes the Chief Executives Committee, *TWT* Coordinating Committee and TWT Project Groups. At a regional level *TWT* Regional Engagement Groups (REG) oversee implementation – the Coastal Sydney and Western & South Western Sydney REGS are contingent with SSWAHS. Local TWT programs include *Community Justice Groups* (Redfern/Waterloo), walking Together (Newtown and Redfern) and *Intensive Family Based Services* (Campbelltown). SSWAHS is also a member of coordinating groups for specific State inter-agency strategies that may target Aboriginal Health within their broader mainstream focus e.g. Families NSW Project Management Group.	Identification of cross-agency work targeting Aboriginal communities within the Workplans of Human Services & Justice SOGs. Current workplan for South West Sydney has a high-level goal of *Strengthening Aboriginal Communities* under which SSWAHS takes the lead in expanding outreach health services to Aboriginal communities and promoting health, prevention, early detection and intervention. SSWAHS is also identified as playing a supporting role in TWT implementation, implementing the Aboriginal Child Youth and Family Strategy and community capacity building to better support Aboriginal children.	▪ Fully participate in implementation of local TWT initiatives through participation in REGs ▪ Take lead and supporting roles in the implementation of regional initiatives targeting Aboriginal Health through the Workplans of Human Services & Justice SOGs. ▪ Encourage participation of SSWAHS AHWs in relevant Koori Interagency processes. ▪ Full participation in Statewide cross-agency strategies targeting Aboriginal communities including ACYFS ▪ Continued cooperation with other Human Services agencies addressing issues of relevance to the determinants of Aboriginal Health disadvantage in areas such as numeracy and literacy rates and school readiness. ▪ Encourage the in-reach of partner agencies to SSWAHS services targeting Aboriginal communities e.g. Miller holistic care day.	The major agencies SSWAHS will need to continue to work with include: C'wealth Human Service Providers e.g. ▪ HIC/Medicare ▪ PBS ▪ Centrelink NSW Government Departments e.g. ▪ Aboriginal Affairs ▪ Ageing, Disability and Home Care ▪ Community Services ▪ Arts, Sports and Recreation ▪ Corrective Services ▪ Education and Training ▪ Attorney Generals ▪ Housing ▪ Juvenile Justice ▪ Premier and Cabinet ▪ Police ▪ TAFE
F6. SSWAHS contribution to community renewal agendas			
SSWAHS has been involved in implementing focussed approaches in South West suburbs such as Cabramatta, Airds, Miller, Macquarie Fields and the Canterbury/Bankstown area – usually in		▪ Ensure the work that SSWAHS Population Health and the Planning Unit undertake on urban design and planning is cognisant of the particular needs of Aboriginal communities.	SSWAHS Population Health SSWAHS Planning Unit SSWAHS Aboriginal Health Unit Local Government NSW Government Departments e.g.

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
partnership with local government and in the Inner West through the Redfern/Waterloo Partnership. A focus for Human Services in the region will be in places where the NSW Government is committed to redevelopment and regeneration of housing estates (Bonnyrigg, Claymore, Macquarie Fields, Minto).		▪ Include Aboriginal Health representation on all SSWAHS planning committees addressing future service provision in geographical areas with significant Aboriginal populations e.g. Macarthur. ▪ Ensure AHWs and ALOs working within defined geographical areas are supported to undertake a community capacity building role. ▪ Support AHWs and ALOs working within defined geographical areas to work with partner agencies on policy development that reflects Aboriginal community culture, values and needs.	▪ Aboriginal Affairs ▪ Ageing, Disability and Home Care ▪ Community Services ▪ Arts, Sports and Recreation ▪ Corrective Services ▪ Education and Training ▪ Attorney Generals ▪ Housing ▪ Juvenile Justice ▪ Premier and Cabinet ▪ Police ▪ TAFE NGOs working with Aboriginal communities.
F7. Working with clinicians on awareness raising of the principles of holistic care provision			
	There is an absence of guidelines as to how individual clinicians can ensure holistic care in clinical practice for Aboriginal populations. Conceptually, holistic care goes beyond a healing focus on symptoms or diseases towards one of the person within the environment that determines their health. Care provision is cognisant of physical, spiritual, mental, cultural, emotional and social wellbeing. It accepts that beliefs, values and attitudes affect health and the potential for cure. Approaches consistent with holistic care include: ▪ healing and wellness programs; ▪ health empowerment and advocacy; ▪ encouraging personal responsibility, active participation and engagement in self-care and risk avoidance; ▪ creating systems to support self-care; ▪ health education and preventive care; ▪ co-operation and co-ordination between community practitioners and supportive care providers; ▪ traditional healing and wellness perspectives; ▪ using the strength of family and kinship ties inc. Elders.	▪ Ensure clinician leadership and involvement in the development of clinical services targeted to Aboriginal communities in priority areas where mainstream models of care have limitations in addressing Aboriginal communities needs e.g. chronic care, mental health, drug health, sexual health, oral health. ▪ Expand clinical specialist involvement in Aboriginal health programs operating within a holistic care framework e.g. Miller clinic. ▪ Integrate AHWs and Aboriginal Health Programs within the Clinical Stream structure of SSWAHS. ▪ Ensure the use of AHIS process in Clinical Services planning and program development within Clinical Streams that impact on Aboriginal communities. ▪ Provide clinical staff with access to training modules that increase their awareness of Aboriginal cultural perspectives on health, wellness and healing. ▪ Explore possibility of preparing clinician toolkit for mainstream clinical providers	Clinical leadership from Clinical Streams where holistic care approaches to Aboriginal Health are required: ▪ Aged Care and Rehabilitation; ▪ Cardiovascular; ▪ Complex Care, General Practice and General Medicine; ▪ Drug Health; ▪ Gastroenterology and Liver; ▪ Mental Health; ▪ Oral Health; ▪ Paediatrics; ▪ Population Health ▪ Women's Health and Neonatology SSWAHS Community Health SSWAHS Centre for Education and Workforce Development

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
	▪ culturally relevant recruitment, assessment tools and training strategies. Culturally coherent clinical care should also go hand in hand with work addressing : ▪ environmental determinants of health such as food, water, housing and unemployment ▪ social determinants of health and wellbeing, such as racism, marginalisation, history of dispossession and loss of land and heritage.	on enhancing outcomes for Aboriginal people from the clinical encounter and subsequent management of disease. ▪ Increase mainstream clinician knowledge of and ease of referral to services that can support Aboriginal people in self management of disease. ▪ Work with clinical training programs to increase exposure of mainstream clinical students to Aboriginal perspectives on health, wellness and healing.	
F8. Developing an Area Charter of Commitment to Advancing Aboriginal Health through a salutogenic (strengthening of health-enhancing attributes) approach, recognising cultural identity and richness			
▪ SSWAHS has a long standing commitment to advancing Aboriginal Health through provision of a range of Aboriginal specific health programs, support of AHWs who facilitate these programs and orientation of mainstream services to meet the particular needs of Aboriginal communities. SSWAHS has become a signatory of Close the Gap and staff have been encouraged to sign the OXFAM/ANTaR pledge. ▪ There is corporate support for the celebration of Aboriginal cultural richness through formal support of National Close the Gap Day, Sorry Day and NAIDOC week. All SSWAHS facilities are asked to organise local activities and fly the Aboriginal and Torres Strait Islander flags on these occasions. ▪ Formal support to development of an SSWAHS Aboriginal Health plan through the SSWAHS Health Service Strategic Plan. ▪ Strategic Plans in Health specific areas such as community, youth, sexual health etc. address Aboriginal Health as specific focus areas. ▪ Cultural awareness training for mainstream health staff has been made	AHMAC has agreed to a *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*. Under this Framework cultural respect is defined as: *"recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres strait Islander peoples"*. The Framework seeks to influence the Australian health care system to be more culturally respectful through accountability mechanisms for mainstream programs to be inclusive of the needs of Aboriginal people in the planning, development, implementation and evaluation of health services. Cultural respect requires organisational commitment to ensure mainstream services can demonstrate: ▪ understanding and awareness of Aboriginal history, experience, culture and rights; ▪ practices, behaviours and protocols that are culturally appropriate; ▪ business practices that uphold and secure cultural rights (inc. workforce and workplace management); ▪ review and evaluation mechanisms (inc. data collection) to ensure continued focus	• Develop a formal SSWAHS Charter of Commitment to advancing Aboriginal Health outlining how SSWAHS will shape its services to respond to the needs of Aboriginal communities. This Commitment should outline how SSWAHS will: ▪ Respect Aboriginal relationship to land; ▪ Celebrate Aboriginal culture; ▪ Include the needs of Aboriginal communities in the planning and development of mainstream services; ▪ Understand and respect Aboriginal identity, experiences and rights; ▪ Focus on Aboriginal access to mainstream services; ▪ Make the business practices (inc. clinical care) of mainstream services culturally appropriate; ▪ Support and nurture its Aboriginal workforce. • Continue to support the current Cultural Committee arrangements overseeing the SSWAHS celebration of significant cultural events. • Work towards tangible recognition of Aboriginal country within the entry spaces of all major SSWAHS facilities.	SSWAHS AHW network. SSWAHS Aboriginal Senior Officer's Group SSWAHS Aboriginal Health Unit SSWAHS Centre for Education and Workforce Development Support in advancing cultural respect and recognition of identity from Clinical Streams working extensively with Aboriginal communities including: ▪ Aged Care and Rehabilitation; ▪ Cardiovascular; ▪ Complex Care, General Practice and General Medicine; ▪ Drug Health; ▪ Gastroenterology and Liver; ▪ Mental Health; ▪ Oral Health; ▪ Paediatrics; ▪ Population Health ▪ Women's Health and Neonatology SSWAHS Community Health

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
available on an as required basis, however capacity constraints have not enabled a regular program to be developed or for offering as a component of orientation.	on Aboriginal communities needs.	• Expand training and education available to SSWAHS workers on culturally respectful means of communication with Aboriginal community members.	
F9. Supporting Aboriginal communities in addressing "men's business" in health			
▪ First National Aboriginal and Torres Strait Islander Male Health Convention in October 1999; ▪ National Aboriginal and Torres Strait Islander Male Health Policy Forum in August 2000; ▪ draft National Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Males in 2001; ▪ Aboriginal men's groups have been established within the boundaries of SSWAHS – Tharawal, Babana, Muru Nanga Mia and Dula Yalla. ▪ A joint planning committee with representatives from these groups, SSWAHS AHWs and the AMS' has developed an Aboriginal Men's Health Implementation Plan (2008-2011). ▪ The Plan advocates a partnership approach between mainstream health services and Aboriginal Men's groups; identifies priority health issues for Aboriginal men in alcohol and other drugs, mental health and cardiovascular disease; takes a holistic approach recognising socioeconomic factors such as employment, education and housing; and highlights the importance of improving accessibility to and appropriateness of services.	Best practice is reflected in the Guiding Principles of the National Framework: ▪ reconstructing male empowerment and self-determination through supporting individuals to define, understand, prioritise and control the determinants of their health and well-being. ▪ "whole of family approach" recognising the interconnectedness between individuals, family and community. ▪ continuum of care through access to a full range of service options, from prevention and education to clinical care, treatment and follow up. ▪ shared and integrated responses across the health and related sectors. ▪ community capacity building creating and delivering gender appropriate services and programs ▪ equitable access to gender specific and culturally appropriate services and programs. ▪ male recruitment as a priority within all health workforce initiatives.	In partnership with Aboriginal male communities, work on activities from the SSWAHS Aboriginal Men's Health Implementation Plan (2008-2011): ▪ culturally appropriate activities for men; ▪ programs on men's health; ▪ discussion groups on social & emotional issues for local men; ▪ access to a range of health services; ▪ culturally specific male health services. Specific focus areas to include: ▪ Strengthen partnerships with an Aboriginal men's group network and pathways to SSWAHS services - mental, sexual, drug and vascular health; ▪ primary care health checks for men; ▪ health education and group discussion; ▪ cultural restoration at Men's groups; ▪ skill enhancement - literacy, numeracy , leadership and computer literacy; ▪ management of conflict, anger, grief and loss; ▪ culturally appropriate social, recreational and craft training opportunities; ▪ access to group and individual counselling.	The Aboriginal men's group network. ACCHS Redfern and Tharawal. Aboriginal Land Councils. SSWAHS Clinical Streams working extensively with Aboriginal men including in: ▪ Mental health ▪ Drug health ▪ Sexual health ▪ Vascular health – cardiovascular, renal., diabetes; ▪ Oral health; ▪ Cancer; ▪ Aged care; ▪ Endocrinology and obesity. SSWAHS Health Promotion Service. SSWAHS Community Health Centrelink Aboriginal programs. TAFE programs. Local Councils. Adult and Juvenile Justice Services. Divisions of General Practice.
F10. Supporting Aboriginal communities in addressing "women's business" in health			
SSWAHS actively participates in Statewide projects that address the needs of Aboriginal women e.g. ACFYS Strategy. Local programs have been developed in	A number of good practice initiatives are already underway in SSWAHS, including: ▪ Biyani Camp ▪ Healing Program (woman against abuse)	▪ In consultation with Women's support groups in the community, develop a strategic framework or Women's Health Implementation Plan to identify specific	Aboriginal Women's support groups in the community. ACCHS Redfern and Tharawal. Other Government human services agencies.

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
partnership with Aboriginal communities to address health related needs of Aboriginal women. SSWAHS employ a number of female AHWs who work extensively with Aboriginal women addressing gender specific needs.	▪ Aboriginal Women Against Violence Program ▪ Gadaga program (with CHETRE)	programs SSWAHS can participate in to address health issues for Aboriginal women from a gender perspective; ▪ In partnership with communities develop a cultural healing program to support women of the Stolen Generation in addressing the impacts on families; ▪ Consider employment of Aboriginal Women's Health Nursing positions to support activities undertaken with Women's support groups in the community.	SSWAHS Community Health SSWAHS Clinical Streams working extensively with Aboriginal women including: ▪ Aged Care and Rehabilitation; ▪ Cardiovascular; ▪ Complex Care, General Practice and General Medicine; ▪ Drug Health; ▪ Gastroenterology and Liver; ▪ Mental Health; ▪ Oral Health; ▪ Paediatrics; ▪ Population Health ▪ Women's Health and Neonatology.
F11. Encouragement of research into issues of Aboriginal health of importance to the Aboriginal communities of SSWAHS			
Consistent with the NSW Health Aboriginal Health Information Guidelines (1998) and the NSW Aboriginal Health Partnership Agreement 2008-2013, SSWAHS has continued to ensure that the protocols and approach for research activities targeting Aboriginal communities are assessed by the AHMRC Ethics Committee on an individual proposal basis. Some of the more significant research programs SSWAHS has been involved with include: ▪ *Kanyini Vascular Collaboration* – NHMRC funded research program aimed at identifying and overcoming barriers to best practice chronic disease care. Project managed by Baker Heart Research Institute Alice Springs and The George Institute for International Health, Sydney, with SSWAHS and Tharawal Aboriginal Corporation as collaborators. ▪ *Gudaga* – NHMRC and Ingham Foundation funded longitudinal birth cohort study describing the health, development and health services use of over 150 Aboriginal children and their mothers living in South West Sydney.	Good practice principles in research are outlined in the NHMRC *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, demonstrating: ▪ Spirit and integrity – respecting cultural richness binding generations, credibility in intent and process; ▪ Reciprocity – inclusion, engagement respectful of values and culture, providing benefit and enhancing community capacity; ▪ Respect – acknowledge aspirations and contributions, minimise difference blindness, understand consequences; ▪ Equality – value community knowledge and wisdom, treat all partners as equal, distribute benefits equally; ▪ Responsibility – doing no harm, accountability to individuals, families and communities; ▪ Survival and Protection – consistent with values based solidarity, respecting social cohesion, not diminishing cultural distinctiveness Examples of research projects reflecting these principles include:	▪ Continue to ensure all research proposals targeting Aboriginal communities are subject to AHMRC Ethics Committee approval and are developed consistent with the AHMRC Guidelines for Research into Aboriginal Health; ▪ Encourage use of the CRIAH Tools for Collaboration resource to facilitate appropriate collaboration between SSWAHS affiliated researchers and local Aboriginal communities; ▪ Work with academic researchers to establish research project(s) addressing the impact of early childhood experiences in areas such as out-of-home placement resilience among children; ▪ Develop action research projects around the areas SSWAHS can through workforce development activities contribute to capacity building in Aboriginal communities e.g. Senior Aboriginal Officer's Group; ▪ Contribute to the evidence base for good practice initiatives impacting on improved health outcomes, through presentation at conferences and contribution to peer-	AHMRC The Clinical Streams of SSWAHS undertaking research into aspects of Aboriginal Health, including: ▪ Aged Care and Rehabilitation; ▪ Cardiovascular; ▪ Complex Care, General Practice and General Medicine; ▪ Drug Health; ▪ Gastroenterology and Liver; ▪ Mental Health; ▪ Oral Health; ▪ Paediatrics; ▪ Population Health ▪ Women's Health and Neonatology Universities and affiliated research bodies with links to SSWAHS e.g. Sydney University, UNSW, UWS, CHETRE etc. SSWAHS AHW network. SSWAHS Aboriginal Senior Officer's Group SSWAHS Aboriginal Health Unit

What has been happening	Good practice principles	Strategic Focus → 5 years	Partners in these activities
Project managed by CHETRE with SSWAHS and Tharawal Aboriginal Corporation as collaborators. ▪ *Koori Growing Old Well Study* NHMRC funded study looking at lifetime experiences in early, mid-life and elder-life that influence healthy ageing, involving around 1,000 people aged 45 years and over living in cities, smaller towns and country areas.	▪ Kanyini ▪ Gadaga ▪ D& A programs ▪ Kooris growing old well study	reviewed journals etc.	

5. Corporate Initiatives – Rationale for Program Development

Chapter 4 outlined the strategic focus required over the next 5 years to strengthen the framework within which work to bridge the health disadvantage gap for Aboriginal people can proceed. Within this framework, SSWAHS as an organisation will need to ensure the particular needs of Aboriginal people are at the forefront of its corporate organisational focus across a number of areas.

The need for continuing work to better orient the corporate operations of SSWAHS to Aboriginal Health was often emphasised in the extensive consultation processes undertaken in development of this Plan and in other planning processes where Aboriginal Health issues have come to the fore. Themes of - improving access to targeted and mainstream services for Aboriginal people, ensuring holistic care consistent with Aboriginal cultural constructs of wellness, forging and strengthening partnerships and building community capacity - all require corporate work that is organised on an Area-wide, cross-program basis.

Most corporate services within SSWAHS are increasingly being organised on an Area-wide basis, with the aim of creating the economies of scale and consolidation of expertise that enable high quality and efficient support to the Clinical Streams in providing the clinical services required by their target populations. This gives significant opportunities to further orient corporate activity towards Aboriginal Health and make synergistic impacts across all of the communities of SSWAHS.

This chapter outlines the rationale for corporate developments that will be undertaken over the next five years to support SSWAHS Clinical Streams in providing the care services that are required to make progress on bridging the gap in health disadvantage in our generation.

5.1 Workforce Development

Progress on closing the gap requires availability of a competent health workforce with the capacity to be able to engage Aboriginal communities into treatment and healthy lifestyles, to communicate effectively and address multifactorial causes of ill health, to provide care within a holistic paradigm and to build community capacity and self-reliance. Health service providers, including SSWAHS are major employer within Aboriginal communities (see Tables ....) and through its Aboriginal health workforce SSWAHS can not only ensure that it responds appropriately to the needs of Aboriginal patients but also that it maximises Aboriginal access to services, extends service provision outside the confines of a mainstream episode of care, create enduring partnerships with Aboriginal communities and build community capacity and self reliance.

Workforce development initiatives recognise that coordinated effort is required across Commonwealth, State and regional health, education and training agencies and in partnership with training providers and ACCHS' to ensure the appropriate skill mix and distribution of the Aboriginal health workforce. For SSWAHS, workforce development initiatives are cast within the context of broader objectives applying across all NSW public sector agencies.

NSW Public Sector Key Result Areas in Aboriginal Employment

Recruitment:
- increase the representation of Aboriginal people to 2% (minimum) employed in the workforce;
- increase the permanent employment of Aboriginal people in the workforce;
- provide opportunities within the workforce to enable Aboriginal people to gain skills and experience that may assist them in gaining permanent employment;
- promote innovation and flexibility in the recruitment and selection of Aboriginal people into the workforce.

Skills acquisition & career development:
- provide professional learning and career development opportunities for Aboriginal employees;
- increase the number of Aboriginal people progressing to middle and senior management levels;

Retention:
- develop and foster support mechanisms and networks for Aboriginal employees;

Cultural education:
- build an environment that affirms and respects Aboriginal cultural values in the workplace;

Community engagement:
- develop and strengthen positive relationships and partnerships with Aboriginal communities and groups;
- promote NSW public sector employment opportunities to Aboriginal people and communities;
- identify skills shortages and provide appropriate training and support to Aboriginal people and communities to fill vacancies.

Source: Making it Our Business, Improving Aboriginal Employment in the NSW Public Sector, NSW Policy Statement 2006-08, p. 7.

Area Health services have committed to higher Aboriginal workforce employment targets of 2.2% by 2008 and 2.4% by 2013. Achieving these levels of employment will require action not only to increase the number of identified Aboriginal workforce positions in SSWAHS but also to increase Aboriginal employment within mainstream positions and to provide training and development opportunities to increase the supply of suitably qualified workers. SSWAHS can play a role in partnership to expand training opportunities to help address national shortages - illustrated by 2003 data showing that 167 Indigenous students (aged over 20 years) completed health related undergraduate courses and 105 completed welfare-related undergraduate courses, representing 1.0% and 1.5% respectively of all students completing undergraduate courses in these fields - well below the 2.4% Indigenous representation in the Australian population.

Therefore, the SSWAHS focus in Aboriginal workforce development will need to be both in recruitment and retention and in the development of skills and capabilities.

5.2 Cultural Safety

The concept of Cultural safety originally grew from a Maori nursing perspective and has been defined as:

> *more or less - an environment, which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what, they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening.*
>
> Williams R, *Cultural Safety – What Does it Mean for Our Work Practice*.

A culturally safe environment would be characterised by tangible demonstration of the following characteristics.

Characteristics of Cultural Safety

- respect for culture, knowledge, experience, obligations;
- no assault on a person's identity;
- clients treated with dignity;
- clearly defined pathways to empowerment and self determination;
- culturally appropriate service delivery/environment;
- respect for basic rights to - education, housing, medical services, employment, environmental health services and hardware etc;
- acknowledging the right to promote, develop and maintain own institutional structures, distinctive customs, traditions, procedures and practices;
- recognition of more than one set of principles, one way of doing things
- promoting access to prerequisites of effective participation in the system of the 'dominant culture', including organisational and communication skills, financial resources, administration support, appropriately trained and resourced staff, and advocacy resources;
- commitment to the theory and practice of cultural safety by personnel and trained staff;
- debunking of the myth that all Indigenous people are the same;
- Working with where people are at and not where you want them to be;
- Acknowledging the 'right to make own mistakes', people doing it for themselves, being active and not passive.

Source: Williams R, Cultural Safety – What Does it Mean for Our Work Practice.

There is ample evidence that health services in urban areas are not always culturally safe e.g. one in ten urban Aboriginal and Torres Strait Islander people report difficulties in understanding or being understood by service providers. Also, older urban Aboriginal people report that their sense of shame about their health problems and the lack of success in following the advice of health care providers is a major barrier to accessing health services.

The Commonwealth has funded the RACGP to provide cultural safety training for general practitioners working with Aboriginal patients across Australia. The former CSAHS and SWSAHS have previously provided cultural awareness training for their mainstream service providers. Reviews of the outcomes of these programs have indicated that greater impact would be achieved where cultural awareness was progressed within the broader context of cultural safety.

It is important to recognise that the terminology used in advancing concepts of embedding cultural understanding within service operations may vary between jurisdictions, nationally and internationally. This may include references to cultural awareness, cultural security, cultural respect, cultural safety and cultural competency (inc. transcultural competency). Some would see there being an evolutionary path through these related concepts. Cultural awareness and training therein aims to heighten providers consciousness and sensitivity as to how history, social and cultural issues need to be considered in service delivery, however may not translate into changes in

practice. Cultural security aims to respect the legitimate cultural rights, values and expectations of Aboriginal people in the construct of the health system. Cultural respect aims to promote behavioural changes by practitioners as well as modifications to the systems themselves. Cultural safety has been claimed to provide firmer theoretical emphasis on equal partnership in decision making processes. Others have made the case that cultural competency implies a higher standard of proficiency than safety whilst still encompassing safe practice. Similarly, transcultural competent practice has been characterised as recognising organisational and systemic obstacles and actively seeking to modify these. Whilst these distinctions may be seen as academic discourse, they can also influence the shape of initiatives that aim to embed cultural considerations in service practice.

From the literature it is possible to identify some strategies that would be considered consistent with advancing cultural safety or competence across systems.

Strategies consistent with advancing cultural safety and competence

- Making available written materials that suit the linguistic and cultural backgrounds as well as literacy levels of target groups;
- Developing evaluation instruments that identify faults from a lack of culturally competent practice;
- Identifying standards for assessing cultural competence to ensure quality control in service provision across organisations;
- Outreaching services to appropriate locations;
- Providing in-service cultural competence training for practitioners;
- Involving community members as liaisons;
- Involving family (and in some cases, community) members in decision-making processes as appropriate;
- Cultural immersion experiences for practitioners;
- Valuing diversity;
- Undertaking cultural self-assessment;
- Modifying services to make them culturally appropriate;
- Enhancing cultural competence in clinical encounters addressing – communication styles; appropriate space and distance; social issues of family, roles and spiritual belief; time orientation; relationship to environment; biological predisposition and diversity;
- Adopting a strengths based perspective of culture, diversity and identity;
- Integration of Aboriginal cultural competency content in curricula.

Source: Grote E (2008), Principles and Practices of Cultural Competency: A Review of the Literature, paper prepared for the Indigenous Higher education Advisory Council (IHEAC), pps. 15-22.

Further work needs to be done in SSWAHS to advance the agenda of cultural safety and to ensure SSWAHS mainstream service providers are aware of the concepts of cultural safety and equipped to provide services consistent with these characteristics.

5.3 Access to health services

Communities can experience difficulties in accessing health care because of problems of availability, affordability, acceptability and appropriateness. For Aboriginal communities the acceptability and appropriateness of services are particularly relevant in assessing the adequacy of access.

Government policy focus on access to health services for Aboriginal communities has tended to focus on rural and remote communities with less attention being paid to the difficulties faced by urban Aboriginal populations. There has been an implicit assumption that the needs of urban Aboriginal people can be met by mainstream programs because services are already in place to serve the wider community and as many Aboriginal people in urban areas follow a lifestyle quite similar to the wider society are better placed to utilise mainstream services.

However, there is evidence of relative under-utilisation of mainstream services by urban Aboriginal populations and the Commonwealth Grants Commission has identified a number of barriers to access in urban areas.

Barriers to access to services for urban Aboriginal communities

- mainstream services are structured to meet the requirements of the most common users, and do not allow sufficiently for the extreme disadvantage and special needs of Aboriginal people;
- requirements for accessing services do not take sufficient account of the lifestyle of Aboriginal people;
- very low incomes and little accumulated wealth create financial barriers that constrain access;
- in outer suburban fringes of large urban centres, where public transport infrastructure is more limited, physical access to services is compromised;
- mainstream workforce may not be sufficiently trained to work in a cross-cultural context or deal with the complex multiple problems Aboriginal people often face;
- relatively low number of Aboriginal staff in some services, especially in large urban areas, adds to insecurity in using mainstream services;
- legacies of history and unpleasant previous experiences reduce use of facilities;
- service delivery in ways that make Aboriginal people feel uncomfortable i.e. services are not culturally appropriate or culturally secure;
- poor links between complementary services, e.g. between primary health providers and hospitals or ancillary health services.

Source: Social Justice Report 2006, Aboriginal & Torres Strait Islander Social Justice Commissioner, p. 35.

There is some data available nationally pointing to reasons why Aboriginal people have poorer access to health services e.g. the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) shows that approximately 60% of Aboriginal people aged 18 years and over have access to and are able to drive a motor vehicle, compared to 85% of non-Aboriginal people. Aboriginal people were 3 times as likely to have transport difficulties in that they could not, or often had difficulties getting to places they need to go, compared to non-Aboriginal people (12% compared to 4%). Also, results from the 2001 National Health Survey show that 17% of Aboriginal Australians in non-remote areas had private health insurance, compared with 51% of other Australians, reducing the access of Aboriginal people to specialist care, such as private hospitals and services within the private health system.

Service incompatibility to cultural practices and social arrangements in Aboriginal communities and the confidence-sapping effects of a lifetime led in the shadow of racism, also represent real barriers to accessing services.

For all these reasons and consistent with broader SSWAHS objectives to address inequities in health service provision, specific attention is required to improving access to services for Aboriginal communities.

5.4 Extended support to patients and families over a course of care

It is known that Aboriginal people living in urban areas are a heterogeneous and mobile population, with frequent movement between urban and other areas and within urban areas. People living in any major urban area include people whose ancestors lived on the land that is now built upon, people whose families moved to the urban centre generations ago (either forcibly or voluntarily), people from rural and remote areas who now spend most of their time in the urban area, and people from rural and remote areas who are visiting the urban area for various reasons (inc. seeking health care) and for various lengths of times. Some of those with ongoing links to rural and remote communities may be transient visitors arriving in urban areas without accommodation and likely to become homeless or public-place dwellers. Research (Maypilama et al) indicates that for Aboriginal public place dwellers the motivation to reside in urban areas is often related to accessing services for their own health needs or to support family members in hospital for extended periods of time.

Within SSWAHS areas of higher Aboriginal population concentrations have become culturally identified as meeting places for widely dispersed Aboriginal community members who remain connected by kinship and other cultural ties. The long established presence of ACCHS' in these areas both strengthens an Aboriginal community identity and through referral links provides continuing ties to communities outside the metropolitan area. The major teaching principle referral hospitals in SSWAHS attract a significant proportion of their Aboriginal patients from outside SSWAHS. At RPAH in 2006-07, 18% of Aboriginal patients with an overnight stay were from outside a Sydney metropolitan health area (cf. 11% for non-Aboriginal patients).

It is challenging for the health system to meet the needs of those with complex and multiple health conditions and fee-for-service primary medical care does not always provide sufficient remuneration to enable comprehensive management of complex health problems. It is known that there is a higher rate of admission for Aboriginal and Torres Strait Islander people to hospital with ambulatory-sensitive conditions, many of which are chronic and require on-going management in the community. However, usually these individuals are admitted under the speciality that deals with the presenting problem, but not necessarily assessed or treated for other conditions. After discharge from hospital, Aboriginal patients do not always receive the follow-up that is required.

For these reasons there is a perceived need for Aboriginal patients (a significant proportion coming from areas outside Sydney) admitted to hospital to have access to extended support that will facilitate their access to hospital from home, link accompanying family to local support, ensure support needs are met over the period of hospitalisation and link the patient back to continuing care in the community. Within SSWAHS, Aboriginal Liaison Officers (ALOs) operating out of the hospitals with significant numbers of Aboriginal patients, have provided additional support to that which has been able to be provided by mainstream services.

5.5 Data collection

Issues relating to the quality of data available identifying Aboriginality in health data collections are discussed in chapter 5 of Volume 1 *Principles and Practice*. Australia-wide, Aboriginality may be either inadequately reported or not reported at all in health data collections and there are likely to be deficiencies in all data sources. These problems occur to varying degrees in vital statistics and in point-of-service administrative data, such as hospitalisations and primary health care services records. For NSW, it is estimated that there is less than 90% coverage of Aboriginal deaths in the National Mortality Database and only around 85% for hospitalisation data. Population survey data, even from the large national surveys e.g. those conducted by the ABS and the NSW Population Health surveys, are not considered to provide totally reliable estimates for Aboriginal populations. Ensuring a large and representative sample of Aboriginal communities in surveys can be problematic for sampling techniques and the collection of health information also needs to be done in a manner appropriate to the community being sampled.

Good-quality data on health need, service use and outcomes for Aboriginal people is a pre-requisite in assessing the effectiveness of programs and interventions, to evaluate policies and to inform policy and program development. This data is required at a range of geographic levels to distinguish rural/urban and local influences on health status. Diversity in the expression of Aboriginal culture, conceptualisation of health and wellbeing, family structures, living arrangements and suburban clustering all create practical and statistical challenges for the collection, interpretation and analysis of data on Aboriginal people.

Varying levels of identification between different data collections, and within each data collection over time and between regions, makes it difficult to assess changes in health status over time and between different regions. Data mismatches e.g. Census to death records, pose analytical problems. Also the collection of information that is conceptually and culturally relevant to Aboriginal people can be challenging to mainstream statistical collections. Nationally, the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data advises AHMAC on ways of improving the quality and availability of data on Aboriginal Health and health service delivery. The Strategic Plan 2006-2008 from this group outlines priority themes for improving data collection in Aboriginal Health, as follows.

20 Priority Themes for Improving Data Collection on Aboriginal Health

- Identifying evidence-based approaches to inform policy and program development;
- Developing national data protocols;
- Returning data to communities in a useful format;
- Building capacity of the Aboriginal workforce to collect, analyse and interpret data;
- Developing culturally appropriate measures of health;
- Undertaking regional and international comparisons of indigenous health trends and disparities;
- Enumerating Aboriginal populations within the census;
- Identifying Aboriginal health information requirements to be gathered using survey methodology;
- Gaps and identification variability in administrative data arising as by-product of service use;
- Identifying data items for the core set of services provided in primary health care;
- Data collection for other services e.g. dental, allied health, post-acute care and palliative care;
- Mental health and emotional well-being outcomes inc. isolation and coping;
- Impact of violence – causation, patterns, evidence-base for health interventions;
- Health status of prisoners inc. post-release, evidence-base for health interventions;
- Enumerating the Aboriginal workforce – across health, in Aboriginal health, in study or training;
- Understanding trends in health demands and differentials from non-Aboriginal populations;
- Measuring avoidable mortality and morbidity;
- Measuring burden of disease with culturally appropriate measures;
- Providing consistent, comprehensive and regular expenditure estimates;
- Ensuring data collections are shared and inform policy, program and outcome development;

Additional important themes for further work on data needs include disability, children's hearing loss, nutrition, community grief, cultural competency and cultural awareness

Source: AIHW (2006) National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data Strategic Plan 2006- 2008, Canberra, ACT

The difficulties in collection and use of informative data at national and state levels also apply and are exacerbated at sub-regional and suburban levels where high statistical error rates with low sample sizes have increasing impact. Many of the priority themes in improving data collections nationally are of equal importance locally within SSWAHS.

There is much work in SSWAHS to be undertaken to improve data capture and the use of data within local planning, policy and program development. A range of activities will need to be undertaken to systematically improve the data collection on Aboriginal Health within SSWAHS, including:

- technical and cultural competency training for the front-line staff collecting administrative information at patient registration;
- development of meaningful data items in data collections for key areas of activity where Aboriginality has been inadequately or not identified;
- the incorporation of relevant data items within the roll-out of electronic data collection systems across SSWAHS;
- improved collection of data on the Aboriginal workforce of SSWAHS to better plan for recruitment, training and professional development requirements;
- development of culturally appropriate data covering the variety of services provided by AHWs as they undertake the holistic care, partnership development, capacity building and access facilitation work at the core of their role;
- working with partners in ACCHS', across Government agencies, within Aboriginal communities and with researchers to identify and share relevant data for planning, policy and program development;
- identifying data to assist in community capacity building within Aboriginal communities including activities relating to health literacy, self-management of disease and preventive health activities.

6. Health Priority Area Initiatives – Rationale for Program Development

As outlined in the *Policy and Practice* volume, PAWGs were established to develop service initiatives in priority health areas where a targeted approach to Aboriginal communities needs was considered necessary to begin bridging the gap in health outcomes.

The priority areas for service initiatives were:

- Early Years, Children and Young People
- Chronic Diseases and Ageing
- Mental Health
- Drug Health
- Infectious Diseases and Sexual Health
- Oral Health

This chapter outlines the rationale for program development in these areas over the next five years. This work will be undertaken within and consistent with the framework initiatives previously identified and hand-in-hand with the corporate initiatives which support the work undertaken within the Clinical Streams.

6.1 Early Years, Children and Young People

Health status data for Aboriginal children and young people is included in the *Policy and Practice* volume at page 31. On many measures there is a gap in health outcomes for Aboriginal children and youth and disadvantage in access to good nurturing environments for Aboriginal families. Although caution needs to be used in applying Census and other data, there are many indicators of social and economic exclusion experienced by Aboriginal families through exclusion from the mainstream economy and its benefits. Data indicates that for households identifying as Aboriginal there are higher proportions (compared with overall population) – multi-family, renting, single parent, low-income, no employed adult, parent not completing year 12.

Importantly, however, some of these characteristics demonstrate social inclusion strengths in that the central importance of family and kin in everyday life enables a valued form of social and cultural capital in many Aboriginal families and communities. Extended family rather than the nuclear family enables child care arrangements and support in raising children, economic support through sharing of resources and greater opportunities for cultural transmission. The risk, however, is that the pressures faced by families in exclusion from the mainstream economy, with high levels of poverty, erratic cash flows and unrestrained demand sharing, poor health and low quality housing, erodes the existing social and cultural capital of communities.

Ensuring children receive a healthy start to life commences before birth and is influenced by good antenatal care to monitor and promote the health of both mothers and babies, identify antenatal complications and where necessary intervene early. The foundations for good parenting that are incorporated in the social fabric of strong communities can be reinforced through individual parenting skills development antenatally and supported post natally.

Programs targeting the Aboriginal maternal experience include the NSW Aboriginal Maternal and Infant Health Strategy (AMIHS), commencing 2001 and evaluated 2005, with a goal of improving the health of Aboriginal women during pregnancy and decreasing perinatal morbidity and mortality. The evaluation of this program found that home visiting, the inclusion of an AHW/AHEO in the team and reminders about, and transport to, antenatal appointments were the most important aspects for Aboriginal women. Greater success in accessing women occurred when programs were linked with the local Aboriginal controlled health services based in the community. These types of approaches had positive health outcomes in areas such as reducing alcohol use in pregnancy and increasing the proportion of women initiating breastfeeding, but were less likely to reduce smoking in pregnancy.

The strengths of models such as AMHIS are seen to be the:

- team approach, where a skilled AHW/AHEO and a midwife work together in a primary health care model to provide continuity of care;
- level of trust developed and continuity provided by a culturally appropriate caregiver;
- ability of the teams to be in the community, provide home visits, and follow up women, especially those who are hard to find
- ability to retain committed staff.

Australian and international evidence confirms that the early years of a child's life are critical to future development and that while a child's brain is rapidly developing; the foundations for future learning, behaviour and health are set. It is known that poor outcomes such as school difficulties, welfare dependency, and poor physical and mental

health are associated with parenting styles, family factors and life events in early childhood (resulting in poor attachment or poor social skills); and community factors such as socio-economic disadvantage and lack of support services. Health services have a role not only in addressing physiological aspects of antenatal and maternal health and nutrition, but also in partnership with other agencies, in addressing parental communication and positive attention from both parents, family harmony and participation in broader social networks.

There are a range of strategies that are considered to have a role in towards ensuring that children have the best possible start in life including home visiting, early learning and literacy programs, early development of social and communication skills, parenting and family support programs, child nutrition programs and community capacity building through events to celebrate the importance of children, families and the early years. A number of these approaches have been developed within an early intervention in early childhood perspective i.e. beginning in pregnancy and continuing until the child is at school. Early intervention is seen as offering longer term benefits in child development, parent-child attachment and broader family relationships between parents and/or the extended family. Good practice programs in early intervention are characterised by:

- responsiveness to local needs and consumer participation;
- holistic approaches that build community connections;
- a focus on family strengths and building skills;
- accessible and inclusive approaches;
- early intervention in the child's life and at key transition points, with a long-term preventative orientation;
- effective coordination and inter-sectoral collaboration;
- a skilled workforce;
- an outcome, evidence-driven approach.

Early intervention projects seek to reduce risk factors and increase protective factors, but long-term outcomes require availability of further supports post-infant years, particularly at times of subsequent transitions (lifecycle, developmental stages, social settings, significant life events). Universal approaches are preferred because they have a better chance of providing support before problems appear or become entrenched and also avoid damaging 'labelling' effects. However, targeted approaches to those who are either at most risk or who have been identified as having problems, may appear to be more efficient in delivering services to where they are most needed. Also, strengths-based approaches, that focus on identifying and building on the existing strengths of individuals, families and communities, are seen to be more effective than deficit-based approaches that focus on people's gaps and inadequacies, and can reinforce perceptions of incompetence.

The Commonwealth funds programs in this context under the *Stronger Families and Communities Strategy (SFCS) 2004-2009,* the National Agenda for Early Childhood and associated programs such as *Communities for Children* (inc. a project at Miller) and *Child Care Links (CCL).* A range of activities are undertaken aimed at improving the health and well-being of young children, strengthening family and caregiver resilience and developing child-friendly communities e.g. social events, parent information and education sessions, local networking and collaboration, community needs analysis, developing community service directories and the promotion of the importance of the early years in local communities.

Some programs target child care centres as settings for education. Evaluation has shown that these models work best for Aboriginal families where there is awareness of local cultural ways and workers are well supported by the sponsoring service, the advisory group and human services agencies. The importance of community consultation and working at the communities' pace have been highlighted as key factors in successfully building community capacity in Aboriginal communities.

NSW Government strategies adopt similar models through the ACYFS, with a headline goal of working together to better support Aboriginal children, young people, their families and communities. ACYFS is based on research foundations that emphasise benefits from networks of formal and informal support in communities to:

- Improve the health of mothers and babies;
- Help children start school better equipped to learn;
- Build communities that work to support families;
- Reduce the conditions that lead to child abuse, crime and drug use;
- Provide children and young people with the resilience they need for problem solving;
- Keep young people at school and improve their educational attainment.

The models of care supported under ACYFS are characterised by a community development approach (capacity building and participation), early support and primary prevention and making mainstream services more responsive to Aboriginal community needs. An example of work undertaken within the ACYFS framework in SSWAHS is the *Growing Up Strong Guring* booklet which provides simple advice for Aboriginal parents and family workers about

raising children aged 0-5 years, to help them have a good start to a healthy life. SSWAHS advised on the development of this resource that was produced by the Inner West Aboriginal Community Company Ltd.
For young people of school age the ACYFS approach is based on research suggesting that a positive adolescence and smooth transition to adulthood requires the promotion of young people's social, emotional and cognitive development and that the best chance of avoiding risky behaviour is through strengthening connections to families, schools and communities. It emphasises connectedness as the key strategy in empowering youth to avoid risky behaviour, in the context of:

- Family – supportive relationships, networks of trust, support when needed;
- School – caring teachers, social ties with classmates, parent's participating in child's education;
- Community – family and friends, neighbours, teachers, community members, employers.

In many ways young Aboriginal people are no different from any other youthful segment of the general population in that there is identification with the ideas, activities and preoccupations of their peers and a reliance on the mass media as they establish their identities as adults. Their health is low on their list of priorities, and risk-taking is normal behaviour. They are vulnerable to violence, accidents and poisonings, the leading causes of morbidity and mortality among them.

Most Aboriginal youth in urban areas are living with family and relatives. However, the homes for some urban Aboriginal youth are not stable, and young people may be in transit from one to another, with no consistent caregivers. They may suffer from the disadvantages of an uncertain and changing care giving environment.

Good practice in providing health services to Aboriginal youth should be consistent with the generic principles espoused through the Centre for the Advancement of Adolescent Health (CAAH), *NSW Youth Action Plan and* NSW Association of Adolescent Health which include emphasis on accessibility, youth participation and sustainability of effort. Research indicates that the focus of service provision in youth health in Aboriginal communities needs to be on supporting resilience i.e. the capacity to deal with, overcome, learn from, and even be transformed by the inevitable adversities of life. Resilience approaches aim to empower Aboriginal youth to develop and draw on their own resilience in order to take responsibility for their own lives, develop strategies to deal with their problems and minimise behavioural risks. The promotion of cultural pride, identity and self-confidence in Aboriginal youth is seen as central to this approach.

A resilience focus is also based on establishing and strengthening supportive structures so that Aboriginal youth can have:

- External Supports – trusted persons within the family who love without reservation, trusted persons outside the family, limits to behaviour, encouragement of independence, good role models, access to health, education, and the social and security services, a stable family and community;
- Inner Strengths – likeable, calm, good-natured, achiever who plans for the future, respectful, empathic and caring of others, responsible for own behaviour and accepting of the consequences, confident, optimistic, hopeful and with faith;
- Interpersonal and problem-solving skills - generate new ideas or ways to do things, stay with tasks until finished, find humour in life and use it to reduce tensions, express and communicate thoughts and feelings, solve problems in various settings – academic, job-related, personal and social, manage behaviour – feelings, impulses, acting-out and reach out for help when needed.

Attachment A outlines how risk and resilience modelling provides the theoretical underpinnings for the work that is proposed with Aboriginal young people within this plan. Much of the work undertaken with Aboriginal youth has and will continue to be led by agencies and organisations outside of Health, with health providing a supporting role through health education, preventative health and health promotion activities. For example in SSWAHS there are well equipped and functioning sports and recreation facilities, which although not specific to Aboriginal youth, can provide settings for empowerment activities. A range of mentoring programs have also been developed e.g. the Australian Indigenous Mentoring Experience offers Year 9-12 Indigenous high school students over 60 hours of extra one on one mentoring support from Indigenous and non-Indigenous university students. Other leadership programs are offered under the ACYFS in mainly rural areas, including the NSW Aboriginal Youth Leadership Project available to groups of two or more young Aboriginal people aged 12 to 25, providing action learning through seeding money to put ideas into action.

However, other settings that have been identified in consultations and through youth policy frameworks, such as drop-in centres with some health servicing attached specifically for Aboriginal young people; do not have widespread availability across Sydney. This can create community perceptions that the larger, more dispersed population of Aboriginal youth in Sydney have less access to services targeted to their needs than may be available

in rural areas. Those services that are available are often seen by youth as largely for the benefit of babies, children and women, with teenagers, particularly boys, presenting for medical help only under extreme duress.

6.2 Chronic Diseases and Ageing

Although population pyramids for Aboriginal communities generally demonstrate higher proportions in younger age groups, there remains a high burden on communities in caring for those with chronic disease and age related disability. It is known that Aboriginal populations are almost twice as likely as non-Aboriginal people to have disability requiring assistance with core activities and 1.2 times as likely to be carers. Also, the median age of Indigenous carers is 37 years; 12 years less than the median age of non-Aboriginal carers.

Chronic diseases cover a broad diagnostic spectrum; however, of particular concern are cardiovascular disease (CVD), diabetes and chronic kidney disease (CKD) that contribute significantly to deaths and levels of ill health in Aboriginal communities. These diseases are considered comorbid in that they share many risk factors and have complex causal relationships meaning that each of them may be caused by, or be a complication of, one or both of the other diseases. Comorbidity is often regarded as an indicator of severity and poorer prognosis of these diseases and the clinical management for people with comorbidity is much more complex and time consuming than for those with single diseases.

Shared risk factors promote co-occurrence and strengthen the association between these diseases, effecting their progression and increasing the risk of complications. These risk factors include gender, overweight or obesity, lifestyle and socioeconomic conditions (Table 8.1 illustrates the shared risk factors). Other factors, such as genetic background and environmental factors also play some role.

A high predictor of progression to chronic vascular disease is among patients with metabolic syndrome, a cluster of risk factors comprising excess abdominal weight, insulin resistance, hypertension (high blood pressure) and/or lipid abnormalities. The risk of having CVD, diabetes and CKD among people with metabolic syndrome is three times as high as for those without (Dekker et al. 2005; Stern et al. 2004). People with Type 2 diabetes who also have this syndrome are more likely to develop CVD complications and have kidney problems (Isomaa et al. 2001). Early identification of patients with metabolic syndrome or at risk of progressing there, is seen as the key precursor to instituting lifestyle modification and preventive health initiatives to ameliorate progression to chronic disease.

Table 6.1 Risk factors for progression to chronic vascular disease

Disease	Non-modifiable risk factors	Modifiable risk factors
Diabetes	Age, genetic factors, pregnancy, low birth weight	Overweight and obesity, poor nutrition, impaired glucose tolerance, physical inactivity
Cardiovascular disease	Age, genetic factors, male gender, family history	Overweight and obesity, poor nutrition, impaired glucose tolerance, physical inactivity, smoking, high blood pressure, diabetes, chronic kidney disease, atrial fibrillation, heavy alcohol consumption.
Chronic Kidney Disease	Age, genetic factors, family history, ethnicity	Overweight and obesity, poor nutrition, impaired glucose tolerance, physical inactivity, smoking, high blood pressure, diabetes, urinary tract infections, kidney and urinary stones, glomenulonephritis, streptococcal infections, drug toxicity.

Source: Comorbidity of cardiovascular disease, diabetes and chronic kidney disease in Australia, AIHW, p. 3

Around one in seven Australian adults have chronic kidney disease (CKD). CKD causes or contributes to almost one in ten deaths in Australia. In addition, individuals with CKD have a significantly higher risk of suffering a heart attack or stroke, as people with moderate to severe CKD have at least a 40% increased risk of hospitalisation for a cardiovascular event.

Although Aboriginal Australians make up approximately two per cent of the Australian population, they constitute almost ten per cent of people commencing dialysis for end-stage kidney disease (ESKD). Also, Aboriginal Australians with ESKD are much less likely to receive a kidney transplant than other Australians (particularly in rural areas) and experience longer delays between starting dialysis and receiving a transplant.

Screening and intensive management of the major risk factors surrounding CKD — high blood pressure, diabetes and protein in the urine have been clearly highlighted as appropriate and cost-effective interventions to ameliorate progression to chronic disease. In the general Australian population, screening of 50-69 year olds in primary care practice settings, along with intensive management of patients known to have these three major risk factors, should be highly cost-effective strategies. In Aboriginal communities, screening could be considered in earlier age cohorts.

The importance of targeting interventions in Aboriginal communities towards vascular syndrome risk factors has been recognised by NSW Health in its direction of Aboriginal Health Promotion funding towards strategies to

prevent chronic disease and is reflected in the *SSWAHS Aboriginal Health Promotion Action Plan 2008-2011* focus on modifiable risk factors such as smoking, physical activity and nutrition.

Although local data is generally not available, there is broader evidence available that points to an underutilisation of aged care services in Aboriginal communities relative to need. National data (AIHW 2007) indicates that at 30 June 2005, out of a total of 28,899 people receiving community aged care packages (CACP), 1,141 (3.9%) identified as being of Aboriginal or Torres Strait Islander origin. Of Aboriginal CACP recipients, only 15% were living in major cities and 5% were aged 0-49 years, compared with less than 1% of non-Aboriginal people. Whereas 90% of non-Aboriginal CACP recipients are aged over 70 years, only 44% of Aboriginal recipients fall into this age group, highlighting the much younger age profile of Aboriginal people requiring aged care services, compared to other Australian aged care recipients.

At 30 June 2005, Australia-wide there were 832 Aboriginal people receiving permanent residential care, representing 0.6% of all permanent residential care residents, and 34 Aboriginal people receiving respite care places, making up 1.2% of all respite care residents. The overall permanent residential aged care usage rates were higher for non-Aboriginal permanent aged care residents, 7.3 per 1,000 compared to 1.8 per 1,000 for Aboriginal residents.

In 2004-05, 44,197 individuals received HACC services from 3,100 agencies. Approximately 2.6% of these clients (19,236 individuals) identified as being of Aboriginal and Torres Strait Islander background. Aboriginal HACC clients were younger than non-Aboriginal HACC clients and received more services with higher overall levels of assistance compared to non-Aboriginal HACC clients. These data reflect the younger age profile and higher levels of disability in the Indigenous population.

6.3 Mental Health

Policy directions in Aboriginal Mental Health are driven by complementary documents, at the Commonwealth level the *National Strategic Framework for Aboriginal and Torres Strait islander Peoples Mental Health and Social and Emotional Well Being 2004-2009* and at the State level by the *NSW Aboriginal Mental Health and Well Being Policy 2006-2010*. The NSW policy has been mapped to the National Framework.

High levels of unmet need for mental health services have been documented in Aboriginal communities across Australia and Government policy to address these needs has been a high priority in Aboriginal health since at least the release of the *National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health, 'Ways Forward' (1995)*, which was the first national analysis of Aboriginal mental health. This report highlighted both need and policy directions, which are consistent with the broader policy directions outlined in this plan and recognise the potential to build on the strengths, resilience, and diversity of communities that is reinforced through family ties and kinship. Key issues highlighted in that Report included:

- Aboriginal people suffer from mental health problems such as depression at a very high rate;
- Rates of self-harm and suicide are higher, and that substance abuse, domestic violence, child abuse and disadvantage contribute additional risk factors;
- Trauma and Grief are seen as overwhelming problems, both related to past history of loss and traumatisation and current frequent losses with excess mortality in family and kinship networks;
- racism, stigma, environmental adversity and social disadvantage have negative ongoing impact on health and well-being;
- There remains a strong relationship between mental health and well-being and physical health, with the loss of mental well-being contributing in a major way to the poor physical health of Aboriginal people;
- Aboriginal people perceive mainstream mental health services as failing them, both in terms of cultural understanding and response, and have strong desires for services recognising their concepts of the holistic value of health and their spiritual and cultural beliefs, as well as the contexts of their lives;
- There are data deficiencies, but all the validated scientific literature that is available highlights the severity of problems identified, the multiple risk factors contributing, the extent of the despair and hopelessness, and the failure of service provision.

At present there is no comprehensive national data about the incidence or prevalence of mental disorders among Aboriginal people. The data that is available is limited in quality and mainly relates to hospitalisation and mortality due to serious mental disorders and illnesses. It is likely that many less serious or emerging mental health problems such as depression and anxiety go unrecognised or unreported. For example, depression has been identified as one of the six most frequent problems managed by GPs for Aboriginal and Torres Strait Islander patients (AIHW, 2004). A summary of available data is available on the *Response Ability, Mental Health Resources for Tertiary Education* website – created as part of the Commonwealth's *Mindframe* initiative and funded by the Department of Health and Ageing (www.responseability.org). This national data indicates for Aboriginal people:

- 3 to 5 times higher chance of being involuntarily admitted to psychiatric care - in particular, the rate of hospitalisation is higher for disorders relating to substance use, psychotic disorders and dementia;
- Hospitalisation for mental and behavioural disorders at a rate 1.4 times that of the general population;
- 4.8 times higher rate of hospitalisation for males diagnosed with mental disorders due to psychoactive substance use and 3.6 times higher for females;
- over three times the death rate associated with mental disorders among males, but for females the rates are the same - the majority of these deaths are attributed to mental disorders due to psychoactive substance use;
- almost one-and-a-half times more likely to report in surveys experiencing at least one stressor (82%) than other Australians (57%) - most frequently reported stressors were death of a family member or close friend, serious illness or disability and inability to get a job;
- rates for schizophrenia, schizotypal and delusional disorders more than double those for other Australians, and those for mood and neurotic disorders slightly higher;
- despite the high prevalence of serious mental illness, Aboriginal people receive proportionately less specialised care for mental disorders and behavioural disorders - specialised care received by males in 53% of admissions for mental and behavioural disorders compared with 67% for other Australian males and for females in 46% of mental health admissions, compared with 69% for other Australian females.

Lack of culturally appropriate treatment options is also reported as an issue by Aboriginal people nationally and in the consultations undertaken within this plan. Some Aboriginal people have indicated that they would seek traditional treatments rather than those offered by mainstream services and would access mainstream services only when all traditional avenues had been exhausted and there was no other treatment option available (Vicary & Bishop, 2005). There is also fear in some Aboriginal and Torres Strait Islander communities that treatment in a mental health service may result in unwanted outcomes such as involuntary hospitalisation and medication (Vicary & Bishop, 2005).

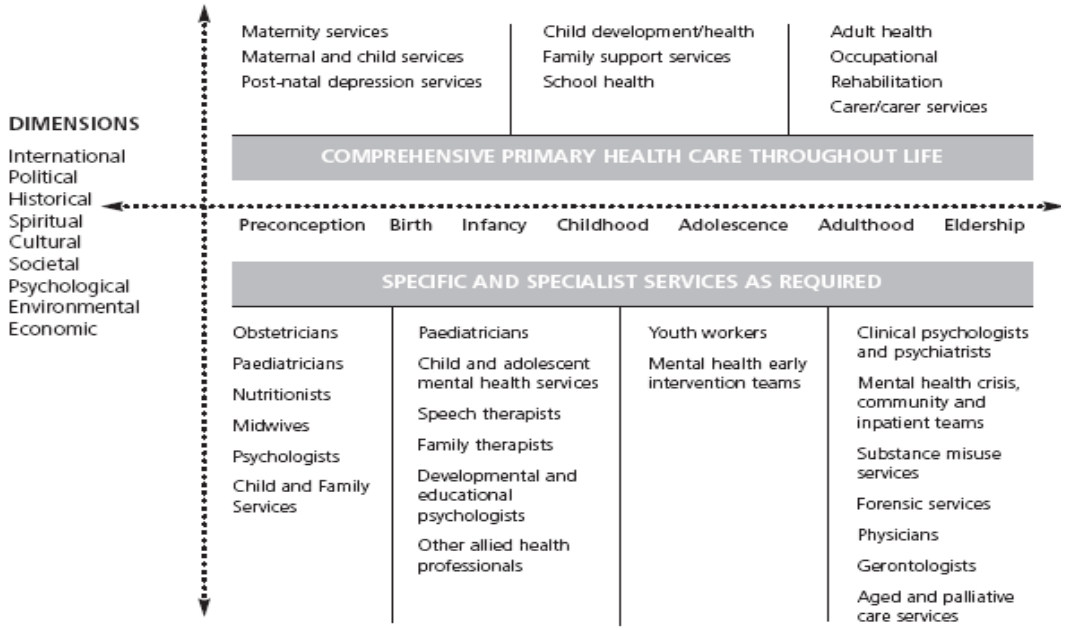
The models of care that are advanced in Aboriginal mental health are constructed in the broader context of promoting health and *well-being*, enabling individuals to grow and develop within the context of family, community, culture and broader society to achieve optimal potential and balance in life. For Aboriginal communities this requires a strengths approach, recognising the importance of connection to land, culture, spirituality, ancestry, family and community. Models aim to support inherent resilience in surviving profound and ongoing adversity and reinforce values of integrity, commitment to family, humour, compassion and respect for humanity.

Models seek to improve an individual's capacity to establish social and emotional well being early and maintain it throughout the lifecycle. This requires resources to adequately prevent and intervene early to enhance and restore well being as problems arise and access to a full range of services and facilities for treatment and rehabilitation for significant distress and disorders. Milroy, referenced in the National Strategic Framework (p.9), has identified the basic prerequisites for ensuring safety and well-being.

Source: Milroy, H (2002), Unpublished diagram prepared for the Social Health Reference Group – in *National Strategic Framework for Aboriginal and Torres Strait islander Peoples Mental Health and Social and Emotional Well Being 2004-2009 (p.9).*

Models are grounded in and start from a perspective of addressing the broader social determinants of health, through promotion and prevention programs, as well as early intervention in high-risk groups or during early warning signs. There is recognition that effective long-term care requires strong linkages between primary health and mental health services and that a balance of interventions across all human services sectors such as health, child protection, housing, education, employment and criminal justice can meet diverse community needs. Many interventions are lead from outside the health sector and include, for example, housing and community infrastructure, education, employment, recreation, welfare services, crime prevention and justice services, family and children's services, and building on community capacity. Health plays a supporting role in these activities and a primary role in areas such as ensuring comprehensive primary health care, community health, maternal and early childhood services, child development services, occupational health, screening programs, counselling and social support and family reunification programs.

Models recognise the importance of mental health issues across the lifespan, from conception to old age, including the effect of mental illness occurring co-morbidly with drug and alcohol problems and other conditions. Interventions cover the spectrum from prevention to recovery and relapse prevention. The National Strategic Framework (p. 11) illustrates the services that are required to maintain mental health and wellbeing across life spans.



The *NSW Aboriginal Mental Health and Well Being Policy 2006-2010*, identifies the role that Area mental Health services should play in addressing Aboriginal mental health and well being.

The role of AMHS in Aboriginal mental health and well being

- Deliver specialist mental health assessment and care, across both community and inpatient settings and in partnership with other service providers to all ages;
- Provide mental health promotion, prevention and early intervention services;
- Provide emergency and acute services;
- Provide rehabilitation services promoting recovery and reducing disability;
- All mental health services:
  - Encourage consumer, family and carer participation
  - Provide culturally appropriate services to specific groups, particularly Aboriginal people and those in rural and remote areas
  - Include adult and adolescent forensic mental health services
  - Support workforce development and research, monitoring and evaluation

Source: NSW Aboriginal Mental Health and Well Being Policy 2006-2010, Appendix B, p. 32.

In addition the NSW policy outlines a range of actions to improve Aboriginal mental health and well being, most of which involve some responsibility by AMHS and more broadly by AHS in planning contexts and within other clinical disciplines partnering with mental health. The actions of relevance to AMHS are outlined in Table 6.2.

Table 6.2 Actions for AMHS from the NSW Aboriginal Mental Health and Well Being Policy

Strategic Aim	Actions for AMHS
Partnerships – strong working relationships: ▪ Social and emotional well-being as everybody's business; ▪ Mental health in the NSW Aboriginal Health Partnership; ▪ Collaborative work between AMHS and local ACCHS	▪ With DoH, AHO and AH&MRC, implement JGOS addressing access to stable housing for Aboriginal people with mental health problems; ▪ With DoCS, improve pathways (e.g. Families First program) to CAMHS for Aboriginal parents, children and adolescents with mental health problems; ▪ With DoH, AHO and NGOs, further develop HASI to meet the diverse needs of Aboriginal people with mental health problems, their families and community; ▪ With DADHC and NGOs, establish programs for Aboriginal family and carers of people with a mental illness, e.g. Koori Yarning; ▪ The NSW Aboriginal Health Partnership, at State and Area levels is to include Aboriginal Mental Health and Well Being as a standing item on its agenda; ▪ Establish an Aboriginal Mental Health and Well Being Working Group at the Area level; ▪ Establish cooperative agreements between AMHS and ACCHS addressing - outreach services, consultation and clinical support to ACCHS staff; referral links inc. to other services and GPs; information management protocols; shared care; joint workforce development; joint initiatives/programs.
Accessible and responsive services: ▪ Clinical and managerial mental health leadership; ▪ Mental health and well being proportion in communities; ▪ Involvement of aboriginal people in service planning and delivery; ▪ Involvement of aboriginal people in service planning and delivery.	▪ Identify high level manager responsibility for the overall development of services and partnerships in Aboriginal mental health; ▪ Promote Aboriginal mental health as an area of clinical specialisation, identify specialist position(s) in each clinical profession; ▪ In partnership with communities, develop an Area Aboriginal mental health strategic plan addressing partnerships, service coordination, promotion and prevention, workforce development and service review; ▪ Use Koori media to provide pamphlets, fact sheets and other resources promoting best practice in Aboriginal mental health and social and emotional well being; ▪ Develop strategies that sustain mental health and well being; ▪ Use Mental Health First Aid training as mental health promotion mechanism; ▪ Work with GPs and primary care staff (e.g. diabetes nurses) to increase capacity to advise community members and liaise with specialist mental health services; ▪ Facilitate friendlier Aboriginal environments in mental health facilities, including PECCs, acute and non acute inpatient units and community centres; ▪ Promote availability of AMHWs to the community inc. at critical points - initial assessment, crisis response, admission and discharge from inpatient units; ▪ Area mental health working groups to consult with Aboriginal community; ▪ Make available advocacy and support inc. by AMHWs for Guardianship and Mental Health Review Tribunal clients; ▪ Review service accessibility and develop guidelines for managing priority presentations – emergency assessment, treatment options and referral pathways; ▪ Review needs and provide culturally appropriate resources care plans; ▪ Increase early outreach in community mental health inc. through ACCHSs and NGOs; ▪ Identify and develop rehabilitation and accommodation support options.
Mental health care for all ages – priority groups: ▪ integrating the holistic approach into health service delivery; ▪ children, adolescents, young people and families; ▪ social and emotional well being of Aboriginal men and woman; ▪ Elders and older people; ▪ substance use problem and co-occurring needs	▪ Screening, consultation and liaison for co-occurring mental and physical illness; ▪ mandatory staff training on holistic assessment and culturally sensitive treatment ▪ responses; ▪ inter-agency work on mental health promotion, prevention and early intervention programs e.g. Integrated Perinatal Care, Children's Mind Matters, Parenting and identity, Out-of-home care; Life skills inc. problem solving, Mental Health First Aid, and family support; ▪ competency development through School-Link Training Program for partners working with Aboriginal young people and those with co-existing mental health and substance use problems; ▪ clinical guidelines, assessment and intervention protocols and service pathways for Aboriginal young people and their families; ▪ appropriate training and traineeships; ▪ involve families and carers in the processes/stages of care and treatment - clear explanations of diagnosis and treatment options, education on symptoms and treatment, family conferences, involvement in decisions, support programs inc. for children of Aboriginal families affected by mental illness; ▪ partner in development of community owned and controlled anger management, grief and loss and empowerment programs e.g. fathers parenting skills; ▪ Provide gender choice in access to AMHWs; ▪ guidelines for the management of suicide risk covering police, family liaison, specialised supports for high risk individuals; ▪ further develop mental health support arrangements and diversion programs for courts and

Strategic Aim	Actions for AMHS
	community justice initiatives e.g. Circle Sentencing; ▪ Work with Justice agencies on protocols and support structures for offenders post release and their families; ▪ Inter-agency work on community owned and controlled grief and loss programs inc. for the Stolen Generation; ▪ Recognise in planning the early onset of dementia and age-related mental health and respite needs of family and carers; ▪ Involve Elders as leaders in their communities in planning and service delivery; ▪ Coordinate AMHS and aged care service delivery; ▪ culturally sensitive service pathways and support for older people inc. outreach support services; ▪ collaboration between mental and drug health services – involve local Aboriginal service networks, holistic approaches, joint screening and assessment, treatment choices, reflect cultural/community values with evidence based practice, assertive follow-up; ▪ intensive cross-discipline training in assessment and intervention for mental and drug health staff.
Increased expertise and knowledge - retention, creation and dissemination of knowledge	▪ Training on collection of patient registration information with Aboriginal clients; ▪ Record service utilisation by Aboriginal people in mental health services; ▪ With Aboriginal partners, review and evaluate effectiveness of programs, promote best practice models; ▪ Cultural sensitivity review of assessment tools e.g. the Integrated Perinatal Care psychosocial assessment; ▪ forums and networks providing up-to-date information and linking expertise.
A supported and skilled workforce: ▪ Aboriginal mental health worker recruitment; ▪ Training, supervision, mentoring and support ▪ Aboriginal mental health worker qualifications and competencies	▪ Work towards target of one AMHW per 1,000 Aboriginal people; ▪ Promote AMHW positions as identified, in line with merit based selection; ▪ Define roles for AMHWs within specialist mental health teams; ▪ review professional development and utilisation of AMHWs; ▪ Develop workforce of Child and Adolescent AMHWs through CAMHS; ▪ Develop specialist capacities in the AMHWs e.g. child and adolescent, grief and loss, justice health, co-morbidity; ▪ Use elements of the Far West Aboriginal Workforce Development Project; ▪ Tertiary training and education, for Child and Adolescent AMHWs; ▪ AMHW access to training – clinical and in problem solving, negotiation skills, management and leadership, also supervision and post training support; ▪ Joint training, rotations and education between AMHS and ACCHS; ▪ Support NSW network of Aboriginal mental health staff; ▪ Training and recognition for non-Aboriginal staff with Aboriginal clients; ▪ Support development of Diploma and Degree courses in Aboriginal mental health; ▪ scholarships and cadetships with mentorship e.g. mental health nursing; ▪ promote opportunities in mental health professions in communities, schools and other relevant forums.

The action proposals in mental health are identified in the *Agendas for Action* volume at pages 30 to 33. They have been developed within a framework of reference consistent with the conceptual basis outlined in the National and NSW frameworks and strategies.

6.4 Drug Health

Alcohol, tobacco and to a lesser extent other substance use, contribute to the gap in health disadvantage experienced by Aboriginal populations and also have contributing impacts on domestic disruption including violence, and to personal, family and community suffering. These in turn are risk factors for future problems for children of the community.

Across Australia, alcohol has been said to account for six years of life lost by Aboriginal men, and three years life lost by Aboriginal women; smoking has been estimated to be responsible for 14% of deaths for Aboriginal people in Western Australia and together alcohol and/or smoking are well recognised risk factors for each of the major causes of excess deaths in Aboriginal people, including vascular disease. Smoking is a one of the best recognised, reversible risk factors for vascular disease.

Alcohol and/or cigarette use play a significant role in excess deaths from many causes across the Australian community - violent deaths from all causes, neoplasms and respiratory diseases (7-8% and 10% of excess mortality respectively), diabetes, diseases of the digestive system (cirrhosis, oesophageal varices, alcoholic pancreatitis) and liver disease. Substance misuse is also likely to play a role in injury-related hospital separations among Aboriginal people and the CHO Reports suggest consistency in the rate of hospitalisations attributable to alcohol at around four times higher in Aboriginal compared to non-Aboriginal people.

The health and development of infants can be directly impacted by substance misuse. Excessive alcohol use is a significant contributor to low birthweight. Within the community rate of *Foetal alcohol syndrome (FAS) at* 0.48 per 100,000 children under 15 years of age, 61% have been identified as aboriginal. *Neonatal abstinence syndrome* may also affect babies born to mothers with opiate, alcohol or other drug dependence.

It also well documented that Aboriginal people are over represented in the Australian prison system. Alcohol has been reported to be third among six major factors underlying the high rates of arrest amongst Aboriginal people and that Imprisonment may in turn result in introduction to illicit drug use. Aboriginal people in NSW are between 2.7 times and 5.2 times more likely than non-Aboriginal people to become victims of crime, with between 70 and 90 per cent of assaults involving Aboriginal people estimated to have occurred while under the influence of alcohol or other drugs. NSW Bureau of Crime Statistics and Research shows that in the urban areas of NSW during 2004-05, 45% of police-recorded domestic assaults, 45% of non-domestic assaults and 33% of police-recorded sexual assaults involving Aboriginal defendants were alcohol-related.

There is some evidence available of high patterns of substance use in Aboriginal communities:

- while urban Aboriginal people are more likely to be abstainers than non-Aboriginal people, among those who drink there are high rates of heavy drinking;
- regular smoking is over twice as common among Aboriginal people than among the remainder of the population;
- Aboriginal people have a significantly lower average age of onset of regular smoking - early initiation is associated with increased nicotine dependence, normalisation of behaviour and reduced success at cessation attempts in later life;
- limited data that needs to be viewed in light of the younger age profile of Aboriginal populations, indicates higher rates of illicit drug use among urban Aboriginal Australians;
- the disproportionately high rate of incarceration of Aboriginal Australians may contribute to higher prevalence of injecting – Aboriginal NSP clients at 8-10% in Australian NSP survey (estimated at 15-19% in Sydney), are significantly more likely to report injecting two or more psychoactive drugs and are considered at increased risk of sharing, with 70% reporting HCV antibody prevalence.

Good practice in intervention for substance use disorders (alcohol, tobacco, prescribed medications or illicit drugs) ideally involves use of prevention, early intervention, treatment and harm reduction. However, few prevention or treatment efforts have been specifically evaluated in urban Aboriginal populations.

Successful interventions are cognisant of cultural and social contexts. It is well documented that simply telling school children of any cultural background about the risks of drugs may not reduce their drug use, and in some cases may increase their curiosity about drugs. In contrast, measures that increase a young person's sense of belonging, and quality of schooling have been shown to reduce substance use by up to 25%. Health promotion exercises reported as effective in Aboriginal communities have typically involved community driven or supported approaches, and often broader initiatives which enhance culture, community empowerment and sense of belonging. These strategies address underlying risk and protective factors and enhance the community's capacity to identify and address health issues.

There is increasing evidence that traditional western models of one-to-one psychotherapy or behavioural interventions need modification to be appropriate to Aboriginal cultures (this issue was highlighted in consultations undertaken for this plan). Models that consider whole families or whole communities, in addition to individuals, would appear to be more useful. This is particularly so where there is a high background rate of substance use disorders, and where behaviour has become normalised within community constructs.

Early intervention philosophies would suggest a role for outreach services. Across Australia, it appears that access to services by Aboriginal IDUs is low, with cultural issues, fear of breach of confidentiality and shame identified as the main barriers to treatment. Young injectors in particular, may not be benefiting from peer education or harm reduction programs, as many rely on friends to supply their injecting equipment rather than accessing NSPs where education is available. This is despite evidence from small scale studies demonstrating that opioid replacement pharmacotherapy is beneficial to opioid-dependent Aboriginal people in urban settings. Focus group consultations have identified that for those Aboriginal people who do enter treatment, client retention rates depend on developing trust between clients and treating staff, and that Aboriginal clients are more likely to develop this trust with Aboriginal workers.

It is known that early and brief intervention by clinicians in hospital settings has marginal impacts both for alcohol use and smoking cessation. In fact, across settings, there is little evidence that tobacco cessation programs for Aboriginal people have had a discernable impact on cessation rates.

Holistic care principles suggest good shared care needs to exist and that inter-agency partnership approaches are required. It is known that attention to social factors such as housing can have a significant impact on prognosis in substance use disorders.

The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*, outlines at a broad level strategic directions that have been endorsed by Governments to address drug health issues in Aboriginal communities. There are six key result areas identified and these can be seen as representing the core characteristics that need to be reflected in intervention strategies in Aboriginal communities. These core characteristics are consistent with what has been identified elsewhere within this Plan covering concepts such as capacity building, promoting health, whole-of government, access, holistic care, workforce and partnerships. The following table outlines for each KRA examples of good practice that have been identified within the National Strategy and that appear to be relevant to urban Aboriginal populations.

Table 6.3 Good Practice Examples from the National Drug Strategy Complementary Action Plan

Key Result Area	Examples of Good Practice
Enhanced **capacity** of Aboriginal individuals, families and communities to address issues in the use of alcohol, tobacco and other drugs and **promote** their own health and wellbeing.	▪ Peer education programs enhancing communication on drug-related harm; ▪ Aboriginal representation on key policy committees; ▪ Involvement of Aboriginal people in sentencing processes; ▪ Use Koori media to convey health promotion messages to young people; ▪ Educational material and resources targeted to Aboriginal communities; ▪ Life skills programs for young people; ▪ Social and recreational activities for young people as alternatives to substance use; ▪ Youth committees, councils and advisory groups ▪ Partnerships and exchanges between mainstream services and ACCHS; ▪ Involvement of family and significant others in specialist treatment services; ▪ Flexible service delivery hours and after hours services.
Whole of-government action, collaborating with ACCHS' and NGOs on comprehensive approaches to reduce drug-related harm among Aboriginal peoples.	▪ Collaborative models in health promotion between communities and industry; ▪ Community leadership and involvement in planning and coordination of services; ▪ Strengthened collaboration between drug health, primary care and mental health providers; ▪ Information and resources to communities to plan and implement interventions; ▪ Networking between health and law enforcement sectors; ▪ Peer based empowerment strategies ▪ Alcohol, tobacco and other drugs related education in schools and in the community; ▪ Parenting and life skills programs for children and young people; ▪ Increased availability of NSP services; ▪ Targeted education about alternatives to injecting as routes of administration; ▪ Referral protocols between primary health care and specialist drug health services; ▪ Improve links ACCHS and mainstream drug health services.
Improved **access** for Aboriginal peoples to a range of health and wellbeing services that play a role in addressing the use of alcohol, tobacco and other drugs.	▪ Action-based research identifying access barriers to drug treatment; ▪ Trials of outreach drug health case management services; ▪ Educate communities about availability and relevance of pharmacotherapy; ▪ Address transport barriers in access to dispensing facilities; ▪ Include AHWs in clinical intake meetings; ▪ Education and training on use of injectable drugs, polydrug use, solvent use, unsafe sexual practices etc. ▪ Link drug health promotion to broader health promotion activities; ▪ Incorporate drug health messages within early childhood home visiting programs; ▪ Community targeted materials on FAS and FAE; ▪ Post release programs for prisoners, relapse and aftercare programs; ▪ Interagency guidelines for early intervention and increased spread of brief interventions; ▪ Screening and brief interventions for pregnant women ▪ Early intervention programs for young people who do not attend school; ▪ Address admission and discharge, referral and after care procedures in rehab and detox services;
A range of local and accessible **holistic** approaches from prevention through to treatment and continuing care.	▪ Culturally effective tobacco awareness programs; ▪ Culturally appropriate monitoring and evaluation of programs; ▪ Comprehensive care plans enabling engagement, stabilisation and management; ▪ Injury, mental health and sexual health programs targeting alcohol-related harm; ▪ Reduce exposure of children to environmental smoke in the home; ▪ Health promotion addressing effect of smoking and alcohol in pregnancy; ▪ Education programs for upper primary and secondary schools; ▪ Develop culturally appropriate screening tools and brief interventions; ▪ Improve capacity of ACCHS to provide early counselling, screening and brief motivational advice; ▪ Promote culturally acceptable inpatient detoxification capacity ▪ Increase access to culturally appropriate services for dual diagnosis; ▪ Allow for family admissions and on-site childcare; ▪ Assist GPs to increase skills in addiction medicine and cultural awareness ▪ Promote shared case management for clients with co-morbidity issues;

Key Result Area	Examples of Good Practice
	▪ Participate in community-based leadership programs; ▪ Deliver treatment in community-based settings and provide outreach services.
Workforce initiatives enhancing capacity of ACCHS and mainstream organisations to provide quality services.	▪ Policies and practices supporting AHWs working out-of-hours in their communities; ▪ AHW education and training through accredited courses; ▪ Provide cultural awareness training to staff in mainstream health services; ▪ Increase recruitment, employment and training opportunities for AHW in drug health; ▪ Mentoring networks to assist Aboriginal case workers; ▪ Improve communication between law enforcement, corrections and the health system; ▪ Models of education and training for Divisions of General Practice; ▪ AHW input to health education programs in schools focussing on drug health; ▪ Education programs for the community about the range of preventive activities; ▪ Provide AHWs with training on – recognition of withdrawal, infection control guidelines, safer injecting techniques; ▪ Provide AHWs with support networks of counselling and debriefing; ▪ Encourage primary health care workers to use brief opportunistic intervention programs; ▪ Provide AHWs with training to provide culturally effective brief and group smoking cessation interventions; ▪ Develop culturally sensitive best practice guidelines for clinical management of drug health issues.
Sustainable **partnerships** among Aboriginal communities, government and non-government agencies in research, monitoring, evaluation and dissemination of information.	▪ Meaningful partnerships with ACCHS to become involved in action research; ▪ Training in research methods for local community workers; ▪ Protocols for the use of data about Aboriginal people collected through mainstream research; ▪ Ensure monitoring and evaluation of harm reduction strategies pays attention to family and community impacts as well as individual impacts; ▪ Identify social, cultural and economic factors influencing uptake of tobacco and cannabis and identify risk factors in cultural context to inform effective prevention initiatives. ▪ Action research to improve practice in early intervention,; ▪ Document the harm-reduction strategies that are effective in particular community settings; ▪ Conduct rapid assessment methodology research on illicit drugs in all major centres; ▪ Researchers feedback information to communities in culturally appropriate manner.

The action proposals in drug health are identified in the *Agendas for Action* volume at pages 34 to 38. They have been developed within a framework of reference consistent with the conceptual basis outlined in the National Drug Strategy and the complementary action plan for Aboriginal peoples.

6.5 Infectious Diseases and Sexual Health

Infectious diseases and sexual health covers a range of infectious bacterial, viral and parasitic diseases characterised by their being communicable. Infectious diseases that have been identified as of particular importance to Aboriginal Health include tuberculosis, hepatitis (A, B, and C), sexually transmitted infections, HIV/AIDS, Haemophilus influenzae type b (Hib), pneumococcal disease, and meningococcal disease. It is known that infectious diseases are more prevalent in Aboriginal populations with nationally, hospitalisation rates for infectious and parasitic diseases being twice that experienced by other Australians. The highest rates of hospitalisation for infectious and parasitic diseases occur in Aboriginal children aged 0–4 years.

Protection from some infectious diseases can be afforded through vaccination. Under the *Immunisation Australia Program*, vaccination is available free of charge through primary care settings, both in childhood and for older Australians. Aboriginal people have access to some vaccinations free of charge in adulthood at ages earlier than that applying to other Australians and to a wider range of vaccinations in childhood in some high risk areas (does not include Sydney metropolitan area). The current recommended vaccination schedule is as follows.

National Immunisation Program (NIP) Schedule (commenced 1 July 2007)

Birth
- Hepatitis B (hepB)

2 months
- Hepatitis B (hepB)
- Diphtheria, tetanus and whooping cough (acellular pertussis) (DTPa)
- Haemophilus influenzae type b (Hib)
- Polio (inactivated poliomyelitis IPV)
- Pneumococcal conjugate (7vPCV)
- Rotavirus

4 months
- Hepatitis B (hepB)
- Diphtheria, tetanus and whooping cough
- Haemophilus influenzae type b (Hib)
- Polio (inactivated poliomyelitis IPV)
- Pneumococcal conjugate (7vPCV)
- Rotavirus

6 months
- Hepatitis B (hepB)
- Diphtheria, tetanus and whooping cough (acellular pertussis (DTPa)
- Haemophilus influenzae type b (Hib)
- Polio (inactivated poliomyelitis) (IPV)
- Pneumococcal conjugate (7vPCV)
- Rotavirus

12 months
- Hepatitis B (hepB)
- Haemophilus influenzae type b (Hib)
- Measles, mumps and rubella (MMR)
- Meningococcal C (MenCCV)

12-24 months
- Hepatitis A (Aboriginal and Torres Strait Islander children in high risk areas)

18 months
- Chickenpox (varicella) (VZV)

18-24 months
- Pneumococcal polysaccharide (23vPPV) (Aboriginal and Torres Strait Islander children in high risk areas)
- Hepatitis A (Aboriginal and Torres Strait Islander children in high risk areas)

4 years
- Diphtheria, tetanus and whooping cough (acellular pertussis) (DTPa)
- Measles, mumps and rubella (MMR)
- Polio (inactivated poliomyelitis) (IPV)

10-13 years
- Hepatitis B
- Chickenpox (varicella) (VZV)

12-13 years
- Human Papillomavirus (HPV)

15-17 years
- Diphtheria, tetanus and whooping cough (acellular pertussis) (dTPa)

15-49 years
- Influenza (Aboriginal and Torres Strait Islander people medically at-risk)
- Pneumococcal polysaccharide (23vPPV) (Aboriginal and Torres Strait Islander people medically at-risk)

50 years and over
- Influenza (Aboriginal and Torres Strait Islander people)
- Pneumococcal polysaccharide (23vPPV) (Aboriginal and Torres Strait Islander people)

65 years and over
- Influenza (flu)
- Pneumococcal polysaccharide (23vPPV)

The CHO reports on immunisation status by Aboriginality for children aged 12 to 15 months (DTP, Polio, HIB, Hepatitis B) and as at 31 December 2005 the coverage reported for Aboriginal children resident in SSWAHS was higher than for non-Aboriginal children for each vaccination type and over 90% (although the overall full immunisation rate at 88.51% was marginally less - 89.50%) and higher than the NSW average for Aboriginal children in each instance.

For adults, it is known that communicable respiratory illnesses are a major cause of illness in Aboriginal communities and that a serious complication of these illnesses is pneumonia, especially in persons with pre-existing heart or lung disease. The National Indigenous Pneumococcal and Influenza Immunisation Program has provided since 1999, free vaccines to Aboriginal people to protect them from communicable respiratory illnesses, pneumococcal disease and influenza. Data from the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases (NCIRS) confirms that, among adults aged 50–64 years, vaccination coverage is higher in Aboriginal communities than for other Australians (47% compared with 26% for influenza vaccine and 20% compared with 3% for pneumococcal vaccine) (Menzies, McIntyre & Beard 2004).

As for the whole Australian community, prime carriage of immunisation in Aboriginal communities is through primary care providers. Under the NSW immunisation Strategy 2008-2011, there is a key result area identified for Aboriginal people with the objective of achieving:

- at least 90% coverage for Aboriginal children aged 12 to <15 months (including pneumococcal vaccination);
- at least 90% coverage for Aboriginal children aged 24 to <27 months;
- at least 90% coverage for Aboriginal children aged 60 to <65 months;
- improved uptake for influenza and pneumococcal vaccine in Aboriginal adults aged 50 years and older.

The strategies of relevance to Area Health Services identified here are as follows, all of these initiatives require work in partnership with primary care providers.

Aboriginal Health roles for AHS under NSW Immunisation Strategy 2008-2011

- Review local availability, assess gaps, if appropriate provide alternate outreach models;
- Local initiatives to improve identification and recording of Aboriginality;
- Local initiatives to improve reporting of immunisation encounters to the ACIR;
- Develop local reminder/recall notices for immunisation milestones within general practice, community health services and ACCHS';
- Support inclusion of immunisation initiatives within EPC health checks for children aged to 14 years, adolescents and adults aged 15 to 54 years, adults aged 55 years and older;
- Strengthen collaboration and partnerships between stakeholders;
- Workforce strategies for training, recruitment, retention and succession planning for immunisation service provision to Aboriginal people;

Source: NSW Immunisation Strategy 2008-2011, p. 16.

Given the high levels of coverage already achieved within SSWAHS and the comparability between Aboriginal and non-Aboriginal populations already achieved, this Plan does not include specific new action strategies for vaccine-preventable infectious diseases. Continuing work will be undertaken with primary practice providers under the Framework initiatives of working with ACCHS and other primary care providers to maintain the success of immunisation strategies.

Another infectious disease of childhood that is of importance in Aboriginal communities is otitis media or middle ear infections that can include manifestations that are acute, repeated, persistent fluid in the ear and chronic runny ear. Otitis media is usually the result of a pneumococcal invasion of the nasopharynx, with chronic otitis media often characterised by a perforated eardrum, leading to hearing loss, deafness and further complications such as learning difficulties. Otitis media is considered the main contributor to national data indicating that Aboriginal children are twice as likely to be recorded as having ear and hearing problems as other Australian children.

The NSW Otitis Media Strategic Plan for Aboriginal Children was developed in 2000 to address this issue and a four year screening program was initiated under *Two Ways Together* from 2004. These programs targeted intervention at children aged up to 6 years old where the greatest benefits can be realised in terms of improving language development, learning ability, educational attainment, related health status and social interaction. The focus for screening is through primary care providers including ACCHS and SSWAHS community health services. In 2007-08 there was an approx. 50:50 share in the SSWAHS/ACCHS loci of screening undertaken.
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The State strategy aimed to increase capacity of the health system by developing specialised training courses, recruiting additional AHWs to complete training and supplying otoscopes and tympanometers which are used in the detection of otitis media. Another key strategy was to increase the level of awareness of otitis media amongst Aboriginal communities and to increase the rate of participation in screening. Aboriginal Otitis Media Coordinators have been funded to encourage local parents/carers to participate in screening of their children. SSWAHS developed an Otitis Media Screening Action plan 2006-2008 to guide its screening efforts. Evaluation of the Statewide screening program was undertaken in 2008 with the recommendation that focus change from near-universal screening to developing indicators which focus more on hearing health problems. An expert panel has now been established by NSW Health to plan strategies for 2008-09 onwards.

This Plan does not include specific new action strategies for screening of otitis media. Continuing work will be undertaken with primary practice providers under the Framework initiatives of working with ACCHS and other primary care providers to maintain appropriate focus on otitis media, consistent with revised Statewide strategies that will be developed through the expert panel.

Sexually transmissible infections (STI) i.e. those transmitted through sexual contact, are of significant concern for Aboriginal populations. STIs affect people's physical health, psychosocial wellbeing and relationships and are a significant source of morbidity in NSW. Some STIs also play an important role in facilitating human immunodeficiency virus (HIV) transmission.

Nationally, it has been reported that several STIs occur in Aboriginal communities at rates significantly higher than in the non-Aboriginal population (syphilis, gonorrhoea, trichomoniasis and chlamydia), where accurate data exists. Other STIs, such as HPV, appear to be no more common than in the non-Aboriginal population. It has been suggested that these disparities mainly arise from limited access to clinical services rather than from differences in rates of sexual partner change between the two groups. Other factors that require consideration in relation to reported higher rates of sexually transmitted infections and blood borne viruses in Aboriginal populations include:

- less access to culturally appropriate primary health care services to enable early detection, treatment and follow up of STIs;
- shortage of clinical staff, particularly of the same gender, who are able to deal with cultural sensitivity and competency with sexual health issues;
- lack of understanding of transmission dynamics and networks of sexual contact;
- high rates of screening in some remote communities which have led to early detection and treatment of bacterial sexually transmitted infections;
- a younger and more mobile population, adding to the complexity of appropriate sexual health testing and treatment;
- the impact of socio economic disadvantage including lower education standards and subsequent lower health literacy as a predictor of poor health;
- shame, stigma and historical factors associated with treatment for STIs, including past discriminatory practices;
- mainstream STI and BBV social marketing messages do not always reach and/or have impact in Aboriginal communities;

It should be noted that there are significant limitations with surveillance data on STIs in Aboriginal communities in NSW. Nevertheless, any excess in prevalence of bacterial STIs in Aboriginal communities is associated with substantial morbidity, including vaginal and urethral discharge, acute and chronic pelvic inflammatory disease (PID), premature labour, ectopic pregnancy and infertility. A significant proportion of these STIs are asymptomatic. STIs also contribute to mortality statistics through deaths associated with AIDS, liver cancer, anogenital cancers, miscarriage and still births. NSW strategies recognise that ongoing efforts to prevent new infections and improve detection and management of STIs, particularly chlamydia, gonorrhoea and syphilis, need to continue.

Controlling STIs depends on a multistrategic response including - health promotion strategies such as developing personal skills, advocacy, and public policy; the provision of adequate facilities for the diagnosis, treatment and contact tracing of STIs; and ongoing social and medical research.

The strategic focus for STI control in NSW Aboriginal communities is guided by the *NSW HIV/AIDS, Sexually Transmissible Infections and Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009*. This plan outlines good practice strategic directions that include a focus on behaviour change, such as increased use of condoms, as well as ensuring increased access to services and testing and treating those at increased risk. Increased emphasis on opportunistic testing of individuals who may be at greater risk is also a priority. Some of the goals in the NSW strategy can be considered as stretch ones, including the elimination of syphilis transmission within Aboriginal communities. This will involve improved mobilisation of a range of key partners such as sexual health services, ACCHS', Area Clinical Stream services such as antenatal and human service agency partners such as Justice Health.

The Plan recommends that the provision of sexual health services to Aboriginal people in NSW:

- have community participation and ownership;
- adopt a holistic health approach;
- be implemented in collaboration and partnership;
- with local communities and key stakeholders;
- include an active outreach program;
- be evidence-based;
- develop the knowledge and skills of the workforce.

Strategic objectives in STI and BBV control in Aboriginal communities

- Increase the use of condoms with casual and new sexual partners;
- Eliminate syphilis transmission within Aboriginal communities by 2009;
- Increase in early detection and treatment of bacterial and viral STIs;
- Increase in culturally appropriate and sensitive public sexual health service provision;
- Build the skills of the workforce;
- Improve the capacity of and collaboration with ACCHS' and GPs who see Aboriginal people, to respond to STIs;
- Improve culturally appropriate STI surveillance and monitoring;
- Increase culturally appropriate STI related research within Aboriginal communities.

Source: NSW HIV/AIDS, Sexually Transmissible Infections and Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009.

NSW strategies acknowledge that responsibility for diagnosing, treating and managing STIs has been shared between publicly funded sexual health services and general practice. In most instances, sexual health screening and treatment is the responsibility of primary care practitioners and there is emphasis on supporting the management of STIs in general practice, including with GPs and clinicians working in ACCHS'. This includes the integration of STI and blood-borne virus checks into existing MBS biennial health checks for Aboriginal people aged between 15 and 54, as these checks aim to ensure early intervention and diagnosis of treatable conditions.

Another priority strategic focus is to improve access by Aboriginal people to publicly funded sexual health clinics, which are seen as an integral component of the NSW response to STIs. It is highlighted that outreach clinics to Aboriginal people have proved appropriate and successful, particularly if undertaken with other health programs and services within a holistic care paradigm. Proactive strategies to increase the reach of services to Aboriginal communities are supported.

It is also acknowledged that surveillance of STIs within Aboriginal communities in NSW requires improvement and that accurate, timely and culturally appropriate surveillance is essential to inform program development and implementation. Improving current surveillance of STIs and ascertaining the true prevalence and incidence of specific STIs, such as chlamydia, gonorrhoea and infectious syphilis, within Aboriginal communities has been given a high priority. Research is also highlighted as vital to improve outcomes for Aboriginal communities and enable service delivery and access to all within the community.

Prevention and health promotion activities remain identified as a key strategy to reduce the rates of STIs within Aboriginal communities, aiming to increase STI awareness, promote condom use and highlight the asymptomatic nature of many STIs.

Workforce development initiatives are also strongly supported to reinforce the important role ASHWs play in facilitating access to appropriate services. Workforce development initiatives also need to extend to health workers in sexual health services in order to build their capacity to provide culturally sensitive services to Aboriginal people. Workforce development initiatives that re-orient health services with specific population groups such as men's clinics, women's clinics and youth groups are also needed.

The strategic focus presented is grounded in the requirement that the expertise of Aboriginal communities is bought to the development of sexual health initiatives and that they need to be undertaken in partnership with Aboriginal communities, ACCHS' and with a range of other health programs working with Aboriginal people in NSW, including Aboriginal health, child and maternal health, mental health, women's health and men's health services, alcohol and other drug services, the AIDS Council of NSW, Justice Health and the Department of Corrective Services.

6.6 Oral Health

Oral health is often not given a high priority or may even be overlooked when examining the serious and complex health issues faced by Aboriginal people. The consequences of poor oral health can be devastating and often lead to a dramatic reduction in the quality of life. Pain, infection, reduced ability to eat, impairment of speech and poor self image are just some of the symptoms of untreated oral disease.

The physical factors that affect oral health include diet, preventive dental habits, exposure to fluoridated water and fluoride toothpastes, age, alcohol consumption, smoking, emotional stress and other medical conditions such as diabetes that impact on the immune response. The availability of and timely access to dental treatment is an overarching factor in the prevention and management of dental pathology.

The aetiology of both dental caries and periodontal disease is now well known. The interaction of specific organisms with complex carbohydrates and sugars in the form of biofilms within the oral cavity and on the teeth determines

the activity of dental disease. A number of mitigating factors associated with individual host susceptibility and exposure to biological transfer of organisms also exist.

Dental disease is indeed preventable and there is opportunity through targeted program provision to dramatically decrease the levels of dental disease in the Aboriginal communities of SSWAHS, which will have significant flow on effects in improving quality of life and contributing to improvement in overall health status. Targeted program provision by SSWAHS will contribute to improving oral health status, alongside broader public policy initiatives such as the availability of fluoridation in the water supply which has now been well documented as a major influence in the reduction of dental caries.

Oral health status in Aboriginal communities has been the subject of examination by Government committees and parliamentary inquiry at National and State levels. For example the Standing Committee on Social Issues of the NSW Parliament Legislative Council highlighted Aboriginal oral health needs in its report on Dental Services in NSW (report 37) in 2006. This report indicated that "Aboriginal and Torres Strait Islander communities are at significant risk, experiencing dental decay at twice the rate of non-indigenous populations, 16% loss of all natural teeth compared to 10% of non-indigenous people and worse periodontal health, in many cases exacerbated by a higher incidence of type 2 diabetes." (p. 118).

A recommendation of the Standing Committee was that oral health planning in NSW consider the need to provide culturally appropriate and accessible oral health services for indigenous people, comprising education for children and adults, the provision of a wider range of services beyond emergency treatment, and the means of providing preventive treatment and education.

National policy directions are guided by *healthy mouths healthy lives Australia's National Oral Health Plan 2004-2013*. This plan identified oral health in Aboriginal communities as one of 7 headline action areas and developed action items requiring attention in short, medium and longer timeframes, as follows.

Action items on Aboriginal Health from *healthy mouths healthy lives*

Short term:

- Biennial adult health checks for Aboriginal people to include an oral examination;
- Improve accessibility through partnerships with ACCHS, patient transport schemes, cultural appropriateness of mainstream services;
- Dedicated student placements and scholarships for Aboriginal oral health students;

Medium term:

- Increase oral health promotion – stand alone and within other strategies e.g. diabetes, cardiovascular, drug health, nutrition; access to oral hygiene materials; access to nutritious and affordable food supplies;
- Integrate in primary care through inclusion of oral health in health check guidelines for well people and recall mechanisms in chronic care;
- Improve data collection through national MDS, data standards and data consolidation;

Long term:

- Increase Aboriginal oral health workforce through - scholarships; role clarification and acknowledgement of contribution; ascertaining development needs; improved training recruitment and retention; expanded role for dental therapists, dental hygienists and oral health therapists.

Source: healthy mouths healthy lives, Australia's National Oral Health plan 2004-2013 pp. xiii, xiv.

NSW policy is guided by documents produced under the NSW Oral Health Strategy. The overarching document is *NSW Oral Health Strategic Directions 2005-2010*. Complementary documents are *NSW Oral Health Promotion: Framework for Action 2010* and NSW *Oral Health Implementation Plan 2005-2010*.

The Strategic Directions document is high level however; it does provide an indication of the types of interventions that should be targeted towards Aboriginal communities as a priority population grouping in oral health, as follows.

Interventions identified as of particular relevance to Aboriginal communities from NSW Oral Health Strategic Directions

- Provide smoking cessation advice and/or oral hygiene and dietary advice at the chairside;
- Build significant relationships to support advocacy for oral health;
- Intervene early and provide appropriate follow-up;
- Include oral health in policies that advocate for low sugar (consumption and frequency) diets;
- Identify and address barriers for people accessing oral health services;
- Provide culturally appropriate information on oral health.

Source: NSW Oral Health Strategic Directions 2005-2010 pp. 6-14.

NSW policy on oral health promotion in Aboriginal communities is outlined in a stand alone document which was produced as part of the planning process for the overarching Oral Health Promotion Framework for Action 2010. This document uses a life-course approach (mothers and young babies, children and young people, adults and Elders), identifies sectors and settings for action (home, early childhood, education, youth, elders, disability, health, housing, sport and recreation, media and government) and employs a population health approach.

This framework includes some examples of strategies that would be appropriate in providing oral health promotion in Aboriginal communities:

- Whole of community – media based oral health promotion campaigns; fluoridation; culturally appropriate oral health information; partner with transport providers; mobile dental vans; increase oral health workforce;
- Prenatal – link with antenatal and home visiting programs; chairside smoking cessation, oral hygiene and dietary advice; promote oral health within EPC; culturally appropriate oral health information for pregnant women;
- Infants and preschool children – oral health within childcare health and safety guidelines; oral health component in *Families NSW* programs; *Oral Health Promoting Centres Program*; chairside advice and culturally appropriate oral health information for parents;
- School aged children and adolescents – oral health within confidence and self-esteem projects, the *Tooth Book*, oral health in *Health Promoting Schools* projects, *School Assessment Program*;
- Young adults 18-25 years – partner with youth, education, sporting and health services targeting youth; chairside advice and culturally appropriate oral health information for youth;
- Adults – chairside smoking cessation, oral hygiene and dietary advice; promote oral health within EPC; culturally appropriate oral health information and health advocacy to womens' and mens' groups;
- Elders – integrate oral health information into aged care policy setting; oral health considerations in programs promoting healthy ageing; chairside smoking cessation, oral hygiene and dietary advice; oral health information in *Community Aged Care and Carers* packages;
- Health professionals and clinicians - incorporate oral health information into general and disease specific health education, promotion and prevention initiatives e.g. Diabetes Week, obesity and injury prevention packages; build capacity of primary care and specialty health providers to recognise oral health links to general health, identify oral health conditions and refer appropriately; support oral health research in aboriginal communities; develop clearing house for oral health promotion activities and research; work with corporate dental and oral pharmaceuticals sector on proven and sustainable oral health promotion programs.

The NSW *Oral Health Implementation Plan 2005-2010* poor oral health and limited access to care in some Aboriginal communities as a major area of need. Budget enhancements of $40m over four years were identified over the 2006-2010 period, including $1.05m to increase specialised and special needs services in Aboriginal oral health. Under the Implementation Plan Aboriginal communities are identified as one of the "communities with the greatest need" along with people in rural and remote areas, people with special needs, very young children and older people. Strategies identified that are of relevance to Aboriginal communities include:

- Provide additional dental providers and services for Aboriginal Oral Health Services;
- Develop specific strategies to address high risk/high need communities, using currently available best compromises;
- Develop sustainable models for high risk/high need communities;

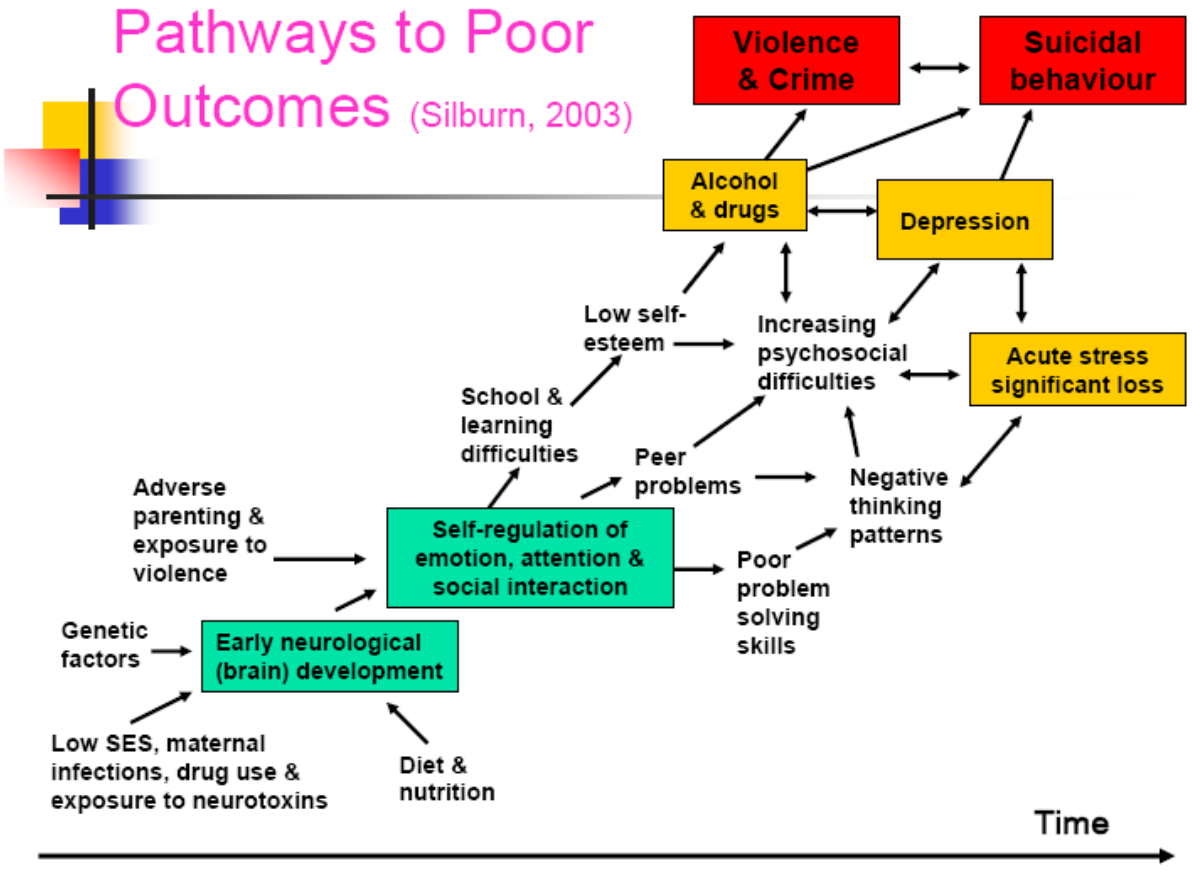
There is little clarification in all the Plans as to what these models or strategies might be.

The action proposals in oral health are identified in the *Agendas for Action* volume at pages 49 to 52. They have been developed within a framework of reference consistent with the conceptual basis outlined in the national and NSW oral health plans, focussing on oral health promotion strategies through direct delivery to Aboriginal community groups and integration of oral health components into broader health promotion and preventive health activities in Aboriginal communities.

Pathways of Risk and Resilience for Young People

More recent models of youth health have moved beyond excusive focus on correcting problems or remediating developmental incapacity and deficit towards an understanding of the pathways to poor health outcomes for young people and how preventative approaches can promote affirmative, supportive interventions that emphasise potentialities of young people. Understanding of the pathways to poor health outcomes enables prevention programs to be established to reduce risk for young people. Similarly, understanding of the factors that enable the majority of young people to achieve transition from adolescence to adulthood without any major problems enables the promotion of protective factors that can enhance resilience in young people.

The pathways to poor health outcomes for youth have been illustrated as follows.



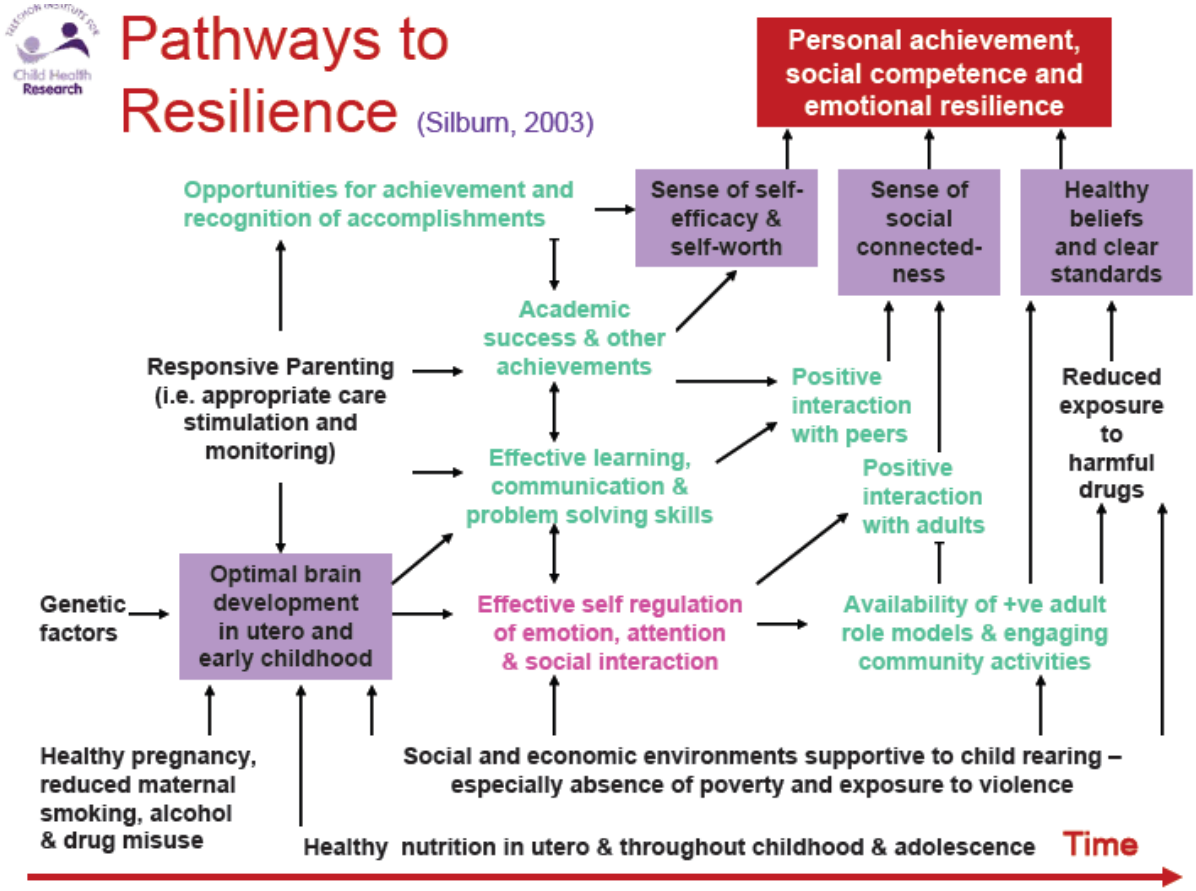
Source: Silburn, S. R. (2003), *New directions in Australian Suicide Prevention*, Invited keynote address to the 1st Asia-Pacific Injury Prevention Conference & 6th National Conference on Injury Prevention and Control, Fremantle, Western Australia, 16-18 March 2003.

Resilience models identify pathways in a person's life which make it less likely that the pathway to poor outcomes is followed. Resilience pathways lead to personal achievement, social competence and emotional resilience through:

- genetic factors;
- healthy pregnancy, reduced maternal smoking, alcohol & drug misuse;
- healthy nutrition in utero and throughout childhood & adolescence;
- social and economic environments supportive to child rearing - especially absence of poverty and exposure to violence;
- optimal brain development in utero and early childhood;
- effective self regulation of emotion, attention & social interaction;
- effective learning, communication and problem solving skills;
- academic success & other achievements;
- responsive parenting (i.e. appropriate care stimulation and monitoring);
- opportunity for achievement and recognition of accomplishments;
- availability of positive adult role models and engaging community activities;
- positive interaction with adults;

- positive interaction with peers;
- reduced exposure to harmful drugs.

The pathways to resilience for youth have been illustrated as follows.

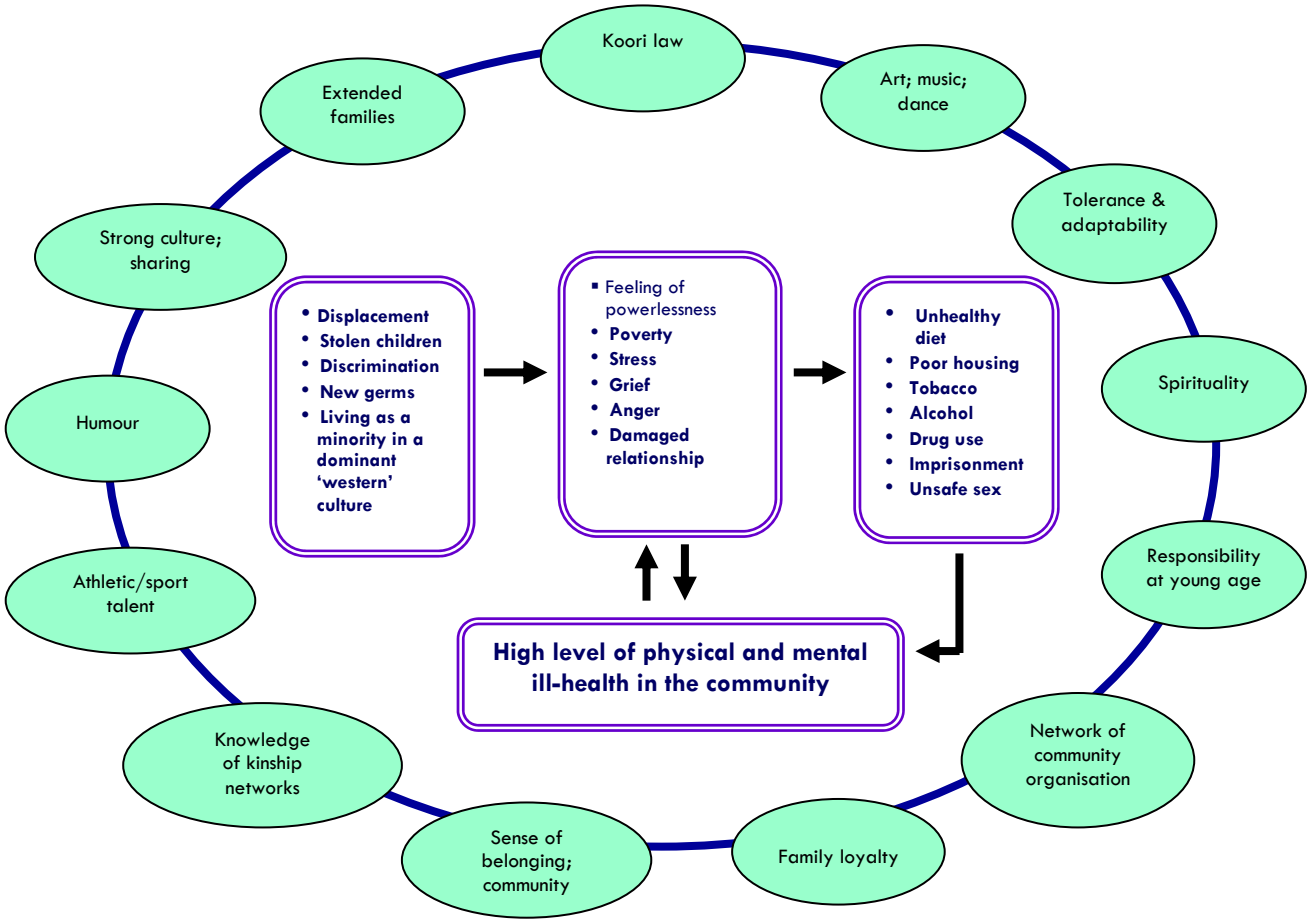


Resilience models suggest that all the above will lead to a sense of self efficacy and self worth; a sense of social connectedness and healthy beliefs and clear standards, which will in turn lead to personal achievement, social competence and emotional resilience.

Source: Silburn, S. R. (2003), *New directions in Australian Suicide Prevention*, Invited keynote address to the 1st Asia-Pacific Injury Prevention Conference & 6th National Conference on Injury Prevention and Control, Fremantle, Western Australia, 16-18 March 2003.

Some work has been done in applying resilience theories to the experiences of Aboriginal youth. Holmes (2002) has explored a range of risk and resiliency factors, with the following model bringing together the factors that push towards a pathway to poor outcomes and the protective factors that enable resilience.

Risk and Resilience Model For Aboriginal Youth



Source: Holmes W et al, *Researching Aboriginal health; experience from a study of urban young people's health and well-being*, Social Science & Medicine, Vol 54 (2002), pps 1267-1279.

Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACCAHSS	Aboriginal Chronic Conditions Area Health Service Standards
ACE	Adolescents Coping with Emotions
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACYFS	Aboriginal Child Youth and Family Strategy
AHEO	Aboriginal Health Education Officer
AHET	Aboriginal Health Executive Team
AHIS	Aboriginal Health Impact Statement
AHMAC	Australian Health Ministers' Advisory Council
AHMRC	Aboriginal Health & Medical Research Council of NSW
AHO	Aboriginal Housing Office
AHP	Allied Health Professional
AHS	Area Health Service
AHSM	Aboriginal Health Service Manager
AHU	Aboriginal Health Unit (Bangala)
AHW	Aboriginal Health Worker
AIDB	AIDS/Infectious Diseases Branch (NSW Health)
AIHW	Australian Institute of Health and Welfare
ALO	Aboriginal Liaison Officer
AMHS	Area Mental Health Service
AMHW	Aboriginal Mental Health Worker
AMIHS	Aboriginal Maternal and Infant Health Strategy
AMS	Aboriginal Medical Service
AN_SNAP	Australian National Sub-Acute and Non-Acute Patient Classification
ANTaR	Australians for Native Title and Reconciliation
ANZDATA	Australian & New Zealand Dialysis & Transplant Registry
ASHM	Australasian Society for HIV Medicine
ASHW	Aboriginal Sexual Health Worker
BBV	Blood Borne Virus
CAAH	Centre for the Advancement of Adolescent Health
CAMHS	Child & Adolescent Mental Health Services
CAPACS	Community Acute & Post Acute Care Service
CBT	Cognitive Behavioural Therapy
CEWD	Centre for Employment and Workforce Development
CFHN	Child & Family Health Nurse
CHC	Community Health Centre
CHETRE	Centre for Health Equity Training, Research & Evaluation
CHOCIP	Community Health and Outpatient Care Data Collection
CKD	Chronic Kidney Disease
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CPITN	Community Periodontal Index of Treatment Needs
CRIAH	Coalition for Research to Improve Aboriginal Health
CSAHS	Central Sydney Area Health Service (former)
DADHC	Department of Ageing, Disability & Homecare
DAA	Department of Aboriginal Affairs
D&A	Drug & Alcohol
DHS	Drug Health Services
DMFT	Decayed, Missing or Filled Teeth
DoCS	Department of Community Services
DoH	Department of Housing
DoHA	Department of Health and Ageing (Commonwealth)
DV	Domestic Violence
ECOH	Early Childhood Oral Health
ED	Emergency Department
EDD	Estimated Date of Discharge
EPC	Enhanced Primary Care
ESKD	End Stage Kidney Disease
ESRG	Enhanced Service Related Group
FAE	Foetal Alcohol Effects
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FAS	Foetal Alcohol Syndrome
G&S	Goods and Services
GP	General Practice
HACC	Home & Community Care Program
HARP	HIV and Related Programs
HASI	Housing & Accommodation Support Initiative
HCV	Hepatitis C Virus
HIC	Health Insurance Commission
HITH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HS&JMSRN	Human Services & Justice Metropolitan Sydney Regional Network
HS&JSOG	Human Services & Justice Senior Officers Group
HSNet	Human Services Network
ICC	Indigenous Coordination Centre(s)
IDU	Intravenous Drug User
IPTASS	Isolated Patient Transport & Accommodation Assistance Scheme
JGoS	Joint Guarantee of Service
KPI	Key Performance Indicator
LGA	Local Government Area
LOS	Length of Stay
MDS	Minimum Data Set
MHDAO	Mental Health and Drug and Alcohol Office
MH-OAT	Mental Health Outcomes Assessment Tool
MOU	Memorandum of Understanding
N/A	Not Applicable
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIDOC	National Aborigines and Islanders Day Observance Committee

NCHECR	National Centre in HIV Epidemiology and Clinical Research
NCIRS	National Centre for Immunisation Research & Surveillance of Vaccine Preventable Diseases
NGO	Non Government Organisation
NSP	Needle & Syringe Program(s)
NSW Health	NSW Department of Health
OATSIH	Office for Aboriginal & Torres Strait Islander Health
OHFSS	Oral Health Fee for Service Scheme
Oxfam	from Oxford Committee for Famine Relief (1942)
PAWG	Priority Area Working Group
PBS	Pharmaceutical Benefits Scheme
PDHPE	Personal Development, Health and Physical Education
PDS	Pensioners Dental Scheme
PECC	Psychiatric Emergency Care Centre
PHU	Public Health Unit
POA	Principles of Action
RACF	Residential Aged Care Facility
RACGP	Royal Australian College of General Practitioners
RCMG	Regional Coordination Management Group
REMS	Research Evidence Management & Surveillance (SSWAHS Unit)
REG (*TWT*)	Regional Engagement Group (*TWT*)
REPIDU	Resource & Education Program for Injecting Drug Users
RPAH	Royal Prince Alfred Hospital
SAAP	Supported Accommodation Assistance Program
SAOG	Senior Aboriginal Officers Group
SCATSIH	Standing Committee (to AHMAC) on Aboriginal and Torres Strait Islander Health
SDH	Sydney Dental Hospital
SDPP	Sydney Diabetes Prevention Program
SHIP	Sexual Health Information Program
SNAP	Sub and Non-Acute Patients Data Collection
SOG	Senior Officers Group
SSWAHS	Sydney South West Area Health Service
SSWOHS	Sydney South West Oral Health Services
STI	Sexually Transmissible Infection
SW	Social Work(er)
SWSAHS	South Western Sydney Area Health Service (former)
TACP	Transitional Aged Care Program
TAFE	Technical & Further Education
TAG	Transport Access Guide
TOR	Terms of Reference
TWT	*Two Ways Together*

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