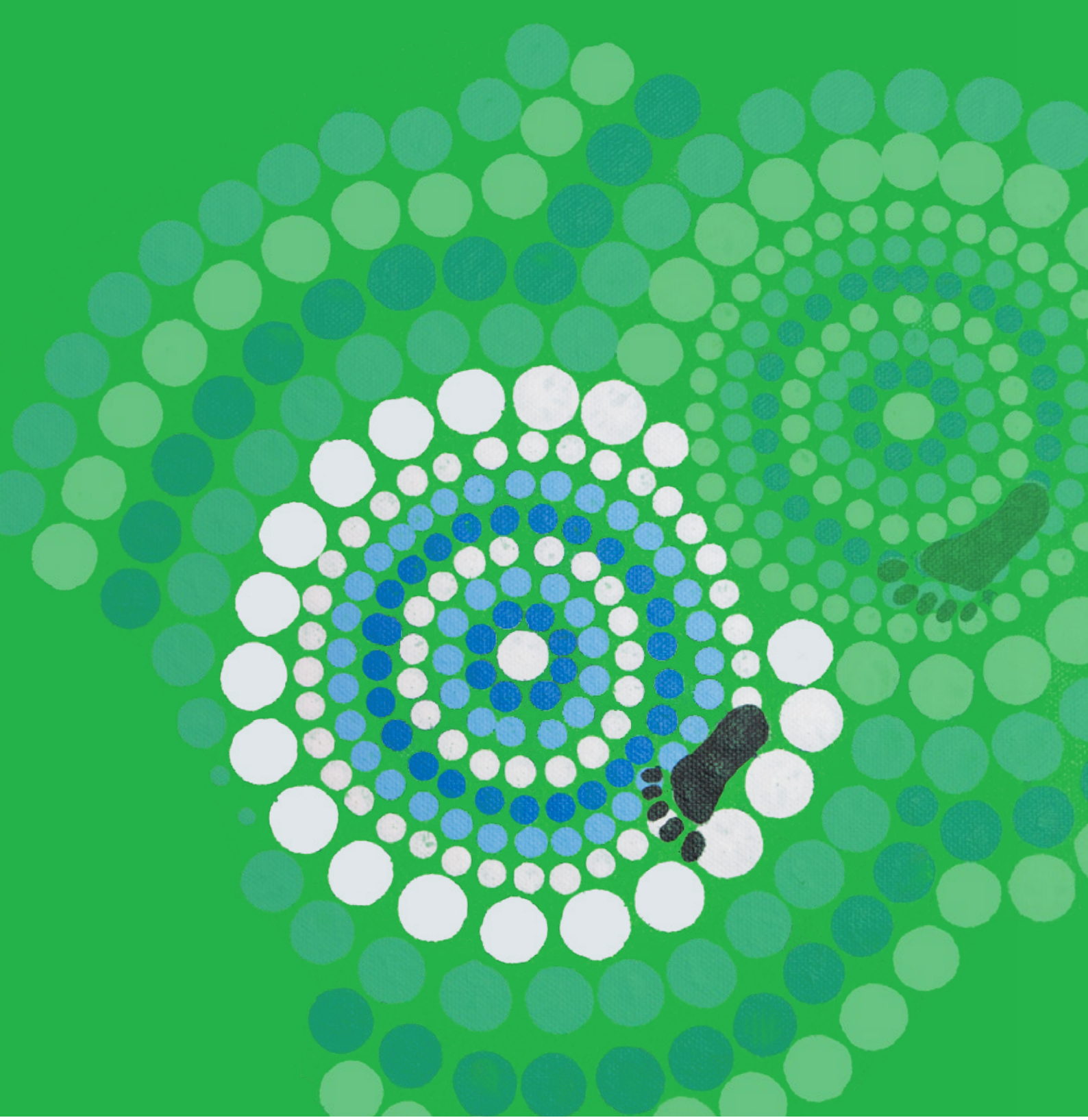


Making Better Connections

Urban Aboriginal Health Promotion:
Improving referral pathways in the Outer East

May2015

Unity in the Community was created by Wiradjuri artist, Kelvin Smith to represent the themes of the Making Better Connections project.

The Making Better Connections initiative was undertaken by Barb Dobson, Aboriginal Health Promotion Officer, from Inspiro

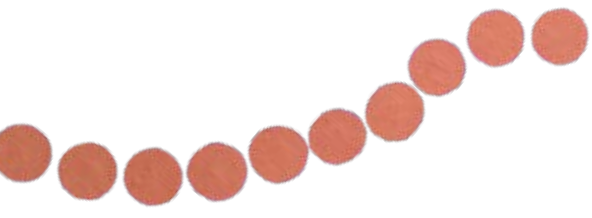
Acknowledgement of Country

The Board of the Healesville Indigenous Community Services Association Incorporated would like to acknowledge the traditional custodians of the land, the Wurundjeri people, and pay respect to their Elders past and present. We would also like to acknowledge those peoples, including Elders, who came to live on Wurundjeri land from all over Australia as a result of dispossession from their homelands, and in more recent time through choice. We will strive to uphold a cultural respect model that further includes and strengthens all our people, stories, tradition and culture for now and future generations.

The Board of Inspiro respectfully acknowledges the traditional custodians, the Wurundjeri people past and present of the Kulin Nation. We also pay respect to all Aboriginal Community Elders and people, past and present who have resided in the Eastern Metropolitan Region and have been an integral part of the history of this Region.

The Board of Quality Innovation Performance respectfully acknowledges traditional custodians of the land the Wurundjeri people past and present of the Kulin Nation. We pay respect to all Aboriginal Community Elders and people, past and present.

Throughout the report there is a mixed use of names Aboriginal and Indigenous. Where an organisation is formally known and listed with the term Indigenous this has been kept. Otherwise the term Aboriginal has been used inclusively to refer to Aboriginal and Torres Strait Islander community members. No offence is intended to any community members.



e c t i o n s

Making Better Connections

Urban Aboriginal Health Promotion: Improving referral pathways in the Outer East

'Image of Bunjil by Mandy Nicholson'

Traditional Lands

The Urban Aboriginal Health Promotion: Improving referral pathways in the Outer East project was based in Healesville, the land of Bunjil. Located on the ancestral lands of the Wurundjeri peoples, where the Yarra River flows, Healesville is now home to a diverse Indigenous community. This is made up of Traditional Custodians and community members whose traditional lands are elsewhere.

Traditional Voices

"Welcome readers to the story of our project. This has been about finding ways that our community can better access the health and support services they need. It's been about working together to find the best ways to improve things. We listened to each other; spoke to workers and community at different events and activities. There are some good ideas that have been shared that we can work on together with our friends and colleagues in other local organisations. Our Land, Our Story, Our People and their wellbeing are really important to us, so we want to say thank you to everyone who made it possible. We invite you to learn more about our local culture, some of which is included on the next page".

Brooke Collins, Traditional Custodian; Anne Jenkins, Manager of HICSA

Russell Renhard *was an inspirational leader and innovator in quality improvement, mentor and valued colleague to many of us in the community health sector. Working with Russell in the early days of QICSA was both challenging and enjoyable. His incisive mind, capacity for self-reflection and inclusive approach was an excellent example of cultural competence in action. His dedication to reorienting health systems and his joyful sense of humour has pervaded this project. Any positive outcomes are offered with respect to the Elders and community members in Healesville and dedicated to Russell's memory.*

Our Story

Painted By: Safina Stewart

The Tree of Life and Knowledge

Local leaders would like to share some information about local culture with readers and those who will make decision about health services for our local Indigenous community.

Our Story is made up of our history, our culture, our connection to land and country. Local community leaders on the Indigenous Advisory Committee to Yarra Ranges Council recently worked together to describe and share our local Story and Culture. They asked one of our talented local artists to create a painting that represents and shares our Story. The painting is of the Tree of Life and Knowledge which hangs in the local Council offices. Local council gave permission for us to share with you what is written in the Background Paper on Reconciliation[1] where some of our local story is shared and we thank them for that.

In recognition of the Country that our community lives on, our tree is a Manna Gum. The Manna Gum is an important Wurundjeri symbol, and our tree acknowledges and respects the traditional people of this land. The Manna Gum is also a tree which endures. Our tree grows in this land of the Wurundjeri people. The land is the mother of life. The roots of our tree represent the core cultural elements of family and kinship, spirituality, language, land and country, art and cultural practice. These are the elements that support the tree of Life and Knowledge and flow up from the ground as our cultural life –blood- through the tree to its very tips.

The leaves are a representation of our community and out people: the different colored leaves reflect the diversity within our community. Our tree also provides connection back to more traditional times, to when our ancestors walked the earth. They are now spirits providing guidance to us today. The sun as the giver of life shines on our leaves, on our community. This eternal energy source is the same one that shone on our Elders across time, and it unites the past and the present as one timeless space.

The whole tree is embraced in a circle of Respect, Caring and Sharing.

Respect, Caring and Sharing is our culture.

[1] Background Paper on Reconciliation Yarra Ranges Council January 2014.

Coranderrk Story

Healesville is also home to Coranderrk, a site of deep cultural significance both for local community and many other Aboriginal Victorians. The cultural heritage of Coranderrk is a source of strength and pride for local Aboriginal community members. Its history tells an inspirational story about sound leadership, community resilience and viable local industry. It also tells a story of the deleterious impact of government policies at that time. A story that still reverberates strongly today. The social impact of a Stolen Generation, the intergenerational aftermath of trauma, disconnection from land and culture, all continue to influence the present day health and well-being of local community. This needs to be appropriately acknowledged, recognised and incorporated into health service planning and delivery.

The story of Coranderrk below was told by Traditional Custodian and Elder, Aunty Joy Wandin-Murphy.

Residents of Coranderrk would have mainly been from the Kulin nation – Woiwurrung, Boonwurrung, Daungwurrung, Djadjawurrung and the Wathawurrung – the five groups from around Port Phillip. Other residents were soon moved to Coranderrk from across Victoria. Although the reserve was on Wurundjeri (part of the Woiwurrung) land, the Wurundjeri had no say as to who came onto their home lands.

Initially Coranderrk started with a population of around 40 people, by 1865 the population of Coranderrk numbered 105 making it Victoria's largest reserve at the time. Within four years the mission's residents had cleared much of the property to develop the competitive farming community. Coranderrk residents had also established a bakery, butcher, numerous houses and a schoolhouse under the direction of the Superintendent of Coranderrk, John Green.

By 1874 the Aborigines Protection Board (APB) were looking to move the residents off Coranderrk due to their successful farming of the land. There was a push from the general community that the land was too valuable for Aboriginal people. The people of Coranderrk, with the support of Mr. Green, protested this move, and it was during this decade that many of the residents walked the 40 miles into the Victorian Parliament to personally deliver protests to the proposed closure. In 1874, Mr. Green was eventually forced, by the APB, to resign due to his continued support for the residents. Coranderrk remained

operating as an Aboriginal station until its closure in 1924, but during this time there were protests by the residents regarding payment for their work. The APB refused to do so and instead continued to provide rations for their labour.

During these years of debate over the closure of Coranderrk, resources were not provided for the maintenance of the buildings, which meant that the health of the residents was added as an argument to it being closed. The huts were prone to dampness, the schoolhouse was leaking and in need of repair, and the management had changed hands five times in ten years. Despite these conditions residents lobbied the APB for financial assistance for maintenance of the reserve rather than movement from their area.

In 1881, a government enquiry into the Board's activities at Coranderrk was initiated. The Enquiry interviewed twenty-one of the residents and reported that the APB had a lack of sympathy for the residents, particularly in relation to their health and well-being. The Enquiry went on to criticise the ration system of the reserve, witnessing houses without food. The Enquiry concluded their report (1882) by recommending that Coranderrk become a permanent reservation in trust for the Aboriginal people living there. The Board responded reluctantly to the Enquiry and its recommendations, suggesting that the conditions were beyond their control and that they would have to apply to His Excellency, the King for funds to better the conditions.

With the passing of the 'Half-Caste' Act (1886) numbers at Coranderrk began to dwindle until they fell below 100, and by 1905 Coranderrk had only 72 residents. In 1924, Coranderrk closed and the majority of the residents were moved to Lake Tyers Mission Station. However, there were nine people who refused to go and remained at Coranderrk. The remaining land went to solider settlements in 1948. Few Aboriginal people were allocated land under this scheme.

Despite the hardship, people have fond memories and/or have passed their stories onto their loved ones of the good times as well as the bad. For some the stories were about their land and its connection, for others it was how they fought and continued to fight through protests and petitions to the government. Due to this connection through the land, stories and history, the Coranderrk community continues to fight for their land. So far, they have control of Coranderrk's cemetery and have purchased some of the land and the manager's house with help from the Indigenous Land Corporation.[2]

[2] http://www.abc.net.au/missionvoices/coranderrk/default.htm Accessed November 2013.

Acknowledgements

Learning and growing together is made of many ingredients. One of the key ingredients is generosity in sharing knowledge, experience and time.

There were many people who gave of their time and experience to the project. Particular thanks and appreciation is extended to representatives and members of the following organisations and networks.

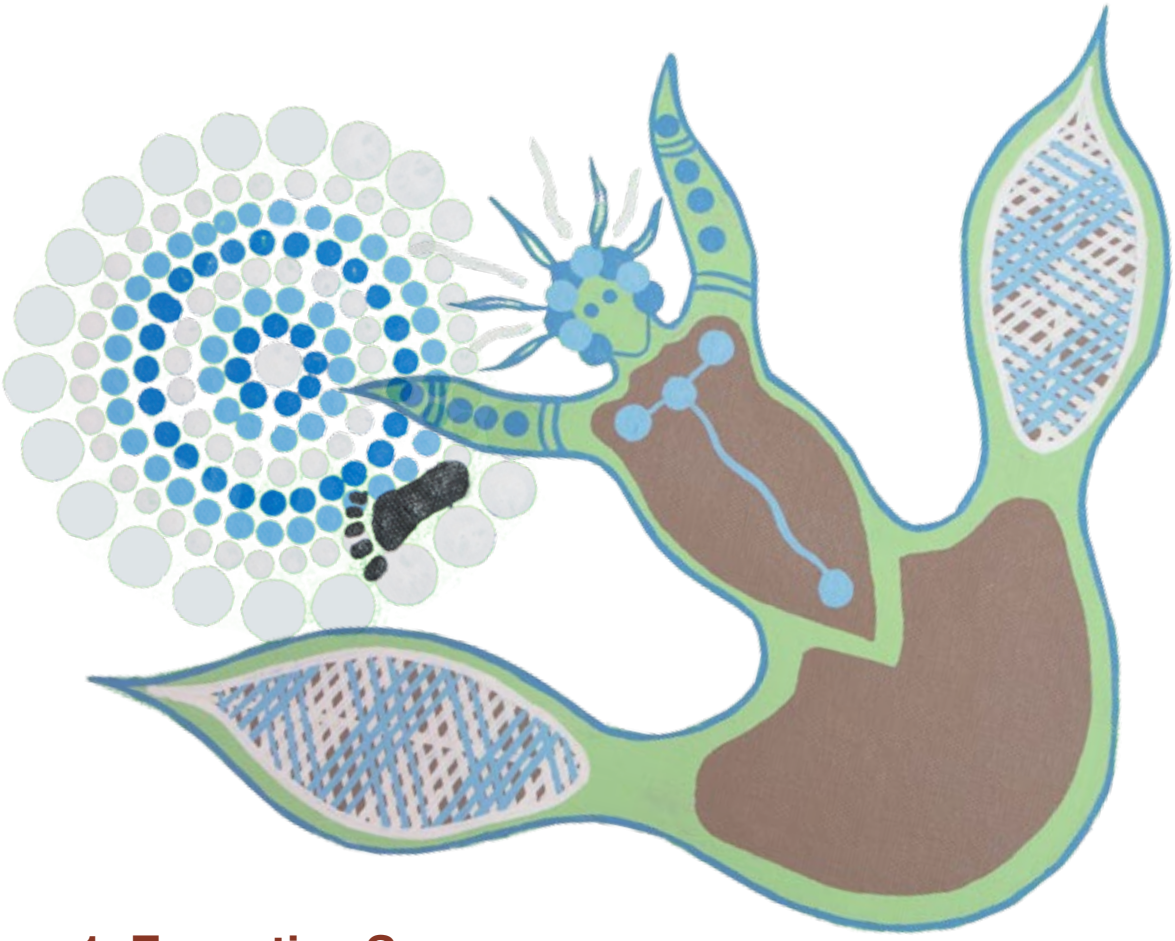
Aboriginal Health and Wellbeing Network
Boorndawan Willam Aboriginal Healing Service
Care Connect
EACH
Eastern Community Legal Centre (ECLC)
Eastern Domestic Violence Outreach Service (EDVOS)
Eastern Health (EH): Aboriginal Health Team (AHT), Aged and Disability Services, Yarra valley Community health (YVCH)
Eastern Melbourne Medicare Local (EMML)
Healesville Indigenous Community Services Association (HICSA)
Healesville Interchurch Community Care Inc. (HICCI)
Healesville Living and Learning Centre (HLLC)
Inspiro
Ngwala Willumbong Co-op.
RAJAC
Vic Police
Wurran Child and Family Place
Yarra Ranges Council: Economic and Community Development Department,
Youth Services Department.

Acronyms and Terms

The following abbreviations have been used throughout the document.

ACCO	Aboriginal Community Controlled Organisation
ACCHS	Aboriginal Community Controlled Health Services
ACAS	Aged Care Assessment Service
AHT	Aboriginal Health Team
BTH	Bringing Them Home
BWAHS	Boorndawan William Aboriginal Healing Service
CtHG	Closing the Health Gap
COAG	Council of Australian Governments
DEECD	Department of Education and Early Childhood Development
DoHA	Department of Health and Ageing
DoH	Department of Health
EACH	EACH (Social and Community Health Service)
EH	Eastern Health
EDVOS	Eastern Domestic Violence Outreach Service
EMML	Eastern Metropolitan Medicare Local
EMR	Eastern Metropolitan Region
HICSA	Healesville Indigenous Community Service Association
HICCI	Healesville Interchurch Community Care Inc.
HLLC	Healesville Living and Learning Centre
HSPN	Healesville Service Providers Network
HREOC	Human Rights and Equal Opportunity Commission
IAC	Indigenous Advisory Committee to Yarra Ranges Council
IFVRAG	Indigenous Family Violence Regional Advisory Group
KESO	Koori Education Support Officer
MCATSIA	Ministerial Council for Aboriginal and Torres Strait Islander Affairs
MoU	Memorandum of Understanding
MMIGP	Mullum Mullum Indigenous Gathering Place
NAIDOC	National Aboriginal and Islander Day of Observance Committee
NWD	No Wrong Door
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OEPCP	Outer East Primary Care Partnership (OEPCC)
RAJAC	Regional Aboriginal Justice Advisory Committee

Contents



1. Executive Summary

1.1 Overview

Urban Aboriginal Health Promotion: Improving referral pathways in the Outer East was a project initiative developed in response to a request from the local Aboriginal Controlled Community Organisation, Healesville Indigenous Services Community Organisation (HICSA). Sponsored by Quality Improvement Performance (QIP), previously known as QICSA, via the inaugural Russell Renhard Scholarship, it was a twelve month project implemented on location in Healesville throughout 2013- 2014.

The overall goal was to improve access to culturally responsive health services and contribute to better health outcomes for Aboriginal community members in the Outer East Melbourne area of Healesville and surrounds. The Department of Health divides the state of Victoria into seven regions. Healesville and surrounds belongs to the Eastern Metropolitan Region.

Despite its proximity to the urban eastern areas, Healesville is a rural town. Its surrounds are comprised of small rural communities. Potentially people are closely connected by family, socially and/or in their places of employment. Community members of the town and smaller surrounding areas were also deeply impacted by the 2009 Victorian bushfires. Implementation of the project required sensitive attention both to cultural appropriateness and also to the intricate web of community and professional connections. Given the core cultural values of respect, caring and sharing, it was important to everyone involved that relationships between organisations and community members were strengthened through the project.

Project development, implementation, evaluation and reporting were constructed to reflect local Aboriginal cultural values. Consequently, project design elements included: foundational core cultural values of respect, caring and sharing, a participatory action research methodology modified to incorporate *dadirri* principles and a systems approach to service improvement.[3]

Project implementation occurred at time of significant leadership change, at both State and local levels. In May 2012, the new Victorian government policy direction on Aboriginal health became clear with the launch of Koolin Balit.[4] A restructure of the Victorian State government departmental alignment in 2013, saw Aboriginal health move under the direction of the Department of Premier and Cabinet. Koolin Balit strategic priorities for the Eastern Region were in a development and consultation phase during 2013. These were finalised and formerly endorsed by the Minister for Health, Daniel Davis, in 2014.

The Eastern Metropolitan Region Closing the Health Gap (EMRCtHG) Plan 2009 – 2013, was in its final phase and a project review process was under way.[5] The regional Closing the Health Gap initiatives had contributed to an increasing awareness of the importance of visibly embracing Reconciliation. Local regional organisations were demonstrating their commitment to the spirit of Reconciliation though a range of activities. These included the development of Reconciliation action plans, reconciliation policy statements, formal partnerships with local ACCOs, along with reviews of policies and procedures to ensure these were consistent with the spirit of cultural safety and reconciliation.

[3] Background Paper on Reconciliation. January 2014. Yarra Ranges Council

[4] Victorian Government Department of Health. Koolin Balit. Victorian Government strategic directions for Aboriginal Health 2012- 2022

[5] Closing the Gap in Aboriginal Health Outcomes. Initiative Interim Evaluation Report Urbis March 2013

Throughout the project development phase, there were changes in personnel who played strong roles in Closing the Health Gap and reconciliation initiatives. A significant champion of reconciliation and cultural respect at Eastern Health retired at the end of 2013. There were also significant changes in local and regional Eastern Health personnel relevant to the project. Management of HICSA, Yarra Valley Community Health Service and the Eastern Health Aboriginal Health Team changed during the shift from the project inception to the development phases. Personnel in these three roles remained stable throughout the implementation phase.

The project development and implementation phase also paralleled other significant project initiatives in the Eastern region. The No Wrong Door project was reaching its final phases; Eastern Health was in the process of developing a Mental Health Navigation Tool; the Outer East Primary Care Partnership commenced work on an E Case Management project; Yarra Ranges Shire Council finalised and launched its Reconciliation Framework for Action; and the Department of Health was engaged in community consultation processes to identify the direction of regional Koolin Balit priorities.

Aboriginal health promotion in the urban context is an emerging field of practice. The Improving referral pathways in the Outer East project endeavored to contribute to building the evidence base in Urban Aboriginal Health Promotion. The project had two main aims: to translate the theory and principle of cultural respect into practice which supports improved access to local health services; and, to improve culturally appropriate referral systems for Aboriginal residents from Healesville and the surrounding areas.

It was originally envisaged that potential mechanisms for improvement would include identifying opportunities for strengthening collaboration and partnership amongst local services via the implementation of interagency communication policies, protocols and processes. Findings have indicated that while these are important tools and lead to improved infrastructure to support referrals, two other issues emerged as requiring prioritised local attention. These are the need for an Aboriginal controlled, co-located health service delivery point, and the need to strengthen efforts to embed cultural competence in local and regional organisations. In practice, cultural respect translates to strong interpersonal relationships based on effective and increasing levels of cultural competence. The project has identified embedding cultural competence as a foundational element for improving referrals and service access. It has also identified the importance of service provider networks as conduits for facilitating culturally appropriate referrals.

The structure of this report has been designed to reflect cultural ways of doing things. Consequently the report opens with stories that are important to local community. Following these, there are four sections to the report: executive summary, research question discussion, recommendations, and context.

While the focus of the project was based in Healesville and surrounds, it became obvious that only some ideas and improvements could be implemented locally, and directed by local organisations. Other areas for improvement had implications for the region, as well as relevant Victorian State Departments who set policy directions and provide funding. Recommendations have consequently been made at three tiers: strategic, organisational and community. The key findings are summarized in section 1.4.

1.2 Research Focus

The focus question for the research was: “How can local health and community services in Healesville improve access to services for local Indigenous residents?” Areas for investigation included barriers to service, communication protocols, referral articulation and alignment with the Department of Health’s Service Delivery Model.

1.3 Rationale

Late in 2012, the management of Healesville Indigenous Community Services Association (HICSA) identified a need for improved access to culturally appropriate local and regional services. Strengthening local referrals was identified as an important step to improving health service access for Aboriginal residents from Healesville and surrounding areas.

Preliminary investigations of potential interest in the initiative included: discussions with senior Eastern Health (EH) management; exploratory discussions with the Indigenous Community Development Worker at Yarra Ranges Shire Council; sharing the initiative concept at two key local networks, Aboriginal Health and Wellbeing Network (AHWB) which is the local Aboriginal Health Promotion and Chronic Care (AHPACC) network; and with the members of EWIN (Eastern Workers Indigenous network).

The need for the project and the proposed outcome was affirmed by all those consulted. The project concept and broad scope was then presented to the members of Yarra Ranges Council Indigenous Advisory Committee who supported the need and endorsed the implementation of the project.

In February 2013 HICSA formally signed an MOU with Eastern Health. A strategic planning day was then held in 2013 where operational applications of the MOU were considered. Several areas for action were identified on that day. The need for an improved approach to local referrals and service coordination emerged as an important area for improved processes. Also identified was the need to implement formal communication processes between HICSA, the Eastern Health Aboriginal Health Team and Yarra Valley Community Health.

1.4 Improving Local Referrals: Summary

Themes for action

Several themes indicating areas for action emerged from the data. These indicated the need for:

- Aboriginal control, co-location and integration of services
- Embedded cultural competence
- Culturally sensitive practice that respects first nation status
- Targeted, cohesive regional training in cultural competence
- Integration of Aboriginal concepts of health and wellbeing
- Centralised information access
- Support and strengthen the role of networks

From a local perspective there were two themes for action which stood out strongly. Of prime importance is the need for local, co-located, integrated, Aboriginal community controlled service delivery. The idea is in accord with Aboriginal Health Promotion principles.[6] It would elevate cultural leadership, strengthen existing and emerging programs, promote integrated planning and delivery of services, encourage community cohesion, increase visibility of, and access to, local and outreach services and, increase opportunities for collaborative engagement between community and service providers.

[6] Victorian Health Promotion Foundation Life is Health is Life. May 2011

The second is the need for sustained and cohesive efforts to both improve and embed cultural competence at organisational and practitioner levels. Translating the theory of cultural respect into effective practice implies, and requires, cultural competence. To be effective and visible, cultural competence needs to be embedded in the organisations providing service to local community.

While the Closing the Health Gap initiative contributed to range of positive changes, there remains a need for organisations to systemically embed cultural competence. Embedding cultural competence requires attention at two levels: regionally coordinated training programs and a systems approach at the organisational level. A systems approach for individual organisations ideally encompasses strategic leadership, self-reflective leadership and opportunities for individual practitioners to engage professional development designed to support the personal change process.[7] It also attends to human resource management and the systems associated with recruitment, orientation, professional development and supervision of employees.

The Eastern Region has made significant steps forward in building organisational cultural capacity. Several mainstream organisations have entered into formal agreements with local Aboriginal health organisations. While Memorandums of Understanding (MOUs) and other interagency communication protocols are an effective and supportive tool for improving communication and referrals, they have more potency when there is effective and visible cultural competence in participating organisations. Developing MOUs and other interagency communications without a strong foundation in cultural competence leaves the process open to regressive outcomes, despite well-meaning intent.

Embedded systemic cultural competence will act as a strong enabler in improving access to health and well-being programs and services for local Aboriginal community members. Implementing a planned regional approach to strengthening and sustaining the work begun through the Closing the Health Gap Program will ensure the momentum in building cultural competency continues. Achieving strategic objectives outlined in Koolin Balit will be augmented through a range of partnerships and programs, including a coherent regional approach to practitioner training and professional development.

A regional plan for sustainable professional development in cultural competence would include several baseline elements. These are:

- training modules designed to achieve steps along the cultural competence continuum (see appendix 1),
- systems for ensuring consistency of training provided by contracted providers,
- processes for standardised evaluation of program implementation and participant feedback, and
- systems for analysing and dissemination findings.

Collectively referring to health practitioners under the heading of mainstream requires sensitive disaggregation when designing and delivering professional development programs. Mainstream health systems are comprised of practitioners from a wide range of health and social health disciplines. Training and skill emphasis in undergraduate courses varies amongst the disciplines. Not all disciplinary graduates will have experience in self-reflective practice, and since self –reflective practice has been identified as a core capacity in cultural competence, a graded approach to skill development in this area would be effective.[8] At the same time respect for the considerable experience in self-reflective practice of particular disciplines requires respectful accommodation.

There is also a need for clear definitions of terms related to cultural competence. Cultural awareness, cultural respect, cultural safety and cultural competence were used interchangeably by practitioners and other key informants. Ensuring explanations of the cultural competence continuum is included in local and regional training will enable a consistency regarding the definitions and use of these terms. It was noted that cultural awareness training and cultural competence training was not well delineated. Some informants to the project used the term cultural competence to refer to cultural awareness training. An improved understanding of the cultural continuum, or a similar model, will assist organisational leaders, practitioners and managers to identify graded learning and development goals, both for individuals and teams. The term competence may also need revision. There are concerns in the community that mainstream practitioners may be assessed as competent when the behaviors and attributes associated with competence are not yet visible. The term also requires context and distinction from being qualified and competent to practice in a given field of expertise.

[7] Judith Miralles & Associates Increasing Cultural Competency for Healthier Living: Discussion Paper. Cultural Perspective Discussion Paper NHMRC March 2005

[8] Increasing Cultural Competency for Healthier Living: Discussion Paper. Cultural Perspective & Judith Miralles & Associates NHMRC Discussion Paper March 2005

This project has focused on cultural competence from an Aboriginal cultural perspective. Current standards of health care require services to provide health care in a way that is culturally sensitive and informed across a range of cultures. As organisations investigate how their systems will address cultural inclusiveness more broadly, it will be crucial that the distinction between Aboriginal cultural competence and more generic cultural competence remains clear. Using umbrella terms to collectively address cultural competence runs the risk of diminishing the particular status of Aboriginal people as Traditional Custodians and first nation peoples of this land. Retaining and respecting this distinction in striving for organisational and individual cultural competence will prevent an inadvertent repeat of colonialist practice.

Using umbrella terms to collectively address cultural competence runs the risk of diminishing the particular status of Aboriginal people as Traditional Custodians and first nation peoples of this land.

Notions of health and well-being emerged as areas for ongoing communication between mainstream and Aboriginal organisations. Mainstream organisations have long term cultures and systems approaches based on mainstream notions of health and associated structures and attribution of power. Genuine reorientation of health systems to cultural competence will require an integration and accommodation of Aboriginal concepts of health and well-being. This would include genuine acknowledgement, and integration into practice, of the importance of cultural wellbeing which includes: connection to family, community and country, language, art and artefacts, ceremony, respect for elders and identity. Working closely with and following the guidance of local Elders, community leaders and organisations ensures reorientation is locally appropriate. Being prepared to listen and genuinely integrate community feedback into system reorientation signals cultural competence to community.

A strong theme of disjointed and disconnected information flow arose. It applied both locally and regionally. Community, workers and managers would all benefit from improved access to information about services, networks and strategic documents that apply to current practice and direction in delivering culturally safe Aboriginal health care. There is a pressing need for a centralised system that will support regional communication, information sharing between strategic and local networks, and coordination of regional and local network planning. Current web-based statewide information channels could be examined for amendment, however a range of options, including the establishment of a regional website are worth considering. Exploring options for web links between the websites of key providers would add further strength to improving online information access. Presently resources for these activities are not allocated. Consequently there is an opportunity for regional organisations, planning networks and the Department of Health and Human Services to discuss and identify opportunities for action.

1.5 Achievements

The project has achieved a range of outcomes both intended and unintended. Activities and dialogue connected to the project have also contributed to other projects underway in the Eastern region. The current project has influenced thinking at the strategic level, raised options for project collaboration at the regional level, and contributed to a range of outcomes for the local community. The research identified a range of activities that could be implemented to improve access to services for local Aboriginal community members. These vary from local to regional in terms of spheres of action and are discussed in more detail in the research discussion section.

Responsiveness

Enabling responsiveness is a powerful contribution to local community. Through sponsoring this initiative, QIP made it possible for Inspiro and key stakeholders to respond to the service improvement need identified by HICSA. Local ACCOs are familiar with mainstream organisational constraints that can act to inhibit requests for project collaboration or systems improvements. A positive response to HICSA has contributed to strengthening relationships and building trust between the organisations involved. The impact was evidenced qualitatively via worker commentary, strengthened relationships, increased willingness to meet with mainstream staff, new systems for sharing and planning

between HICSA and the Aboriginal Health Team, invitations extended to mainstream staff to attend cultural events, and working together on identifying ongoing projects, service delivery and access opportunities.

Importance of Place

The need for a co-located, integrated Aboriginal controlled health and well- being service was identified as a significant factor in contributing to local health outcomes. This has been raised with State government representatives who have given a commitment to explore options for co-located service delivery.

Translating Cultural Respect

In practice, cultural respect translates to cultural competence. The project has identified embedding cultural competence as a foundational element for improving referrals and service access. At the local level the initiative emphasised the need for service providers to work closely with HICSA and the Aboriginal Health Team, which enables mainstream organisational representatives to follow the guidance of local Elders and community leaders in working with local community. At the regional level the project has emphasized the need for cultural competence standards which reflect local culture. Discussions are underway with regional representatives on the most effective way to address the development of cultural competence standards. There is a pilot project in development to scope a locally appropriate training module. There is an increased awareness of what "reorienting a health service" really means. It has contributed to an increased recognition of the importance of systems in embedding sustainable organisational cultural competence. Recommendations for operational and systems improvements to support organisational capacity building in cultural competence have been made. This includes the identification of human resource system improvements. Local organisations are considering their capacity to implement these recommendations. The project has also increased local Aboriginal community awareness of the commitment by mainstream organisations to cultural competence capacity building and improving access for local Aboriginal community members.

Improved Pathways

Organisations that could be incorporated into local pathway mapping were identified. This included two key community organisations and the local police. Access to common referral systems such as the InfoXchange S2S was raised as an area for improvement. The significance of worker networks as a forum for culturally appropriate referral process was identified. The monthly community lunch facilitated by HICSA was identified as a positive example of this approach. An opportunity also arose to contribute to the work of other organisations looking to improve service delivery in the local region. The findings of the project are being shared at key networks including the EMML Indigenous Pathways Working Group, the Aboriginal Health and Wellbeing Network and the Healesville Service Providers Network.

Information Access

Regional representatives from the Department of Health and Human Services have acknowledged the need for a centralised access point for information pertaining to Aboriginal health and well-being related services. There has been recognition of the need to implement systems that will support regional communication and information sharing between networks, along with the coordination of regional and local network planning.

Resource Tensions

The project highlighted a service delivery tension between funding deliverables and the resources required to achieve ongoing culturally competent service delivery. This applied to both mainstream and Aboriginal organisations; however the demand is particularly high for Aboriginal organisations. It highlighted the demands being placed on the three Eastern Regional Aboriginal Community Controlled organisations to resource local mainstream efforts to improve competence and coordinate services. Implementing a culturally appropriate approach requires consultation with local Aboriginal Controlled organisations, however these organisations have limited resources which are being stretched to accommodate consultative and engagement processes requested by mainstream organisations.

Local Service Communication

During the life of the project joint staff meetings between HICSA and Eastern Health Aboriginal Health team improved. They are now regularly scheduled. Content of the meetings has moved from information sharing to joint planning on projects and programs. The Aboriginal Health Team has established communication with the local emergency relief organisation that provides volunteer transport. There is a need to improve the connectivity of service provider networks to broader systems such as local orientation and induction of new workers. Processes are underway to explore the potential for integrating the Healesville service provider network into the local area orientation systems.

1.6 Methods and Design

Literature Review

A review of existing literature was conducted on the health status and barriers to health service access of urban Indigenous communities, including a review of recent government health system strategies and models aimed at improving primary health care access. A search of existing scientific literature using the search engine PubMed, which accesses references primarily from the MEDLINE database, was undertaken using search terms such as 'health', 'access' 'service co-ordination', 'referral pathways', 'Aborigin*', 'Indigenous', and 'urban'.

This yielded a very limited number of relevant primary research studies and few reviews of studies on the topic. To broaden the search, reference lists of review papers were also examined for relevant studies. Recently released Victorian State Government policy and framework documents were included the background reading. Additional key sources of publications, including government and non-government reports and policy documents, were identified through the Australian Indigenous HealthInfoNet, and Victorian Government Health websites. Sources of demographic and epidemiological data were derived from official Australian Bureau of Statistics data, Indigenous and non-Indigenous research institute reports, and Victorian Department of Health publications.

1.7 Project Stages

Needs Assessment

Issues relating to health service access for Aboriginal community members from Healesville and surrounding areas were identified by two parallel processes. Management at HICSA initially identified the need for improvement in access to services and referral processes amongst local services. Secondly, Eastern Health staff and HICSA staff held a joint strategic planning day with a view to grounding the practical applications of an MOU signed on February 2013. The project need was confirmed through consultation with community Elders, regional Aboriginal Health worker networks, Yarra Ranges Shire Council Indigenous Advisory Committee and staff. Staff members at HICSA worked in collaboration with the project manager from Inspiro community health to determine culturally appropriate ways to involve community members.

Project Concept

The research approach used throughout the project was a combination of Participatory Action Research (PAR) incorporating *dadirri* principles. PAR is increasingly acknowledged as being consistent with the principles of reconciliation and self-determination while *dadirri* is culturally appropriate and informed practice.[9]

[9] Baum, F., MacDougall, C. & Smith, D. 2006. Participatory action research. Journal of Epidemiology and Community Health, 60, 854-857

PAR intentionally involves the community as co-researchers, working in partnership to affect change based on self-reflective inquiry - a process that is "directly linked to action, influenced by understanding of history, culture, and local context and embedded in social relationships." [10]

Dadirri was developed by Aboriginal researcher Judy Atkinson (2001) and stipulates the principles and processes required to respectfully engage with Aboriginal communities. The principles outlined by Atkinson suggest that the research must seek respect for

- the knowledge and consideration of community and the diversity and unique nature that each
- individual brings to community;
- ways of relating and acting within community: a non-intrusive observation, or quietly aware watching;
- a deep listening and hearing with more than the ears;
- a reflective non-judgmental consideration of what is being seen and heard; and,
- acting on learning's in a responsible way.[11]

Engagement, Data Gathering and Analysis

A series of data gathering and engagement activities were undertaken to identify and establish a shared understanding of issues relating to referral and access for the local Aboriginal community. These included: formal and informal meetings with key stakeholders, focus groups, community conversations, a community art competition, network presentations and discussions, and a service provider network. Eighteen semi structured interviews and three focus groups were held. Broad research questions were used as starting points for discussion on health service access and referral experiences.

The topic list used to guide focus group discussions is found in Table 1.

Table 1

Community access to information	Service provider access to information
Perspectives on culturally appropriate service	Reflections on referral mechanisms
Access to culturally appropriate services	Shared planning
Suggestions for improvement	Case management

Key Informant Interview Themes

Themes emerging from the key informant interviews and focus groups included:

Local Strengths	Improvements
• Strong focus on relationships • Presence of local services • Local and regional networks • Client focussed orientation of services • High level of Signatories to No Wrong Door • Monthly community lunch at HICSA	• Access to information: clients and workers • Coorodination of local service planning and program delivery • Embed the practice of No Wrong Door • Resourcing requirements No Wrong Door re client tracking and support • Referral forms : varied forms with inconsistent use

[10] Baum, F., MacDougall, C. & Smith, D. 2006. Participatory action research. Journal of Epidemiology and Community Health, 60, 854-857

[11] International Journal of Critical Indigenous Studies Volume 4, Number 2, 2011
Aboriginal People's Experiences of Health and Family Services in the Northern Territory Terry Dunbar, Charles Darwin University

Service Provider Workshop

A significant milestone in the project was a service provider workshop held in May 2014 which involved 36 participants. The workshop was designed to deepen local worker engagement in the project, capture qualitative data on participant referral experiences and to explore opportunities for action and improvement.

Service provider workshop themes

- **Need for an Integrated, Co-located, Aboriginal Controlled service delivery**
- **Ensure culturally safe and welcoming services**
- **Need for embedded cultural competence**
- **Health literacy**
- **Referral systems**
- **Improved integration of networks**

Community Art Competition

A community art competition invited participants to submit entries which reflected the themes of the project. Entries were judged by community representatives. The beautiful work of the winning entry is featured throughout this report.

Advertising for the competition described the project and was a way of letting more people know that organisations were working together to improve referrals. Entrants were asked to reflect the following themes in their work:

- Local culture
- Better connections
- Sharing information
- Support for our elders
- Better health

The winning entry was by a local Wiradjeri man, Kelvin Smith. Kelvin's work is reflected throughout the graphics of this report. The painting is reproduced inside the front cover.

Kelvin was presented with the prize at the HISCA community lunch in October where he offered the following explanation of his work to everyone present.

The central circle represents HICSA. The hand inside the circle: Each finger represents the five topics that are being covered in the painting: Local culture, better health, better connections, sharing information and support for our elders.

The different mobs are coming together at HICSA to share information.

The two spirits that are top left and bottom right represent our Ancestors watching over our people.

In the centre the six people facing each other are talking about better connection and better ways of sharing information in the community.

On the top right hand of the circle you can see a young man/woman speaking about ways of better health in the community for young and old.

On the bottom left hand of the circle you can see a few of the workers supporting our elder whether to appointments or at home.

1.8 Outputs

- Stakeholder interviews
- Project overview and introduction document
- Key informant interviews
- Focus groups
- Community conversations
- Community art competition
- Local service provider workshop.
- Workshop report
- Workshop summary document for participants and interested parties
- Presentation on findings at local networks
- Presentation on findings at EMML research conference
- Full project summary and achievement document.
- Full project report with recommendations

Information derived from the data gathering process was processed to extract key themes. A full report on the Service provider workshop describes the processes and thematic outcomes from participant responses. This was made available to participants and key networks. Themes emerging from the workshop have been incorporated into the research question discussion. Content for the discussion below has blended themes derived from existing literature and the data gathering processes listed on the previous page.

2. Research Question Discussion

The focus question for the research was:

"How can local health and community services in Healesville improve access to services for local Aboriginal residents?"

It was proposed to investigate the following areas:

- Barriers to service – including perceived, physical, cultural, historical
- Communication protocols: this has been discussed under the heading of communication
- Referral articulation
- Alignment with Department of Health State-wide Integrated Service Delivery Model.

2.1 Dismantling the Barriers to Service Access

Healesville is a rural town, just on the fringe of Eastern Metropolitan Melbourne. It is characterised by rivers and hills with undulations affecting access to some service sites. Since the town is on the fringe of a major metropolitan region there are mix of issues pertaining to both rural and urban influences which impact on service access. These include access to transport, access to specialist services, concerns connected to cultural safety and intimacy of small town relationships affecting perceptions of privacy and confidentiality.

Barriers to mainstream services for Aboriginal community members are well documented in the research literature. Lau et al (2012)[12] conducted a qualitative study on factors influencing access to urban general practices and primary health care for Aboriginal Australians. They found that successful chronic disease care and interventions require Aboriginal community engagement, strong leadership, local knowledge of the community, shared responsibilities and shared care between health sectors, sustainable resources and integrated data and information systems.[13] They proposed that closing the gap in Aboriginal health care delivery and outcomes will only occur when there is a culturally competent health system that is inclusive of both Aboriginal and non-Aboriginal people, in which all patients and service providers feel culturally safe.

Current barriers to local and regional service access for Aboriginal community members in Healesville include: the legacy of the past; invisible cultural safety at some sites; personal experiences of cultural insensitivity at mainstream services; access to service sites affected by personal or public transport access and the topography of the area; confusion about the services; fragmentation of local services; impact of a close-knit community where relatives, or significant others, may be working at the local service. Further barriers arise from the complexities of the health system.

The research identified a range of activities that could be implemented to improve access to services for local Aboriginal community members. These vary from local to regional in terms of spheres of action.

- Recognise the legacy of the past and the local story
- Create culturally safe and welcoming service spaces
- Embed cultural competence
- Improve access to service sites
- Improve navigation of our complex health system
- Improve local and regional interagency communication
- Support practitioners to engage in culturally appropriate referral approaches.

[12] Factors Influencing access to Urban General Practices and Primary Health Care by Aboriginal Australians Lau et al

[13] Liaw, S-T., Lau, P., Pyett, P., Furler, J., Burchill, M., Rowley, K., & Kelaher, M. 2011 Successful chronic disease care for Aboriginal Australians requires cultural competence. Australian and New Zealand Journal of Public Health, 35(3), 238-248

The Legacy of the Past

It is easy to use this phrase, avoid the discomfort and move on. However, being cognisant of the past is a starting point for genuine reorientation of local services. The importance of mainstream providers appreciating the significance and ongoing impact of the past needs to be strongly elevated. Developing a better understanding of Aboriginal history and its local context leads to a deeper insight into, and appreciation of, Aboriginal culture and way of life. Recognising and acknowledging the challenges that have arisen through the impact of government policies and cultural decimation along with ongoing racism enables a practitioner to respond more effectively.[14] Locally, the story of Coranderrk is pivotal. Ensuring local and regional service providers are attuned to the local history will improve the potential for culturally appropriate local service delivery.

Focusing on the present is necessary as it is the only time for change; however it is the mindset that makes decisions in the now that will make a difference. Mainstream services and their staff have the opportunity to genuinely engage with local community and move towards culturally competent practice or continue to reinforce the impact of colonialist practices, either through poor attention to the issues, or imposing service models that echo practices of the past, and reinforce systemically embedded racism. Positive experiences multiply and facilitate increased referrals.

Creating Culturally Safe and Welcoming Services

"Cultural safety /showing we can be trusted"

Presenting a service as Culturally Safe and welcoming is a well-documented first step in ensuring Aboriginal community members feel safe to walk in the door. Identifying effective promotion of the visibility of a culturally safe service to community will support community engagement in local health services. Whether a community member returns to a service or recommends that others attend, may be influenced by a range of factors. Those factors connected to Cultural Safety include: having culturally appropriate signs and symbols visible to community that indicate Aboriginal clients are welcome; ensuring a warm welcome at reception, being asked about cultural identity preferences and being attended to by culturally sensitive practitioners.

Local service providers expressed a strong desire to listen and learn from local Aboriginal community members or their representatives. They want to implement mechanisms for receiving feedback from community about their experiences of welcome and safety. Ideally, mainstream staff wanted to hear directly back from their clients. At the same time, to expect direct feedback from clients was acknowledged as an unrealistic expectation for a range of reasons, particularly those related to cultural safety. The willingness and interest to learn and grow in this area is positive. There is potential for a feedback system to be developed and implemented that is safe for all involved: clients and practitioners. While individual services may already have in place feedback processes from clients to practitioners, a system that respectfully communicates feedback at an interagency level would add strength to these efforts. Led by HICSA and the Eastern Health Aboriginal Health Team, there is an opportunity for discussion and collaboration with members of the Healesville Service Providers Network to develop and implement processes that enable practitioners to receive and pass on feedback from the community about their experiences at mainstream services.

Access to Services Sites

'A Gathering place'. 'A central location around culture. You go there being proud to be Aboriginal'

Aboriginal Controlled Community Health Organisatons (ACCHOs) play a major role in ensuring that essential primary health care services are delivered to Aboriginal Australians in a culturally secure manner.[15] A strong theme emerging from the research was the importance of co-locating and integrating services in a designated Aboriginal Gathering Place. Achieving this was identified as a significant step forward in improving local community access to culturally safe services. While the Outer East is supported by HICSA and the Eastern Health Aboriginal Health Team, the benefits of an integrated, co- located and community controlled service would be manifold. A centralized location would provide strength to existing programs, promote integrated planning and delivery of services, encourage community cohesion, increase visibility of, and access to, outreach services and, increase opportunities for two way engagement between community and service providers.

[14] North Coast Area Health Service Cultural respect and communication guide 2009

[15] Australian Institute for Health and Wellbeing. Healthy for Life Aboriginal Community Controlled Health Services Report Card 2013

Services are currently provided across different organisations and different sites. For people who are walking or using public transport there are a range of inhibitors which include elevations from the town to the hospital and White St. community health site; bus timetable articulation with available appointment times. Issues related to access, information and eligibility mentioned in the section on Health Literacy are exacerbated by the existence of organisational scope and professional boundaries. Community have also expressed confusion related to "… who does what in town".

Embedding Cultural Competence

"The cultural competence of each organisation. If it's not there the client won't want to access the service."
"Continue to focus on Cultural Competency: being and doing; walk the talk…"

The importance of cultural competence both for practitioners and organisations was strongly emphasized at the service provider workshop and was echoed throughout the focus groups and individual interviews. National and State imperatives to close the gap in health outcomes for Indigenous and non- Indigenous Australians highlight the importance of cultural respect.

The Eastern Metropolitan Region began concentrated efforts to increase cultural awareness via Closing the Health Gap program initiatives over 5 years ago. Beginning in 2009 the Outer East Health and Community Services Association (OEHCSA) coordinated a series of Aboriginal Cultural Respect training for the Eastern Region. Approximately 300 people working in the primary health care sector attended the training. The training was sponsored by the Outer East Primary Care Partnership (OEPCC) while agencies utilised Closing the Health Gap funding to sponsor the attendance of staff at the workshops.

The final report on the Closing the Health Gap program suggests it was acknowledged by stakeholders across regions to have been the catalyst for important changes in health service delivery and health system planning.[16] The need for cultural education within universal health services … [was]… recognised and all universal health services within the state … engaged with some form of cultural education training for staff.[17] The Eastern Metropolitan Closing the Health Gap Plan, 2009–13 also supported a range of activities under the priorities of Improving the Patient Journey and Making Indigenous

Health Everyone's business.[18] Practitioners and organisations increasingly recognise that cultural respect and awareness is only a step, albeit a positive one.

Translating cultural awareness into culturally competent practice emerged as a strong theme. Participants at the service provider workshop identified a need for practical support on how to know if they are heading in the right direction with their individual efforts to translate cultural awareness into culturally competent practice. A topic of discussion was how this can be achieved. Participants expressed the need for guidance on what signposts to use as indicators of cultural competence. This echoes a trend that has emerged in conversations amongst service providers in professional networks both nationally and across the region. Projects such as the study by Judith Miralles and associates, the Background Paper on Creating the NACHHO Cultural Safety Training Standards and Assessment Protocols, and the work done in the Hume Region on an Aboriginal Health Cultural Competence framework provide a sound basis for the next step which is to develop practical tools that take theory to the operational and practice interface.[19. 20. 21] The OEPCP worked with Dr Zane Ma Rhea who has written up the OEHCSA Organisational Leadership Program: Delivering your Aboriginal Strategy program as an integrative case study. This has been submitted to Centage Learning Australia and New Zealand for inclusion in a textbook.[22]

Currently, there is a clear need for innovative work to be done to develop indicators and tools for use by practitioners and their supervisors when engaging in reflective practice inclusive of progression towards cultural competence. The development of indicators and tools would also support ongoing organisational cultural capacity through enabling individual self-assessment, as well as providing an evidentiary trail for more formal mechanisms such as accreditation, supervision and performance appraisals. Early work in this area by Mungabareena Aboriginal Corporation and Women's Health Goulburn North East provides a starting point for a locally appropriate response.[23]

[16] Closing the Gap in Aboriginal Health Outcomes Initiative Urbis 2013

[17] Closing the Gap in Aboriginal Health Outcomes Initiative Urbis 2013

[18] Eastern Metropolitan Closing the Health Gap Plan, 2009–13 Department of Health.

[19] Aboriginal Competence Framework Hume Region 2012. www.cersh.com.au accessed November 2013

[20] Increasing Cultural Competency for Healthier Living: Discussion Paper. Cultural Perspective & Judith Miralles & Associates NHMRC Discussion Paper March 2005

[21] Creating the NACCHO Cultural Safety Training Standards and Assessment Process. A background paper. May 2011. NACCHO.

[22] Email communication from Executive Officer ,PCP , Outer East Health and Community Support Alliance

[23] http://www.whealth.com.au/mtww/ accessed August 2013

Judith Miralles et al have proposed a model of cultural competency that encompasses four dimensions: Systemic, Organisational, Individual, Professional. They propose that systemic and organisational competency is a necessary precursor for individual culturally competent practice. This implies that the skills and resources required for inclusive practice are in place. It also highlights the importance of an organisatonal culture where cultural competency is acknowledged valued as integral to core business activity. Consequently, it is supported and evaluated.[24]

As progress is made to include cultural competence in under and postgraduate education curriculum, it is envisaged that formal disciplinary training and qualification will, in the long-term, address ongoing professional cultural competence. This will add strength to sustaining organisational cultural competence.

However, in the transitional years, there will remain a need for systemically embedded continuing practice education and training support for existing practitioners in this area. As mentioned above, this needs to be supported by organisational systems and cultures which promote and sustain culturally competent practitioners.

Human Resource Systems

The engagement and recruitment of staff with sufficient levels of cultural awareness is foundational for mainstream organisations to achieve effective organisational cultural competence. Human resource management and the systems associated with recruitment, orientation, professional development and supervision of employees could be amended to incorporate cultural awareness requirements. Specifying network attendance and membership, either in position descriptions and/or work plans, will clarify the expectations for workers and organisations. It follows that this area of work would then be included in regular supervision and performance management systems.

[24] Increasing Cultural Competency for Healthier Living: Discussion Paper. Cultural Perspective & Judith Miralles & Associates NHMRC Discussion Paper March 2005

2.2 Communication

Interagency communication protocols
Navigating a complex health system

Local organisations have a reported history of fragmented communication. Representatives from local organizations reflected that momentum to implement initiatives to improve connections with the local ACCO, HICSA, increased throughout 2012.

In February 2013 HICSA signed a Memorandum of Understanding with Eastern Health. The following February HICSA signed a Memorandum of Understanding with Inspiro. Representatives from HICSA increased regularity of attendance at the Healesville Service Providers Network. These positive steps have been supported by the commencement of regular meetings between the Aboriginal Health Team and HICSA in 2104 which is contributing to improved information flow for workers and community. Commentary on local service planning and delivery suggested that while improvements had been made in the last twelve months, there are ongoing opportunities to progress from information sharing to building in systems for program planning and resource sharing.

Navigating a Complex Health System

"So many services with all different eligibility criteria; difficult for workers to navigate let alone clients."

Navigation through health services was raised as a complex issue for both practitioners and clients. Being confused and overwhelmed by the myriad of services was a commonly expressed theme. Supporting clients to access information was identified as being compromised when practitioners are also confused. This is a well-recognised issue across the health service system and is not isolated to the local area. In looking to suggest effective local solutions, several comments were made about the need for an Aboriginal health specific, centralized, point for information about services, eligibility criteria, costs, hours and other related information.

There is an opportunity here for sponsorship of a local project which would ideally support, and link into, regional and state wide information which is currently available on websites. Suggestions for improvement included looking at existing central information models to assess whether they could be amended or improved to meet this need. This discussion included the websites connected to No Wrong Door; the Better Health Channel; the new Mental Health Navigation Tool and InfoXchange.

To assess viability of current website access, search terms such as *Aboriginal health, *Indigenous health,* Indigenous Health service, were entered into the Better Health Channel and it was clear that work would need to be done to make this useful to local residents.[25] Any newly developed, or amended, information access point will require communication with organizations to ensure there is an established process for informing new and existing workers about its purpose, how to access it and how to add updated information.

In the key informant interviews, a frequently mentioned technique for navigating through confusion and information overload was to rely on a key person. While this is reportedly effective on a 1:1 basis, there are implications for workers, organisations and community connect to knowledge management and an effective systems approach when there is an overreliance on a pivotal person. There are also implications for the key person concerning workload management, particularly when their identified role is not in direct referrals.

Understanding how services are funded and applicable eligibility criteria was identified as an area for work in community. Producing a service map by condition using language that is community friendly was a suggestion that arose in the workshop groups, the key informant interviews and the project focus groups. There is also an opportunity for HICSA and the Eastern Health Aboriginal Health Team to plan a series of community information sessions that assist with information sharing on how to find and get to services.

2.2 Articulating Referrals

Strong relationships between workers
Networks
Integrated use of referral systems

One to one meetings were viewed as important between key local providers. Participants in the workshop and the key informant interviews consistently identified building and sustaining effective relationships the major mechanism for achieving effective referrals. This is both culturally appropriate and a feature of the way a small community in a rural setting works. The value of the Aboriginal health worker and local service provider networks were strongly highlighted in this context.

"Can you come and have a chat to....."

The importance of attending community events and programs was also emphasized. This allows other workers and/or community members to make links between people and service providers that reduces the formality and occurs in a culturally safe way. Service providers who are supported to operate in this way report more effective engagement with local community.

"There's no one place to find out. Ask (team leader) or other staff who are here. Ring someone who might know".

Focus group participants were asked how they go about finding referral information when they don't know. There is no one central point that a new worker can go to for information about services, programs and practitioners. There was a consistent theme that workers would be supported having a central place to access information. A book and a website as options to address was frequently mentioned.

[25] Better Health Channel. http://www.betterhealth.vic.gov.au/ Search terms entered: Doctors Healesville; Aboriginal health; 3777 and Healesville into service provider section

"In the first year a lot of my time was spent learning who I go to for what"

When practitioners were new in their roles, navigation of the service system was time consuming. Exceptions to this are workers who enter their new role with previously established knowledge and connections.

Making phone calls to established contacts was a common mitigation strategy used to facilitate client access to services. The monthly community lunch at HICSA was viewed as a culturally safe environment, an opportunity to meet outreach and regional service providers, and an important entrée into the local professional community networks. Being invited to provide services at family focused community lunches at HICSA was viewed as safe way to engage local community members with service providers.

At the service provider workshop participants were involved in case studies. This activity identified that experienced participants from services, both local and regional, were in the room with service representatives they had not known about previously. Since a major requirement of effective referrals is that those involved know what is available and how to access them, this again points strongly to the need for a central access point for information about services and referral processes.

"A No Wrong Door approach would work well. It would require resourcing in the form of person and a system for tracking it. Otherwise a person comes in and no one knows they don't return or they get referred on and no one knows what happened next."

The No Wrong Door initiative was viewed as being an excellent step forward. Worker perspectives on this program are that the benefits and impact of this approach are just beginning. Resourcing of the increased need for follow up and tracking was identified as a barrier to full implementation of the initiative.

Two of the local providers currently involved in facilitating access to health and well-being services are not users of the S2S InfoXchange system. A step forward would be to examine the barriers to HICSA and HICCI being registered as users of the S2S referral system. The local Neighborhood House also plays an important role in facilitating referrals. An integrative approach between health, education, and community support and justice providers exists in pockets. Systematically articulating these areas of service delivery at State and regional levels will assist with local coordination and enable it to mirror regional and state approaches.

Networks/Networking

Regional and Local Network

"Attending networks, being involved in programs and building relationships is the number 1 way to do things"

Networks have been identified as an important element in inducting new workers to the local area. Key local networks include the following: LIN, Healesville Service Provider Network; Healesville Youth Worker Network. Networks are highly valued by workers. They are seen as effective conduits for information flow, reflection and identification of emerging issues, peer support and the sharing of practice wisdom. Attendance at networks is seen as culturally appropriate and effective by workers in Aboriginal health and support roles.

The role of representatives at networks emerged as an area for improvement. While the benefits of attending for individuals were clear, communication of the content and outcomes of Aboriginal and mainstream network meetings back to organisations and management is an area for improvement. Flow on benefits for organisations would be strengthened with improved clarity of the expectations of network participants back to their organizations, supported by internal organisational systems for information dissemination and storage.

Participants in the workshops suggested that large organisations could use their Intranet systems to hold accessible, centrally located information about local networks, their current membership, agendas and projects. There is an opportunity to incorporate the networks into orientation and induction systems. This would necessitate communication between managers of local Aboriginal and mainstream organisations, and designated positions in Aboriginal and mainstream networks. While this already occurs informally, there is an opportunity to formalize communication between the networks and organisations.

Attendance at networks is also seen as a time management issue. There is a high burden on workers from Aboriginal organisations and workers in mainstream Aboriginal health roles to participate in a range of networks. This includes networks that are Aboriginal focused, discipline focused or project focused; both strategic and operational. Workers in organisations with low staffing levels and high demands on organisational outputs are challenged to prioritise attendance at network meetings. Aboriginal workers in particular are often required to attend several meetings which stretch the representational capacity of their organisations. This can mean representatives may not attend a network meeting which impedes information flow, impacts on new workers and inhibits shared planning between organisations.

The hours required traveling from Healesville to regional or city based meetings impact strongly on workers' time. When staff are already working in a part-time capacity this poses an issue for communication. Consideration of web- based tools for communication would augment capacity to attend via a cyber-presence. Systems worth investigation include products such as the suite of Google products such as drop boxes, cloud computing and video conferencing.

While there were many positive comments made about how welcoming workers are to new local colleagues, workers new to delivering services to Healesville from outside the area made comments about how close-knit the professional community is. Finding an entry point or mentor into the local community was raised as a barrier. While it is recognised that individuals will make their own contacts, a systematic approach could include integrating the role of the Healesville Service Providers Network into orientation and induction processes, supported by close communication with Aboriginal Service Provider Networks.

2.4 Alignment with the State Wide Integrated Service Delivery Model

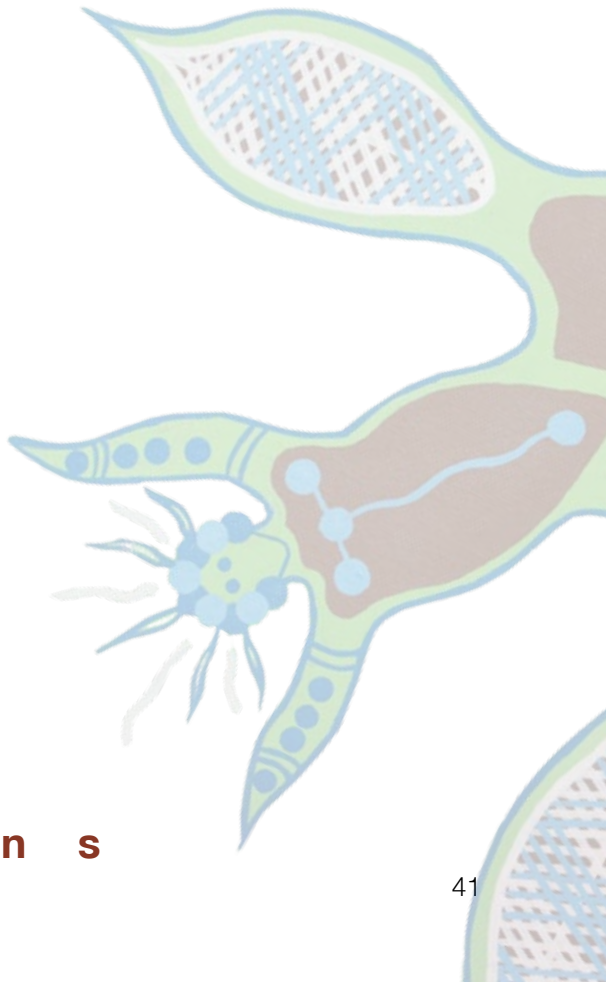
There was diverse awareness of, and involvement in, the Department of Health Service Coordination policy direction and related regional initiatives.[26] Discussion responses to questions on this subject at the service provider workshop indicated that several participants were unaware of Service Coordination as a policy direction. In this case the term was understood to indicate generally coordinating with other agencies. Major regional projects that were highlighted included: No Wrong Door[27] and an E Care planning pilot project for HACC services which is being led by the Outer East Primary Care Partnership.[28]

The awareness of recent amendments to the SCTT was minimal. While the Service Coordination Template tool (SCTT) is used broadly, it is still one of many forms that are used by various services. Compliance by organisations required to use the SCTT was reported as variable.

[26]http://www.health.vic.gov.au/pcps/sctt.htm

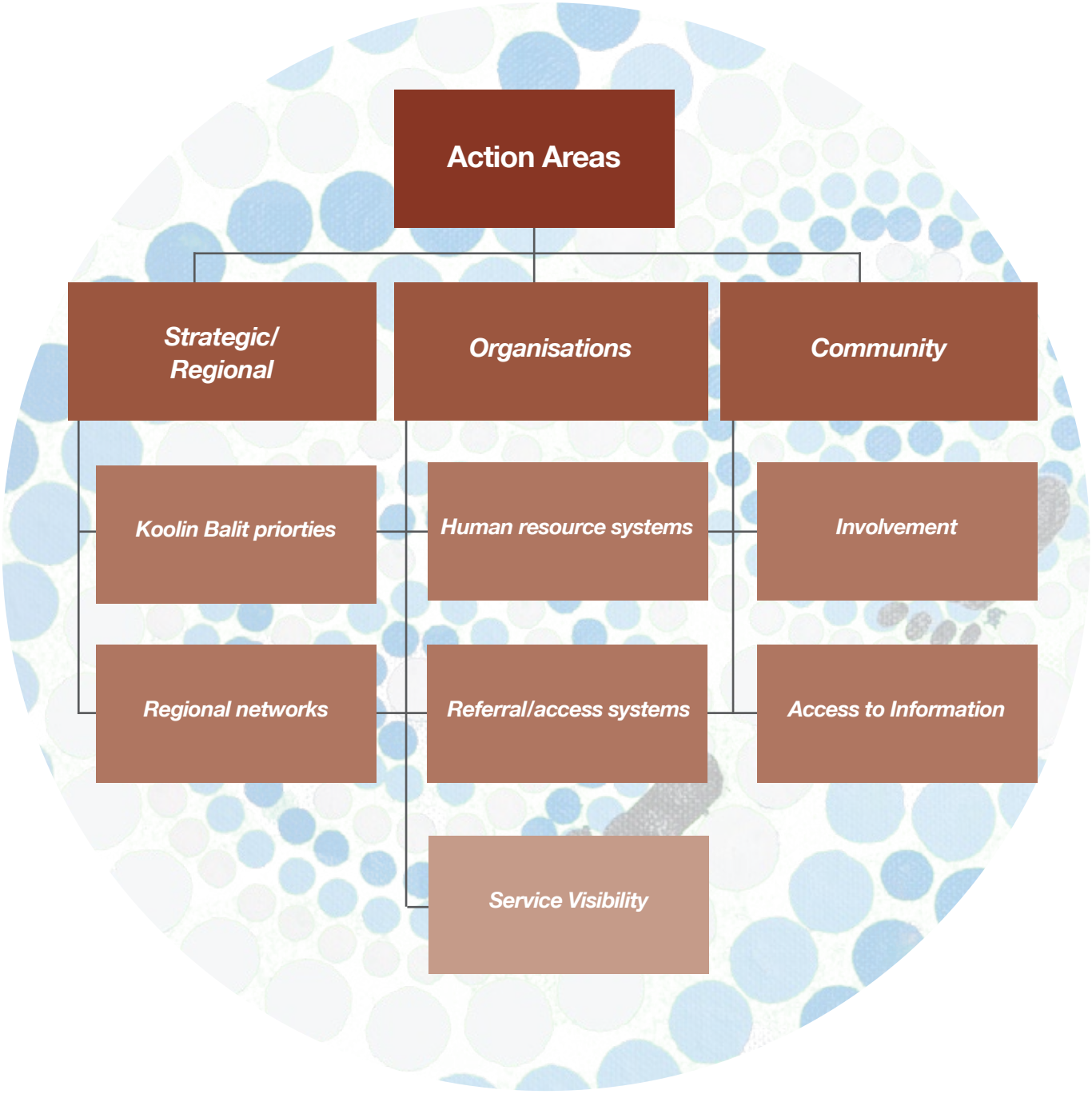
[27]http://www.nowrongdoor.org.au/ accessed June 2014

[28]www.oehcsa.org.au e-Care Planning Project Phase 2 (eCPP2) accesses June 2014



3. Recommendations

There are three tiers where action can be taken to improve access to local and regional health service for local Aboriginal and Torres Strait Island community members in Healesville and surrounds.



ONE: STRATEGIC/REGIONAL

Koolin Balit Priorities

One of the Eastern Metropolitan Region, Koolin Balit priority actions is the allocation of resources to two partnership and governance roles. This will provide an opportunity for centralising and coordinating both local and regional initiatives, along with facilitating information flow between networks and organisations. Streamlining and coordinating the responsibilities of these two roles with similarly designated roles, both in Aboriginal health and wellbeing services, and with affiliated mainstream roles, will maximise potential for achieving some of the actions listed below.

Areas where action could be locally determined by **state department and regional representatives and local leaders:**

- Local leaders work with Members of Parliament and State Department representatives to address the need for co- located, Aboriginal Controlled integrated health service delivery in Healesville.
- Membership of the Koolin Balit governance group includes community endorsed representation, supported by mechanisms for efficient information flow back to communities related to emerging community issues and ongoing priority/ project implementation.
- Establishment of a mechanism that provides an information interface between the Eastern Regional planning bodies of Aboriginal health, local government, hospitals, community health and justice organisations.
- Include community support, service and justice organisations into the communication loop for Koolin Balit related project development and implementation.
- Develop an Eastern regional approach to Cultural Safety training that caters for entry level and ongoing practice development and considers the needs of diverse disciplines
- Convene a working group to develop a set of core, community endorsed, culturally competent practice standards, supported by a self-assessment tool for use in supervision and performance appraisals.
- Convene a gathering of cultural awareness and cultural competence trainers once the indicators and tools have been developed.

Regional and Local Networks

Areas where action could be locally determined by **network participant members**:

- Set Eastern regional network dates that are aligned with strategic coordinating groups such as the Koolin Balit governance meeting, RAJAC meeting, IFVRAG meetings.
- Cross communication, sharing of terms of reference and forward planning between networks.
- Establish/or identify an existing central access for point for the agenda, membership lists and meeting minutes for regional networks.
- Network representation: Organisations to identify network member roles and responsibilities with emphasis on preparation and feedback mechanisms that ensure a two way flow of up to date information.

Aboriginal health worker networks

- Establish a group email approach for including information flow between existing and new members of the network into the local area.
- Identify the method for inducting new members into the networks.
- Identify an effective communication mechanism between networks and managers of local organisations.
- Consider opportunities and establish systems for planning and coordinating network meeting dates, agendas and project initiatives e.g. network wiki, drop boxes, google groups.
- Develop and implement a mechanism for updating the group email list annually.

TWO: ORGANISATIONS

Areas where action could be implemented by **local and regional organisations**:

HUMAN RESOURCE SYSTEMS

RECRUITMENT

- Establish a standard item for inclusion in position descriptions that refers to an appropriate standard of cultural awareness or cultural competence.
- Establish a process that clearly identifies expectations of network membership and participation which includes systems for information sharing and dissemination throughout the organisation.

ORIENTATION

- Develop and implement an orientation resource for a new worker that includes appropriate local Cultural history, identifies key organisations and local networks and suggests key local contacts. Include mechanisms for annual updates of contact information.
- Managers of key local organisations to explore potential for collaboration and planning on visits to Aboriginal services. This will strengthen links between new workers to the area and avoid a time impost on local Aboriginal services.
- Include scheduled visits to key local organizations for new workers: HICSA, EHAHT, BWAHS, HICCI, Eastcare.
- Include a list of updated information about worker networks, current meeting cycle and Chairperson.
- Network representation: Identify network member roles and responsibilities with emphasis on preparation and feedback mechanisms that ensure a two way flow of up to date information.

SUPERVISION

- Embed practice reflection on the development of Cultural Competence in supervision discussions and performance appraisals.
- Include discussion on the progress and development of relationships with local Aboriginal organisations.
- Utilize an individual self – assessment tool on the achievement of Cultural Competence in annual performance appraisals.
- Embed practice reflection on network participation in supervision discussions and performance appraisals.

PROFESSIONAL DEVELOPMENT

- Implement a cycle of annual Cultural Awareness professional development.
- Implement a complementary cycle of Cultural Competence professional development.

QUALITY IMPROVEMENT

- Work collaboratively at a regional level to implement and review the Cultural Competence Standards, once they are developed (see Strategic area)
- Implement an annual Cultural Audit cycle focused on Cultural Safety.
- Share findings and action plans with local Aboriginal organisations.
- Identify culturally appropriate ways to include Aboriginal representation in the development and review of organisational Aboriginal Health and well-being; Reconciliation action plans/position statements.

REFERRAL/ ACCESS SYSTEMS

INTAKE/ REFERRALS

- Local networks to explore the potential for implementing a NWD approach for presenting Aboriginal clients, thus ensuring clients make the next step in the referral process.
- Strengthen existing processes for implementing the current NWD process for supporting access for young people to services.
- Identify a key contact person on referrals and a process for connecting the client and contact person.
- Assess the eligibility for community organisations such as HICSA and HICCI to participate in commonly used referral systems e.g. S2S;
- Invite representatives from Aboriginal health and well-being organisations to periodically attend the Intake/Referral Coordinator network meeting to share information and identify opportunities for improving culturally appropriate intake.

SERVICE VISIBILITY

- Local organisations to review their websites and brochures with a Cultural Safety lens and in communication with the local ACCO.

THREE: COMMUNITY

COMMUNITY INVOLVEMENT

- Work with local Aboriginal community organizations to identify an appropriate method for local Indigenous Elders/Leaders to provide and receive regular feedback on how community and services are travelling together.
- Establish a culturally safe feedback mechanism to hear from clients about their experiences in services.
- Ensure Aboriginal community representation in the composition of consumer reference groups.

COMMUNITY ACCESS TO INFORMATION

- Develop a culturally appropriate online central point of information/access for services, giving hours, fees, how and who to contact.
- Explore opportunities for using existing mechanisms as the Central Point of Information Access e.g. Better Health Channel.
- Tag online references in the central point of access using language that community members use.
- Ensure organisational websites, and website updates, are sufficiently tagged to allow increased visibility from web searches.
- Consider the viability of paper based flip book tabbed with community friendly headings.
- Explore options for the local Healesville service directory to have health service information listed. If viable:-

  - Establish a mechanism for supplying updated information to Healesville Rotary in line with the Service Directory print deadlines.
- Facebook groups: seek advice from community about the level of information that would be welcome on community face book pages e.g. Eastern Metro Mob.
- Seek community advice about the appeal, readability and user friendliness of brochures and websites.
- Create a service map of the client journey through local and regional services. Identify gate keepers and key “go to” people along the journey.
- Distribute the map to local community organisations.

4. Context

4.1 Background

The various measurement scales used to describe the health status of a population all unambiguously show Aboriginal Australians as significantly more likely to be in poorer health to non- Aboriginal Australians.[29] At a national level, compared to non-Indigenous people, life expectancy of Aboriginal people shows a gap of 9.7 years for women, and 11.5 years for men[30]; and, the overall burden of disease for Indigenous people is 2.5 times higher, with 70% of the disparity in health status attributable to non-communicable diseases, such as cardiovascular disease, diabetes, chronic respiratory disease and mental disorders.[31]

The physical health of our Indigenous community is less than that of our non-Indigenous brothers and sisters.

Our Story - The Tree of life and Knowledge Yarra Ranges Council Background paper on reconciliation

In Victoria, both perinatal and child mortality are more than double the rate of non-Aboriginal babies and children, Aboriginal people are 2.4 times more likely to have a disability, hospitalisation rates are higher, preventable hospitalisations are three times higher, and hospital emergency department presentations are double the rate of non-Aboriginal people; likewise, rates of tobacco use and alcohol-related harm are higher for Aboriginal compared to non- Aboriginal Victorians.[32] Depression, anxiety, cancer, stroke and asthma all have a significantly higher prevalence for Aboriginal Victorians compared with their non-Aboriginal counterparts, as are Aboriginal Victorians significantly more likely to self-report their overall health as being fair or poor and less likely to rate their health as excellent or very good.[33]

[29] Australian Institute of Health and Welfare (AIHW), 2013; Department of Health, 2011; Freemantle, Officer, McAullay, & Anderson, 2007.

[30] Australian Bureau of Statistics, 2009

[31] Vos T, Barker B, Stanley L, Lopez AD 2007. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane: School of Population Health. The University of Queensland.

[32] Department of Health, 2012

[33] Department of Health, 2011

Unlike most Australian states and territories, Victoria has a relatively high proportion of urban Aboriginal people, with almost half (47.4%) of the total Victorian Aboriginal population residing in metropolitan or "urban fringe" areas.[34] However, the specific health status and health needs of this heterogenous, often invisible, population are poorly understood.[35] As Eades et al (2010) note in a recent comprehensive review on the health of urban Aboriginal people, "there were too few studies about any aspect of urban Aboriginal health to give a meaningful understanding of either health needs or current service provision, and very little research about the impact of programs or policies." [36]

As noted within a 2001 report of the House of Representatives Standing Committee on Aboriginal Affairs on the needs of urban dwelling Aboriginal and Torres Strait Islander people.

"Aboriginal communities in remote areas are relatively easy to identify spatially, socially and for the purposes of service delivery. It may be harder to identify more dispersed groups in urban areas, particularly when they are a small proportion of the total population. In fact, there may not be a 'community' at all, but a loose network of geographically dispersed family and organisational affiliations not at all obvious to non Aboriginal observers. The needs of those without networks at all often go unnoticed and unmet. The disadvantages of cultural isolation can be just as acute as those of geographic isolation." [37]

and

"Urban dwelling Aboriginal people may also suffer from having their Aboriginality denied and be assumed to be assimilated. The stereotypes of 'real' Aboriginals being those living 'out bush' or in 'traditional' settings may lead to a denial of the possibility of a dynamic, contemporary Indigenous culture in urban areas." [38]

Findings from the Victorian Population Health Survey 2008 highlight some of the challenges faced by Aboriginal Victorians that impact on health and wellbeing:[39] They were:

- twice as likely as non-Aboriginal people to report not being able to get help from family when needed,
- significantly more likely to experience food insecurity,
- significantly more likely to not feel valued by society.
- A significantly higher proportion of Aboriginal Victorains do not believe that there were opportunities to have a real say.

In a literature review on health care access for urban Aboriginal Australians, there is some evidence for differences in morbity patterns between Aboriginal people living in urban, rural and remote settings.[40]

They also note higher rates of infectious diseases in remote areas and higher rates of chronic diseases and mental health problems in urban areas; drug use patterns also appear to differ, with petrol sniffing more common in remote areas, whereas opiate and amphetamine use are the more likely drugs chosen in urban areas.

Whilst national and state level statistics are a useful indicator as to overall morbity and mortality of the Aboriginal population, the limited data on urban Aboriginal health, specifically on morbity patterns and health service access, leaves a significant research gap in how best to address the health disparities between Aboriginal and non- Aboriginal Australians.

[34] Australian Bureau of Statistics, 2011.

[35] Eades, Taylor, Bailey, Williamson, Craig & Redman, 2010; Scrimgeour & Scrimgeour, 2007

[36] Eades, Taylor, Bailey, Williamson, Craig & Redman, 2010; p.522

[37] House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 2001: 18. p18: Para 2.28

[38] House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 2001: 18 Para 2.30

[39] Department of Health, 2011

[40] Scrimgeour, M. & Scrimgeour, D. 2007, Health care access for Aboriginal and Torres Strait Islander people living in urban areas, and related research issues: A review of the literature, Cooperative Research Centre for Aboriginal Health, Darwin.

The Australian Institute of Health and Welfare Aboriginal and Torres Strait Islander Health Performance Framework report identifies access to appropriate health care as one of the main areas of continuing concern in Victoria's health system performance.[41] As reflected in the quote below, inequities in access to health services by urban Aboriginal people are complicated by inadequate identification of and consultation with Aboriginal community members on their health needs.[42]

In urban areas with a dispersed Indigenous population, it may be more difficult for service providers and planners to know whether they are reaching the Indigenous people most in need of assistance or involving all sectors of the community in decision making. Indigenous people, when only a small proportion of a community, may have 'a very quiet voice' in local decision making forums.[43]

Utilisation of appropriate health care services will improve health outcomes for Aboriginal people.[44] At present there are limitations in accurate service utilisation data on access to appropriate health care by urban Aboriginal people, whether through Aboriginal Community Controlled Health Organisations, mainstream primary health care services or acute health care services, and figures available likely reflect significant under-reporting.[45]

……it is the acceptability and appropriateness of health care services that are arguably the more significant barriers to access.

In their review of health care access, Scrimgeour and Scrimgeour (2007) attribute low utilisation of health services by Aboriginal people to barriers related to factors of availability, affordability, acceptability and appropriateness. Whilst urban Aboriginal people are disproportionately located within areas of low socioeconomic advantage with relatively poor access to health services, and disadvantage is linked to an inability to pay for the costs of health care, they suggest it is the acceptability and appropriateness of health care services that are arguably the more significant barriers to access. Health service delivery that provides cultural security and is respectful of Aboriginal culture is seen as more important to improving access than geographic proximity within an urban setting. The influence of shame associated with health problems or an inability to adequately follow health care advice also impacts health service utilisation.[46]

Two overarching themes influence access to health services:

history (of dispossession) and racism and discrimination.

A recent study investigating factors influencing access to urban general practices and primary health care by Aboriginal people, identified two overarching themes as influencing access to health services: history (of dispossession), and racism and discrimination.[47] Participants included Aboriginal diabetes patients, Aboriginal and non-Aboriginal health service providers and representatives from government[48] and non-government health agencies.

[41] Australian Institute of Health and Welfare Aboriginal and Torres Strait Islander Health Performance Framework report AIHW, 2013

[42] House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 2001: 18.

[43] House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 2001: 18 Para 2.29

[44] Department of Health, 2012

[45] Lau, P., Pyett, P., Burchill, M., Furler, J., Tynan, M., Kelaher, M. & Liaw, S-T. 2012, Factors influencing access to urban general practices and primary health care by Aboriginal Australians – A qualitative study. AlterNative, 8(1), 66-84.

[46] Scrimgeour and Scrimgeour, 2007.

[47] Lau, P., Pyett, P., Burchill, M., Furler, J., Tynan, M., Kelaher, M. & Liaw, S-T. 2012, Factors influencing access to urban general practices and primary health care by Aboriginal Australians – A qualitative study. AlterNative, 8(1), 66-84.

[48] Lau, P., Pyett, P., Burchill, M., Furler, J., Tynan, M., Kelaher, M. & Liaw, S-T. 2012, Factors influencing access to urban general practices and primary health care by Aboriginal Australians – A qualitative study. AlterNative, 8(1), 66-84.

Focus groups were used to explore Aboriginal patients' experience of mainstream healthcare providers. Poor health and reluctance to access mainstream services were explained by all participants as a consequence of dispossession and ongoing marginalisation. For some, that included experiences of mainstream institutions' devastating effect on their family, and the invisibility of the impacts of trans-generational trauma, and being treated like second-class citizens; for others, the impact of loss of land on spiritual wellbeing was part of a painful history too easily recalled. Many Aboriginal participants were also traumatised by the many experiences of negative stereotypes and prejudices in health care delivery: "I broke my arm in the shopping centre, and I got taken into hospital. And I heard them saying "Ask her if she was drunk."

Research indicates that some of the best interventions to improve primary health care at a local level, relating to service provision, involve genuine local Indigenous community engagement, collaboration with local service providers, and service delivery that is culturally safe.[49]

As Lau et al (2012) comment, "because of the specific circumstances of Australian history, closing the gap requires a particular sensitivity and understanding of a people and culture that have been suppressed and marginalised for a long time" and "as a result of history, trust and confidence are fragile commodities for Aboriginal people, and are easily shattered by the slightest hint of insensitivity, intolerance and inability to follow up words with consistent action or behaviour'

Awofeso's (2011) review of the literature on the ramifications of racism on health and health care of Aboriginal Australians also concludes that Aboriginal health and health care access solutions need to address the structural determinants of health inequities, requiring not just a culturally competent workforce, but multifaceted anti-racist interventions aimed at all levels of society. Article 24(1) of the 2007 United Nations Declaration on the Rights of Indigenous People states that "Indigenous individuals have the right to access, without any discrimination, to all social and health services." (p.6)

Health system improvements, particularly in the areas of primary health care, can have a significant impact on health outcomes for Aboriginal people.[50] As such, health service provision has been prioritised within many recent international, national, state, regional and local standards and strategies aimed at improving the lives of Aboriginal people.

Formally endorsed in 2009 by the Australian government, The United Nations Declaration on the Rights of Indigenous People, sets out the standard to be pursued by member states with regard to upholding the rights of Indigenous people. Article 24 Right to Health states that:

"Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right".

Whilst not legally binding under international law, the endorsement of this instrument and articles therein is part of the Australian government approach to addressing the disparities in health between Aboriginal and non- Aboriginal Australians.

4.2 Local Context

HEALESVILLE TODAY

Established in 1864, Healesville is a rural community in the Yarra Ranges, located on the out edge of the Eastern Region. The nearest main town is Lilydale which is accessed via the Maroondah Highway. Trains stop at Lilydale. A fire- affected community, Healesville is characterized by leaders and community are currently working together to acknowledge and celebrate the 150th anniversary of the township.

There is a large Aboriginal community in Healesville which is comprised of Traditional Land Owners and peoples from other lands who have moved to the area. The 2011 Census data reports the resident Aboriginal population increased by 15.3 % to 2970 people. Yarra Ranges has the highest Aboriginal population of the Eastern Region 32.8%, 974. 269 Aboriginal and Torres Strait Islanders live in the 3777 area. Of these, 121 (or 45.0%) were male and 148 (or 55.0%) were female. The median age was 23 years.

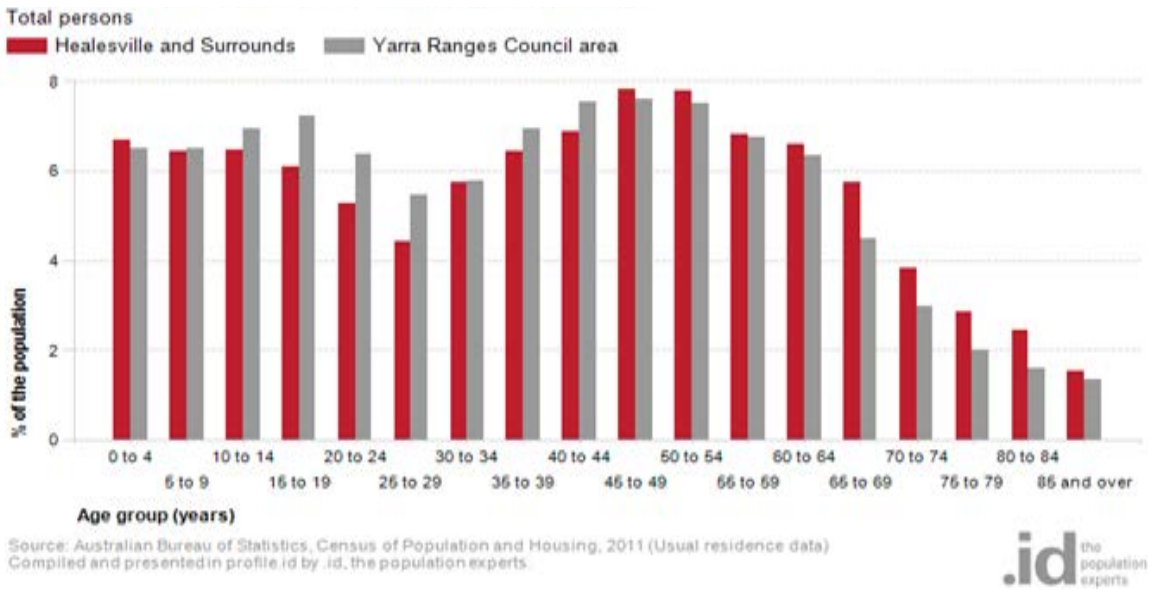
[49] (Griew, 2008, Lau et al, 2008, Liaw, 2011).

[50] (Griew, 2008

3. 3 % of the Badger Creek Population (63) and 2.6 % (193) of the Healesville population are Aboriginal. In the 2011 Census, there were 1,922 people in Badger Creek (State Suburbs) of these 49.6% were male and 50.4% were female. Aboriginal and Torres Strait Islander people made up 3.3% of the population. Badger Creek is approximately 7 km out from the main township of Healesville.

There is also a stronger representation of young people in the local Aboriginal community and in contrast to the overall profile for the Local Government Area of Yarra Ranges; there is lower representation of older Aboriginal people.

Age structure - five year age groups, 2011



Healesville and surrounds is bounded by Murrindindi Shire in the north, East Warburton and Warburton in the east, Wesburn, Don Valley, Launching Place and Woori Yallock in the south and the Yarra River, Tarrawarra, Old Healesville Road, School House Ridge and Dixons Creek in the west. Badger Creek and Chum Creek make up the broader residential area around Healesville.[51]

The Healesville township and surrounds share many characteristics with other rural Victorian towns. Situated at the base of the Great Dividing Range in the Yarra Valley, it is characterized by hills, valleys, creeks and rivers. Outside the main township, access from point to point is more likely to be on a track rather than a paved footpath. Public transport and taxi access issues from the township to "down the line" services is well documented in a range of reports. [52. 52. 54. 55. 56]

SERVICES

The Eastern Health Aboriginal Health Team is located in Healesville and provides services under the auspice of, and in collaboration with, Yarra Valley Community Health. Outreach services from Regional and State-Wide Aboriginal services are provided by Victorian Aboriginal ChildCare Agency (VACCA), Regional Aboriginal Justice Advisory Committee (RAJAC), Victorian Aboriginal Health Service (VAHS), Ngwala Willumbong Inc., Boorndawan Willam Aboriginal Healing Service (Inner East). The outreach and state- wide services are all issue specific.

Other organisations who provide health and well- being support to the Aboriginal community in the local Healesville area include: Healesville Interchurch Community Care Inc. (HICCI); Eastern Region Legal Centre (ERLC); Salvation Army Eastcare; Care Connect; EACH and Eastern Metropolitan Medicare Local (EMML).

Access to general medical service In Healesville is via three private providers and an Eastern Health community health clinic based at White St. Eastern Metropolitan Medicare Local reports that by June 2014, two of the private practices in Healesville are PIP registered. The town is also serviced by practitioners of Natural Medicine and Tradition Chinese Medicine.

[49] (Griew, 2008, Lau et al, 2008, Liaw, 2011).

[50] (Griew, 2008

[51] http://fe.yarraranges.vic.gov.au/ accessed March 2014

[52] Knox/Maroondah/Yarra Ranges Bus Service Review – Summary Report Victorian Government 2010

[53] Taxi Industry Enquiry Draft Report. Victorian Government May 2012.

[54] Final Report Customers First. Service, Safety, Choice September 2012.

[55] Submission Inquiry into Growing the Suburbs: Infrastructure and Business Development in Outer Suburban Melbourne January 2012

[56] Yarra Ranges Council Health and Wellbeing Profile 2012/2013

4.3 Project Context

Project implementation commenced at time of significant political and organisational change. The project sponsor was in the process of a national amalgamation of new partners. This saw the formation of Quality Innovation Performance (QIP) out what QIP formed in 2012 as a result of a merger between Australia's four major primary care accreditation bodies: Quality In Practice: The Quality Improvement Council (QIC): Quality Improvement and Community Services Accreditation Inc. (QICSA); Quality Management Services (QMS).[57]

A new Victorian government was elected in 2010. Its policy direction on Aboriginal health was emerging, becoming clear in May 2012 with the launch of Koolin Balit. A restructure of the Victorian State government alignment saw Aboriginal health move under the direction of the Department of Premier and Cabinet. Koolin Balit priorities were in development during 2013. These were finalized in 2014.

The Eastern Metropolitan Region was reaching the end of the Closing the Health Gap Plan 2009 – 2013. Over 300 people had attended Cultural Awareness training in the Eastern Region which provided increased momentum for organisations seeking to build organisational capacity in cultural awareness and reorient their service delivery to include demonstrable cultural respect.

At the local and regional level there were changes in personnel who played strong roles in Closing the Health Gap and reconciliation initiatives. A key champion of reconciliation and cultural respect at Eastern Health retired at the end of 2013. There were also significant changes in local and regional Eastern Health personnel in both management and practitioner roles relevant to the project. Management of HICSA, Yarra Valley Community Health Service and the Aboriginal Health Team changed during the shift from the project inception to the development phases. These three roles remained stable throughout the implementation phase.

The project development and implementation phase paralleled other significant project initiatives in the Eastern region. The No Wrong Door project was reaching its final phases; Eastern Health was in the process of developing a Mental Health Navigation Tool; the Outer East Primary Care Partnership commenced work on an E Case Management project; Yarra Ranges Shire Council finalised and launched its Reconciliation Framework for Action; and the Department of Health was engaged in community consultation processes to identify the direction of regional Koolin Balit priorities.

4.4 Policy Context

FEDERAL

The Closing the Gap strategy is the primary national strategy for improving the health and wellbeing of Aboriginal Australians. Endorsed in 2008 by the Council of Australian Governments (COAG), which represents all levels of Australian government, this strategy aimed to significantly reduce Indigenous disadvantage and achieve Indigenous health equality within 25 years. Through National Partnership Agreements between the Commonwealth of Australia and each of the states and territories, the same framework of outcomes, measures of progress, and policy directions were committed to by all levels of government. In 2009, COAG committed over $1.5 billion over four years to achieving substantial improvements in the health and well-being of Indigenous people. The objectives of the agreement set out to achieve gains in the following areas: preventative health; primary health care; hospital and related care; patient experience, particularly as it relates to cultural appropriateness in service provision; and sustainability and reform. The responsibility for the implementation of the strategies to address these objectives is predominantly with the states and territories.

[57] http://www.qip.com.au/ accessed June 2014.

Since the federal election in September 2013, the Abbott Coalition government has made statements about committing to continuing a federal level of support to achieve health equality between Indigenous and non-Indigenous Australians within a generation and has provided in-principle support for Closing the Gap initiatives. Significantly, the Department of the Prime Minister and Cabinet (PM&C) have become the agency responsible for the majority of Indigenous policies, programs and service delivery, one of the purposes of which was to prioritise expenditure to achieve practical outcomes within the community.

As such, some health related policy and program areas (e.g. Health performance framework; health expenditure analysis; and life expectancy modelling) are now located with the PM&C, however, most Indigenous health related areas are still with the Indigenous and Rural Health Division (formerly the Office of Aboriginal and Torres Strait Islander Health) within the Department of Health. A review to examine possible funding models in the delivery of comprehensive primary health care services is currently in progress.

VICTORIAN GOVERNMENT

The Victorian Government Aboriginal Inclusion Framework was released in November 2011. It outlines a number of important actions that gave shape to Aboriginal affairs policy. One of the key actions was to develop departmental action plans to demonstrate how access to and inclusion in mainstream services will be improved. The framework 'is designed to be flexible in its implementation and departments and agencies will be encouraged to develop their own plans, structures and strategies that suit the context within which they operate'. It is intended to provide a tool to assist departments to develop their action plans. The framework outlines the main barriers Aboriginal Victorians face in accessing services and resources. The main barriers cited are actual and perceived discrimination by service providers, language and cultural barriers, lack of trust in services and organisations, and lack of awareness of and engagement with local Aboriginal communities.

Victorian Aboriginal Affairs Framework 2013–18

In November 2012, the government released the Victorian Aboriginal Affairs Framework 2013–18 (VAAF) which was designed to build on the previous the Victorian Indigenous Affairs Framework (VIAF) which was first released in 2006 and revised in 2010. The VAAF is the primary whole-of-government framework related to Aboriginal affairs. It identifies six strategic action areas, covering early childhood, education, economic participation, health and wellbeing, safe families and justice outcomes, and strong culture and confident communities. Each strategic area includes sub-objectives with specific improvement targets and expected outcomes. Many of the indicators under VIAF related to service access and participation and are similar to the VAAF indicators and targets—for example, in action areas such as improving maternal and early childhood health, and developing and improving education outcomes. VAAF requires all Victorian Government departments to have an Aboriginal inclusion action plan consistent with the Victorian Government Aboriginal Inclusion Framework.

VAAF recognises that more than any other state or territory, Aboriginal people in Victoria have been directly affected by the Stolen Generation. The Stolen Generation still has a significant impact on the way Aboriginal people feel about mainstream services and the level of trust they have in services that were once used as government instruments for removing Aboriginal children from their families. Also, evidence indicates that historically, Aboriginal Victorians have been excluded or discriminated against when trying to access mainstream services.

Victorian Aboriginal Affairs Framework p. 4.

At a State level, Koolin Balit provides the framework for statewide directions in Aboriginal health in Victoria. It aims to make a significant and measurable impact on improving both the length and quality of the lives of Aboriginal Victorians by 2022. Objectives set out within Koolin Balit are to: close the gap in life expectancy for Aboriginal people living in Victoria; to reduce differences in health outcomes between Aboriginal people and the general population for infant mortality rates, morbidity and low birth weights; and to improve access to health services and improve health outcomes for Aboriginal people. To achieve improvements in Aboriginal health within a decade, Koolin Balit requires active partnerships between the Victorian government, Aboriginal communities, and service providers.

One of six priorities within Koolin Balit is to manage illness better with effective health services, with a particular focus on improvements in access to health, mental health and other support services, and to the coordination and integration of health services for Aboriginal people.

In a pledge to provide better co-ordination of community services through holistic case management, the Victorian government's Human Services: The Case for Change documents what the government hopes to achieve for the most disadvantaged within the community. It aims to reform the service systems, streamline client pathways and move toward a client-centred approach. The model individualises care of the vulnerable within society as its first priority, with an aim to achieving improved health outcomes and reduce disadvantage.

Another initiative recently introduced by the Department of Health is the Active Service Model, which is being implemented into health and community settings in Victoria and across Australia. Home and Community Care (HACC) services have traditionally provided a set range of services for clients. Under an ASM health service providers work collaboratively with the client (and families or carers) to explore what their goals are and how and what HACC services will best assist them in realising those goals and maximise independence. It aims to provide holistic care that addresses a client's overall physical, mental, spiritual, and emotional wellbeing. Essential to this aim, individualised, person-centred care requires that service providers recognise diversity and acknowledge the importance of providing culturally appropriate care.

Ensuring clients have access to the services they need requires systematic care coordination within the health system. The practice of service coordination aims to place consumers at the centre of service delivery. Facilitated regionally by Primary Care Partnerships, service coordination brings together service delivery agencies within a region to agree upon how services can be better coordinated, particularly for those with complex and multiple health needs. The Service Coordination Tool Templates (SCTT) are templates that have been developed to facilitate service coordination and to standardise care planning and enable more effective communication between service providers and facilitate information sharing across agencies. A recent revision of the SCTT tool included changes which were intended to be more culturally appropriate.

EASTERN METROPOLITAN REGION

No Wrong Door is an initiative of the municipalities of Knox, Maroondah and Yarra Ranges within the Outer Eastern metropolitan area of Melbourne. It aimed to enable a cohesive and coordinated approach to service delivery for young people (aged 10-25 years) across the region, particularly vulnerable youth. No Wrong Door requests and formalizes a commitment by service providers within the region to actively support all young people who approach them to ensure they receive appropriate and adequate support for their needs, regardless of which organisation they initially access. Integral to the success of this initiative is that services provide client-centred care that is timely, coordinated, planned, reliable, non-discriminatory and culturally competent.

Improved experience of quality health care for the Aboriginal population residing within the Eastern Region of Melbourne was priority one of the Eastern Region Closing the Heath Gap Plan. The Practice Incentives Program (PIP) Indigenous Health Incentive was implemented by Eastern Metropolitan Medicare Local (EMML). It aims to assist general practice to strengthen culturally safe health service delivery to Aboriginal patients, particularly in managing chronic disease. Under this initiative, general practices are provided monetary incentives for improving the health care provided to Indigenous patients. Practices are required to make available to staff professional development in cultural awareness and competency in working with Indigenous patients, the aim of which is to educate staff on how to provide a clinical environment where Indigenous culture is taken into account, thus providing a culturally safe place for Indigenous patients to access the services needed in the management of chronic diseases. However, a recent review by EMML has highlighted several issues significant to the successful implementation of such an incentive scheme.

The Australian Institute of Health and Welfare (AIHW) Aboriginal and Torres Strait Islander Health Performance Framework report identifies access to appropriate and culturally safe health care as one of the main areas of continuing concern in Victoria's health system performance.[58] The health disparities between Indigenous and non-Indigenous Australians are in part contributed to by issues relating to the accessibility of the health system.[59]

The alternative to mainstream primary health care services, chosen by many Indigenous community members, is to attend an Aboriginal Community Controlled Health Service (ACCHS). There is no ACCHO in the Eastern or outer Eastern metropolitan areas of Melbourne. The absence of an ACCHO in the Eastern region potentially results in lower levels of access to health services and imposes longer distances travelled by those who prefer to only attend an ACCHS. Anecdotally, many Yarra Ranges Aboriginal community members travel out of their communities to the Dandenong & District Aborigines Co-operative or the Victorian Aboriginal Health Service in Fitzroy because there is more confidence in the cultural safety of the services. Victoria's peak representative Aboriginal health body, the Victorian Aboriginal Community Controlled Health Organisation Inc. (VACCHO), argues that each Aboriginal community "needs its own community based, locally owned, culturally appropriate and adequately resourced primary health care facility." VACCHO is also committed to facilitating and improving Aboriginal involvement in the decision making that impacts Aboriginal health and wellbeing.

Whilst the Aboriginal community controlled health sector is a leading provider of primary health care services to Indigenous community members, Aboriginal Community Controlled Organisations (ACCOs) play a significant role in improving health and wellbeing outcomes. Set up with a similar intent to ACCHOs, with a core belief in self-determination through community control, ACCOs provide their communities with access to support services, information and programs to assist in building stronger, healthier communities. Aiming to better meet the health needs of their communities ACCOs are increasingly establishing partnerships with mainstream health organisations to ensure health services available in the community are both accessible and appropriate for Aboriginal people.

Memorandum of Understandings (MOUs) have been signed between Healesville Indigenous Community Services Association (HICSA) and Eastern Health, and HICSA and Inspiro Community Health. Both of these partnerships serve to develop a closer working relationship between Indigenous and mainstream services.

Established in 2005, the Yarra Ranges Indigenous Advisory Committee (IAC), advises the Yarra Ranges Shire Council on matters of importance to the local Indigenous community across a range of issues. Recently, the IAC offered leadership in the development and implementation of the Yarra Ranges Reconciliation Framework for Action 2013 – 2023. This document outlines the strategic directions and approach of Council in relation to Reconciliation. It builds on the work of previous Reconciliation Action Plans and continues to enshrine the commitment of Council to addressing the over-representation of disadvantage within the local Aboriginal community and sets out a vision for how this will be achieved:

"Our local vision is for a united community that recognises the special place and culture of Indigenous peoples as first Australians, values their participation, and provides equal life chances for all." (Yarra Ranges Reconciliation Framework for Action 2013 – 2023)

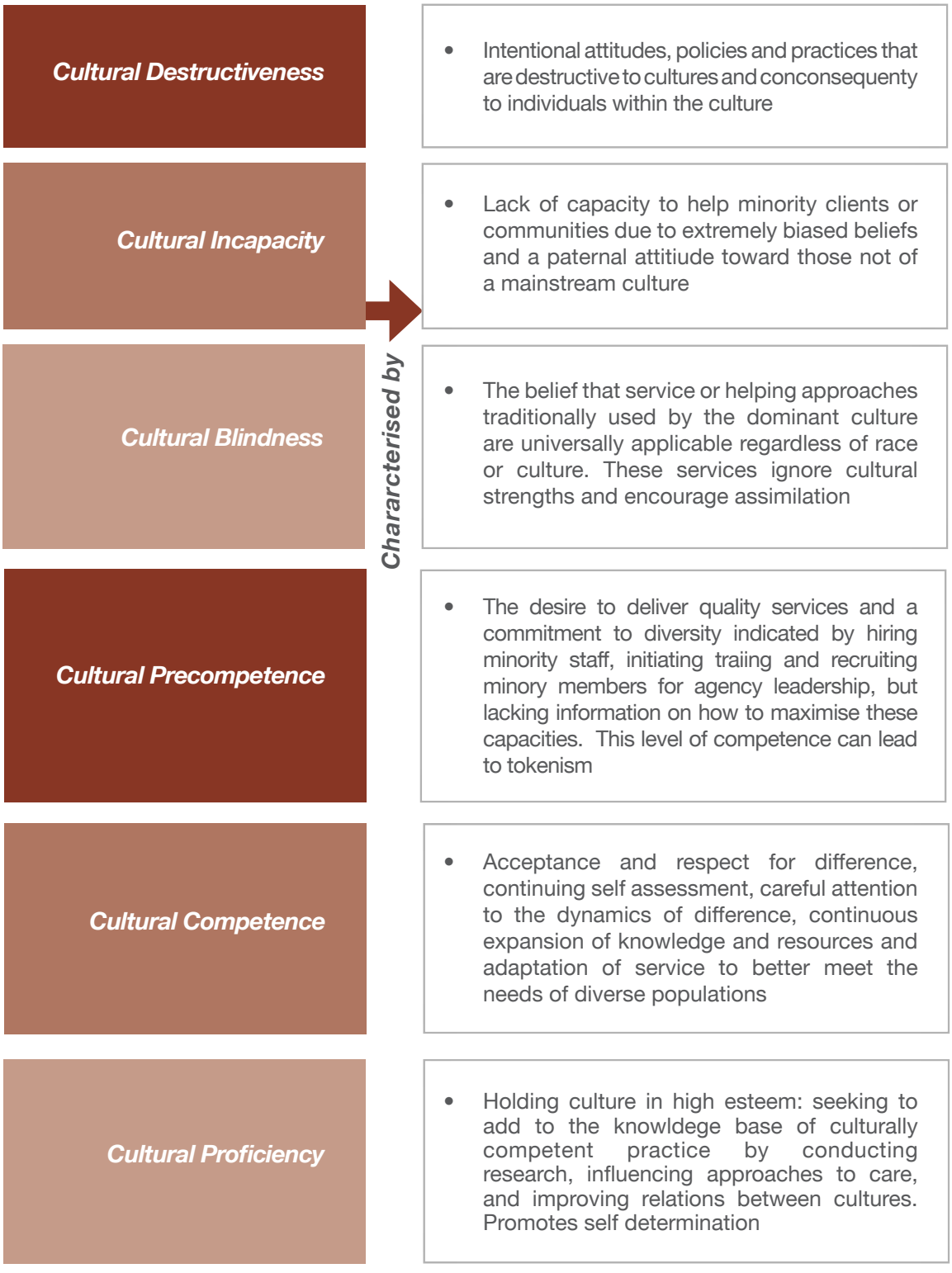
Central to this vision is an acknowledgement of the importance of strengthening culture for Indigenous people, in supporting health and wellbeing and reducing disadvantage. It also acknowledges the role played by Council in advocating for the Indigenous community and in facilitating partnerships with key stakeholders and partners.

The Eastern Region Department of Health instigated a community engagement process involving Elders and local Aboriginal community representatives. This has identified several projects which have been prioritised under Koolin Balit (Department of Health, 2012) for implementation within the Eastern region.

[58] The Australian Institute of Health and Welfare (AIHW) Aboriginal and Torres Strait Islander Health Performance Framework report. 2013

[59] Griew R, Tilton E, Cox N, Thomas, D. 2008, The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. Sydney: Robert Griew Consulting. 2008

Appendix 1 Cultural Competence Continuum



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Terms

Competence The combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as an accredited and/or registered clinician.

Competency A defined area of skilled performance.

Cultural Awareness An understanding of how a person's culture may inform their values, behaviors, beliefs and basic assumptions ... [It] recognises that we are all shaped by our cultural background, which influences how we interpret the world around us, perceive ourselves and relate to other people'.[61]

Cultural Competence Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

Cultural Continuum The Cross framework emphasizes that the process of achieving cultural competency occurs along a continuum and sets forth six stages including: 1) cultural destructiveness, 2) cultural incapacity, 3) cultural blindness, 4) cultural pre-competence, 5) cultural competency and 6) cultural proficiency.

Cultural Safety Cultural safety is an approach that puts the onus for change on the health service provider rather than on the client. It is an undertaking to consider the things that make us unique and to provide care that takes account of these differences.[62] It is to provide and receive care in a manner that is respectful of a person's culture and beliefs, and that is free from discrimination.[63]

[60] NACCHO.Creating the NACCHO Cultural Safety Training Standards and Assessment Process. A background paper p 58 May 2011.

[61] Available at http://www.culturaldiversity.com.au/. Accessed August 2014.

[62] Health Care and Indigenous Australians Kerry Taylor. Pauline Guerin 2010. Palgrave Macmillan. Sth Yarra pg 11.

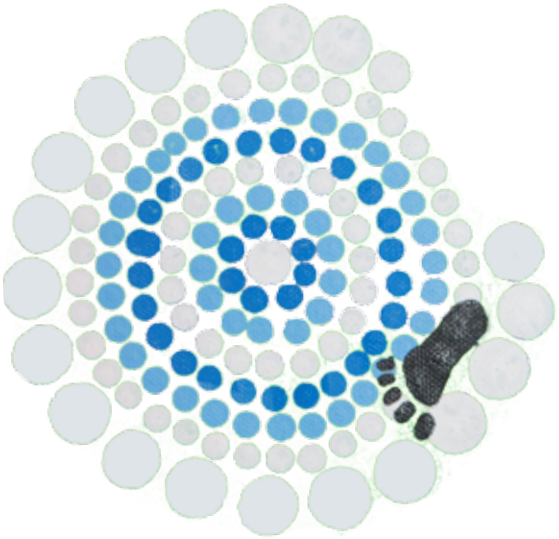
[63] NACCHO.Creating the NACCHO Cultural Safety Training Standards and Assessment Process. A background paper p 58 May 2011.

Cultural Safety Principles The concept of cultural safety involves empowerment of the healthcare practitioner and the patient. The determinants of 'safe' care are defined by the recipient of care. These are participation, protection and partnership. Importance is placed on identifying and evaluating one's own beliefs and values and recognising the potential for these to impact on others. This concept provides recognition of the indices of power inherent in any interaction and the potential for disparity and inequality within any relationship. Acknowledgement by the healthcare practitioner that imposition of their own cultural beliefs may disadvantage the recipient of healthcare is fundamental to the delivery of culturally safe care.

Cultural Sensitivity Cross cultural sensitivity encompasses the knowledge, awareness and acceptance of other cultures.

Culture Refers to the beliefs and practices common to any particular group of people.

Health consumer Individual, group or community who works in partnership with health professionals to plan and receive health care. The term includes patients, residents and/or their families, representatives or significant others.



References

Australian Bureau of Statistics (ABS) 2009, Experimental life tables for Aboriginal and Torres Strait Islander Australians, 2005–2007. ABS cat. no. 3302.0.55.003, ABS, Canberra.

Australian Bureau of Statistics (ABS) 2011, Census of Population and Housing - Counts of Aboriginal and Torres Strait Islander Australians, 2011. ABS cat. no. 2075.0, ABS, Canberra.

Australian Institute of Health and Welfare (AIHW) 2013 Aboriginal and Torres Strait Islander Health Performance Framework 2012 report: Victoria. Cat. No. IHW 86. Canberra: AIHW.

Awofeso, N. 2011 Racism: A major impediment to optimal Indigenous health and health care in Australia. Australian Indigenous HealthBulletin, 11(3), 1-13.

Baum, F., MacDougall, C. & Smith, D. 2006. Participatory action research. Journal of Epidemiology and Community Health, 60, 854-857.

Bhui.K., Ascoli.M., The place of race and racism in cultural competence: What can we learn from the English experience about the narratives of evidence and argument? Journal of Transcultural Psychiatry April 2012.

Victorian Department of Health, The health and wellbeing of Aboriginal Victorians: Victorian Population Health Survey 2008 Supplementary report. State Government of Victoria, Melbourne. 2011

Victorian Department of Health, Koolin Balit: Victorian Government Strategic Directions for Aboriginal Health 2012-2022. State Government of Victoria, Melbourne. May 2012.

Dreachslin.J., Jean Gilbert.M., Beverly alone Diversity and Cultural Competence in Health Care: A Systems Approach December 10, 2012

Eades S.J., Taylor, B., Bailey, S., Williamson, A.B., Craig, J.C., & Redman, S., 2010 The health of urban Aboriginal people: insufficient data to close the gap. Medical Journal of Australia, 193 (9), 521-524.

Freemantle, J., Officer, K., McAullay, D. & Anderson, I. 2007, Australian Indigenous.

Griew R, Tilton E, Cox N, Thomas, D. 2008, The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians. Sydney: Robert Griew Consulting.

Health—Within an International Context, Cooperative Research Centre for Aboriginal Health, Darwin.

House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 2001, We Can Do it! The Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples, AGPS, Canberra.

Kendall, Sunderland, Barnett, Nalder & Matthews, 2011. Beyond the rhetoric of participatory research in indigenous communities: advances in Australia over the last decade. Qualitative Health Research, 21(12),1719-28.

Kirmayer.L.. Rethinking Cultural Competence Journal of Transcultural Psychiatry April 2012.

Larry D. Purnell PhD RN FAAN Transcultural Health Care: A Culturally Competent Approach September 18, 2012.

Lau, P., Pyett, P., Burchill, M., Furler, J., Tynan, M., Kelaher, M. & Liaw, S-T. 2012, Factors influencing access to urban general practices and primary health care by Aboriginal Australians – A qualitative study. AlterNative, 8(1), 66-84.

Liaw, S-T., Lau, P., Pyett, P., Furler, J., Burchill, M., Rowley, K., & Kelaher, M. 2011 Successful chronic disease care for Aboriginal Australians requires cultural competence. Australian and New Zealand Journal of Public Health, 35(3), 238-248.

NACCHO.Creating the NACCHO Cultural Safety Training Standards and Assessment Process. A background paper. May 2011.

North Coast Area Health Service. Cultural respect and communication guide 2009.

Ronnie Leavitt PhD MPH Cultural Competence: A Lifelong Journey to Cultural Proficiency February 15, 2010.

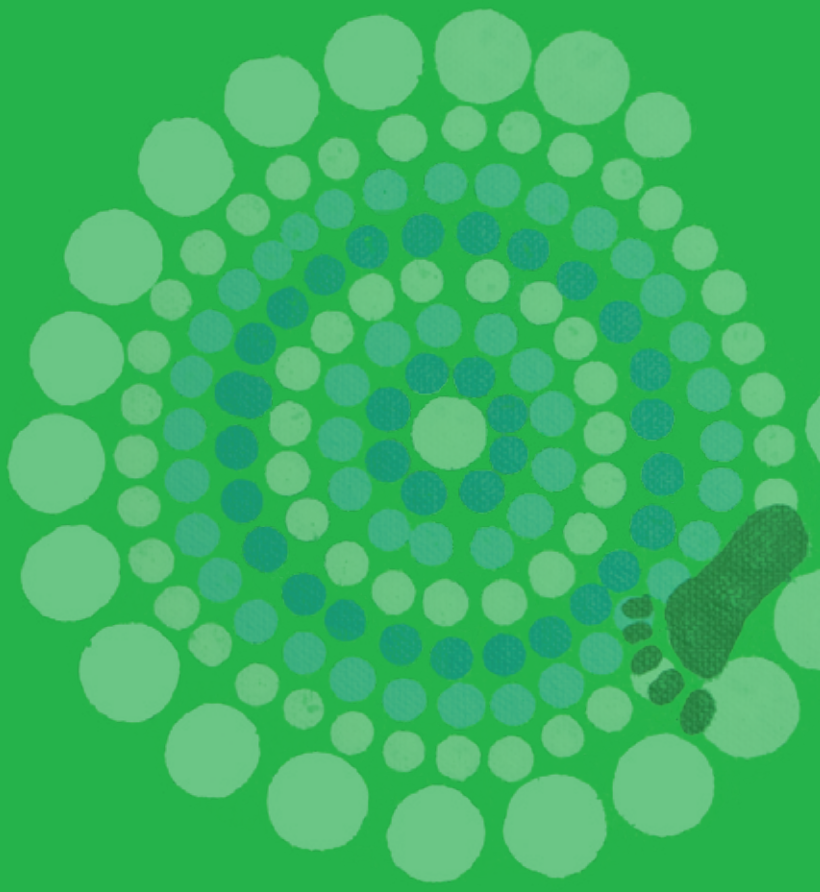
Scrimgeour, M. & Scrimgeour, D. 2007, Health care access for Aboriginal and Torres Strait Islander people living in urban areas, and related research issues: A review of the literature, Cooperative Research Centre for Aboriginal Health, Darwin.

Tawara D. Goode, Cultural Competence Continuum. National Center for Cultural Competence. Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities Revised 2004.

United Nations. United Nations Declaration on the Rights of Indigenous Peoples. United Nations. 2008.

Victorian Auditor General. Accessing mainstream organisations for Aboriginal Victorians May 2014.

Vos T, Barker B, Stanley L, Lopez AD 2007. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane: School of Population Health. The University of Queensland.



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