

# Talking up Strong – Voices of Our Mob:

Report for The Salvation Army on the Characteristics and Needs of  
Aboriginal Clients at Access Health, St Kilda, Victoria

Kerry Arabena, Sarah Howell-Meurs, Leanne Coombe, Maurice Shipp,  
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February 2014

## **Dedication**

*This report is for all the Aboriginal people in the St Kilda community. We acknowledge your Elders past and present. Thank you for your insight, wisdom, your strength and courage.*



# List of Abbreviations

<b>ACCHOs</b>	Aboriginal Community Controlled Health Organisations
<b>ABS</b>	Australian Bureau of Statistics
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>AMA</b>	Australian Medical Association
<b>AMS</b>	Aboriginal Medical Service
<b>AOD</b>	Alcohol and Other Drugs
<b>CQI</b>	Continuous Quality Improvement
<b>DFCS</b>	Department of Family and Community Services
<b>DHS</b>	Department of Human Services (Victorian Government)
<b>DoH</b>	Department of Health (Victorian Government)
<b>DoHA</b>	Department of Health and Ageing (Australian Government) (now Department of Health)
<b>GP</b>	General Practitioners
<b>PD</b>	Professional Development
<b>PHC</b>	Primary Health Care
<b>TAFE</b>	Technical and Further Education
<b>WHO</b>	World Health Organization

## Notes on Terminology

In this report the term 'Aboriginal people' is used to identify the First Peoples of Australia and refers specifically to Aboriginal people residing in Victoria. The term 'Aboriginal and Torres Strait Islander people' is used to refer to and recognise the two unique Indigenous populations in Australia. The term 'Indigenous' refers collectively to the First Peoples of Australia, New Zealand, North America, and other countries around the globe. 'Non-Indigenous' is used to refer to those who do not identify as a member of the community of First Peoples of their respective countries.

The 40 Access Health clients interviewed for this study were predominantly Aboriginal, generally from the local Koori community, as are most of AH's Indigenous client group. As only one respondent identified equally as Torres Strait Islander, South Pacific and Other, throughout the report we refer to all clients we interviewed as 'Aboriginal'.

# Executive Summary

This report is based on research conducted by the Onemda VicHealth Koori Health Unit (Onemda) in the Melbourne School of Population and Global Health, the Faculty of Medicine, Dentistry and Health Sciences at the University of Melbourne. It was carried out at the behest of Access Health (AH), a program run by the Salvation Army in Grey Street, St Kilda, an inner city suburb of Melbourne. The research was commissioned as part of a continuous quality improvement (CQI) program to improve access by Aboriginal clients in the region to Access Health. Its numbers of Aboriginal clients had increased over the past years, in correlation with the increase in work hours of its Aboriginal Access Worker, and AH was keen to find other ways to engage with them.

To assess whether it was meeting the needs of its Aboriginal clients, AH engaged Onemda to consult with staff and clients to see how the current services were responding to need, and to get advice about what could be done differently or better. These consultation questions were further developed by a Reference Group made up of key Aboriginal people, of staff and management at Access Health and of service providers who form part of the service's referral network. The group designed the survey tool, ensured the issues of vulnerability of the client group were managed, and provided feedback on the process and results of the research. This group also gave support through the University of Melbourne Ethics Application process and provided cultural authority and on-site support in relation to the research work.

More than 50 people were interviewed over a five-week period from March to April 2013, made up of 40 Aboriginal clients<sup>1</sup> recruited from within the service and 12 staff with a range of positions across Access Health.

The staff on-line survey identified key factors that could enhance access by Aboriginal clients to the range of services on offer. Staff demonstrated a strong commitment to improving the health and wellbeing of marginalised and vulnerable populations by:

- » optimising access to comprehensive service provision
- » facilitating case management strategies and demonstrating cultural competency
- » working through specific strategies for marginalised populations, and
- » investing in individualised and innovative services.

An overall assessment of the services available through Access Health shows that the work is founded on best practice strategies and well-communicated 'equity' principles. However, there are opportunities both to enhance current services and to accelerate system responses to the needs of clients within complex and challenging contexts, as well as highly individualised needs.

This client population, often characterised as marginalised and vulnerable, felt comfortable using Access Health, with the majority having received services for 5–10 years with many episodes of repeat service. New clients were assisted to access the health service via the AH networks, or through the Aboriginal Access Worker.

Almost all of AH's clients experience complex social determinants that negatively impact on their health and wellbeing – including access to safe and affordable housing, a regular and adequate income, food safety and nutrition – and had been negatively impacted on by issues such as low level school completion, incarceration, and poor quality relationships with family members, neighbours and store owners in the area. These social determinants, combined with poor organisational skills, compounded the difficulties of access, particularly for new clients needing primary health care (PHC) services. In addition, the maintenance of ongoing relationships with and between health care providers and the client group, who often demonstrate broad and complex needs requirements, needs to be promoted.

Implementing best practice solutions for optimal service provision of PHC to Aboriginal people are identified in the following recommendations. Implementing these recommendations will enhance the AH's current CQI strategies, and guarantee that its services will continue to have a high degree of acceptability by its Aboriginal clients.

<sup>1</sup>See Notes on Terminology opposite.



# Recommendations

- 1** Consider creating an advisory group and a well-regarded quality improvement procedure that allows for Aboriginal clients and key community people to have input in to strategies for Access Health services to better meet client need. Communicate information about any new measures, such as these, with clients and referral agencies.
- 2** Mental health issues are prevalent in the Aboriginal client group so better referral mechanisms to psychiatric and other key services are needed. In developing these mechanisms, put in place strategies to deal with institutional racism and heighten health-seeking behaviour among clients.
- 3** Develop systems that support clients with limited organisational skills to access AH services by addressing lengthy waiting times and low staffing numbers especially in the clinic.
- 4** Develop a plan to address issues in the workplace. The plan could incorporate the recruitment of additional staff – especially General Practitioners (i.e. increase hours of second GP), GP registrars (work with universities), Aboriginal support officers (male support for male clients), counsellors and nurses/nurse practitioners – and expanding currently available services.
- 5** Invest in brokerage and extending the range of services available to Aboriginal clients by strategically partnering with other health and wellbeing services to provide more holistic treatment, care and support. These services might address dental, physiotherapy, alcohol and drug (AOD) counselling, and financial and social work needs – thereby creating more of an allied health professional strategy.
- 6** Establish a discrete budget for funding community/staff engagement through orientation, professional development and cultural awareness and induction programs, and enable staff participation at local, relevant events with community people.
- 7** Ensure all CQI strategies incorporate and address the specific needs of Aboriginal clients with regard to clinical access, diagnostic equipment, referral, professional development (PD), orientation and brokerage with other agencies. Ensure there is adequate reflection of these activities in the annual report, and feedback to the Aboriginal community on the scaling up of services.
- 8** Establish cultural awareness/cultural safety training as the preferred PD training in this and referral agencies, and meet on an annual basis with other services in the region to address issues that impact on Aboriginal clients.



**9** Develop the capacity at AH to address specific dietary needs and nutrition services, and work with other services (especially rehabilitation) on providing opportunities for people to develop healthy cooking habits on low budgets.

**10** Provide new clients with an 'Awareness Package' full of information about the other services in the region, particularly for new clients who have often relocated from interstate or other parts of Victoria and do not have family close by.

**11** Through networking with other agencies, develop an annual plan to engage with community through appropriate events, master classes or common learning (e.g. cultural awareness and cultural safety courses) to enhance the health and wellbeing of Aboriginal clients accessing these services.

**12** Work with other referral agencies in the region that are not currently well utilised by Aboriginal clients to explain what Access Health is and what it does. Informing clients about the other services and what they do will increase their visibility and, consequently, increase their usage by Aboriginal clients.

**13** Develop a communications strategy that adequately captures what Access Health does with and for Aboriginal clients. This could be simply ensuring information is captured in your annual report, or that Aboriginal designs are included on fact sheets, or there is a small orientation package for new clients in the region that specifies the range of services that focus on Aboriginal people.

**14** Incorporate the following recommendations into the CQI strategy:

- a. Implement outreach work where appropriate and affordable.
- b. Employ a male Aboriginal support worker to enhance gender equity.
- c. Develop strategies to expand the range of allied health and dental services available through AH.
- d. Develop systems to ensure there are measurable reductions in client waiting times, and improvements in client referrals to hospitals and psychiatric services.
- e. Engage in regular cultural safety training for staff at Access Health and in referral networks.
- f. Evaluation of programs and policies affecting Aboriginal clients, and where possible report on the AH model at conferences, in journals and in teaching courses for postgraduate degree courses.

# Introduction

Access Health (part of The Salvation Army Crisis Services) in Grey Street, St Kilda provides a range of health and community support services for vulnerable populations including those experiencing homelessness, those engaged in sex work and/or those with illicit drug and alcohol addictions. In 2004, the service employed an Aboriginal Access Worker to undertake liaison, advocacy, access, support, education and referral services with vulnerable Aboriginal living in the St Kilda area. Initially funded for one day per week, over the past few years this was increased to four days a week. Since recruiting this identified position, AH has seen a marked increase in the number of Aboriginal people accessing its full range of services.

This research was initiated by Access Health as a direct result of its Aboriginal Access Worker's outreach work in the community, with the aim of improving current services and considering new opportunities – both to meet the health needs of Aboriginal clients and to facilitate service enhancement through a commitment to continuous quality improvement.

## Project Aims

Onemda VicHealth Koori Health Unit in the Melbourne School of Population and Global Health at the University of Melbourne was engaged to work collaboratively with Access Health in the implementation of this project. Three specific aims of the research were:

1. To get to know the Aboriginal people who are using the service and develop a demographic profile of them.
2. To understand and identify why there has been an increase in the numbers of Aboriginal people engaging with Access Health.
3. To understand the health care service needs of those Aboriginal clients who currently access the service.

By meeting these aims, Access Health will be able to:

- » Provide tailored interventions for Aboriginal people based on stated need.
- » Improve outcomes for Aboriginal people through its services.
- » Provide better pathways to other services in the area.

## Reference Group

All work was guided by and developed in conjunction with a Reference Group made up of predominantly Aboriginal workers engaged with the Aboriginal client group through community organisations, AH staff and community Elders. Reference Group members were either service users, or engaged in delivering services or referring clients to Access Health. The role of the Reference Group was to contribute to the development of the Ethics application and protocols through the University of Melbourne, design the questionnaire for clients, provide cultural leadership and support for the Onemda staff engaging with the local community, advise the project workers, and develop pathways for clients between AH and its services after clients needs have been identified. The group also provided key letters of support for the Ethics Application through the University of Melbourne Ethics Committee. Hosted by Access Health, the group met regularly throughout the project to assess preliminary results and to make recommendations as to what should be included in the report. Members of this Reference Group demonstrated a willingness to work together, deal with legal and cultural issues, attend meetings, keep confidentiality and provide constructive feedback and support.



## Research Process

The first phase of the project involved identifying and surveying Aboriginal people who were recruited from the Access Health waiting room and reimbursed for their time. Those who agreed to be surveyed were read a Plain English Statement and signed a consent form, then worked with the researcher to answer questions about age, main source of income, participation in education, living arrangements, family circumstances, risk behaviours and social issues, health problems, experience of services and finding out what they would recommend to the service. This survey took between 30–40 minutes to complete.

In the second phase, staff at Access Health were asked questions about their views of Aboriginal people's health care needs, their capacity to work with an increased Aboriginal client base, why workers think that there are more people accessing their service, the key reasons why people present, and whether there were some partnerships that could be developed to better support their work.

Two researchers from Onemda were based at Access Health for one day per week over a six-week period, and supervised on site by appropriate staff. Forty face-to-face interviews with Aboriginal clients over the age of 18 were undertaken, and a survey circulated to the 12 AH staff. Recommendations emanating from these interviews with Aboriginal clients and surveys with AH staff were generated. Information was then provided to the Reference Group, which in turn identified opportunities to improve health services for Aboriginal people using Access Health.

The data from these interviews were developed into data sets by another staff member at Onemda. A thematic and trends analysis technique was used to identify how the service meets needs, identifies gaps and enhances access to health services through partnerships and referral pathways for example. This analysis forms the basis of the recommendations in this report.

The information generated from this research was further supported by a literature review to identify issues faced by Aboriginal and Torres Strait Islander people throughout Australia when accessing mainstream services, and to ascertain the core elements of PHC services that are most used by vulnerable people and the best practice solutions in providing services. The literature review also scoped out the partnerships approach to providing services to Aboriginal and Torres Strait Islander people and the best point of access through which they can source a more appropriate range of primary and other health care services.

### Managing issues of 'vulnerability' in the project

Strategies developed by the Reference Group mitigated some of the expected difficulties with the project. 'Vulnerability of the client group' was identified as a key issue for those Aboriginal people who experience multiple disadvantages, are marginalised and stigmatised, and not often asked their opinion on how to improve their health services. Time was spent discussing how difficulties, such as the following, could be managed throughout the project:

- » Trusting those who deliver the survey – telling people what they want to hear.
- » Recruiting people to the project – fear of information becoming public knowledge.
- » Issues of interpretation – misunderstanding the questions, not understanding the context.
- » Cross-cultural issues – promotion of understanding and respect.
- » Differentiating between service experiences – clients may attribute previous experiences and expectations of services to Access Health.
- » Fear of telling the truth – in case there are negative consequences for how they accessed health services through AH in the future.



Several measures were put into place in the design of this study to minimise participant risk:

- » Recruitment based on prior consent for sharing of information to avoid perceived coercion of those who do not wish to do so.
- » Giving participants the choice of completing the survey with or without assistance to reduce the risk of perceived coercion, participant bias and/or lack of understanding of the context or study questions.
- » Providing information about the study and data collection tools that are easy to understand for those with literacy issues.
- » Being cognisant of the personal circumstances of participants at the time of their presentation at the clinic.
- » Conducting the surveys at the commencement of the client visits so that data can be screened immediately following collection while clients are receiving the service, and so that any misunderstandings apparent in the data can be clarified with the client prior to their departure.
- » Providing researchers with detailed induction and cultural awareness training prior to the placement, close supervision by academic and service staff, and oversight by the Reference Group to maximise the effectiveness of the data collection process.

In addition, the research project was discussed at a staff meeting both to brief staff and to develop an 'alert system' that would identify participants who may need to debrief about the experience following their participation. Protocols for dealing with clients who needed to debrief were linked to existing service procedures concerning client counselling. Health professionals and counselling staff were also available to clients at Access Health throughout this study to deal with any health- or wellbeing-related matters.

## Structure of this Report

The introduction highlights the research aims and outlines how the project was managed by the Reference Group, provides an overview of the methodology and discusses how issues of vulnerability were managed in the project.

Section 1 is a literature review undertaken to better understand the health and wellbeing needs of the Aboriginal people accessing AH's primary health care services. This section also includes an overview of Access Health's structure in the context of the Salvation Army's broader crisis services, and current trends in the health and wellbeing of Aboriginal clients nationally and those in the Victorian population utilising the service.

Section 2 captures the data derived from interviews with AH staff that was part of an on-line survey. While it is apparent that the current services are comprehensive, holistic and consistent with the Salvation Army Statement, staff identified individual and systems-based innovations that, if implemented, could better meet the needs of its Aboriginal clients.

Section 3 outlines information from the client survey. Of the more than 40 Aboriginal clients recruited, some are new clients, some have been engaged with AH for between 5–10 years while others have been visiting the service on an ad hoc basis for more than 10 years. In addition, key information regarding pattern of use, social determinants of health and recommendations to improve the service are considered.

Section 4 includes recommendations from each of the previous sections and combines this advice with the findings contained in the data set created from this project.

# Section 1: Literature Review

## Background

This literature review identifies issues facing Aboriginal people when accessing mainstream services. It also identifies the core elements of primary health care services that are most used by vulnerable Aboriginal people and best practice solutions in providing services to those with multiple needs. Also scoped in this review are partnership approaches with other organisations detailing the best point of access through which Aboriginal people can source a more appropriate range of primary and other health care services.

## Overview of the Salvation Army Crisis Services

The Salvation Army Crisis Services provide confidential, practical assistance and support to people in crisis within the Victorian community. The program acts as a Statewide crisis support and information provider to individual clients or families in need of services related to housing and accommodation, family violence, financial difficulties, substance

abuse and/or mental health problems, but for whom access to mainstream community facilities is impaired or prevented. Funding is jointly provided by the Victorian Department of Human Services and the Commonwealth Department of Health and Ageing (now the Department of Health), augmented by public donations. The program emphasises outcomes across four key areas:

1. Providing practical and responsive services
2. Delivering transparent and accountable programs
3. Developing strong and active community partnerships
4. Advocating for an equitable and just society.

Service provision occurs across five primary agencies, augmented by finance and research divisions, as shown in Table 1 below.

**Table 1: Structure of Salvation Army Crisis Services**

Service	Program
Crisis Support	Crisis Contact Centre Interim Support Linkage Program
Chaplaincy Community Support	Chaplaincy Program
Family Violence	Family Violence Outreach Program Private Rental Access Program
Health Services	Access Health Program Health Information Exchange Program Bridge AOD Service
Operations/Finance	
Research & Program Development Services	
Youth and Family	Youth and Family Crisis Accommodation Program Youth and Family Outreach Program Youth Private Rental Access Program

Source: *The Salvation Army 2012b*

Crisis Support makes available a 24-hour telephone service for homeless people – the Homelessness Support Line – in addition to housing, Centrelink and legal services (The Salvation Army 2012b). The Interim Support Linkage Program provides temporary intensive support for individuals and families wanting to acquire long-term housing and other services in partnership with community-based organisations, while the Chaplaincy Program offers pastoral assistance around issues of faith and spirituality. Family Violence services, including the Family Violence Outreach program, provide safety, legal, advocacy, housing information and referral support in addition to a crisis response to women and children experiencing or at risk of violence.

The Youth and Family Crisis Accommodation Program makes available emergency accommodation, assistance with securing long-term housing, and support for legal issues, independent living skills, and problems of substance abuse and/or domestic and sexual violence. The Youth and Family Outreach Program provides similar supports, but within a community-based outreach model. And, finally, the Research and Program Development Services coordinate strategic program development and planning according to the priority areas of student placement and linkages to tertiary research institutions, the development and management of the research and advocacy plan, and quality improvement.

### Access Health program

Health services delivered through the Access Health program and the Health Information Exchange Program constitute a vital component of the Salvation Army Crisis Services. Access Health offers easily available and approachable PHC services that augment the health and welfare of people who are underprivileged and ostracised. It provides a cost-free, non-appointment based primary care health service for disadvantaged and vulnerable people, focusing particularly on clients who are homeless, injecting drugs and/or working as street sex workers. The program, in collaboration with other support agencies, provides a full range of allied health services – general practitioners, community health nurses, dietitians, drug and alcohol counsellors, psychiatrists, psychologists, physiotherapists and a sexual health nurse – along with shower facilities (The Salvation Army 2012b). The Health Information Exchange Program is a free and confidential needle and syringe program providing materials for safe injecting and safe sex practices, as well as information and referrals for drug-related issues and sexually-transmitted and blood-borne diseases (The Salvation Army 2012).

**Table 2: Partners of the Access Health and Health Information Exchange Programs**

Access Health Program	Health Information Exchange Program
Alfred Hospital Infectious Diseases Unit	Burnet Institute
Alfred Hospital Department of Psychiatry	National Centre in HIV Epidemiology & Clinical Research
Inner South Community Health Service	University of New South Wales
Royal District Nursing Service Homeless Persons Program	Prahan Psychology
Ngwala Willumbong	
St Vincent's Hospital Department of Community Medicine	

Source: *The Salvation Army 2012a*

Services provision uses a social determinants of health framework, with an emphasis both on health promotion and reducing injustice and inequality (Rowe 2005). There is also a strong emphasis on collaborative partnerships (see Table 2), with more than 80 per cent of services delivered via partner organisations. This acknowledges the complex needs base of the majority of clients and aims to facilitate both comprehensive care, and transition and service uptake, between Access Health and mainstream providers. The coordinated and comprehensive structure of this care model has facilitated client access to, and navigation of, care providers while also optimising health care delivery through mechanisms such as case management and planning. Services are coordinated by a case manager according to individual requirements (The Salvation Army 2012a). Overall a diversity of services, many of which are at Access Health, are accessed, ranging from health and allied health practitioners to social workers, drug and alcohol counsellors and health promotion groups (see Table 2).

More than 1000 clients (1249 in 2011/2012) utilise the service annually, with a significant proportion of these new clients (40.5% in the 2011/2012) (see Table 3), the vast majority of whom (76.8%) are aged 20–49 years. Significantly, the total number of contacts (9725 for 2011/2012, see Table 4 overleaf) suggest that, on average, clients made use of multiple services

at the site. Aboriginal clients comprised approximately 13 per cent of the total, even though they constitute less than 1 per cent of the total Victorian population (ABS 2003). Furthermore, Aboriginal clients represented almost 19 per cent of the total client contacts (18.4%), which suggests repeated and diverse service utilisation. This indicates that Access Health provides services of a type and/or format that are particularly relevant to some Aboriginal people in inner-city Melbourne. Indeed, AH offers a vital role in providing clients with linkages to a variety of government and non-government services.

Thus, high-level specialist health care is accessible through partnerships with tertiary health care and research institutions such as the Alfred and St Vincent's hospitals, the National Centre in HIV Epidemiology and Clinical Research and the Burnet Institute. Services catering specifically to the needs of Aboriginal people are made available through organisations such as the Ngwala Willumbong Cooperative, which offers high-quality, culturally appropriate programs addressing social disadvantage and alcohol and drug issues (Ngwala Willumbong Cooperative Ltd 2011). It may be expected that expansion or enhancement of the service could impact positively on the absolute numbers of and frequency with which Aboriginal people access primary health care in Melbourne.

**Table 3: Access Health Program: Overview of Client Demographics 2011–2012**

Access Health Program 2011/2012	Number of clients	% of total number of clients
Number of new clients	506	40.5%
0–19 yrs of age	37	
20–49 yrs of age	389	
50–70+ yrs of age	80	
Indigenous clients	161	12.8%
<b>Total number of clients</b>	<b>1249</b>	<b>100%</b>

Source: The Salvation Army 2012a

Physical health problems formed the primary reason for an initial consultation, with a majority involving drug and alcohol issues (Rowe 2005) (see Table 4). Clients typically present with multiple, often complex, issues including mental health and behavioural problems. This complexity highlights one of the advantages of a

partnership-based service delivery system, as referrals to on-site and external allied health practitioners can also complement immediate primary care. This affords an opportunity to link the client into services they might otherwise fail to access.

**Table 4: Access Health Program – Service Summary**

Service area	Number of contacts	Percentage of all contacts
Aboriginal Access Worker	682	7.0%
Community Health Nurse	3594	37.0%
Dental Program (off-site)	33	0.3%
Dietitian	29	0.3%
Drug & Alcohol Counsellors	89	0.9%
Duty Social Worker/s	570	5.9%
General Practice Nurse	116	1.2%
General Practitioner	3472	35.7%
Health Promotion Groups	445	4.6%
Infectious Diseases Specialist	38	0.4%
Outreach Case Manager	126	1.2%
Podiatrist	46	0.5%
Psychiatrist	141	1.4%
Psychologist	259	2.7%
Physiotherapist	32	0.3%
Sexual Health Nurse	53	0.5%
<b>Total Number of Contacts</b>	<b>9725</b>	

Source: *The Salvation Army 2012a*



## Salvation Army: Statement of Reconciliation

Through its *Statement of Reconciliation*, the Salvation Army has recognised that Australia's Aboriginal and Torres Strait Islander people experienced enduring and intolerable discrimination throughout the years from the period of white settlement to the present (The Salvation Army (Victoria) Property Trust 2000). The history of colonisation in Australia, and the consequent effects of profound disruption, dispossession and discrimination, have deprived Aboriginal and Torres Strait Islander people of their basic rights to self-respect, good health and decent living conditions. Furthermore, the Australian nation has failed to effectively address these issues, to sufficiently understand Aboriginal and Torres Strait Islander culture and customs in the generation of legislation or in service provision, and to adequately engage in collaboration and the promotion of self-governance (The Salvation Army (Victoria) Property Trust 2000). Inadequate or badly chosen policy responses and erratic service delivery have further contributed to undermining Aboriginal and Torres Strait Islander people's access to essential services like health care, housing, water, food and transport (Uniting Care Children Young People and Families).

The Salvation Army has invested considerable resources toward addressing this inequity through providing comprehensive primary health care services. According to the World Health Organization (WHO), comprehensive PHC is intended to address the major causes of morbidity and mortality in a community in addition to engaging in various health-promoting, preventive, curative and rehabilitative services (WHO 1978). The services to be provided should be determined on the basis of need, and should also include services external to the health sector including housing, food and education (WHO 1978). This is consistent with the holistic view of health held by Aboriginal and Torres Strait Islander people in which health is considered to be multifaceted, involving complex inter-relationships between physical,

social and emotional domains within the context of the wellbeing of the wider community (Australian Government DoHA 2012).

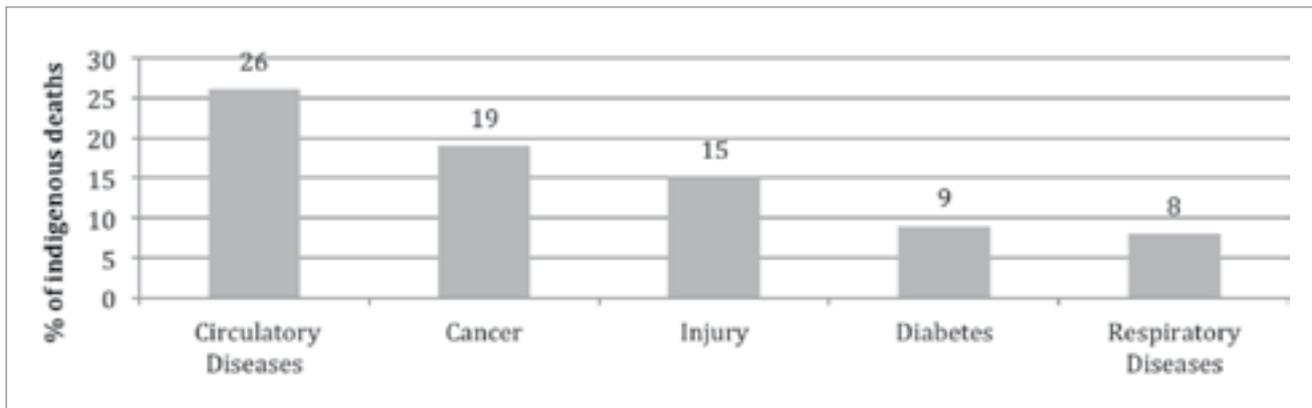
## The Health of Aboriginal and Torres Strait Islander People

### Overview of current health trends

In Australia, the Aboriginal and Torres Strait Islander population continues to experience earlier mortality or greater morbidity rates – including higher rates of illness, disability and injury – compared with other Australians (Australian Government DoHA 2012). This is in contrast to advances made in the health of indigenous populations of comparably colonised developed countries (National Aboriginal and Torres Strait Islander Health Council 2003), and despite numerous federal and State-based government policies and initiatives to improve Australian and Torres Strait Islander health outcomes (Australian Human Rights Commission 2012).

While leading causes of mortality among Aboriginal and Torres Strait Islander people reflect conditions prevalent in the non-Indigenous population – including cardiovascular disease, cancer, diabetes, and respiratory and kidney disease – these chronic health conditions account for approximately two-thirds of the gap in health outcomes between Aboriginal and Torres Strait Islander and other Australians (see Figure 1 overleaf). Aboriginal and Torres Strait Islander people also experience a higher prevalence of infant morbidity, eye and ear infections, sexually transmitted diseases and HIV/AIDS compared with other Australians (Australian Human Rights Commission 2012; Australian Indigenous HealthInfoNet 2012).

**Figure 1: Leading Causes of Death for Aboriginal and Torres Strait Islander People 2006–2010**



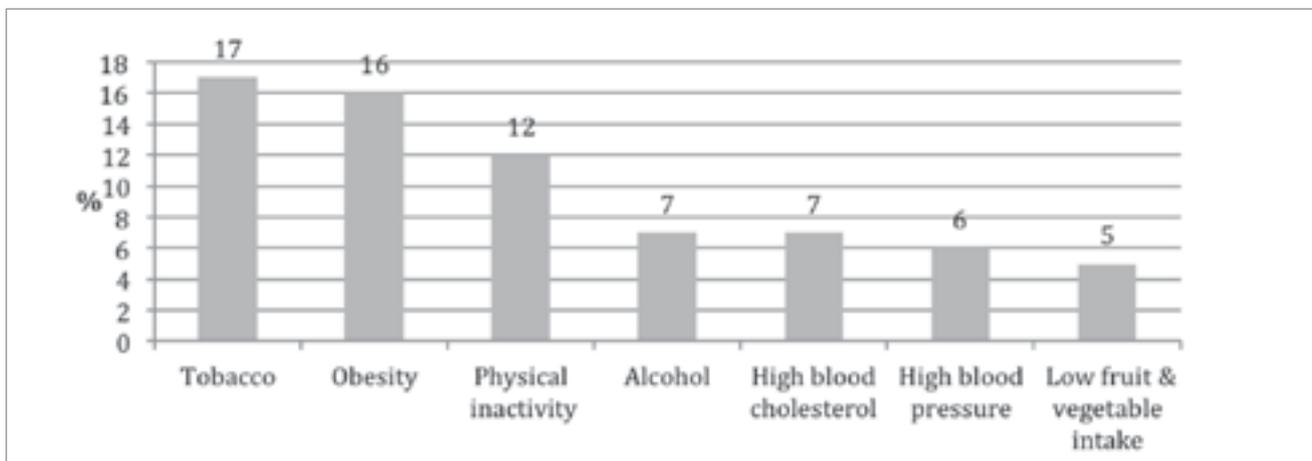
Source: Australian Government DoHA 2012

Aboriginal and Torres Strait Islander people also demonstrate higher rates of preventable diseases, including an increased frequency of communicable and sexually transmitted diseases such as HIV, Hepatitis C, Chlamydia and Trichomoniasis (AIHW 2008; Victorian Advisory Council on Koori Health 2009; MSHC 2012). They are four times more likely to be hospitalised for conditions associated with alcohol use, and more than twice as likely for conditions associated with substance use (Australian Government DoHA 2012). Indeed, the majority of Aboriginal and Torres Strait Islander primary

health care services provide treatment for substance use, while the demand for assistance surrounding multiple drug use is increasing (AIHW 2012).

Higher rates of risk factors – including smoking, obesity and physical inactivity – among Aboriginal and Torres Strait Islander people account for half the gap in health outcomes when compared with other Australians (see Figure 2). Many of these risk factors are strongly linked to social determinants of health including socio-economic status and education.

**Figure 2: Risk Factors Contributing to the Health Gap between Aboriginal and Torres Strait Islander People and Non-Indigenous People**



Source: Australian Government DoHA 2012

## The Koori population in Victoria

The current Aboriginal population of Victoria is approximately 37,600 (0.65% of the total population), with 50 per cent aged 18 or under. The number aged 55 years or over is increasing at a rate three times that of the non-Indigenous population. The health care needs of these groups are likely to differ substantially. According to the Australian Bureau of Statistics in 2001, 26 per cent of Aboriginal and Torres Strait Islander people lived in remote and very remote areas of Australia, compared with 2 per cent of non-

Indigenous Australians. In contrast to these national trends however, almost half of Victoria's Aboriginal population resides in metropolitan Melbourne (Victorian Government DoH 2012). Overall, affordable health services are present in those areas of Victoria with high concentrations of Aboriginal populations (Victorian Government DoH 2012). However, there are still considerable gaps between their health status and that of the non-Indigenous population (Victorian Government DoH 2012) (see Table 5), indicating an inadequate number of primary health care services.

**Table 5: Victorian Aboriginal Health Indicators**

<b>Snapshot of the Victorian Aboriginal Health Indicators</b>
In Victoria, the perinatal mortality rate of babies of Aboriginal mothers is about twice that of babies of non-Aboriginal mothers.
The rate of low-birth weight babies born to Aboriginal mothers in Victoria is around twice that of non-Aboriginal mothers.
In Victoria, child mortality for Aboriginal children aged under five years of age is more than double the non-Aboriginal rate.
Use of tobacco by Aboriginal people in Victoria aged over 18 years is more than one and a half times the rate for non-Aboriginal people.
As per both emergency department and hospital admission data, it is seen that the rates of alcohol-related harm are higher for Aboriginal Victorians than the general population.
Overall rates of hospitalisation for most causes are higher for Aboriginal people in Victoria by one and a half times when compared to non-Aboriginal people. Rates are more than double for several clinical specialities including dental, dialysis, psychiatry, neonatology and antenatal care.
Potentially preventable hospitalisations of Aboriginal people in Victoria are more than three times higher than for non-Aboriginal people.
Presentations to hospital emergency departments for Aboriginal people in Victoria are double the rate for non-Aboriginal people.
In Victoria, mental-health-related admissions of Aboriginal people are considerably higher than non-Aboriginal admission rates.
Aboriginal people are 2.4 times more likely to have a disability than non-Aboriginal people.
The average life expectancy for Aboriginal Australians is 67.2 for males and 72.9 for females compared with 78.7 and 83.5 for non-Aboriginal Australians respectively. The average life expectancy gap between Aboriginal and non-Aboriginal Australians is 10.6 years for men and 9.5 years for women (ABS 2013).

Source: Department of Health 2012



## Health Service Usage by Aboriginal and Torres Strait Islander People

In general, Aboriginal and Torres Strait Islander people in Australia experience lower levels of access to mainstream services than non-Indigenous people and this plays a vital role in their poorer health status (ABS & AIHW 2005). On a national scale, significant factors influencing access to primary health care include:

- » distance from services and transport issues
- » the limited availability of health services, amenities and qualified professionals
- » the unaffordability of services, medicines, health insurance and transport costs
- » language and communication issues, such as poor proficiency in English and limited access to telephones
- » lack of education, and
- » a cultural incompatibility of services that encompasses a lack of trust and conflicting health beliefs (ABS & AIHW 2005; Stoneman & Taylor 2007; Scrimgeour & Scrimgeour 2008).

A further major barrier of significance to older people is shame about health problems, mostly due to a lack of self-esteem stemming from past experiences (Scrimgeour & Scrimgeour 2008).

Racism also constitutes a significant influence over access to health care services, with research indicating that three-quarters of Aboriginal and Torres Strait Islander people frequently experience racial discrimination while accessing primary health, resulting in delays in diagnosis and treatment (Paradies, Harris & Anderson 2008). Indeed, this racism may account for the fear of hospitals and other health care facilities that is reportedly experienced by the majority of Aboriginal and Torres Strait Islander people (Victorian Government DoH 2010). Cultural insensitivity on the part of health care services, in addition to a lack of understanding by Aboriginal and Torres Strait Islander people of the services and facilities available through

health care providers, may also contribute to this. Poor promotion of available services to Aboriginal and Torres Strait Islander communities further accentuates this trend (Victorian Government DHS 2004).

Unsurprisingly, the health needs and access issues impacting on Aboriginal and Torres Strait Islander people's health tend to differ according to demographic variables. Thus, urban Aboriginal and Torres Strait Islander people report lower levels of satisfaction with access to health services when compared to those from remote areas (Scrimgeour & Scrimgeour 2008). This dissatisfaction stems from inadequate cultural security, feelings of alienation within these services and consequent issues of relevancy (Scrimgeour & Scrimgeour 2008; Australian Government DoHA 2012).

By contrast, among marginalised sub-populations of Aboriginal and Torres Strait Islander people – including injecting drug users, street-based sex workers and homeless people – the mechanisms behind lower levels of access to health services can be diverse. Homelessness tends to be associated, through complex relationships, with various behaviours or circumstances that impact negatively upon health status including mental health disorders, substance abuse and sex work (Rowe 2003; Johnson & Chamberlain 2008). The diversion of resources for daily living into substance use behaviours may also precipitate a dependency on emergency relief services, such as those offered by institutions like the Salvation Army Crisis Centre or the St Vincent De Paul Society (Rowe 2007). Furthermore, the complex service needs of these populations are often inadequately addressed through mainstream health services that are ill-prepared to respond rapidly and effectively to acute needs as they arise (McDonald 2002; Rowe 2005). Other potential barriers to accessing health care may include the need to make and keep appointments, extended waiting times, financial hardship, the difficulties associated with negotiating formalised administrative systems such as Medicare (Rowe 2003), and condemnatory or biased attitudes among health providers that serve to alienate vulnerable clients (Abouyanni 2000).



The cultural proficiency of health services impacts significantly on Aboriginal and Torres Strait Islander people's decisions to utilise health services. Experiences of feeling unwelcome or uncomfortable in a particular health service may result in postponement or avoidance of accessing medical care in the future (Australian Government DoHA 2012). The presence of Aboriginal and Torres Strait Islander staff may play a significant role in attenuating exposure to these experiences (ABS & AIHW 2005), which can be augmented further by the presence and availability of appropriately gendered staff (ABS 2003). While access to an Aboriginal or Torres Strait Islander Health Worker can be limited overall, this is especially the case for patients seeking care from a male health worker. Although the majority (56%) of Aboriginal Torres Strait Islander communities have daily access to female Aboriginal or Torres Strait Islander Health Workers, only a minority (27%) had similar access to a male health worker (ABS 2003).

### **Primary health care usage patterns of Aboriginal and Torres Strait people**

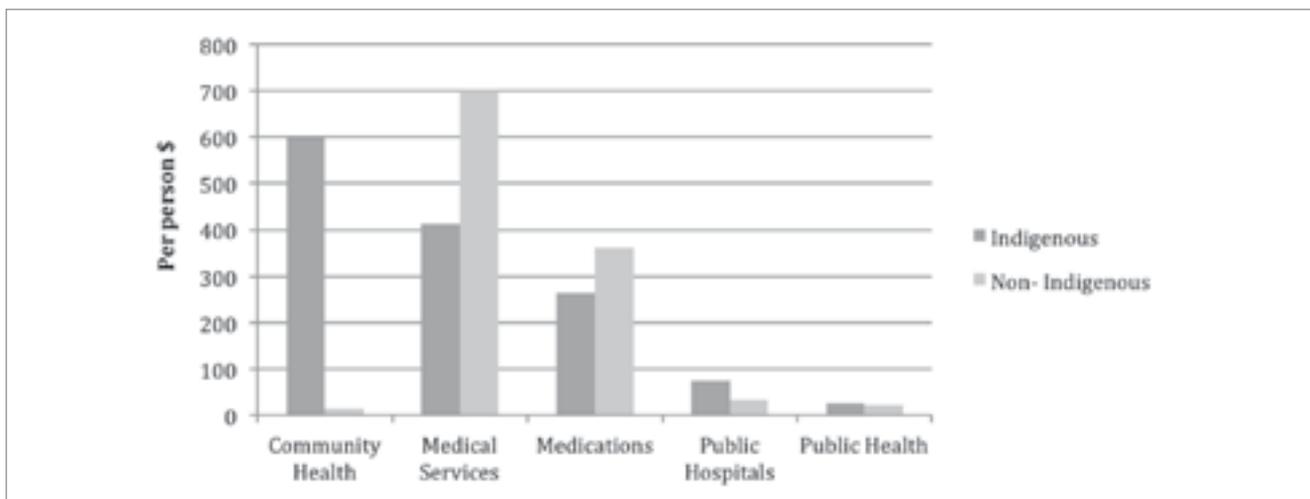
National health expenditure overall is greater per capita for Aboriginal and Torres Strait Islander people when compared with other Australians, averaging 39 per cent more per individual (AIHW 2011). Usage patterns of the health system by Aboriginal and Torres Strait Islander people, however, differs substantially (see Figure 3 overleaf). Statistics on health system usage by Aboriginal and Torres Strait Islander people demonstrate a high use of public hospitals and community health services and a relatively lower utilisation of privately provided medical, pharmaceutical, dental and other specialist health services (AIHW 2009). Indeed, almost a quarter (22.2%) (see Figure 3 overleaf) of total Aboriginal and Torres Strait Islander health expenditure involves community health services, compared to a much lower expenditure among the non-Indigenous population (AIHW 2011).

This increased demand for public hospitals and community health services is driven in part by socio-economic factors. Aboriginal and Torres Strait Islander people have, on average, much lower incomes when compared to other Australians. In the year 2006, for example, median gross weekly household income was \$460 and \$740 for Aboriginal and Torres Strait Islander people and other Australians respectively (AIHW 2009). This, in addition to the lower rates of private health insurance, is likely to promote a greater reliance on public or community health services and charitable institutions (AIHW 2009; Deeble 2009).

Aboriginal and Torres Strait Islander people also differ in their usage of health-based benefit schemes. Records of Medicare (MBS) and the Pharmaceutical Benefits Scheme (PBS) payments indicate that Aboriginal and Torres Strait Islander people claim only 60 per cent of the total benefits available to them when compared to those claimed by other Australians (AIHW 2009). This may, in part, reflect the greater usage of the public hospital system by Aboriginal and Torres Strait Islander people (AIHW 2009).

Analysis of the patterns of health system usage by Aboriginal and Torres Strait Islander people is, however, hampered by a lack of accurate statistics due to the prevalence of under-identification of Aboriginal and Torres Strait Islander people in numerous data sets (AIHW 2010; AIHW 2011). Accurate statistics documenting the health of Aboriginal and Torres Strait Islander people are vital for determining the nature and magnitude of disparities in health outcomes, the efficacy of health services in responding to need, and for policy development and planning regarding health service usage patterns (AIHW 2010).

**Figure 3: Direct Expenditure per Person on Health by the Australian Government for Indigenous and Non-Indigenous Australians, 2008–2009**



Source: AIHW 2011

## Optimising Service Provision to Aboriginal and Torres Strait Islander People

A number of areas concerning primary health usage provide a focus for resources and program development because of their relevancy to the contributors to health disparities for Aboriginal and Torres Strait Islander people and their potential to contribute to optimising health outcomes. These include:

- » issues around access to health care
- » the role of case management
- » the benefit of partnerships
- » cultural competency and staff support measures, and
- » factors particularly associated with the needs of marginalised populations.

### Promotion of service access

Access provides a crucial element in terms of the degree of uptake of services by Aboriginal and Torres Strait Islander people. Flexibility is also an important, if

challenging, aspect of effective service design, structure and function (Stewart, Lohaar & Higgins 2011). This can manifest in various strategies to maximise service relevancy and approachability such as via flexible appointment scheduling, outreach services or innovative methods to engage clients. Building up of trust and rapport within the Aboriginal and Torres Strait Islander communities is an essential element of success in service provision, and this is particularly pertinent in the case of marginalised people. The direct promotion of information about the range and accessibility of services to Aboriginal and Torres Strait Islander communities provides an effective strategy to enhance service access (Hayman, White & Spurling 2009). Thus, the removal of services from a traditional health care setting to one that is more informal, such as the presence of Drug and Alcohol counsellors at Aboriginal and Torres Strait Islander community events and informal discussions about substance use issues with community members, has proven beneficial (Allan & Campbell 2011).

Intensification of service availability through outreach programs and community visits by Aboriginal and Torres



Strait Islander Health Workers greatly enhances the efficacy of service delivery in urban and rural contexts. This permits the establishment of positive relationships outside the service provider–client context (Westerman 2004), and has the added benefit of gaining continued trust and of assisting Aboriginal and Torres Strait Islander people to use more mainstream services (AMA 2011). Methods such as these also permit greater community control over the types and nature of interventions, in addition to reaching those members of the community who will less readily seek treatment through more formalised settings (Allan & Campbell 2011).

Enhancing the approachability of specific health services for Aboriginal and Torres Strait Islander people is also critical in terms of establishing and maintaining an ongoing therapeutic relationship, and various methods of doing so have been identified. For example, increasing the number of Aboriginal and Torres Strait Islander employees has been effective in increasing service access (Hayman, White & Spurling 2009), while the amicability and friendliness of health service staff further influences the perceived approachability of the service for Aboriginal and Torres Strait clients (Isaacs, et al. 2010).

Program structure and organisation will also increase the likelihood of client uptake. The benefit of structuring a service to the context of its clients is evidenced by successful holistic programs such as that adopted for the Jimaylya Topsy Harry Centre for the management of homeless Aboriginal clients in Mt Isa, which permitted its strengths and gaps in service provision to be openly reviewed (Memmott & Nash 2012). Similarly, the Wulumperi Sexual Health Unit, which forms part of the Indigenous Australian's Sexual Health Program, provides services that are cost free, do not require appointments and are highly confidential (Australian Indigenous HealthInfoNet 2012; Melbourne Sexual Health Centre 2012a). Programs may also permit an entry point to additional services of benefit to the client. Thus, needle and syringe programs, while successfully reducing blood-borne virus rates, also act as access points to other PHC and support or rehabilitation services (Dolan 2005).

Federal policy may also benefit Aboriginal and Torres Strait Islander people through broad-based initiatives targeted at particular vulnerable groups. 'Closing the Gap' government programs, like the Practice Incentive Program and Pharmaceutical Benefits Scheme, are helping Aboriginal and Torres Strait Islander people to better manage chronic diseases (Australian Government DoHA & Medicare Australia [n.d.]). Targeted strategies specific to the needs of the particular client community are also required. Thus, in areas where mobile populations are more common, resident counts may assist in assessments of service demand by Aboriginal and Torres Strait Islander populations (Taylor 1996). Additional strategies, such as the display of items celebrating or depicting Aboriginal and Torres Strait Islander culture, promote acceptance and trust in a service and subsequently encourage compliance and improved patient outcomes (Hayman, White & Spurling 2009; Isaacs, et al. 2010).

A service provider's response to racism is also of critical importance to Aboriginal and Torres Strait Islander people (Youth Action and Policy Association NSW 2012), with the adoption of a 'no discrimination' policy serving to enhance the relationship between the client and the service (Youth Action and Policy Association NSW 2012). In this context, cultural awareness training for all staff members is a vital strategy for promoting access to the service. Clearly, the development and implementation of adequate strategies to promote the accessibility and approachability of a given health provider also requires accurate statistics on the cultural identities of clients, with the under-identification of Aboriginal and Torres Strait Islander people being problematic for improved service delivery. National best practice guidelines advise that a response to the Indigenous status question should be a mandatory prerequisite when making client records or registering a client to a service (AIHW 2010), with self-report understood to provide the most accurate record of Aboriginal and Torres Strait Islander status.



## The role of case management

Case management can also constitute a highly effective element of health care provision for Aboriginal and Torres Strait Islander people by assisting clients in developing and utilising their personal skills and traits to overcome obstacles and prevent further setbacks (NSW Government DFCS 2012). Successful case management may, therefore, incorporate the provision of basic needs through universal services that support the client's health, education, life skills and employment prospects, in addition to targeted and longer term interventions through integrated local community networks (NSW Government DFCS 2012).

The benefits of case management are numerous for both Aboriginal and Torres Strait Islander clients and the service providers. For clients, effective case management provides well-organised service delivery, while avoiding replications, and improved outcomes due to clarity in appraisal and planning (NSW Government DFCS 2012). Participation in decision-making, knowledge and skill acquisition, as well as access to essential services, afford clients an opportunity for self-empowerment and resilience. Service providers experience increased client satisfaction, enhanced efficacy of resource use to yield improved outcomes, improved relationships both between different service providers and between providers and clients, decreased rates of re-presentation for services, and less provider stress (NSW Government DFCS 2012). Furthermore, as a result of these effects, gaps in service provision and delivery are highlighted and addressed (NSW Government DFCS 2012).

## The role of partnerships

Best practice in PHC service provision for Aboriginal and Torres Strait Islander people also involves models based on collaborative partnerships between different levels of government, Aboriginal community controlled organisations, and non-government organisations in the health, education, training and employment sectors (AMA 2011; Australian Government DoHA 2012). These partnerships are essential in developing

sustainable long-term health solutions that foster continuity of care and are well matched to the specific needs of the greatest diversity of individuals (AMA 2011; Australian Government DoHA 2012). Ongoing collaborative linkages between services are vital for promoting and maintaining continuity of care, particularly in the context of Aboriginal and Torres Strait Islander people with complex needs and subject to multiple disadvantages (AMA 2011).

Collaborative engagement between Aboriginal and Torres Strait Islander people and PHC policy makers and providers is vital for maximising program efficacy. Encouraging and maintaining the involvement of Aboriginal and Torres Strait Islander people in all processes concerning service delivery provides a critical opportunity for the feedback required to maintain culturally secure and relevant services (AMA 2011). Indeed, health services controlled by Aboriginal and Torres Strait Islander communities have demonstrated superior outcomes over mainstream health providers for certain diseases, such as cardiovascular disease, that contribute significantly to mortality and morbidity (AMA 2011). This process is dependent upon the inclusion of perspectives that incorporate a developed understanding of the culture and practices of Aboriginal and Torres Strait Islander people, and permits scope for self-governance and community ownership. Consultation and the inclusion of Elders and other community representatives during the planning and implementation of programs are critical in promoting these partnerships. The importance of self-determination and community control has been demonstrated through the success of various public health programs. These include the Rumbalara Home Ownership Program initiated by the Rumbalara Aboriginal Cooperative in conjunction with various federal government departments and private partners (Fletcher 2007).

Similarly, the SNAKE Condom initiative comprises a successful sexual health program resulting from a partnership between the Victorian Aboriginal Community Controlled Health Organisation and various private organisations in response to a recognised unmet need for sexual health education



among Aboriginal youth. Many of the health problems encountered by Aboriginal and Torres Strait Islander people are complex and multi-factorial, traversing health, education, training and employment. In order to respond effectively and sustainably to these issues, it is crucial that partnerships operate at multiple levels – across government, the Aboriginal community controlled sector and non-government organisations (Australian Government DoHA 2012). Nevertheless, various difficulties may arise in terms of collaborative service delivery. These include:

- » communication difficulties or lack of trust between partner organisations
- » restricted knowledge of each other's services
- » differing views about staff competencies
- » resource limitations
- » cultural diversity, and
- » diverse work techniques (Taylor, et al. 2013).

However, in spite of these challenges, such partnerships afford significant potential for service enhancement, such as through their scope for ongoing knowledge exchange.

The use of partner organisations also has the potential to address the frequent impediment of inadequate resources in health care service delivery. Lack of resources, whether in terms of funding or human or material resources, constitutes a major impediment to service delivery and this is exacerbated for clients with high needs or from areas of greater disadvantage. Indeed, coordinated service delivery proposals generally do not work well without the investment of substantial time and resources (Stewart, Lohar & Higgins 2011). A shortage of experienced staff, program leaders and practitioners may also compromise program development and delivery (Stewart, Lohar & Higgins 2011). The use of partner organisations and in-kind support can partly attenuate these problems, although clearly defined roles and responsibilities will be required. In order to meet challenges encountered during collaboration, it is important to recognise the critical role of adequate support, in terms of time and funding, for factors such as program implementation

and the fostering of relationships between collaborators (Taylor, et al. 2013).

### **Cultural competency**

Service provision for Aboriginal and Torres Strait Islander people also requires an approach that acknowledges cultural diversity and has scope for its integration into fundamental aspects of program structure (Stewart, Lohar & Higgins 2011). Support for Indigenous cultural awareness programs provides an important strategy for promoting cultural sensitivity. Isolated programs, however, cannot be assumed to satisfy requirements for cultural competency (Australian Government Productivity Commission 2011), as they may in fact increase apprehension among some staff regarding their ability to engage with clients (National Disability Services NSW 2010).

To be effective, therefore, cultural competency training needs to be embedded and supported in the workplace, and promoted via multiple avenues, including positive individual staff experiences, organisational knowledge and consultation, and via ongoing support programs such as tailored Indigenous Cultural Awareness Training sessions (Australian Government Productivity Commission 2011). The involvement of local Aboriginal communities in training sessions can greatly augment the success of these programs as they allow for the imparting of information by Elders on culturally acceptable communication styles, cultural taboos, gender roles and common misconceptions (Australian Government Productivity Commission 2011).

### **Staff support measures**

The professional development of staff constitutes a further target for interventions to enhance the efficacy of health program service delivery. While ongoing professional development should be an essential part of all employment packages, it should also be recognised that the needs of staff will differ depending on their prior experience and education. Training in cross-cultural awareness is a vital issue for all staff, but Aboriginal and Torres Strait Islander staff may require



training in additional skills such as advocacy and leadership (Wood, et al. 2011). Staff support may involve various strategies including mentoring, and the creation of family friendly workplaces and informal learning opportunities (Wood, et al. 2011).

### **Strategies for marginalised populations**

A number of aspects are required in the planning and implementation of successful health care delivery and promotion strategies. This is particularly pertinent in the case of marginalised people, where a holistic approach to service delivery is critical for promoting resiliency and self-sufficiency (Fletcher 2007). The Victorian Homelessness Action Plan 2011–2015, drafted by the Victorian Government, thus advocates for an innovative and broad-based approach focusing on models that prioritise prevention and early intervention strategies, so that resources are utilised to create maximum impact (Victorian Government DHS 2011). Although focusing on accommodation, the Action Plan also recognises the contribution of health and education to overall wellbeing and to attenuating the effects of adverse life circumstances.

Thus, innovative methods for connecting with marginalised populations or those with access difficulties should continually be trialled and promoted in an attempt to overcome barriers. Initiatives such as the Automated Telephone Disease Management system, which addresses chronic disease management, has been shown to elicit accurate patient information, promote increased vaccination rates and improved treatment outcomes, and lessen communication difficulties (Piette 2000; McDonald, et al. 2004). Another is the Youth Foyers that target young people who are currently homeless, or at risk of homelessness, and provide them with secure accommodation in the context of education, training and general support (Victorian Government DHS 2011).

Similarly, strategies addressing the use of alcohol and other drugs occupy an important role in harm

reduction given that reducing alcohol and other substance misuse can significantly reduce levels of violence and disability, as well as improving the overall health and wellbeing of a community (Australian Government DoHA 2012). Victoria's Koori Alcohol Action Plan 2010–2020, for example, recognises the critical need for addressing alcohol-associated harm in Aboriginal communities (Victorian Government DoH 2010). However, Aboriginal and Torres Strait Islander people indicate a preference for alcohol and drug intervention programs that differ from those currently available (Nichols 2010), many of which are inadequate (Scrimgeour & Scrimgeour 2008). Those conducted through the Aboriginal Medical Services have proven more successful, but are in need of increased resources. Current mainstream programs, therefore, require innovative development and resource support to incorporate a focus on the life skills vital for self-determination (Nichols 2010), such as through the inclusion of TAFE (Technical and Further Education) course provisions (Nichols 2010; Memmott & Nash 2012).

A number of strategies and approaches are particularly specific for engaging and maintaining effective health provider relationships with marginalised Aboriginal and Torres Strait Islander populations. The needs of homeless Aboriginal and Torres Strait Islander men, for example, have been shown to be culturally specific, with some arguing for the implementation of individualised and innovative service designs (Memmott, Birdsall-Jones & Greenop 2012). Factors relating to the lifestyle patterns of Aboriginal and Torres Strait Islander people, their kinship practices, avoidance, mourning, and visiting behaviours, and the mechanism of sleeping group formation and partnering, need to be considered during the design of services and throughout individual case management (Memmott, Birdsall & Greenop 2012).



## Conclusion

A number of key factors have been highlighted in this review and warrant further investigation and inclusion in the recommendations contained herein. The review demonstrates that Access Health has a strong commitment to improving the health and wellbeing of marginalised and vulnerable populations by optimising access for its clients to comprehensive service provision, facilitating case management strategies, demonstrating cultural competency, working through specific strategies for marginalised populations and investing in individualised and innovative services.

An overall assessment of the service scope within Access Health shows that it undertakes best practice strategies founded in well-developed and well-communicated principles. However, there is also a range of opportunities both to enhance and accelerate a systems' responses to the highly individualised needs of clients within complex and challenging contexts. These ideas are further explored in the next section of the report, which focuses on staff responses to an online survey about working with Aboriginal and Torres Strait Islander clients.





# Section 2: Results of Staff Survey

The following section is based on survey responses from staff at AH. Survey Monkey was used to collect and collate staff responses, and then to assess and make recommendations based on these responses to questions related to the following:

1. Working in Access Health
2. Working with Aboriginal Clients
3. Working with Community
4. Meeting the Needs of Clients
5. Referral to other Services
6. Support for Staff to Meet the Needs of Aboriginal People in the Community.

## Theme 1: Working in Access Health

The 11 questions were designed to elicit from the staff their knowledge about, and responses to, Aboriginal clients. The theme also explored the focus of individual staff roles and sought input about how these roles could change to improve AH's work with this client group.

Additional questions were developed by the Reference Group to obtain knowledge about overall staff enjoyment and their morale, to strategies they used to undertake their roles in Access Health. 13 staff completed the survey.

Years	0-1	1-3	4-6	7-9	10-15
#	2	6	1	2	2

The stability of the workforce is high, with the majority of respondents employed in their current roles for one to three years, with two staff having worked at Access

Health since its inception in 2004, one staff member employed for nine months and another for five weeks.

Years	0-1	1-3	4-6	7-9	10-15
#	2	6	1	2	2

Staff revealed their main focus within Access Health with most, if not all, staff aware of and using Access

Health's policy and procedures to carry out their everyday duties to meet the needs of their clients.

Staff Role	#
Management	1
Clinical	7
Referral	7
Employment	2
Community work / care	4
Counselling	2
Therapeutic interventions	3
Targeted intervention	3
Crisis interventions	2
Education	4
Nursing care	1
Client support	1
Rehabilitation	1
Supervision triage and assessment	2
Salvation Army	2
Various	1
OTHER	
<ul style="list-style-type: none"> <li>• Managing waiting times for doctor</li> <li>• Supporting clients in the waiting room</li> </ul>	

Overall feedback was positive, with many acknowledging that the variety of their jobs, working with clients and the sense of pride they had from working within a value and ethical framework made a difference in their life. Staff generally recognise, are knowledgeable about and respectful of their client group.

Particular responses include:

- » *Interventions can make a real difference, Generally people are in need of our service and our service can help them greatly.*
- » *Being able to provide a holistic response to the health needs of marginalised clients.*
- » *The variety of situations that I deal with, the knowledge that we are providing a service for a population that is often marginalised by the rest of society, seeing clients move on from homelessness and poor health to a more stable positive lifestyle.*
- » *I enjoy the overall resilience of my clients; I am honoured [by] their trust in me.*
- » *Assisting marginalised clients who need support with their health needs and haven't felt comfortable using mainstream services.*
- » *I like helping those who struggle with basic day-to-day life.*
- » *They are interesting people, with real and complex needs.*
- » *Being able to provide considered primary health care for people with multiple health issues in a supportive setting inclusive of extended community services, where clients' wellbeing is appreciated on multiple levels.*
- » *Assisting marginalised individuals to access primary health care services as well as providing health promotion/preventative focused care.*

The challenges faced by Access Health staff include managing both difficult/aggressive behaviour, and systemic failures that do not allow or facilitate transitions between comprehensive PHC and other specialist or hospital-based services. Positive communication within and between Access Health and other parts of the Salvation Army Services, and collaboration with other health service providers, were seen as important investments to overcoming the challenge of



lowering the waiting times for patients and emergency responses for client care from ambulatory services. And with mental health issues prevalent among the client group, staff highlighted the need to have better

referral mechanisms to psychiatric services. Dealing with less-than-sympathetic health professionals was, however, seen to be an issue when referring clients for heightened health care, treatment and support.

Staff challenges include:

- » *Aggressive or disrespectful behaviour. It can be hard to see a minority of clients who are disrespectful to staff, especially when the staff are trying to help.*
- » *Occasional difficulties getting clients attended to by ambulance / psych[iatric] services.*
- » *Managing expectations of clients around waiting times, trying to meet the needs of clients who are chaotic and don't always attend for early drop in.*
- » *The statistics and double charting that goes along with being co-located at the Salvos but being employed by the Royal District Nursing Service. Negotiating health administrative systems.*
- » *Dealing with less-than-sympathetic health practitioners from other practices / hospitals.*
- » *Barriers to continuity of care and its effects on quality of life (chronic and/or untreated health etc.), homelessness, recidivism, difficulty in accessing mainstream or specialist services, poverty, culturally appropriate responses, timelines.*
- » *Clients' distrust of medical services and the necessity to invest in trustbuilding exercises.*
- » *Patient deaths, patient demands/expectations that I cannot or should not meet and the terrible trauma that people have been through.*
- » *Offering services that are largely reactive to, rather than preventative of, serious co-morbidities.*
- » *Some of the presentations are quite complex and chaotic and it can be challenging determining the clinical priorities for a client.*

Overall, AH staff felt they were meeting the needs of clients. However, during busy times some nominated that it is difficult to offer services to clients who have diminished capacity to manage their own health and wellbeing. Clients with limited organisational skills

who are unable to facilitate medical or counselling appointments are disadvantaged when presenting to the service opportunistically. As a result, staff reported that they regularly turn people away due to long waiting times and low staff numbers, especially in the clinic.

Staff comments include:

- » *Mostly we do have to turn people away because they have come at the wrong time, or because bookings are full.*
- » *We are meeting the needs of clients, however the service is very busy, and at times we tend to just see the people who are more organised and get here early.*
- » *Yes, mostly there is always room for improvement.*
- » *We provide non-judgmental holistic care.*
- » *Yes, I largely think we meet most clients' needs well as a team.*



Client priorities were identified as follows:

- » Pharmacotherapy, acute health problems (injuries, wounds, etc.)
- » Housing, employment, drug and alcohol, chronic disease
- » Nutritional support, physical/mental health, substance use issues
- » Having their immediate health needs met by a respectful service
- » Dealing with issues of isolation, loneliness and human contact
- » Emotional and physical pain
- » Obtaining a non-judgmental approach to health and appropriate health care that is delivered by an interdisciplinary team
- » Accessing holistic, comprehensive, integrated health care.

There is often a multitude of complex health issues for each individual presenting at AH and prioritising these usually means identifying the most problematic/most

important (for the individual and the health professional) and working with that first. Addressing ill-health requires a bio-psycho-social approach (housing, physical health, AOD, mental health, social inclusion etc.), with integrated services necessary to provide holistic care to AH clients. Staff stated that knowledge and awareness of clients' issues translates in to effective service delivery that meets client need. They also identified that increased partnerships are vital across all sectors to support individual, family and community priorities and need.

The Question – *What would you say about your role improves the health and wellbeing of clients at Access Health?* – raised positive responses from staff. Overall staff members understand that their individual role complements and improves the health and wellbeing of clients accessing AH. Staff illustrated that respect, insight and positive communication is at the forefront of effective delivery of services to clients. They made it clear that being positive as an individual can make a difference to the health and wellbeing of a service, as well as heightening the ability to make a difference in an individual's life.

Staff responses include:

- » *Ensuring services are integrated and complementary, easy to access and improve health outcomes.*
- » *By being open, approachable and as informative as possible I can minimise people's frustrations around waiting times. By engaging clients I am able to understand more about the[ir] situations and offer some advice and/or referral to other services that may be of assistance.*
- » *Listening and trying to address their needs. Working on building rapport before encouraging clients to work on what I think will help them.*
- » *Collaborative and team-focused response to health care, which identified the importance of education, prevention, treatment and rehabilitation. Also a continued focus on client-centred practice. My role... allows me to support, encourage and ensure that this occurs throughout the program.*
- » *Treated with health care and not judged so the client can speak openly about their situation. We also provide material assistance to help with costs of health care and advocate for our clients.*
- » *Friendship and practical support beyond the service – doing normal things together.*
- » *Have someone who is understanding to greet and triage appropriately.*
- » *Experience in assisting clients to make informed decisions about health priorities with multiple co-morbidities, rapid effective cost-free treatment options in a primary care setting instead of a hospital emergency department, ready referral to community, medical specialist and allied health services.*
- » *I am able to support the GPs in many of their clinical responsibilities, particularly in providing support to clients who either have chronic health problems or are at risk of developing chronic health problems.*



## Theme 2: Working with Aboriginal Clients

Within Theme 2, questions were raised to ascertain the current staff capacity and experience in working with Aboriginal people either in previous workplaces and/or in their current role. Additionally, staff members were asked to consider how confident they were

in working with Aboriginal clients and families. This was important as all staff, except one, reported that they work with Aboriginal people. Eleven staff stated they had experience in the provision of services to Aboriginal clients in a previous workplace, with only two respondents having no such experience. However, all staff felt empowered to support this community in a positive and pro-active way.

Individual staff responses to working with Aboriginal communities were:

- » *Almost entirely positive, clients are usually respectful, and we have very few cases of bad behaviour from Aboriginal clients.*
- » *I have had some experience working with Indigenous clients but have found that they are often amongst some of the most marginalised clients who experience some of the most significant health issues and chronic diseases.*
- » *Positive – especially with the support and secondary consultations with Aboriginal Access Worker.*
- » *I was team manager in a kinship care service providing support to children who had been permanently removed from their parents but who are living within the extended family network.*
- » *Have enjoyed working with this client group.*
- » *Three years and ongoing employment as a medical officer with a remote AMS in WA.*
- » *Enriching.*
- » *Mostly very respectful and has taught me a lot about culture.*
- » *Limited. Overflow of current Aboriginal worker.*
- » *8 years working with Aboriginal people at Access Health and prior to that I worked as a psychiatric registrar at the Victorian Aboriginal Health Service.*

Staff highlighted that alcohol and other drugs, mental health, and chronic illnesses including diabetes have

been some of the health challenges for their Aboriginal clients in 2013.

Individual staff responses include:

- » *AOD issues, chronic health management, sadly, [Aboriginal] clients still face racism in the community.*
- » *From a podiatry perspective, diabetes and drug and alcohol (Galliamble) clients [have] poor access to footwear choices.*
- » *Chronic diseases are a huge issue for many Indigenous clients.*
- » *Other issues such as mental health and wellbeing and challenges associated with the significant burden of mental illness.*

- » *Discrimination within the community, access to consistent medical services, lack of cultural awareness with the general service system.*
- » *An ongoing lack of recognition of increased needs both medically and socially by the broader community.*
- » *Variety of issues: for those exiting out of the residential rehabilitation in the area, there is a lack of housing options, social inclusion activities and handover / continuity of holistic and assertive care that they receive while in rehab and connected to Ngwalla Willumbong and Access Health. Culturally aware and responsive mainstream services.*
- » *Health issues due to homelessness, alcohol and other drug use and domestic violence.*
- » *Cultural trauma, displacement of family and community, increased health needs.*
- » *Drug addiction, intimate personal violence, mental health, obesity and related conditions and smoking as well as housing and dealing with multiple traumas and loss.*
- » *Social disadvantage with poor recognition of cultural strengths and agency by established social institutions.*

All but one staff member indicated that they are confident in working with or supporting Aboriginal clients. One respondent illustrated that their individual confidence has risen since working in partnership with an Aboriginal organisation. Two staff recognised the benefit of, and had confidence in, having a designated Aboriginal staff member within the team providing a direct service to Aboriginal clients.

Staff confidence improved when there was a healthy two-way respect between Aboriginal culture and Access Health, when there are partnerships with Aboriginal Medical Services, when there is support from the Aboriginal Access Worker, and when there are extra education, cultural awareness and cultural safety programs on offer.

Four respondents recommended that Access Health consider providing cultural awareness training on a regular basis, and that AH increase its access to, and brokerage with, Aboriginal organisations such as the Victorian Aboriginal Health Service. Staff view further expansion of AH's partnerships and brokerage as an important step in fostering positive working relationships with organisations that provide services to the Aboriginal community. It is clear that developing partnerships and relationships like this will heighten the confidence levels of AH staff to work more closely with the Aboriginal community. Most, if not all, staff agreed throughout the survey that the Aboriginal Access Worker is very effective and offers support, education and training to non-Indigenous staff when working with Aboriginal clients.

Staff responses include:

- » *We could increase communication with regional service providers that refer to and receive back clients from the residential rehab[ilitation] services and other inner city services including correctional services with whom we work.*
- » *Building trust is the most important step.*
- » *In my opinion, non-Indigenous workers must undergo continual professional development and engage respectfully with community Elders in order to ensure [their] practice is culturally appropriate and respectful.*
- » *Our Indigenous outreach worker is brilliant and really facilitates Aboriginal clients attending. She also educated the group regarding Aboriginal client issues [and] how to deliver culturally appropriate care.*



## Theme 3: Working with Community

Theme 3 focused on the ability of staff to work with the community, and finding out whether staff had participated in, or had a willingness to participate in, cultural awareness training to foster positive engagement with Aboriginal clients. These questions also identified Access Health's ability to partner and collaborate with other service provider organisations, and sought responses about the services' ability to value add to community service provision in order to meet the changing needs of the Aboriginal community.

The majority of staff, nine out of 13, have participated in cultural awareness training either in previous employment or at AH. However, throughout the survey it was clearly that staff recommend the incorporation of ongoing cultural awareness training as a preferred professional development opportunity, and that this training is important both to their role and to AH.

Eight staff identified that they have other ways of engaging with the Aboriginal community. However, no staff member offered suggestions or outlined their individual process for this alternative engagement with Aboriginal people.

Access Health staff have a high level of awareness about the range of services provided to Aboriginal people. However, there is a great deal of emphasis placed on the Aboriginal Access Worker by many staff, a positive sign that they are engaging with this position. Unfortunately, this places increased pressure on the worker to support both the community and the staff, including running individual training for non-Indigenous staff so as to provide more appropriate services to Access Health's Aboriginal clients.

Ten out of the 13 staff participating in the survey identified that Access Health has seen an increase of clients from an Aboriginal background presenting at the service. Two staff members claimed there had been no increase in clients in the target group and one respondent skipped this question.

A number of staff also offered additional responses with emphasis placed on the Aboriginal Access Worker being available to assist staff to engage respectfully with the Aboriginal community. Interestingly, throughout the survey it was clear that a number of roles were identified for the Aboriginal Access Worker – including Liaison Officer, Aboriginal Access Worker etc. – suggesting that there needs to be some emphasis placed on staff knowledge of this role.

Individual staff responses about why there has been an increase in the number of Aboriginal clients:

- » *The role of the Aboriginal Access Worker assists in engaging Aboriginal members of the community.*
- » *Aboriginal Access Worker, Partnership with Ngwala programs.*
- » *Partnership with Gallamble and Winja Ulupna.*
- » *Numbers are consistent – having Aboriginal Liaison Officers improves our relationship with the community.*
- » *My sense is there has been a steady increase. I would need to check the figures to be certain though...*

The majority of staff agree that AH works well with other services to improve health and wellbeing outcomes for the Aboriginal community, with 12 respondents answering 'Yes' to this question and noting that partnerships and relationships are formed through AH.

Internal processes appear to be working well, e.g. referrals for clients, etc., and the majority of staff

are aware of the key Aboriginal services, such as Winjagali, Ngwalla Willumbong. It is clear that effective relationships are facilitated by individuals, and that the Aboriginal Access Worker is recognised as playing a vital role in developing and supporting engagement and relationships / partnerships with other Aboriginal service providers.



Individual staff responses to the issue of partnerships and awareness of Aboriginal services includes:

- » *We work in partnership with local residential rehabilitation services and many of the key providers located within this service.*
- » *Resi Rehab services.*
- » *Partnership with Winja and Gali, allowing for regular GP times for clients.*
- » *Liaisons / referrals.*
- » *Good relationships built with Ngwalla Willumbong. Aboriginal Access Worker works on enhancing our relationship with Aboriginal services more broadly.*
- » *Strong advocacy for Aboriginal clients.*
- » *Specific clinic each week, Aboriginal worker.*
- » *We have formal partnerships with Gallamble and Winja Ulupna rehab services as well as Inner South CHC, Alfred Psychiatry and two private Forensic and Clinical psychologists. We also work informally as needed to improve patient outcomes.*
- » *Sharing information across services with consent, following up referrals etc.*

Staff clearly articulated the key services for which Aboriginal clients present, and most, if not all, services provided by Access Health are clearly identified. Staff view Access Health as an effective collaborator with Aboriginal service providers in the community, and perceive that it is the role of the Aboriginal Access Worker to initiate and lead collaboration

and relationship development with them. Some staff identified that having a designated Aboriginal staff member was very helpful in the coordination of collaboration with services, but another was concerned that increasing the workload of this worker was not an effective or sustainable model in coordinating effective collaborations.

Individual staff responses include:

- » *I don't know, I am concerned it hinges on the extraordinary work of a single AHW, and thus depends on an individual, not a sustainable model.*
- » *Yes, though much of this is done via the Aboriginal Access Worker and could possibly be adopted more broadly by myself and AH Manager to better support the Aboriginal Access Worker.*
- » *Helpful, we have an Indigenous outreach worker.*
- » *Access Health has many formal partnerships with local services, and works well in partnership.*

Staff agreed that AH does add value to the services in the area and to the local community by providing:

- » Free, easy-to-access and non-judgmental care to individuals who may not otherwise use mainstream health care services.
- » Services such as social work, case management,

psychological services and linkage with the co-located Crisis Centre to assist with other challenges often encountered by this population.

- » Referral to secondary and tertiary care for marginalised clients, that may or may not be supported by other services.

- » Integrated primary health care for clients who would otherwise receive stop gap care only in emergency departments.
- » Flexible service and culturally aware and trained staff.
- » A well-respected, stable and dedicated workforce.
- » A practical, harm minimisation model for the community where we work hard to provide support for individuals when they are vulnerable.

## Theme 4: Meeting the Needs of Clients

Theme 4 identified three questions that required responses from Access Health staff relating to the service's ability to meet the needs of its clients. It also sought understanding from staff on their knowledge of community feedback, whether positive or negative, and/or if the service does or does not meet community need. The theme also provided an opportunity for staff to identify or suggest what Access Health could do in the future to better meet the needs of its Aboriginal clients and the community.

Additional to the aforementioned ways of meeting client expectations around waiting times, accessing specialist services, meeting with the Aboriginal Access Worker, and engaging with rehabilitation services, there was support for different models of services:

- » *'Having a day available for two Aboriginal rehabilitation centres to use AH resources and its duty workers, where possible, to facilitate access to services...'*
- » *'Offer integrated PHC to Aboriginal residential rehabilitation clients, who are largely referred by the regional service...'*
- » *'Having a specific day for Aboriginal folks...'*

There was also a discussion about how to keep people engaged with the service context in which Access Health is positioned:

*'We need to promote the service with more general public Aboriginal clients not just through rehabilitation...'*

*'I think there are probably many Aboriginal clients who are well engaged with the service for a period of time (i.e. during residential rehab) but then disengage after this period, particularly if it is due to geographical challenges (i.e. moving out of the area)...'*

The feedback from clients has been mostly positive with staff stating that clients are 'generally very happy with the Aboriginal Access Worker...' and get told that the service is mostly good. It is a place where people feel supported and safe, and where the services are different to others in the area:

*'...many of the Aboriginal clients who utilise the service report that Access Health is able to provide many different services under the one roof which is advantageous, especially for people who have had limited contact with health care services...'*

Staff commented on what could be done to make Access Health better for its Aboriginal clients and felt that the following would make a difference:

- » Undertake health promotion activities at Winja and Gali.
- » Make the Reception Area more exciting (outside area is ok).
- » Get the reference group to have more discussions with clients about how better to meet their needs.
- » Invest in more outreach work and allocate specific times for seeing Aboriginal clients, further consult with the community and develop more proactive partnerships with communities.



## Theme 5: Referral to other Services

Staff reported that the referral pathways to other services operated professionally most of the time, but clients found the systems to which they were referred 'difficult to navigate, had long waiting times' and that 'they were not always treated with urgency'. Others hinted at a positive/negative experience: some positive when they 'connected to other mob at Our Rainbow and Wommenjenka BBQ', others negative if 'referred to hospitals, mental health services, detoxes and rehabs'. Some responses stated that there were good outcomes for clients when staff attended appointments with people, and that Access Health had fostered good relationships with both services in the area and with tertiary services e.g. public hospitals. Others identified that clients don't give enough feedback to health staff about their capacity or willingness to talk about their experiences with other services in the area, while one staff member noted that the referral network was usually good. However, when it is not good '...we are here 7 days a week to pick up the pieces / address issues...'

## Theme 6: Support for Staff to Meet the Needs of Aboriginal People in the Community

When asked about the types of support AH provide for staff to meet the needs of Aboriginal people in the community, respondents identified the following areas:

- » Outreach work – more flexibility in the service scope to do outreach work.
- » Participation in community events – encourage staff to engage with the community through participating in appropriate events.
- » Orientation and Performance Development – becoming inclusive of cultural awareness training and include this training in orientation and induction programs as well as introducing staff to key members of the Aboriginal community and those involved in relevant services.

## Conclusion

In this section, staff identified six themes and a range of recommendations that, if implemented, would further enhance their capacity and that of the organisation to meet the needs of Aboriginal clients. Staff valued the stability and sustainability of their current practice within the organisation, but were concerned that there were not robust systems that could improve the way in which referrals to other services occurred or reduce waiting times at Access Health. Additional concerns were expressed about the lack of a sympathetic response by these referral agencies to their Aboriginal clients, due in part to staff in these services being unaware of the particular needs of the Aboriginal community.

Some issues could fall within the scope of a workforce development plan to address low staffing numbers, professional development requirements, service expansion opportunities, engagement with universities and increasing the counselling and Aboriginal support staff at AH. Staff also noted the importance of building strategic partnerships and of extending the range of services currently available through AH to provide more holistic treatment, care and support through increased allied health and financial/budgeting services. Additionally, staff highlighted the importance of having a discrete budget for funding staff engagement with the community through orientation, professional development and cultural awareness training, as well as participating in appropriate community events.

Finally, staff indicated there could be different ways of engaging with the continuous quality improvement program – by having a process where the Aboriginal voice could be heard and responded to in service design and in brokerage with other organisations. Additionally, staff thought it was important to ensure there was adequate reflection of these activities in the annual report, and ample opportunities to feedback information to the community on how AH is scaling up its services to meet the needs of Aboriginal clients.

The next section highlights the voice of 40 Aboriginal AH clients interviewed by University of Melbourne staff, who provided input and advice to AH through this process.



# Section 3: Client Survey Results

This section is a compilation of information generated from clients' interviews conducted over a five-week period on site at Access Health, Grey Street, St Kilda.

## Characteristics of the Survey Group

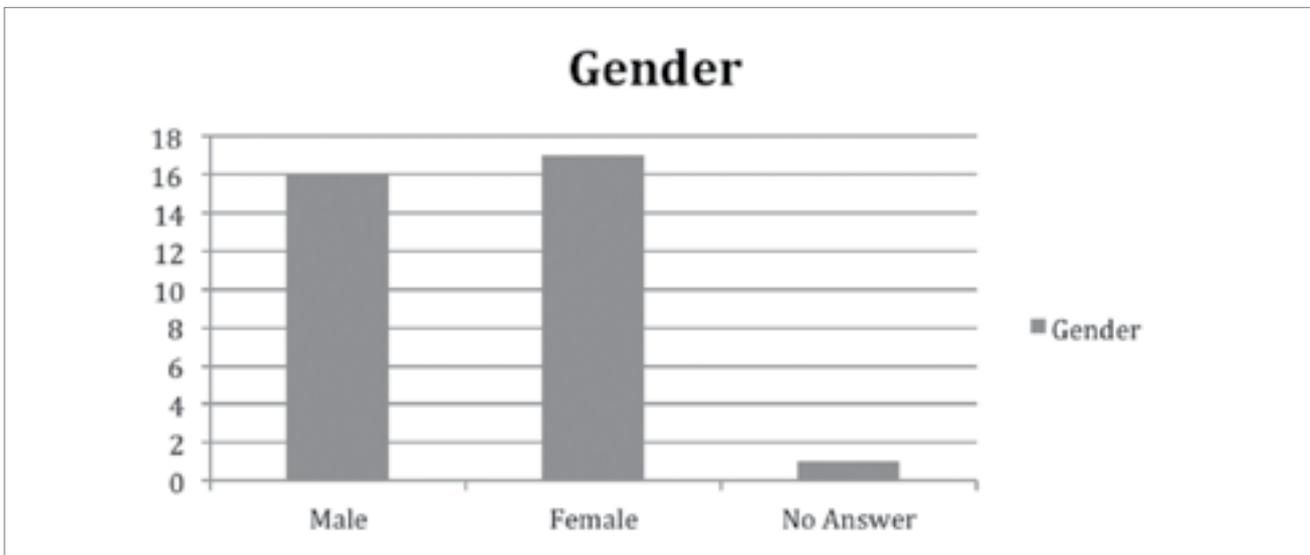
Access Health focuses its work on those in our community who have complex needs. Aboriginal clients comprised approximately 13 per cent of the total number of clients represented, despite the fact that they constitute less than 1 per cent of the total Victorian population (ABS 2003). Furthermore, these clients represented almost 19 per cent of the total client contacts (18.4%), suggesting repeated and diverse service utilisation. While services catering specifically to the needs of Aboriginal people are provided for via organisations such as the Ngwala Willumbong Cooperative, which offers high-quality culturally appropriate programs addressing social disadvantage and alcohol and drug issues (Ngwala Willumbong Cooperative Ltd 2011), it may be expected that expansion or enhancement of the service could further impact positively on the absolute numbers and

frequency with which Aboriginal people access PHC in Melbourne (see Table 3, p.9).

It is thought that the growth in service access has occurred because of the increase in case contact with the Aboriginal Access Worker whose position has increased from one day to four days per week (see Table 4, p.10). In fact, the majority of the referrals to the research program were made by the Aboriginal Access Worker on site. While the 40 people interviewed represent approximately 25 per cent of the total Aboriginal client population of Access Health, the Reference Group agreed that this number, and their diversity, provided a representative cross-section of the Aboriginal client group. The following graphs and commentaries provide an overview of the characteristics of the clients who were interviewed as part of this research.

### Gender

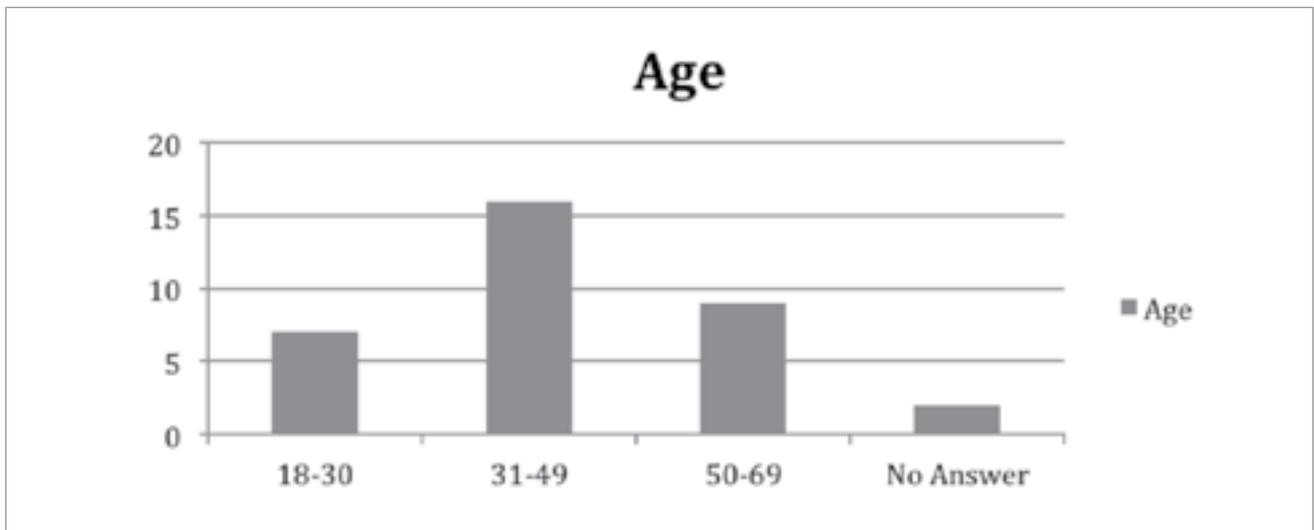
Clients were asked to tick a box to identify their gender, with responses required for Male, Female and Transgender status. Thirty-four (34) responses were received. One (1) person did not respond to this question.



## Age

Clients were asked to identify their age by ticking a range box. Seven (7) people were aged between 18–

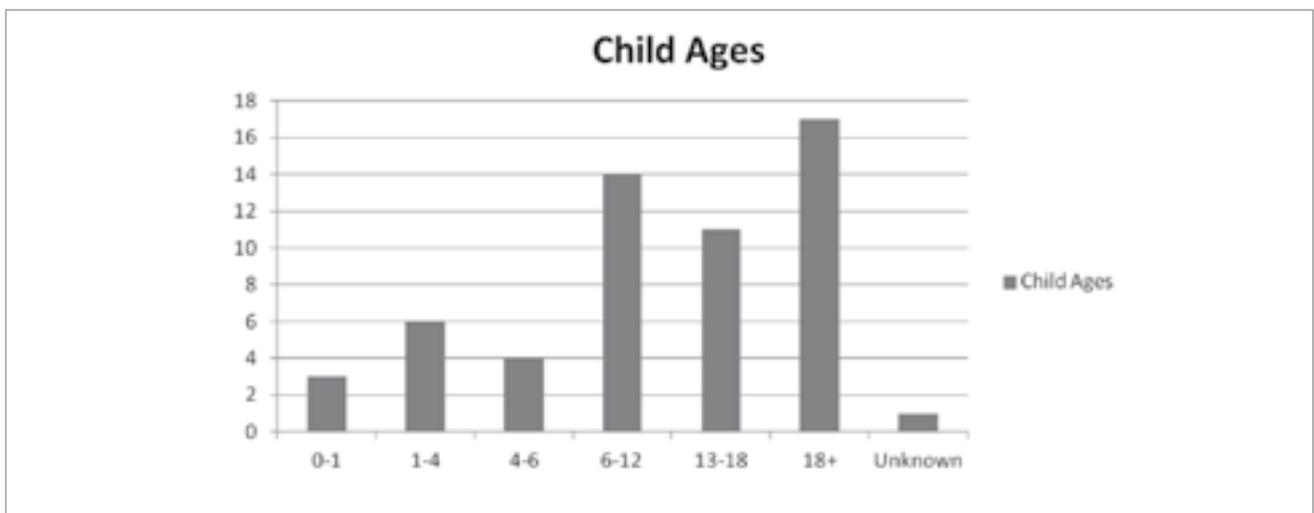
30 years with sixteen (16) responding to the 31–49 age range and nine (9) people aged between 50–69 years. Two (2) clients did not respond to this question.

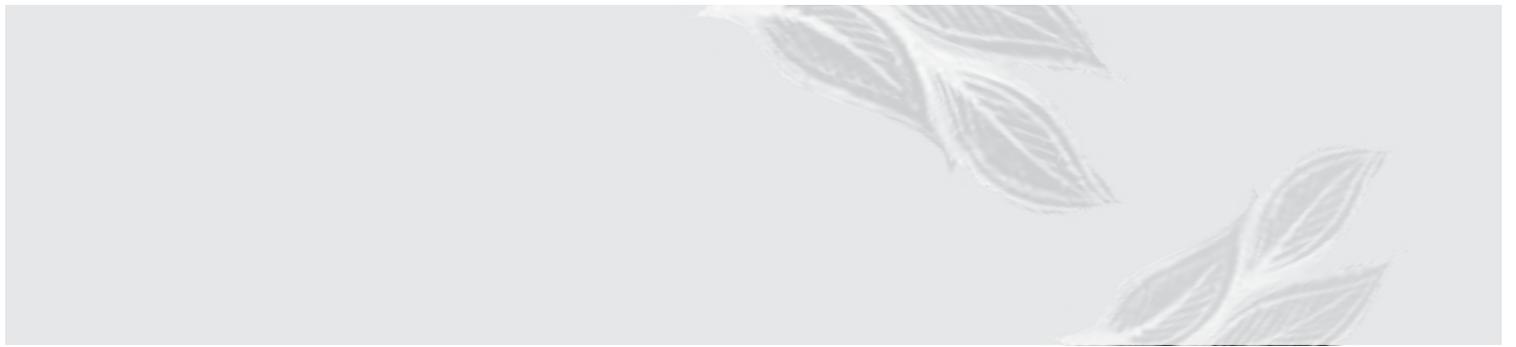


## Children (child age and access)

Clients identified the age range for their biological and non-biological children. A total of fifty-two (52) children were identified for the thirty-four (34) clients who responded to this survey question. Fifteen (15) children were identified over the age of 18 years, with

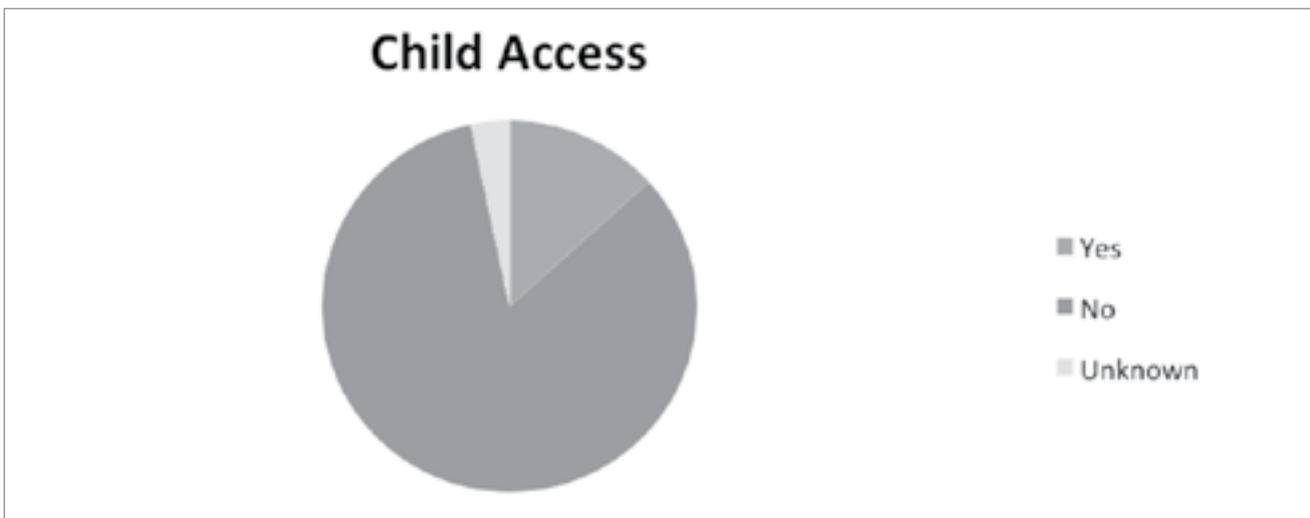
thirteen (13) between the ages of 6–12 years, ten (10) between the ages of 13–18 years; six (6) between the age of 1–4 years, four (4) between 4–6 years and three (3) from 0–1 years of age. One (1) client indicated unknown in response to the question.





Thirty (30) responses were received that identified access to children, with twenty-five (25) clients answering no and four (4) clients answering yes. One (1) client gave an unknown response. The majority of these children were not being cared for by the client of the service, but cared for under formal and informal arrangements. A

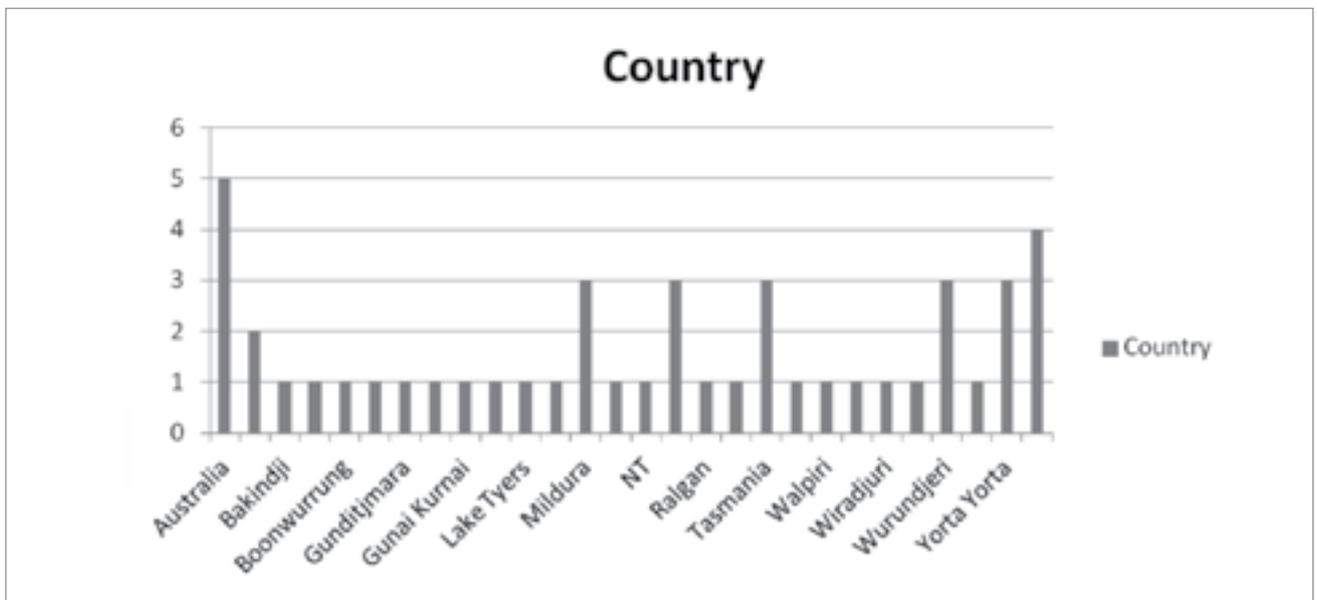
large number of parents had not seen their children for a number of years, while others had them in care under guardianship and foster arrangements. Others were in the care of relatives and some were placed with out-of-home care. None of the current clients of Access Health were the primary carer of their children.



## Country

Clients were asked to illustrate where they came from. Most if not all clients responded to this question by identifying their traditional clan. Three (3) responses were equally received for Australia, Wurundjeri, Yorta Yorta, Palawa, and Mildura. Two (2) responses received equally for Bairnsdale and Tasmania. One (1)

equal responses for Bakindji, Balranald, Boonwurrung, Brisbane, Gunditjmarra, Gunggari, Gunai Kurnai, Jarrah, Lake Tyers, Malanjali, Melbourne, Northern Territory, Ralgan, Shepparton, Tiwi/Larrakia, Walpiri, Wamba Memba, Wiradjuri, Wemba, Yamatji. Two (2) clients did not respond to this question.



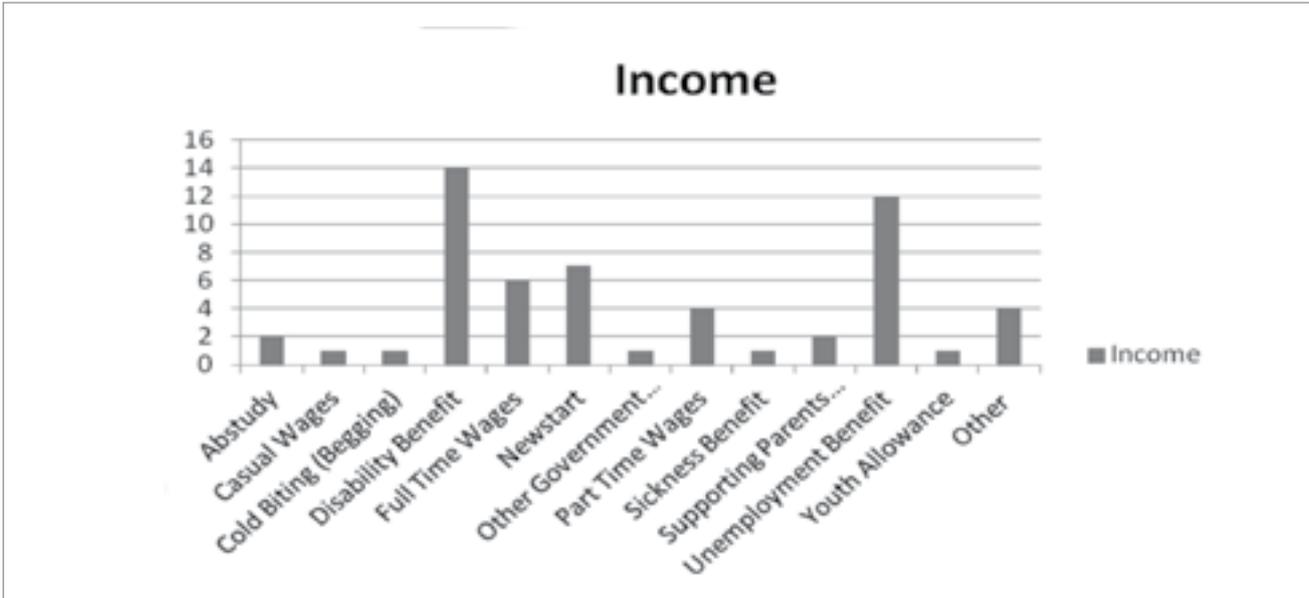
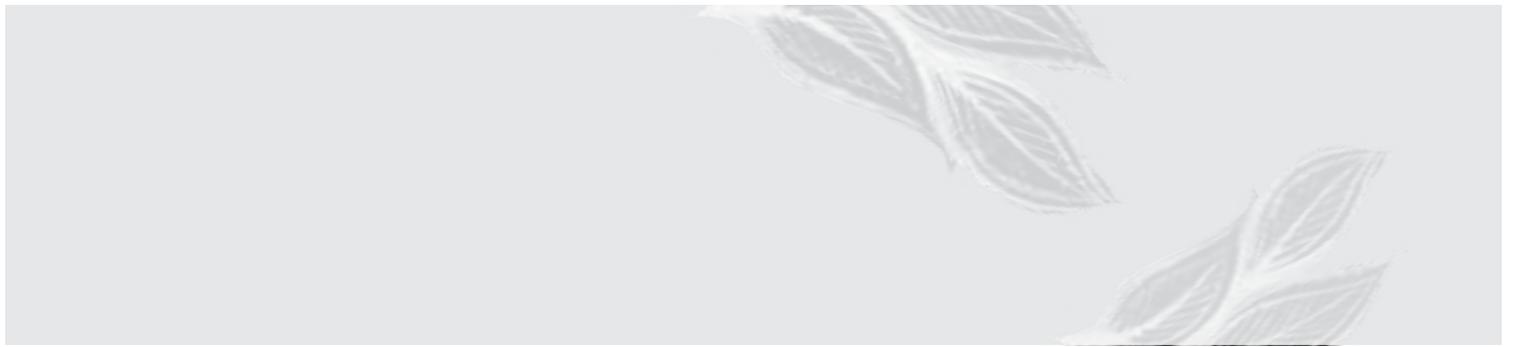
NB: The above graph does not allow for all Aboriginal Countries to be displayed

## Health Determinants of the Survey Group

Understanding the complexities in this group's environments, relationships and financial situations was necessary to comprehend the kinds of issues they identified as important to their overall health and wellbeing. The following section is a descriptor of the health determinants of the survey group.

## Income

Clients were asked to identify their main source of Income. Twelve (12) identified that they receive Unemployment Benefits with ten (10) receiving a Disability Benefit. Six (6) clients equally receive Full Time Wages and Newstart Allowance, while four (4) identified 'Other' as their source of income. Three (3) clients receive Part Time wages, with two (2) clients equally receiving Abstudy Allowance or a Supporting Parents Benefit. Casual wages, Youth Allowance, Sickness benefit, Other Government Benefit or Cold Biting (Begging) all had one (1) client response.



**Days without money**

Clients were asked to illustrate how many days they went without money. Ten (10) respondents illustrated they are never without money, with Four (4) clients

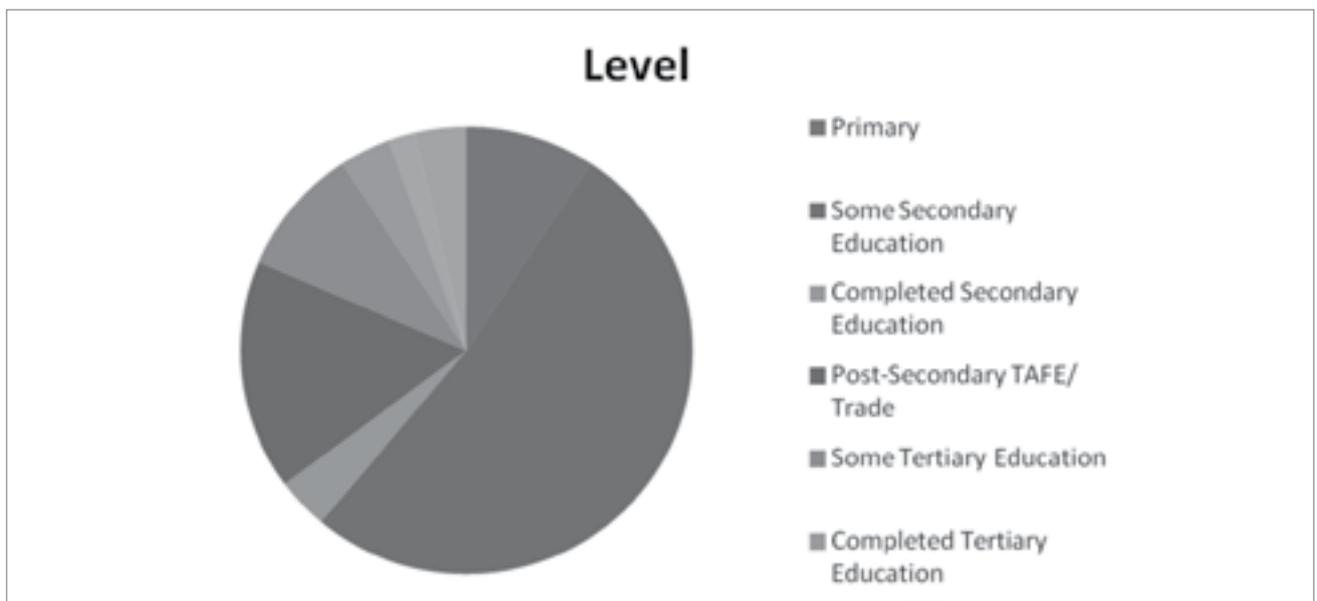
illustrating five days, and Two (2) clients answering yes to two, four, seven, 10 days without money. One (1) client responded to going without funds for six days.



## Education

Clients were asked to identify the amount of education completed. Twenty-four (24) clients illustrated that they had undertaken some Secondary Education, and eight (8) illustrated they had completed Post-Secondary TAFE/Trade. Five (5) clients had undertaken

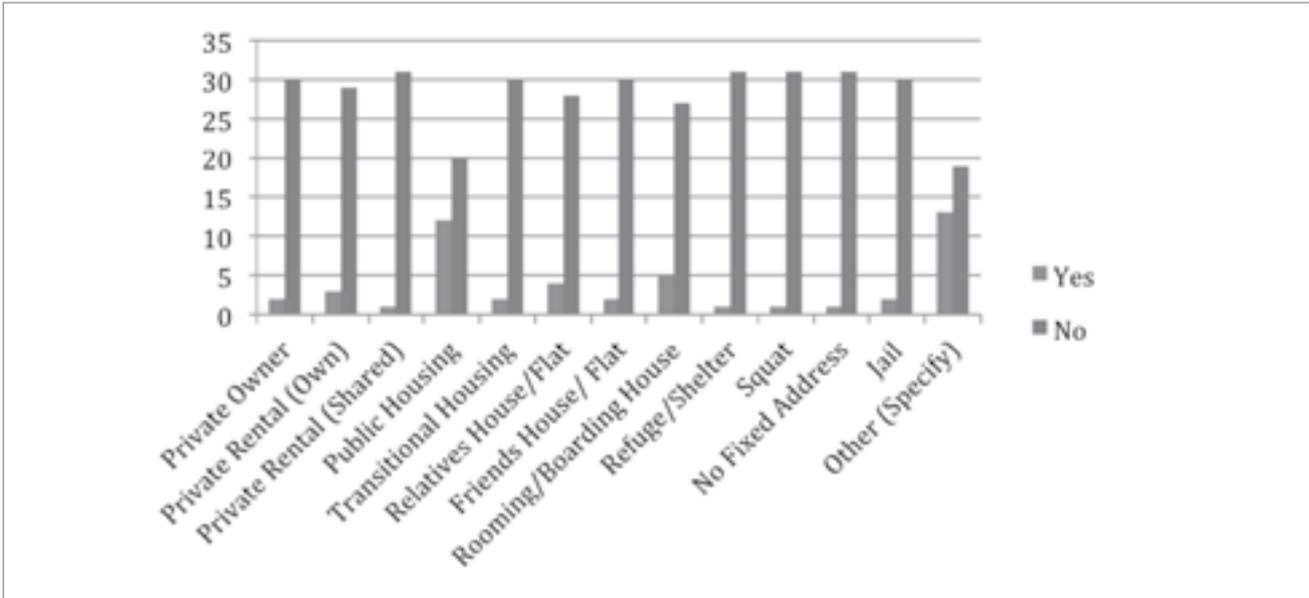
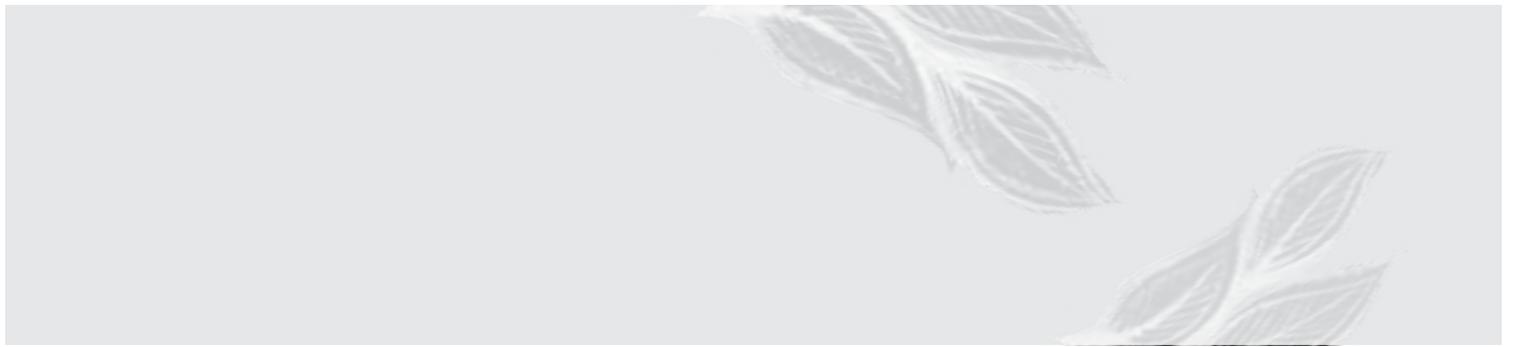
some Tertiary Education with three (3) completing Primary. Two responses equally received for Completed Secondary Education, Completed Tertiary Education and No answer. One (1) client received a Postgraduate Qualification.



## Accommodation

Clients responded to a number of questions relating to their accommodation and living situation. Thirteen (13) clients responded to Other (specifying rehabilitation service), with twelve (12) residing in Public Housing, and five (5) clients residing in Rooming/Boarding

House. Four (4) identified living with relatives, and three (3) in private rental (own). There were two (2) responses equally for Private Owner, Transitional Housing and Jail, while there was one (1) response equally for Private Rental (shared), Refuge/Shelter, Squat, No Fixed Address.

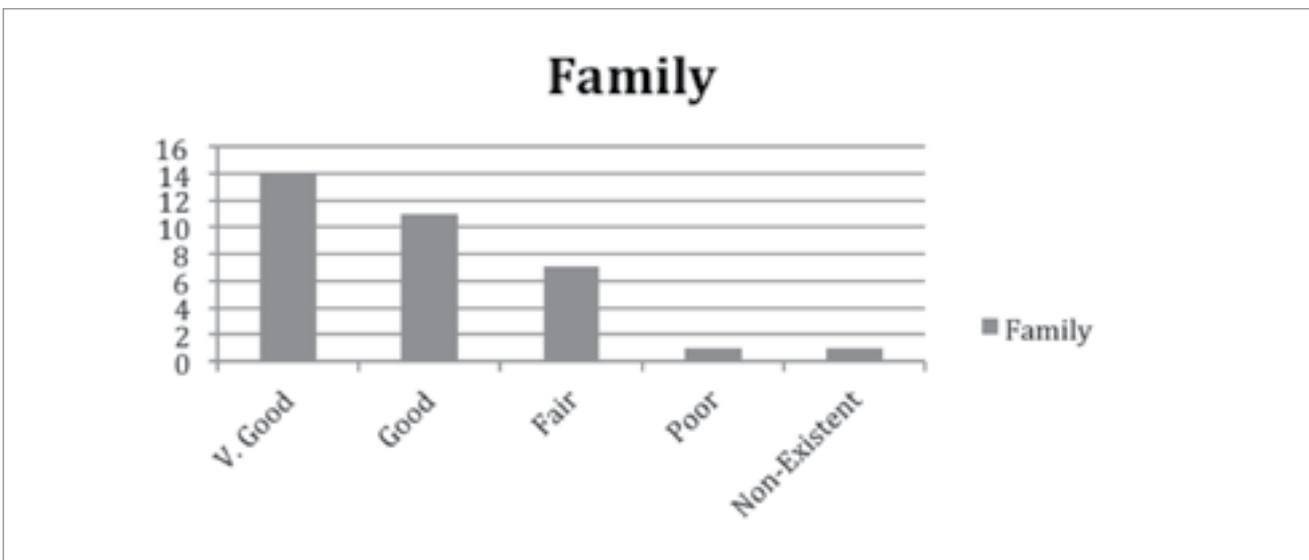


## Social Connections

### Family

Clients were asked to identify how they view their relationship with the following groups of people.

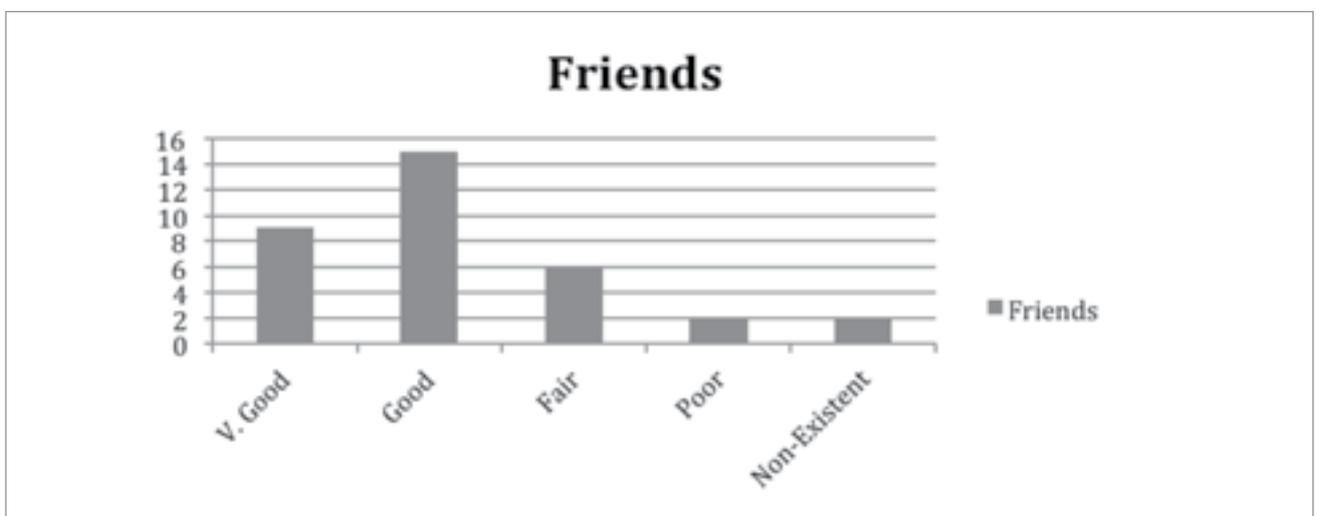
Fourteen (14) illustrated very good relationships with eleven (11) indicating that their relationships with family were good. One (1) responded to Poor relationships and another illustrated that their family relationships were Non-Existent. Seven (7) clients illustrated that they have Fair relationships with family members.



## Friends

Fifteen (15) clients illustrated that their relationships with friends was Good, with nine (9) indicating Very

Good and six (6) Fair. Two (2) clients equally illustrated having Poor to Non-Existent relationships with friends.



## Neighbours

Eleven (11) clients illustrated to having Fair relationships with their neighbours, with seven (7) stating they have Good and Six (6) clients equally identifying Very Good

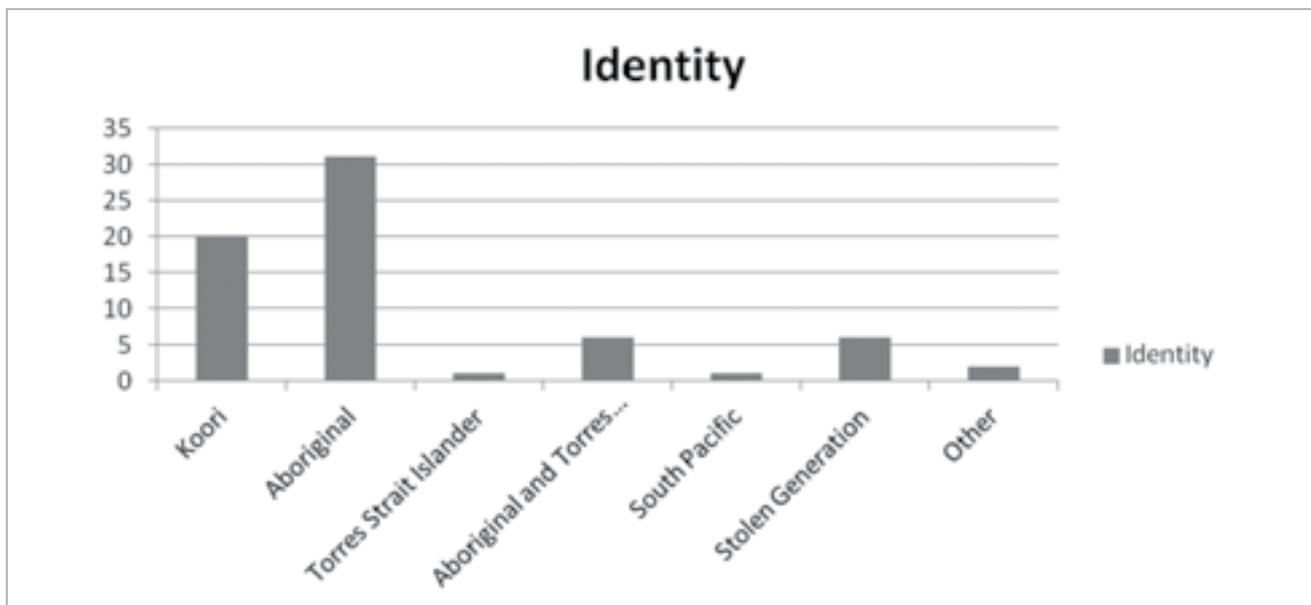
and Non-Existent relationships with their neighbours. Four (4) clients illustrated they have Poor relations with their neighbours.



## Cultural Identity

Clients were asked to identify their cultural heritage against five key determinations. Twenty-nine (29) clients identified as being of Aboriginal descent with eighteen

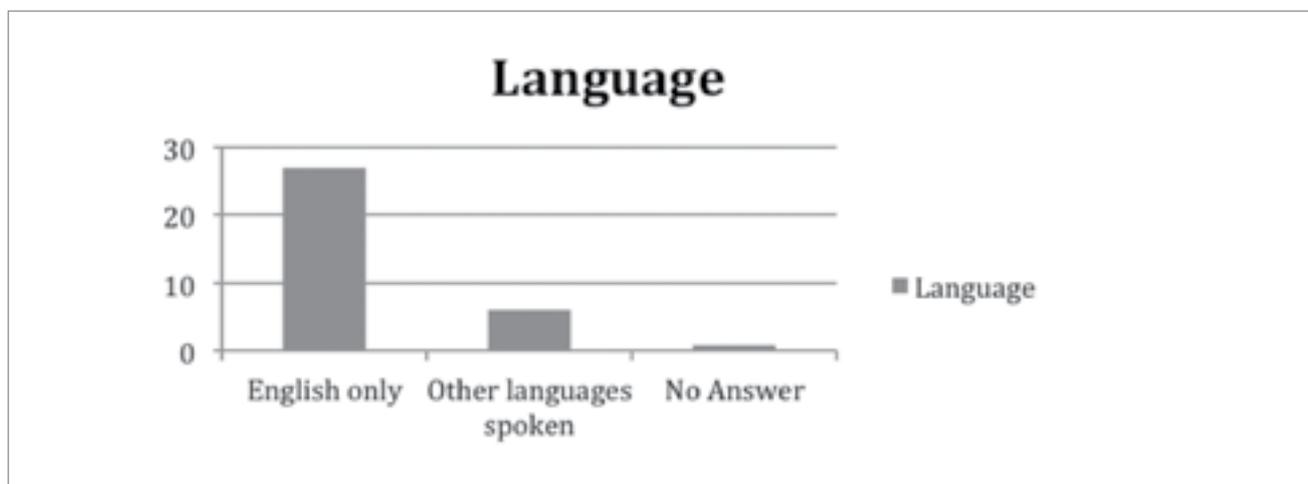
(18) illustrating their preference as Koori heritage. Six (6) respondents equally identified Aboriginal and Torres Strait Islander and Stolen Generation. One (1) respondent equally marked Torres Strait Islander, South Pacific and Other.



## Languages spoken

Clients were asked to identify their main language spoken at home or if they regularly speak another language other than English. Twenty-seven (27)

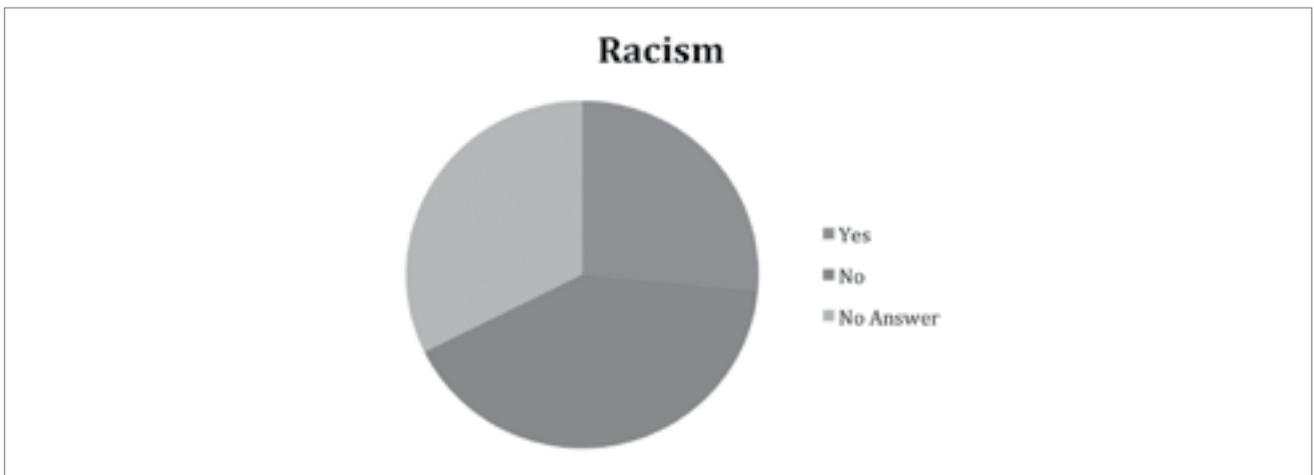
responded to English Only, with six (6) clients illustrating Other Languages Spoken and one (1) client did not provide a response to the question.



### Experience of racism

Clients were asked if they had experienced discrimination or racism in the past 12 months. Nine (9) clients illustrated that they have experienced some form of Racism, with fourteen (14) illustrating that they have not experienced Racism in the past 12

months. Eleven (11) respondents did not provide an answer to this question. Two (2) people suggested that their drug dealers were the people from whom they experienced the most racism. Others responded that they experienced racism when in the streets, on public transport or from their neighbours.

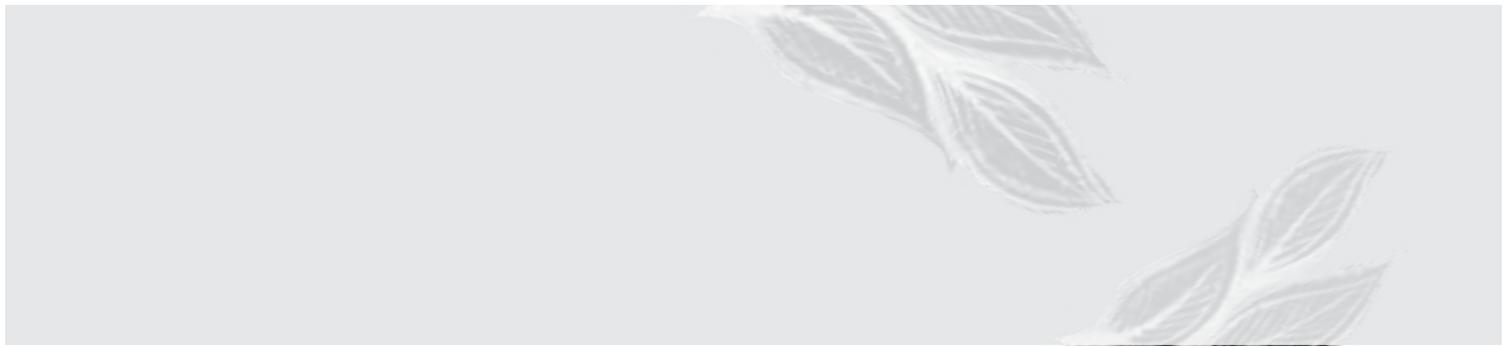


### Food access

Clients were asked if they ate healthy food. Thirty (30) responded Yes, One (1) responded No and Three (3) clients did not provide a response to the question. It is important to note that responses to this question were completed dependent on what the clients were able to identify as 'healthy food'. While this was not specified in the questions, there were a number of respondents who ate infrequently (due to alcohol or drug use)

or who had their meals managed for them (through rehabilitation services). A number of respondents admitted to skipping meals while others confirmed that although they might go without money for a couple of days, they often went without food. People in the survey group also indicated that they went shopping once a fortnight, which suggests that the availability of fresh fruit and vegetables might be compromised. Diet and nutrition is a clear area in which people need more information and need to develop more skills.





Clients were questioned in relation to access to food. Eighteen (18) responded Yes they had access to food,

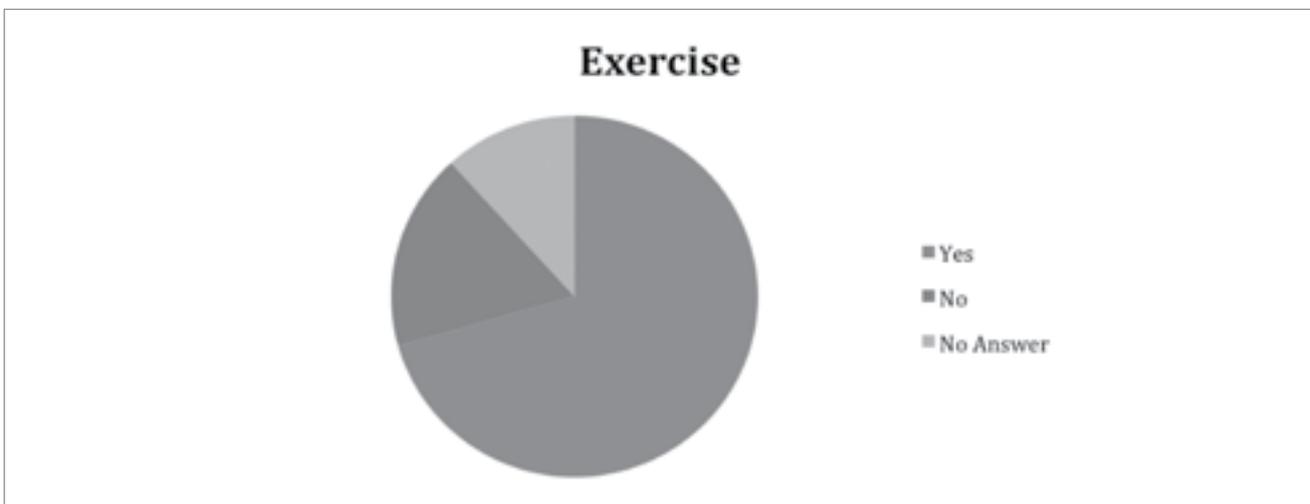
with eleven (11) responding No, while five (5) clients did not provide a response to this question.



### Exercise

Clients were asked if they do Physical Exercise. Twenty-four (24) clients answered Yes, with six (6) illustrating that they did not undertake any physical exercise. Four (4) clients did not provide a response to the question. Most of the exercise related to walking: to catch public

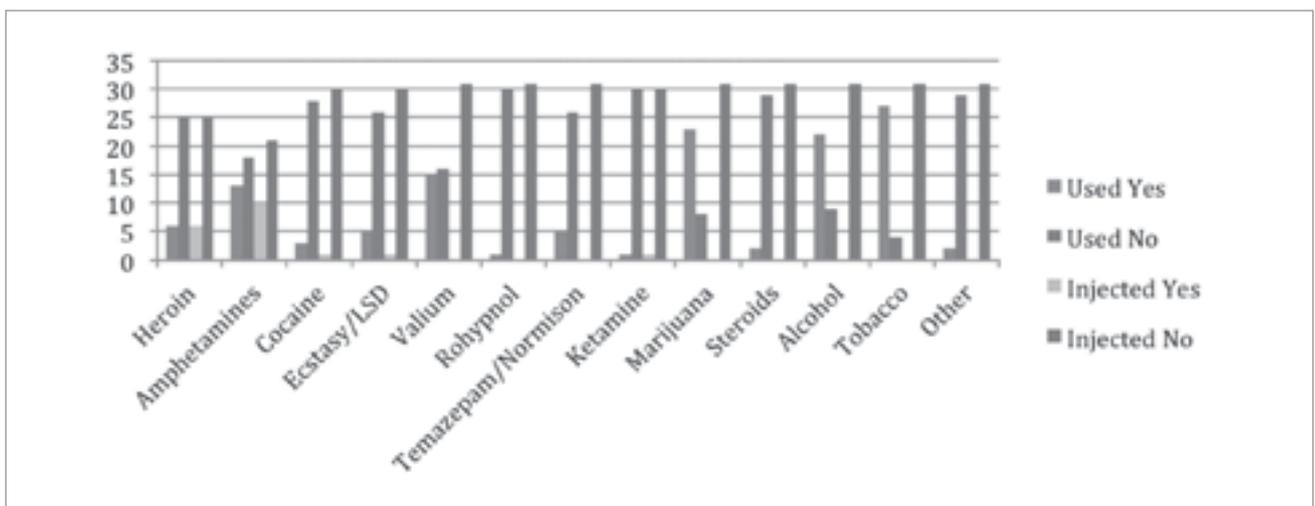
transport, to attending pre-arranged meetings, to go shopping, to visit friends, etc. Only one (1) client interviewed owned a car, while the rest accessed public transport or were able to attend appointments because a worker arranged transportation for them.



## Drug use

Clients were asked to identify what drugs they have used in the past 12 months. Twenty-seven (27) clients illustrated tobacco use, with twenty-three (23) indicating they have used marijuana, and twenty-two (22) having used Alcohol. Fifteen (15) clients indicated they have used Valium, thirteen (13) Amphetamines, six (6) have used Heroin, Five (5) responded equally to use of Ecstasy/LSD and Temazepam/Normison. Three (3)

clients used Cocaine. Two (2) responded equally to Steroids and Other which were not stipulated. One (1) client illustrated they have used Rohypnol and another identified that they have used Ketamine on a regular basis. Ten (10) clients reported they have injected Amphetamines, and six (6) indicated they have injected Heroin. One (1) client responded equally that they injected Cocaine, Ecstasy/LSD and Ketamine.

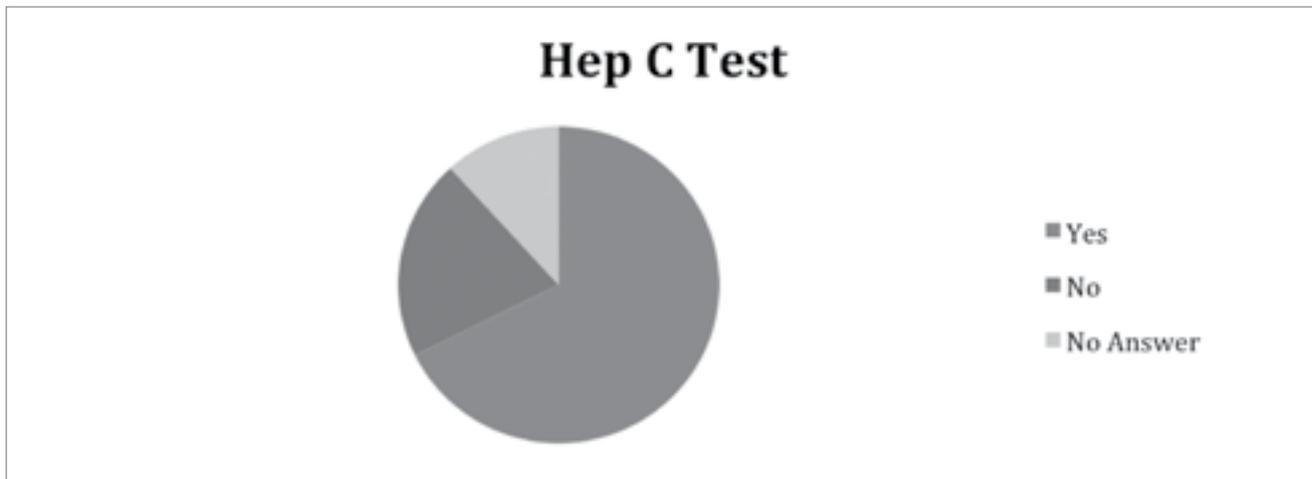


## Hepatitis C

### Hepatitis C testing

Clients were asked to identify if they have ever had testing for Hepatitis C. Of the thirty-four (34) clients

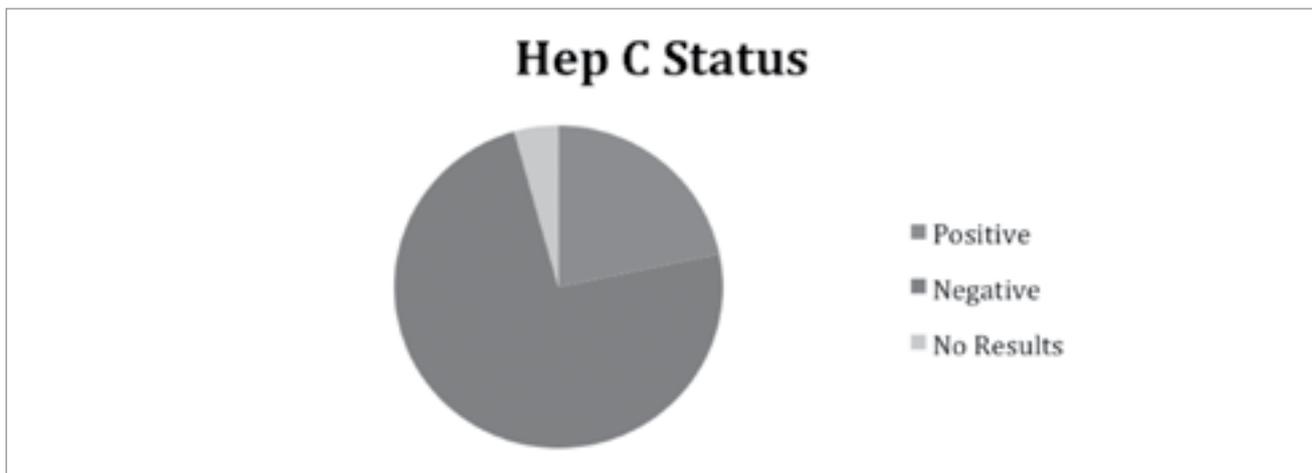
interviewed, twenty-three (23) indicated yes they had been tested for Hepatitis C, and seven (7) indicated that they have not been tested for Hep C. Four (4) clients did not provide a response to the question.



### Hepatitis C Status

Twenty-three (23) clients provided a response to their Hepatitis C status. Five (5) clients indicated that they tested positive for Hepatitis C, and seventeen (17) reported a negative result. One (1) client reported no results were taken.

Several of the clients were on treatment for Hep C, while others were waiting for access to the new Hep C treatment programs. Many who had been diagnosed felt ashamed of their status, and were waiting to go on treatment. Knowing they were positive, but not knowing whether the treatments would be successful was a source of stress for at least one client.

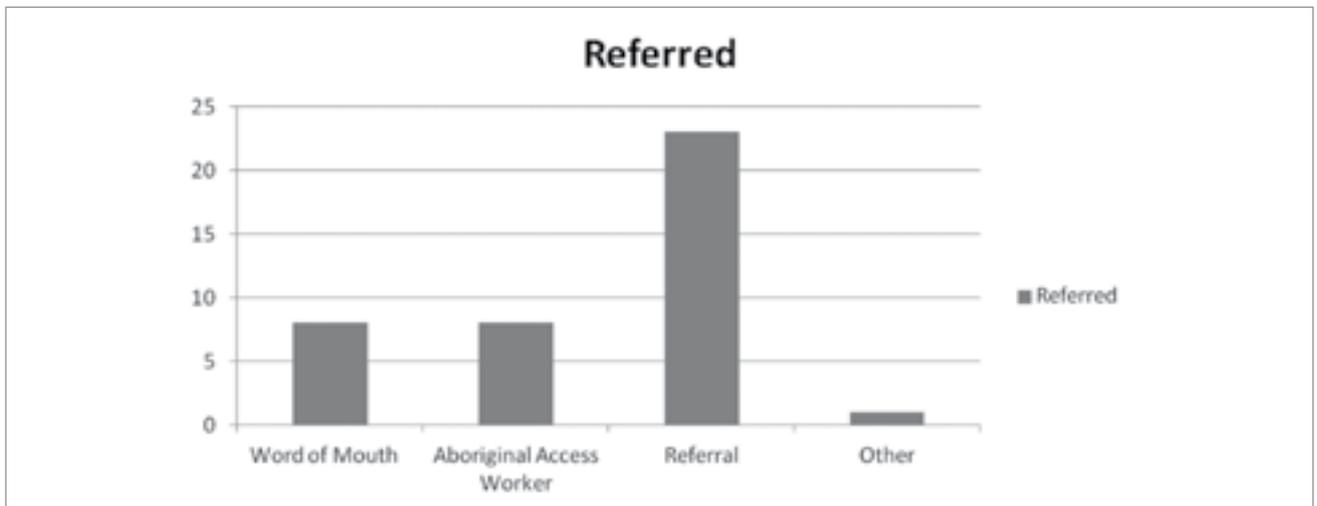


## Access Health Service Use

This next section focuses on how people came to be clients of Access Health, and how often they seek services from Access Health.

## Referral to Access Health

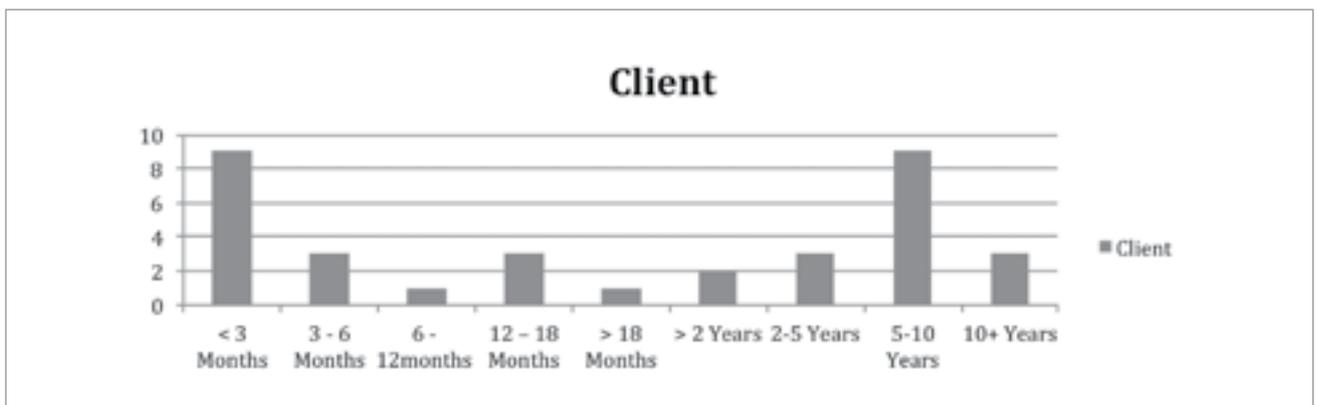
Clients were asked to illustrate how they became a client of Access Health. Twenty-one (21) clients illustrated that they were referred to Access Health, while seven (7) clients attended through Word of Mouth, and six (6) were referred through the Aboriginal Access Worker.



## How long they have been engaged with Access Health

Clients were asked how long they have been a client of Access Health. Thirty-four (34) clients responded to the question. Nine (9) reported being a client of Access Health for between 5–10 years, while another nine (9) reported only being a client for less than three months

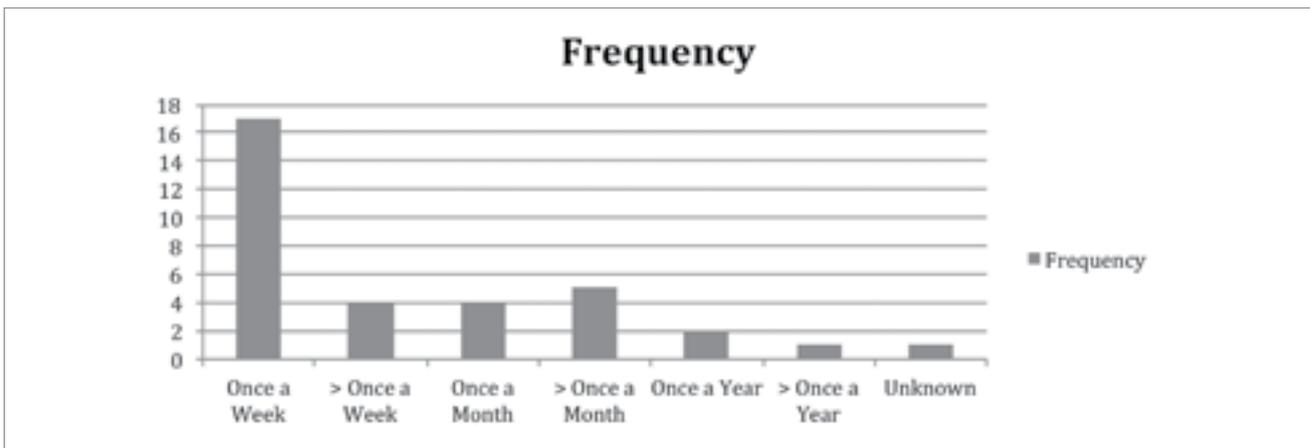
duration. Three (3) equally have been clients for 12–18 months; 2–5 years and 10 years plus. Two (2) indicated that they have been clients for 2 years, with One (1) stating they have been a client of Access Health for under 18 months. The length of engagement indicated a high receptivity of the service, with many in the survey group indicating a high repeat service access rate.



### Frequency of using Access Health

Clients were questioned on their visit frequency at Access Health. Seventeen (17) clients reported that they present at Access Health Once a week. Five (5) clients illustrated they visit once a month, four (4)

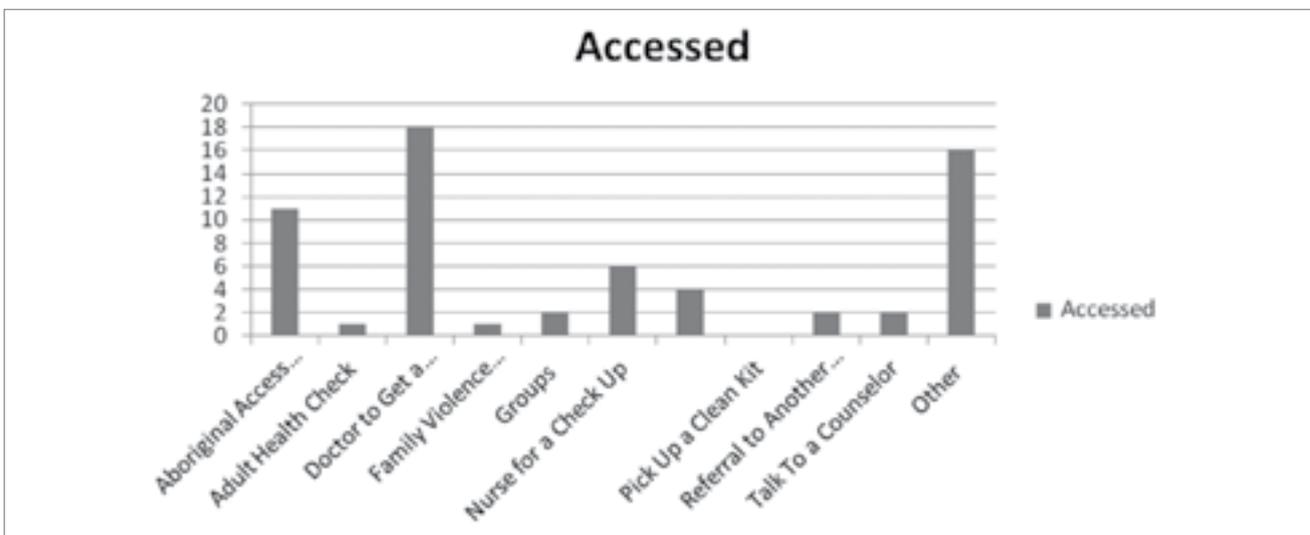
equally reported they visit over Once a week and Once a Month. Two (2) clients reported they have presented Once a Year, with one (1) visiting greater than Once a Year. One (1) client reported unknown to the question.



### What services they accessed

Fifteen (15) clients indicated they present to the Doctor for a Prescription. Ten (10) clients visit the Aboriginal Access Worker, five (5) visit the Nurse for a regular check-up, and four (4) visit as part of their Rehabilitation program. Two (2) clients equally are Referred to another service or talk to a Counsellor.

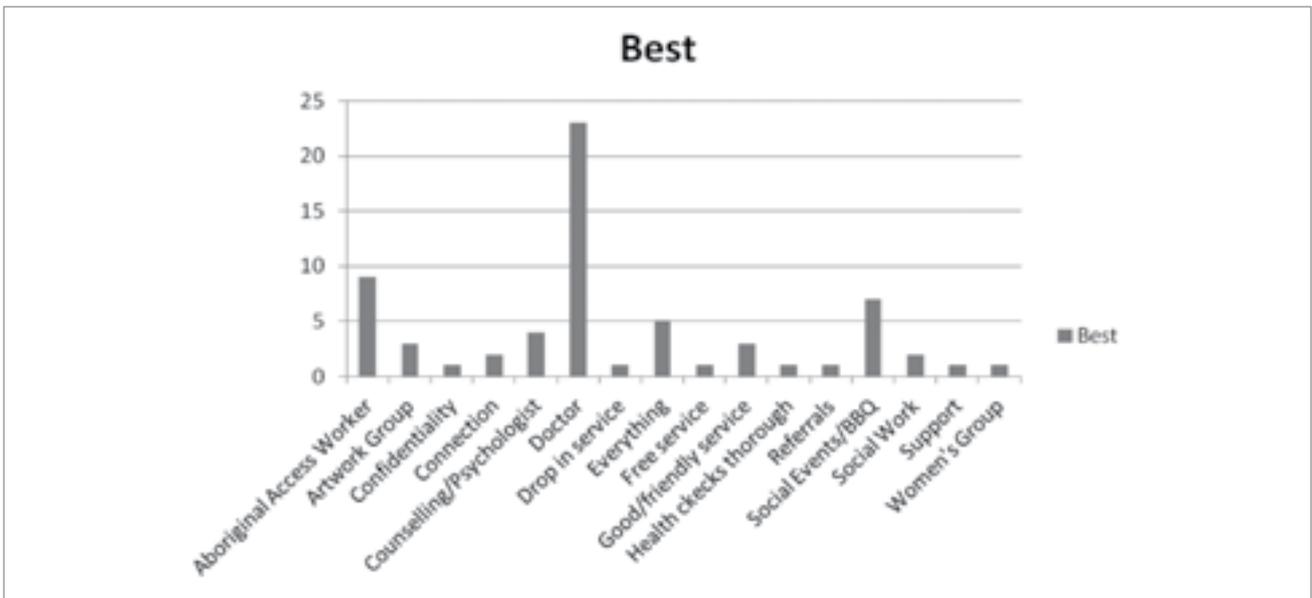
One (1) client undertook an Adult Health Check. One (1) client attended Family Violence Counselling and another attended as part of a Group. Fourteen (14) clients responded 'Other' to the question – nominating that they came for information, for letters to Centalink, for assistance with issues that their case manager were familiar with, while some came in to have a cuppa and to access community activities including the BBQ.



### What services they thought were the best

Clients were asked to identify who provided their preferred service within Access Health. Twenty (20) clients illustrated that the GP service was best, with nine (9) clients indicating the Aboriginal Access Worker. Seven (7) clients reported that Social Events / BBQ was the best service. Five (5) clients indicated

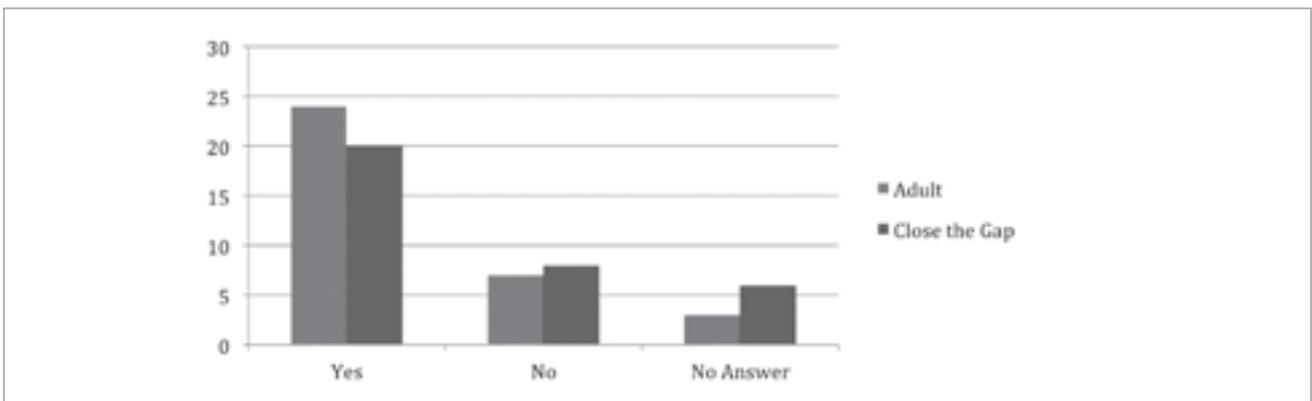
Everything, with four (4) clients illustrating Counselling/ Psychologist. Artwork Group, Connection, Good/ Friendly service, Social Work all received two (2) client best reports. One (1) client each indicated Confidentiality, Drop in Service, Free Service, the Health Checks were thorough, Referrals, Support and Women's Group were best services.



### Preventative health

Clients were asked if they have ever had an Adult Health Check or a 'Close the Gap' Aboriginal Health Check. Twenty-four (24) clients reported that they

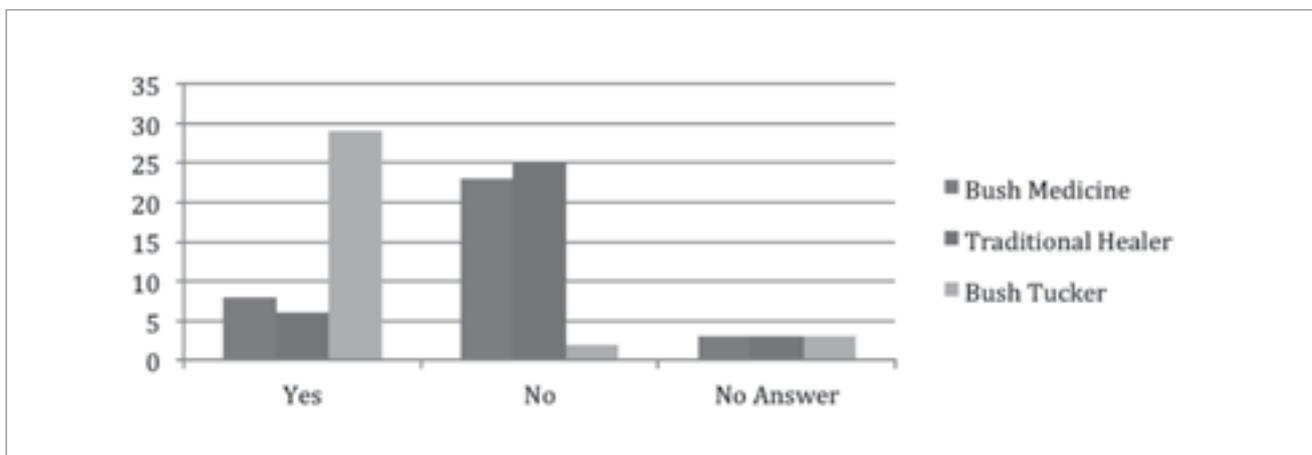
have had an Adult Health Check, and twenty (20) had undertaken an Aboriginal Health Check. Nine (9) clients did not provide a response to the question because they were unsure what a health check was.



### Traditional healer

Clients were asked if they had ever seen a traditional healer or received traditional medicine to fix a health concern. Twenty-nine (29) clients have experienced

Bush Tucker, with eight (8) having had Bush Medicine and six (6) having visited a Traditional Healer. Nine (9) clients did not provide a response to these questions.



### Knowledge about and use of referral services

The survey group indicated that the top services – i.e., those they were aware of and those that they had utilised included Galiamble, Alfred Hospital, Homeground, the Victorian Aboriginal Health Service, Sacred Heart Mission; Emergency rooms in hospitals, Salvation Army Crisis Services HIE, Winja Ulupna, Odyssey House, St Vincent’s Hospital and Inner South Community Services – as making up the majority of their health service ‘landscape’. This service scape indicates three opportunities:

- » more awareness about the other services in the region is required, particularly for new clients who have relocated from interstate or other parts of Victoria
- » collaborative work or cross-organisational professional development could be undertaken to enhance the health and wellbeing of Aboriginal clients accessing these services, and
- » services need to increase their visibility and, consequently, their usage by Aboriginal clients.

**Table 6: Client Knowledge about and Use of Referral Services**

	Aware		Used	
	Yes	No	Yes	No
Galiamble	30	4	9	25
Alfred Hospital	28	6	19	15
Homeground	28	6	11	23
Aboriginal Medical Services (VAHS)	27	7	16	18
Sacred Heart Mission	26	8	13	21

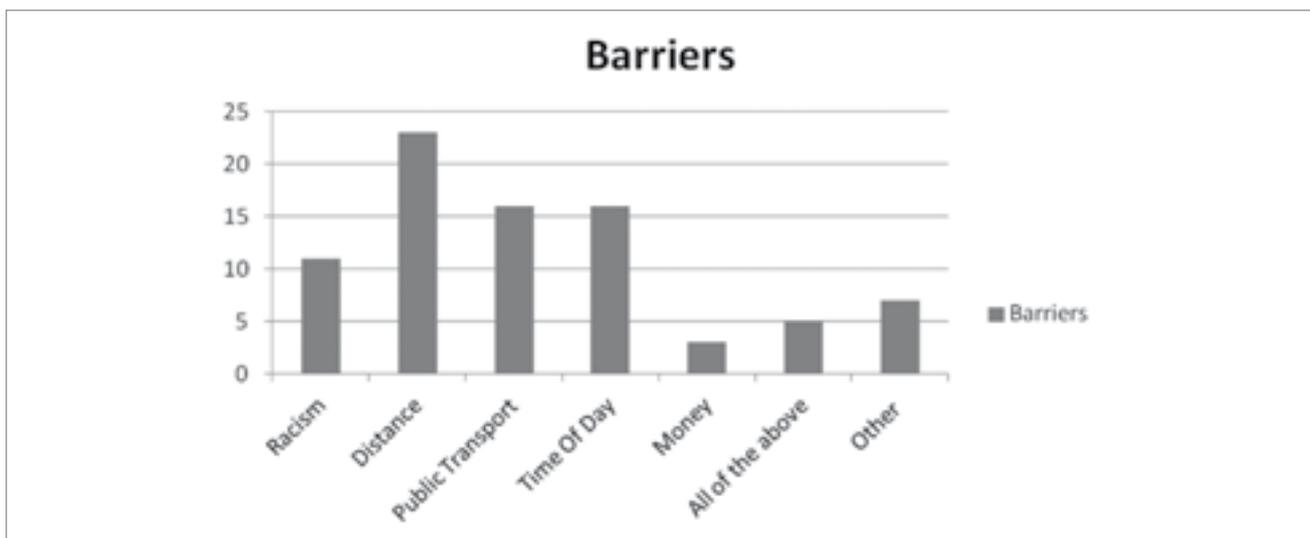


Emergency Rooms – Hospitals	25	9	14	20
Salvation Army Crisis Services Health Information Exchange	25	9	12	22
Winja Ulupna (Women’s Recovery Centre)	24	10	9	25
Odyssey House	24	10	5	29
St Vinnies Hospital	22	12	10	24
Inner South Community Services (Prahan)	22	12	10	24
Inner South Community Health Service (South Melbourne)	21	13	9	25
General Practice	20	14	8	26
Inner Health Community Health Services (St Kilda)	18	16	8	26
Hanover Family Services	22	12	7	27
Salvation Army Bridge Centre	20	14	6	28
St Kilda Legal Service	16	18	6	28
101 Chapel	12	22	6	28
City of Port Phillip Services	17	17	5	29
Good Shepherd Youth and Family Services	16	18	4	30
Sacred Heart Women’s House	14	20	4	30
Maya Centre	13	21	4	30
Child and Maternal Health Services	9	25	4	30
Living Room	6	28	4	30
Gladys Nicols Family and Community Services	16	18	2	32
Elizabeth Hoffman House	12	22	2	32
The First Step Program	10	24	2	32
St Kilda Youth Service	9	25	2	32
Open Family Australia	7	27	2	32
Barkly Street Medical Clinic	14	20	1	33
Dandenong AMS	11	23	1	33
St Kilda Gatehouse	7	27	1	33
Bert Williams Hostel	10	24	0	34
Resourcing Health and Education in the Sex Industry (RhED)	6	28	0	34
Buoyancy Foundation	3	31	0	34

## Barriers to Health Service Access

Clients were asked if they could identify from a list some of the barriers around access to health services. Twenty-one (21) clients reported that distance is a barrier, while sixteen (16) reported that time of day that services were available would impact on their access. A further fifteen (15) reported that money is a barrier, indicating that if they had to pay for services,

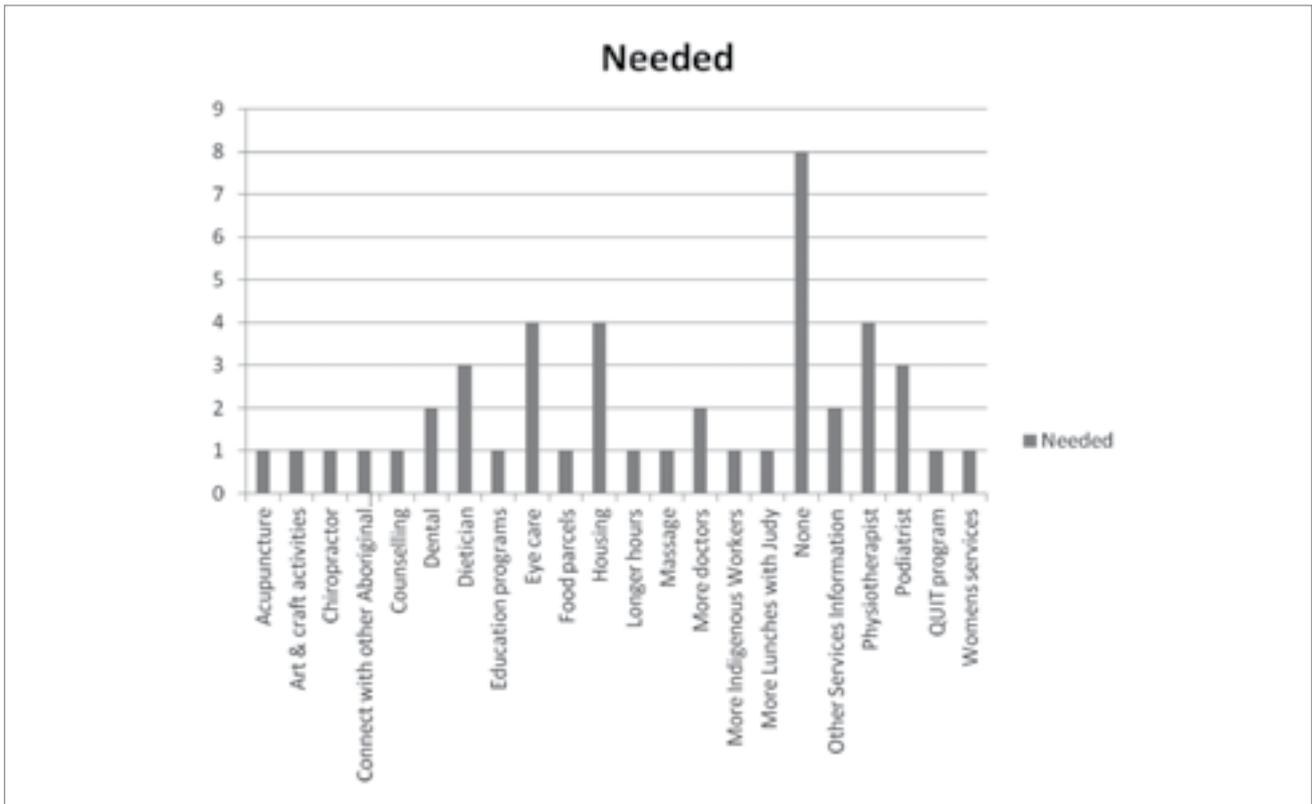
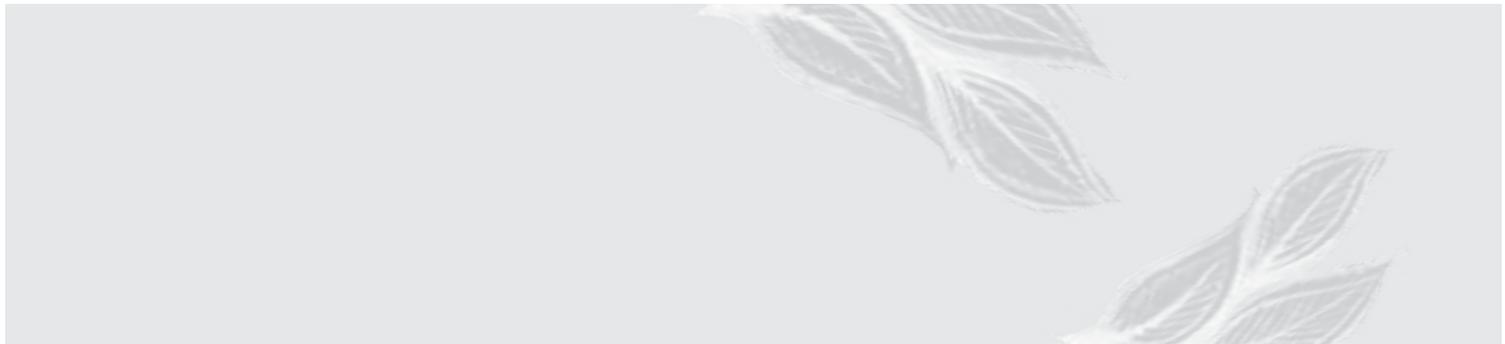
they would not access them. Twelve (12) clients indicated that public transport can be a barrier, and nine (9) indicated that racism is a barrier – that if they experienced racism in a service they would never go back, or that they would be banned because they would deal with it ‘in their own way’. Five (5) clients indicated that the listed factors were all barriers to health service access.



## Unmet Service Need

Clients were asked to identify an unmet service need. Eight (8) clients reported that there were no unmet needs. Four (4) clients reported that Eye care and equally Physiotherapy were an unmet service need. Three (3) clients indicated that Housing, Dietician and Podiatrist were services that were unmet. Two (2) clients

reported that Other Services Information was needed. Acupuncture, Art & Craft Activities, Chiropractor, Connect with other Aboriginal Services, Counselling, Education Programs, Food Parcels, Longer Hours, Massage, More Indigenous Workers were unmet service needs indicated by one (1) client equally (see Figure next page).



## Discussion

Overall, there was a high degree of acceptability by those who completed the survey. People who were new clients appreciated the quality of care, the ability of staff to sit down and discuss with them their health issues and needs and that they often did not feel rushed for time. Many of the people interviewed had been clients for between 5–10 years and had become regular repeat users of the service. It is always difficult for a full range of services to be available for a diverse group of clientele, but it appears that the clients referred to individuals in Access Health being pivotal to

their experiences of health and wellbeing. There were some concerns expressed about what would happen if those individuals left the service. Others identified an unmet need in relation to communication, information, access to dental and allied health care, and some community care support.

Based on the feedback from the staff and from the clients of Access Health, the following recommendations are made to improve the service to enhance access for, and the health outcomes of, Aboriginal clients.



## Conclusion

Issues influencing poorer health outcomes for Aboriginal and Torres Strait Islander people are multi-factorial, while those that confront marginalised sub-populations including the homeless or those with substance use issues are even more complex. Nevertheless, a responsibility exists to address these factors effectively as a means of lessening the wide health disparities between Aboriginal and Torres Strait Islander people and other Australians. Organisations like the Salvation Army Crisis Services, through programs like Access Health, have designed and implemented a number of effective strategies to address these health inequities.

This research highlights that although there is a high level of acceptability of current services among Access Health users, additional and more widespread programs focusing on social determinants services and better targeted interventions could be implemented to

meet the stated aims of the Statement of Reconciliation. Major needs to be addressed include issues around access to services across the region, providing support for clients to access holistic and culturally sensitive health care services that don't discriminate, better access to psychiatric and dental services, and an investment in gender equitable services. There also needs to be a greater recognition of the role and contribution of partnerships and programs to assist marginalised populations. Critically, these must be developed in consultation with Aboriginal and Torres Strait Islander people.

The success of a number of strategies, including the Access Health Program, do show that progress is achievable and provide a basis for the design, implementation and maintenance of similar models within both the Salvation Army and across primary health care services throughout Victoria.



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