

# *Aboriginal Health Plan*



***SOUTH WESTERN SYDNEY  
AREA HEALTH SERVICE***

***2001-2006***

## EXPLANATION FOR THE ART WORK ON COVER

HEALING PLACE BY LENARD CONNOLLY 2001

Aboriginal and Torres Strait Islander people traveling from different areas

(This is symbolised by the footsteps) to a healing place. The two hands represent caring, understanding and friendliness in the health centres. The Aboriginal and Torres Strait Islander people return from this place with knowledge and a sense of wellbeing to distribute to their communities (footsteps).

LENARD CONNOLLY – is a member of the Wiradjuri community. Growing up on an Aboriginal mission in Brungle (situated) near Tumut, NSW in the snowy mountains. Lenard is a registered indigenous creator with the National Indigenous Arts Advocacy Association Inc.

## ACKNOWLEDGMENTS

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*The plan was built on the firm foundation of the draft document "Strategic Directions and Priorities for Aboriginal Health in SWSAHS." This document was drafted by Susan Cragg in association with the Aboriginal Health Committee.*

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The South Western Sydney Area Health Service would like to encourage wide distribution of this plan and photocopies of this plan may be made without seeking permission. However, any reference made to information contained within this plan must be done so with acknowledgment to the South Western Sydney Area Health Service.

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## FOREWORD

This Aboriginal Health Plan was developed in association with the Tharawal Aboriginal Corporation (TAC) in response to the NSW Department of Health's Aboriginal Health Policy (1999). The Plan identifies those priority issues that need to be addressed by the SWS Aboriginal Health Partnership and by the Area Health Service. The Plan has been developed as a response to the issues and concerns of Aboriginal people living in South Western Sydney. It has benefited from the knowledge and understanding of Aboriginal health staff, community groups and representatives from SWSAHS. It is the second Aboriginal Health Plan for south west Sydney.

Aboriginal Australians experience highly significant inequalities in health status. It is frequently noted that an Aboriginal person is expected to live 15 to 20 years less than a non-Aboriginal Australian. Whilst the death rates for all causes for all Australians decreased between 1988-1994, the death rate remained steady for Aboriginal men and actually increased for Aboriginal women. We now know that the health inequality gap has widened between Aboriginal and non-Aboriginal Australians (AIHW 1998).

Numerous commentators have linked the poor health of Aboriginal people and their history of dispossession, injustice, racism, and indeed their struggle for survival. The experience of this history has reverberated through several generations and continues to impact on Aboriginal families and communities living in SWS.

It is a social imperative to seek to develop greater equity in health outcomes for Aboriginal communities living in SWS.

In this endeavour, our SWS health care system has a role in working to provide the highest possible quality, maximally accessible and appropriate services and strategies for health improvement with the best possible health outcomes. It is essential to join together with the community to improve ATSI health in ways which are culturally appropriate and which build on a framework of empowerment. Our community has a role in seeking greater justice and opportunities for co-operative developments. Government departments have a role in working together to develop more sustainable and just enterprises.

Key issues raised in this plan are:

1. The importance of developing and advancing partnership agreements between the mainstream health service and Aboriginal controlled and managed health services.
2. The need to address health issues which have been identified as a priority by Aboriginal communities in SWS. These issues include cardio-vascular disease, diabetes, drug and alcohol, mental health, infectious diseases, child and youth health and oral health.
3. The central importance of improving the accessibility and appropriateness of services so that Aboriginal people may have access afforded to them which is at least equal to their health needs.
4. The importance of demonstrating a strong and lasting SWSAHS organisational commitment to Aboriginal health.

Our commitment to improving Aboriginal health in South Western Sydney Area Health will be demonstrated by the implementation of this SWSAHS Aboriginal Health Plan 2001.

Ian Southwell  
Chief Executive Officer, SWSAHS



## **2. EXECUTIVE SUMMARY**

The SWS Aboriginal Health Plan is founded on four key challenges. These challenges derive from issues raised by Aboriginal community members, Aboriginal health and service providers, partners in Aboriginal health and SWS managers and providers. The four key challenges are:

- 1. Partnerships**
- 2. Addressing Identified Health Priority Issues**
- 3. Improving Access**
- 4. Organisational Commitment**

Local community consultations and epidemiological research clearly identify a number of critical health problems that are leading to high rates of illness, disability and premature death amongst Aboriginal people. However, as strongly recommended in the Evaluation of the 1993 Aboriginal Health Plan for SWS (SWSAHS 1998), there is a need to focus on a more limited number of agreed priority areas with a realistic number of outcomes.

Priority areas identified through ATSI community consultation are child and youth health, mental health, drug and alcohol, diabetes, cardiovascular disease, oral health and infectious diseases. For each of these health issues a focus will be made on the key population groups - men, women, youth and children. The central importance of the extended family network will also be acknowledged. Likewise to maximise effectiveness, work with other government departments and agencies will be encouraged. The importance of ATSI self-determination and involvement will be recognised.

The principles underpinning the planning process that have emerged through the consultation process are closely aligned with the principles that have been used to guide the NSW Aboriginal Health Policy, 1999:

- 1. A whole of life view of health**
- 2. Practical exercise of the principles of self-determination**
- 3. Partnership**
- 4. Cultural understanding**
- 5. Recognition of trauma and loss**



### **3. GLOSSARY AND ABBREVIATIONS**

#### **Aboriginal Community**

The Aboriginal Community as a whole.

#### **Aboriginal Culture**

The way of life which ties an Aboriginal person back to their homelands or family or kinship group.

#### **Aboriginal and Torres Strait Islander Worker**

An Aboriginal or Torres Strait Islander person who is employed in a health service involved in the delivery of health care.

#### **Aboriginal person or Torres Strait Islander (ATSI) person**

A person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by their community.

#### **ATSI Family/Extended Family Network**

The Aboriginal extended family network includes Mum, Dad, Grandmother, Grandfather, Aunties, Uncles and Cousins.

#### **Access**

The capacity or potential to obtain a service or benefit. Access incorporates notions of geographical access, physical/architectural access, cultural/linguistic access, service acceptability and affordability.

#### **Best Practice**

The care that will lead to the maximum benefit for an individual or a population.

#### **Community Control**

Refers to ATSI control of and participation in the management and development of health services. A service or program that is directed or controlled by the local Aboriginal Community.

#### **Cultural Appropriateness**

A service standard for the Area Health Service which requires that an ATSI person receive service(s) that they consider to be culturally appropriate. Such services should also be actively seeking to be maximally accessible to ATSI people and communities.

#### **Equity**

Equal opportunity for equal or similar need. Service equity implies that a person will receive an opportunity to receive equal health care, irrespective of personal characteristics such as income, race, gender, or place of residence.

#### **Health Outcome**

A change in health resulting from a health intervention, program or service.

#### **Illicit drugs**

Drugs which are not legally available and include heroin, amphetamines, cannabis.

#### **Indigenous Models**

Model(s) of health care that are defined and developed by ATSI communities to meet the identified needs.

#### **Intersectoral Collaboration**

Collaboration between a variety of health, governmental and non-governmental organisations in order to improve community health and well-being.

#### **Koori**

An Aboriginal word describing an Aboriginal person living within NSW.

#### **Local Aboriginal Health Plans**

Plans developed in accordance with the NSW Aboriginal Health Partnership agreements.

#### **Mainstream Health Service**

Health and health-related services that are available to, and accessed by, the general community. Refers to those non-ATSI-specific services operated by SWSAHS.

### **Partnership Agreement**

The agreement between Tharawal Aboriginal Corporation and the SWSAHS endorsed by the Minister of Health and the Aboriginal Health and Medical Research Council.

### **Primary prevention**

Interventions or strategies aimed at forestalling the commencement or reducing the likelihood of a health issue or problem arising.

### **Primary Health Care**

First point of access for the community to health services. Examples of primary health care services in SWS are general practitioners, community health centres, dental health, Aboriginal community controlled organisations, emergency departments, outpatient services.

**Secondary prevention** aims to reduce the harm associated with the onset of a health problem.

### **Stolen Generation**

A collective term for persons of Aboriginal or Torres Strait Islander descent who were removed from their biological family and community.

**Tertiary prevention** is aimed at reducing complications and includes any measures available to reduce impairments and disabilities and minimise suffering related to a health problem/issue.

## **ABBREVIATIONS**

<b>ABS</b>	Australian Bureau Statistics
<b>ACCHS</b>	Aboriginal Community Controlled Health Services
<b>AH&amp;MRC</b>	Aboriginal Health and Medical Research Centre
<b>AHW</b>	Aboriginal Health Worker
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>ATSI</b>	Aboriginal and Torres Strait Islander
<b>ATSI Health Co-ordinator</b>	- SWSAHS Aboriginal and Torres Strait Islander Co-ordinator
<b>ATSI Partnership Committee</b>	- SWSAHS Aboriginal and Torres Strait Islander Partnership Committee
<b>CEO</b>	Chief Executive Officer
<b>CVD</b>	Cardiovascular disease
<b>D&amp;A</b>	Drug and Alcohol
<b>DCEO</b>	Deputy Chief Executive Officer
<b>DHP</b>	Director Health Promotion
<b>DDP</b>	Director, Division of Planning
<b>DET</b>	Department of Education and Training
<b>DOH</b>	Department of Health
<b>ENT</b>	Ear Nose & Throat
<b>ESRD</b>	End Stage Renal Disease
<b>FTE</b>	Full Time Equivalent of a Staff position
<b>GMs</b>	General Managers
<b>GPs</b>	General Practitioners
<b>HACC</b>	Home and Community Care
<b>HEO</b>	Health Education Officer
<b>HIC</b>	Health Improvement Committee
<b>LGA</b>	Local Government Area
<b>MDC</b>	Midwives Data Collection
<b>NAIDOC</b>	National Aboriginal Islander Day of Celebration
<b>NGO</b>	Non Government Organisation
<b>NHMRC</b>	National Health and Medical Research Council
<b>NSP</b>	Needle Syringe Program
<b>NSW</b>	New South Wales
<b>NT</b>	Northern Territory
<b>SA</b>	South Australia
<b>SSR</b>	Standardised Separation Ratio
<b>SMR</b>	Standardised Mortality Ratio
<b>SWS</b>	South Western Sydney
<b>SWSAHS</b>	South Western Sydney Area Health Service
<b>TAC</b>	Tharawal Aboriginal Corporation
<b>WA</b>	Western Australia

## 4. INTRODUCTION

The 1993 Aboriginal Health Plan for South Western Sydney (SWSAHS 1993) was the first plan in Australia to be developed in partnership between an Area Health Service, an Aboriginal Community Controlled Health Service and a State Health Department. It provided direction to SWSAHS over a five-year period. In 1998 it was decided that the plan should be reviewed and updated. Under the direction of the Aboriginal Health Strategic Planning Committee this involved:

- A comprehensive evaluation of the first Strategic Plan;
- A series of focus groups with Aboriginal workers, community groups and local residents (1998-99);
- An Aboriginal Health Summit (August, 1998) that identified key priority issues to be taken up in the new plan;
- The development of a demographic profile of Aboriginal people in SWSAHS.

At each milestone draft planning documents were circulated for comment to key stakeholders including Tharawal Aboriginal Corporation (TAC), Aboriginal community representatives, Aboriginal health staff, and SWSAHS managers and clinical staff.

It was decided to undertake the development of the new plan in several stages. Stage one was the drafting of a document entitled *Priorities and Strategic Directions for Aboriginal Health in SWSAHS*. This document sought to provide a strategic direction for the immediate future.

Stage two involved selected SWSAHS Area Health Improvement Committees (HICs) developing specific strategies and implementation plans to address the identified issues in Aboriginal health. This step aimed to fully utilise the extensive expertise in SWSAHS about prevention, early identification and management in those areas of focus. It was also designed to engage those responsible for mainstream implementation and monitoring.

### The agreed health priorities are:

- **Child and Youth Health**
- **Mental Health**
- **Drug and Alcohol**
- **Diabetes**
- **Cardio-vascular Health**
- **Infectious Diseases**
- **Oral Health**

The target populations for each of these priorities are men, women, youth and children.

The third stage was to integrate the information and strategies into a plan. Thus, this plan is a culmination of:

- the issues and concerns raised by local Aboriginal people and community groups in community consultations,
- the strategies which clinicians in partnership with Aboriginal health workers have devised to most effectively address the agreed priority issues, and,
- key policies and plans which impact on Aboriginal health in SWS.

The plan has been particularly guided by the principles underpinning the NSW Aboriginal Health Policy, 1999.

### A whole of life view of health

Aboriginal people have a holistic and social view of health encompassing the physical, emotional, cultural, and spiritual well being of individuals and communities. A holistic approach to the delivery of services is essential to the improvement of Aboriginal health outcomes.

### Practical exercise of the principles of self- determination

The practical exercise of self- determination is central to Aboriginal health. It underpins cultural, community and individual well being. Aboriginal self- determination and responsibility lies at the heart of Aboriginal Community Control in the provision of community-based services.

## **Partnership**

Partnership is about working collaboratively in an environment based on respect, trust and equality. It includes pursuing the achievement of joint positions on matters that are the agreed business of the partnership. Working partnerships are essential to providing Aboriginal people with equitable access to culturally sensitive health services and to address the issues underlying the disadvantage of Aboriginal people and communities.

## **Cultural understandings**

Cultural understandings shape the provision of health services. Understandings of Aboriginal culture need to be applied in mainstream health services in order to achieve sustained improvement in health outcomes for Aboriginal people.

## **Recognition of trauma and loss**

Disruption to cultural well being and the resulting loss and trauma significantly contributes to ill health in the Aboriginal community. Recognising the issues of loss and trauma resulting from the history of the Aboriginal people since colonization is critical to the success of services and programs in preventing Aboriginal ill health and in determining strategies for healing.

## **5. VISION**

This plan aims to advance ATSI health status as far towards good health as is possible. It will result in ATSI health being recognised as a true priority in South Western Sydney. It aims to bring people and organisations together to work for ATSI health and to provide the very best and most effective services and strategies. Most importantly, it aims to engage and empower ATSI people and communities to determine and take control of their own health.

Such high ideals must be built on the grounding realisation that whilst good ATSI health is a long journey, small steps must be taken first. The journey must be founded on an understanding of the path behind - the history of colonisation, the tragedies, atrocities and abuses, the multiple injustices, and the dispossession and loss. The legacy of such a history has inevitably been the poor health, trauma and cultural and physical dislocation which continue to impact on subsequent generations in South Western Sydney.

The health and healing process must be built upon a positive restoration of community and personal well-being, and the self-determination, involvement and ownership of ATSI people. It must derive from a holistic and social view of health. It must recognise issues associated with housing, income, employment and community. It must be built upon evidence of "what works" for ATSI communities. It requires positive, respectful and involved partnerships. These principles are the foundation for change in the South Western Sydney.

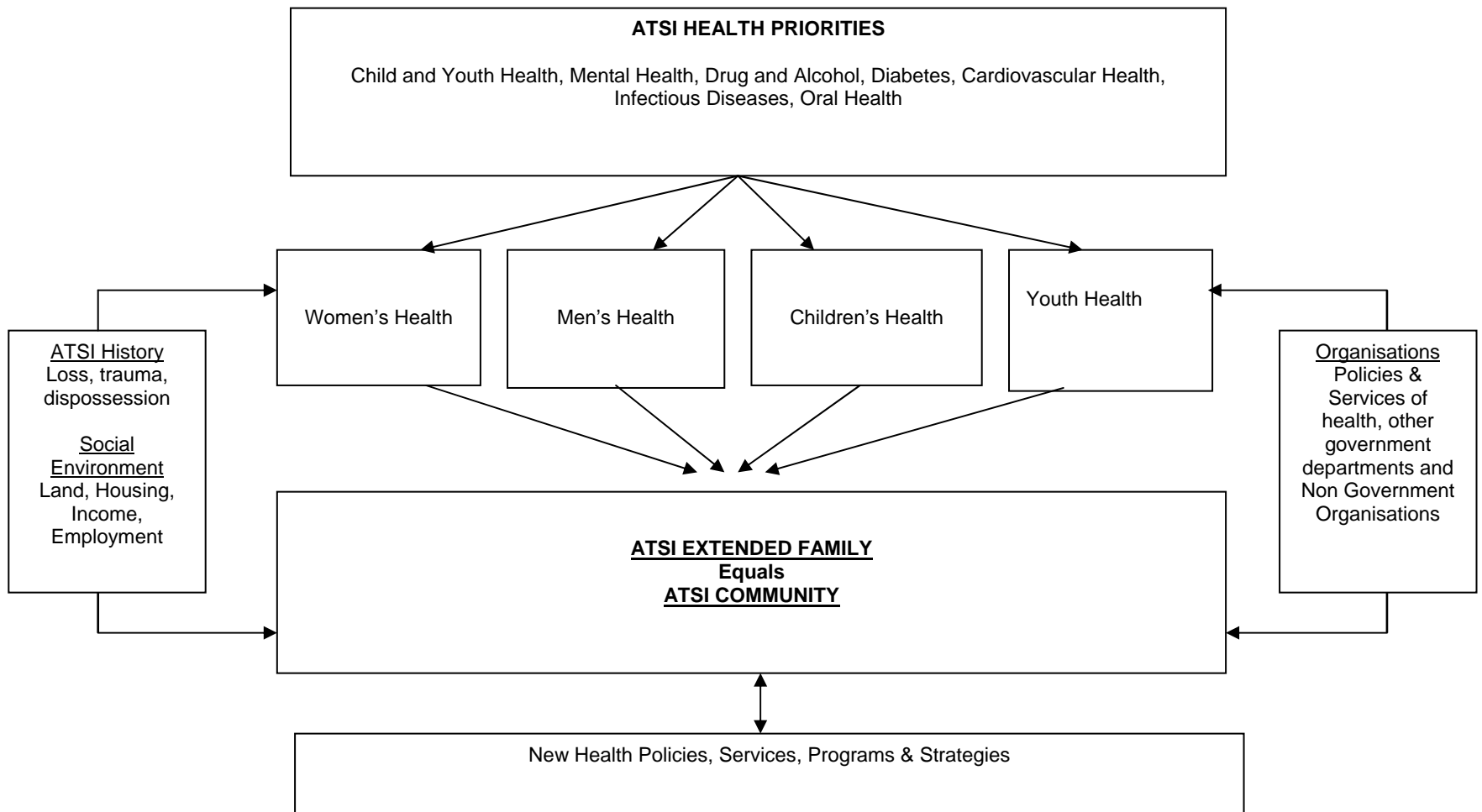
The ATSI communities in South Western Sydney have identified 7 key health priority areas to be addressed (child and youth health, mental health, drug and alcohol, diabetes, cardiovascular health, infectious diseases and oral health). The effectiveness of the strategies rests in integrating these priorities into a framework for working which recognises the centrality of the extended family in the ATSI community and the importance of partnerships, intersectoral action and an understanding of ATSI history (see Diagram 1).

In five years time, an expected outcome is that mainstream health services will no longer be seeking to be culturally sensitive, but will be culturally appropriate. That is, that health providers will recognise that they are required to re-orientate their services to meet ATSI needs. It is planned and expected that the agenda will have matured beyond access to better address true equity. It also is planned and expected that organisational commitment will be unquestionable. A final expected outcome is that partnerships will be strong, respectful and vital.

It is important to acknowledge the work that has been undertaken to date to improve ATSI health in SWS. This foundation provides a strong and vital basis for positive health gain in the future. It is hoped that in five years, ATSI health status will have significantly improved in South Western Sydney.

**Diagram 1: FRAMEWORK**

When working with ATSI people to improve health through addressing ATSI priority health issues, the centrality of the family unit needs to be understood. i.e. if a Diabetes program is developed for Men, then the program/project should recognise the effects on the whole family structure. Consideration also needs to be given to the community and family history, the social environment and the policy and service environment. Health change is built on small changes rippling through the family and extended family to the broader community.



## 6. IMPORTANT POLICIES

The SWSAHS Aboriginal Health Plan is informed by a large array of important policy documents. The most recent include the following:

### A) NSW and SWSAHS Health Service Goals and Challenges

The NSW Health *Strategic Directions for Health 1998 – 2003* provides the framework within which all other plans in the health system should be developed. The four goals, set out in the *Strategic Directions for Health*, are: Healthier People; Fairer Access; Quality Health Care; and Better Value.

As part of a commitment to achieving “Better Health, Good Health Care” SWSAHS has identified the following key challenges:

- Working with our community;
- Ensuring the people in SWS access health services according to need;
- Working in partnership with other agencies to improve health;
- Developing an effective health service and a focus on health outcomes;
- Becoming a teaching/learning organisation;
- Making the best use of and fairly allocating incoming resources;
- Attracting, developing and retaining the best staff.

These key challenges guided the development of this Aboriginal Health Plan and are reflected in the strategies and priorities of the Plan.

### B) NSW Department of Health (DOH) ATSI policies and plans

#### B1) NSW Health *Ensuring Progress in Aboriginal Health- A Policy for the NSW Health System*

This document represents NSW Health’s commitment to restoring the health and the social, emotional and cultural harmony of Aboriginal people in NSW. It reinforces the NSW Government’s commitment to partnerships and was developed in association with the Aboriginal Health and Medical Research Council of NSW (AHMRC).

The goals and key strategies of the policy are as follows:

1. Improved Health Of Aboriginal People Taking Account Of The Need To Restore Social, Economic And Cultural Well Being.  
The key strategic priorities relate to: maternal, infant and child care; chronic disease management; emotional and social well-being; substance misuse; and, injury and poisoning. Access to resources, building partnerships and improving the evidence base of plans and services are emphasised. Complementing this is the need for improved physical environments.
2. Improved Access To Culturally Sensitive And Appropriate Services.  
Key strategic priorities relate to: ATSI peoples’ participation in planning and service delivery; improved employment and career opportunities for ATSI people; improved intersectoral relations and partnerships; increased resources; fostering partnerships; the support and development of the ATSI workforce; improved appropriateness of mainstream service delivery; and, improved access to ATSI community controlled health services.
3. Effective Evidence Based Health Planning.  
Key strategic priorities relate to: improving information, increasing participation and improving the equity of resource allocation
4. An Environment Of Improvement.  
Key strategic directions include: effective monitoring and evaluation and the use of “better practice” to improve quality.

The Policy will be implemented, monitored and evaluated through the NSW Aboriginal Health Strategic Plan which aims to ensure coordinated action between Commonwealth, the NSW Government and the Aboriginal community controlled health sector and Area Aboriginal Health Plans

### **B2) NSW Aboriginal Health Strategic Plan 1999.**

The NSW DOH Aboriginal Health Strategic Plan rests on the following five Supportive Strategies:

- Effective Partnerships and Cultural Awareness. This requires Area Health Services to develop Aboriginal partnerships; to develop collaborative initiatives; and to develop and implement cultural awareness.
- Improved Commonwealth and State Co-ordination
- Support and development of the ATSI Health Workforce. This requires Area Health Services to: establish systems for support and back-up of Aboriginal Health Workers; and, to share training initiatives.
- Effective Monitoring of progress against agreed performance indicators and improved collection of health information. This requires Area Health Services to reach agreement with NSW Health on reporting requirements in ATSI Health and to implement the Aboriginal Health Information Strategy.
- Informed decision-making supported by a needs based resource allocation model.

These Supportive Strategies are linked to five key priorities which drive the plan and which link most closely to the SWS context.

1. Improving Access to Health Services. This requires Area Health Services to develop effective partnerships; and, to develop service networks supportive of ATSI health.
2. Addressing Identified Health Issues. This requires Area Health Services to develop priorities and strategies for early intervention. Priorities identified by NSW Health include: diabetes; maternal, infant and child health; and, oral health.
3. Improving Social and Emotional Well Being. Strategies include implementation of the Aboriginal Mental Health Policy, the Bringing them Home report on the loss and separation experienced by separated ATSI families; the NSW Aboriginal Family Health Strategy and drug and alcohol strategies.
4. Increasing the Effectiveness of Health Promotion. Priority strategies relate to improving health promotion infrastructure and preventing injury.
5. Creating an Environment Supportive of Good Health. Key issues identified included improving environmental health infrastructure; and, improving opportunities within health for employment of ATSI people.

### **B3) NSW Aboriginal Health Regional Plan for South Western Sydney- *From the Ground Up* (2000).**

This plan was developed by the NSW Aboriginal Health Forum to inform funding, policy and service development in NSW. The NSW Aboriginal Health forum comprises representatives of the AH&MRC; NSW Health; the Commonwealth Department of Health and Aged Care and Aboriginal & Torres Strait Islander Commission (ATSIC). The document seeks to identify gaps and opportunities and to determine priorities for improvements in ATSI health. The document is comprised of a state-wide document and regional documents which have been developed by the Aboriginal community controlled organisation with administrative assistance from the Aboriginal Health and Medical Research Council (AH&MRC).

Issues raised in the SWS Regional Plan include: cost of medications; the need for first aid training in families; added dental and environmental health officer services at Tharawal Aboriginal Corporation; the long waiting lists for specialists; the need for detoxification services and emergency accommodation and the need for a funeral assistance program. Major health issues identified included diabetes; respiratory; cardiovascular health; trauma and injury; ear diseases; diarrhoeal diseases; immunisation; HIV/AIDS and dental health.

Key strategies identified include the following:

- The need for more outreach services from TAC
- Improving the primary care services at TAC
- Improving the educational opportunities for TAC staff
- Redeveloping TAC to improve its physical facilities
- Improving cultural awareness education for SWSAHS staff
- Documenting the resources allocated to ATSI health
- Improving data systems
- Ensuring all SWS plans are issued to TAC for comment and further consultation if necessary
- Working with SWS Emergency Departments to improve access
- Improving access to specialist services
- Developing service agreements to address cross boundary issues
- Improving TAC and HACC co-ordination
- Extending the number of GP programs targeting ATSI people
- Funding an extra dentist at TAC
- Establishing an ATSI detoxification facility in Campbelltown
- Establishing a grief counselling service at TAC
- Establishing a crisis team at TAC
- Establishing strategies to improve nutrition in ATSI communities
- Employing an Environmental Health Officer at TAC

### **C) Partnership Agreements**

#### **C1) *Strengthening the NSW Aboriginal Health Partnership***

The NSW Aboriginal Health Partnership Agreement is an agreement between the NSW Minister for Health and the Aboriginal Health and Medical Research Council of NSW (AH&MRC) as equal partners, signed in 1995. This partnership was reviewed and strengthened in 2000. A significant component of this partnership is the need to develop and support local partnerships.

#### **C2) *Partnership between Tharawal Aboriginal Corporation and South Western Sydney Area Health Service, 1999.***

The Partnership Agreement between Tharawal Aboriginal Corporation and SWSAHS constitutes the local partnership referred to in the NSW Partnership Agreement. The Partnership Agreement between Tharawal Aboriginal Corporation and SWSAHS was entered into in September, 1999. The Partnership forms a vital role in the organisation and co-ordination of resources to address ATSI health issues. It is designed to ensure the co-ordination and delivery of services and to ensure that the expertise of ATSI communities is brought to the health care process. The parties are equal members of the partnership.

Key aims of the Partnership are to support ATSI self-determination, to promote partnership between Aboriginal and non-ATSI people and to support inter-sectoral collaboration. Parties are bound to consult regarding Aboriginal health policy, strategic planning and resource allocation issues.

Key parameters of the partnership between SWSAHS and Tharawal Aboriginal Corporation are to enhance primary health care, to develop local plans, to assist in staff development of TAC staff; to develop the cultural sensitivity of SWSAHS staff; to develop closer referral links, to develop collaborative approaches to service delivery and administration; and to assist in the planning and development of mainstream and ATSI services.

Macarthur Health Service also has a local partnership agreement with Tharawal Aboriginal Corporation.

Partnership agreements are only with Aboriginal health services. In SWS there are also two land councils (Tharawal and Gandangara) with which SWSAHS has close links. These links effectively constitute service agreements, rather than partnership agreements.

#### **D) NSW Aboriginal Mental Health Policy**

The aims of the Aboriginal Mental Health Policy (1997) are:

- To promote mental health and well-being of Aboriginal people in their communities and where possible prevent the development of mental health problems and mental disorders in ways consistent with the concept of Aboriginal mental health
- To reduce the impact of mental health problems and mental disorder on Aboriginal people, their families and communities by appropriate measures including provision of optimal and effective care
- To ensure the rights of Aboriginal people with respect to mental health problems and mental disorders. Key strategies in the policy include: integration of services; improved flexibility in work practices; actively recruiting, training and educating Aboriginal people; cross cultural awareness training; employing Aboriginal people in mental health services; promoting two-way education; and encouraging community participation in the design and delivery of services.

#### **E) Bringing Them Home Report**

This important report documents the grief and loss, the tenacity and survival associated with the removal of Aboriginal children from their families and communities and the abuse and neglect that has been suffered at the hands of authorities. The ongoing effects of these policies and issues are outlined. The importance of reconciliation and community and governmental acknowledgment of injustice and oppression is stressed. The report discusses the need for empowerment, self-management and self-determination.

#### **F) NSW Aboriginal Family Health Strategy**

The Aboriginal Family Health Strategy (1995) aims to empower and engage Aboriginal families, communities and agencies to take control and work collaboratively to reduce family violence, sexual assault and child abuse. The key strategies include: establishing safe houses; developing family health projects; creating family health workers; and, educating professionals.

#### **G) Aboriginal Health Information Policy**

The purpose of the NSW Aboriginal Health Information Guidelines is to ensure consistency and good practice in the management of health and health-related information about Aboriginal peoples in NSW. It relates to issues surrounding ownership, storage, security, access, release, usage, reporting and interpretation of information as well as issues of confidentiality and privacy.

#### **H) NSW Aboriginal Employment Strategy**

The NSW Aboriginal Employment Strategy was developed in recognition of the developing career paths, educational opportunities and need for development for Aboriginal Health Workers. It is founded on an understanding of the importance of employing Aboriginal people in all aspects of health service delivery. Key strategies of relevance to the Area health Service include the following:

- Improvement in the employment of ATSI people
- Improved arrangements for the education of ATSI staff
- The need to facilitate reciprocal transfer of skills between the public, private and community controlled sectors
- The importance of implementing practical strategies at the local level to improve Aboriginal employment
- The need to improve the capacity to recruit, select and induct staff.

#### **I) SWSAHS Policy Documents**

There are a number of SWSAHS service plans and documents that have informed this plan and which have fully integrated ATSI issues and strategies.

## 7. HEALTH NEEDS AND ISSUES IDENTIFIED BY ATSI COMMUNITIES/GROUPS

The poor health and disadvantage of ATSI communities in SWS, as elsewhere, is well known. Appendix 1 and 2 provide detailed demographic and epidemiological data demonstrating the key issues and the need for action to improve health. More important than the data however, are the views, ideas and concerns of ATSI communities.

In order to assess community needs and key health issues, a range of consultation processes were commissioned. The purpose of these consultations was to develop directions and priorities and to incorporate these into the Plan. The consultation processes included:

### 7.1 SWSAHS Aboriginal Health Summit

In 1998 SWSAHS hosted a Summit attended by over a hundred community members and service providers concerned with ATSI health. The Summit aimed to collect information to help decide priorities for improving ATSI health in South Western Sydney over the next 5 years.

Some direct quotations from the proceedings indicate the underlying tenor of the discussion.

***“Spend time to build relationships and commitment”***  
***“Contact the community on what has to be done”***  
***“Learn from successful/unsuccessful programs elsewhere”***  
***“Be aware of issues for the Stolen Generation, especially trust”***  
***“With all the issues, the Aboriginal traditional cultural ways need to be incorporated (through) consultation”***

### Summary of discussion at the Aboriginal Health Summit workshops

PRIORITY ISSUES	WHAT CAN BE DONE?
Commitment /ownership by organizations individuals  Participation and representation of Aboriginal people (includes trust, respect, listening, consultation)	<ul style="list-style-type: none"> <li>• Develop a consultation process-identify needs, resources, common goals/outcomes, viability, timeframes</li> <li>• Involve communities in developing services</li> </ul>
Partnerships	<ul style="list-style-type: none"> <li>• Define partnerships</li> <li>• Be aware of successful models as well as local needs</li> <li>• Develop common agreements</li> <li>• Spell out roles and responsibilities of everyone and include in duty statements</li> <li>• Ensure equal representation of stakeholders</li> <li>• Provide appropriate resources</li> <li>• Build partnerships into the resource allocation process</li> <li>• Develop skills to work in partnerships</li> </ul>
Health is broader than just medical problems	<ul style="list-style-type: none"> <li>• Recognise an Aboriginal view of health as being holistic</li> <li>• Through consultation, incorporate Aboriginal cultural ways</li> <li>• Address underlying issues of dispossession including land rights and the stolen generation</li> </ul>
Need for agreed priority areas and a realistic number of outcomes while still having an holistic approach	<ul style="list-style-type: none"> <li>• AHS and community organizations define priorities together</li> <li>• Programs need to be tied to demonstrable health gains</li> <li>• Add working in Aboriginal health to job descriptions and performance agreements</li> <li>• Learn from successful/unsuccessful programs elsewhere</li> </ul>

Mental Health is an emerging issue	<ul style="list-style-type: none"> <li>• Change the perception of mental health in the Aboriginal and wider community</li> <li>• Educate and recognise the Aboriginal mental health worker</li> <li>• Address underlying issues such as dispossession and spirituality</li> </ul>
Drug and Alcohol	<ul style="list-style-type: none"> <li>• Importance of early intervention and prevention</li> <li>• Develop and identify positive role models</li> <li>• Research the relationship between alcohol and violence</li> <li>• Research other Indigenous models of treatment and prevention</li> <li>• Identify health workers for outreach and mobile services</li> </ul>
Culturally appropriate services that are trustworthy	<ul style="list-style-type: none"> <li>• Don't always expect the community to come to services. Fund and support outreach programs</li> <li>• Use "soft " access points eg.arts, recreation, radio, cultural events at NAIDOC week</li> <li>• Provide cross cultural training on Aboriginal health issues</li> <li>• Provide accurate information about available services</li> </ul>
Work on issues around standard of living, employment and social justice	<ul style="list-style-type: none"> <li>• Use a whole of Government approach with an Area Advisory Group of Government Departments, elders, relevant stakeholders</li> <li>• Develop a coordinated Social Justice plan</li> <li>• Evaluate and monitor short term and long term initiatives.</li> <li>• Ensure that Aboriginal Health is resourced from general funds</li> </ul>
Evaluate the effectiveness of programs	<ul style="list-style-type: none"> <li>• Improve data collection on KOORI status</li> <li>• Identify the benefits for Koori community in identifying as Koori i.e. the practical advantages</li> <li>• Involve the community in evaluation</li> </ul>
Maintaining and supporting the Aboriginal workforce	<ul style="list-style-type: none"> <li>• Raise the status of health jobs in the community</li> <li>• Assist, train and orientate AHWs</li> <li>• Be flexible about "ownership " of workers</li> <li>• Provide support through effective interagency liaison</li> </ul>

## 7.2 Community Consultations, Elders Meetings and Focus Groups

In late 1998 a number of community consultations were undertaken by Aboriginal Health staff with the aim of determining priority health issues.

Once again, some direct quotations from focus group meetings most clearly indicate some of the important recurring health themes emerging from the consultations:

***"We can educate other health organizations in Aboriginal issues. That is important-educating them about Aboriginal health. Important to work together. We're all living on the same planet. We can teach each other. Need to share the knowledge"***

***"For us to be able to teach our people about the diseases we have. To have a Koori community person, a layperson, go with the professionals to talk to our people about how to know about the diseases we have. We know what happens. We can tell other people, and for young people to know. If I'd known 20 years ago about diabetes, it wouldn't have happened. "***

***"The waiting times for health services. If something affects you quickly, what are you going to do? Our health is so bad, it deteriorates quickly"***

*Elders meeting at Hoxton Park Community Health Centre*

***“For services to be more welcoming- not just Koori paintings, but to be made to feel more comfortable”***

***“Workshops and education services to make people more aware of how to live healthier, about the living conditions we’ve got now, how this can improve. People are shamed to talk about how they feel, especially to white people. They think people in uniforms are better than them”***

*Focus Group at Tharawal Aboriginal Land Council*

### **Summary of Discussion at Focus Groups.**

#### **Priority Health Areas and Population Groups**

The focus groups had clear and consistent views on priorities for disease prevention and treatment, namely:

- Cardiovascular disease
- Diabetes
- Respiratory illnesses
- Drug and Alcohol problems
- Mental Health
- Child Health including hearing problems
- Dental Health

Many of the participants emphasised the need for prevention of health problems and the importance of targeting families with children and young people. in order to avoid health problems.

The low uptake by men of many services was noted and the need for specific strategies to engage them in health care was discussed.

The recognition of the impact of generations of trauma and loss on health was frequently referred to, as was the need for fostering ATSI specific mental health services.

The impact of Drug and Alcohol misuse on not only the person involved but also the whole family’s health was also recognized as an area that needs to be addressed.

#### **Risk Factors and Prevention**

Focus group participants clearly understood the importance of risk factors in causing health problems and emphasized the importance of prevention and health promotion.

Specifically emphasized were:

- The need to educate about risk factors for the major diseases, particularly for young people
- The importance of preventative health checks e.g. blood pressure, blood sugar
- The need for Health Promotion programs to promote healthier living e.g. in exercise and diet
- The impact of historical and social factors e.g. The Stolen Generation, Aboriginal deaths in custody, generations of trauma and loss
- The need for agencies to work together to improve living and housing conditions to make people healthier

#### **Access to Health Services**

Participants had significant discussion about some of the difficulties in gaining access to health services, including:

- lengthy waiting periods
- lack of locally available primary health care services. Most people reported that GPs were the main primary health care provider.
- Lack of GPs who bulk billed.
- the need for Tharawal Aboriginal Corporation and SWSAHS to promote their primary health care services.
- the need for health services to be more welcoming and accessible
- need for liaison officers as Aboriginal people were often fearful of health services
- need to promote a more positive image and profile for services

## **8. EVALUATION OF THE 1993 STRATEGIC PLAN FOR ABORIGINAL HEALTH IN SOUTH WESTERN SYDNEY**

In 1998 an evaluation of the 1993 Strategic Plan for Aboriginal Health in SWS was conducted. It sought to identify the achievements of the plan and the areas in which progress had not been made. The 1993 plan was visionary and ambitious. The evaluation demonstrated that the plan was indeed significant in addressing the health issues and needs of Aboriginal people in South Western Sydney.

This evaluation was based primarily on the results of a survey of all stakeholders identified as being responsible for implementing a particular strategy. Responses to the survey showed that: 17 strategies were regarded as being fully implemented (38 percent), 19 strategies as partly implemented (44 percent) and 9 strategies (18 percent) as not at all implemented (see Table 1).

Goals and strategies that had been particularly successful related to:

- the development of specific projects, activities or services;
- working with Tharawal Aboriginal Corporation to provide services;
- increasing the number of Aboriginal Health staff and the support for these staff;
- consultation with Aboriginal communities; and
- inclusion of Aboriginal Health items in SWSAHS performance agreements.

A number of difficulties were identified with implementation of the strategies related to improving mainstream access. Difficulties included: the lack of a clear Aboriginal health infrastructure, high turnover of Aboriginal and mainstream staff within SWSAHS (and in external organisations) and problems of engaging mainstream health services in taking action to improve Aboriginal health.

However, over 80 per cent of all strategies in the Plan were fully or partially implemented (see Table 1).

The evaluation identified a number of important issues that needed to be addressed by this plan:

- A commitment to a partnership approach
- Setting a limited number of measurable targets and objectives in a smaller number of health areas
- Adapting mainstream services to promote access to ATSI people
- Supporting mainstream services in developing an integrated approach to ATSI health including protocols and monitoring systems
- Clarifying designated roles of Aboriginal Health Workers, Tharawal Aboriginal Corporation and mainstream service providers
- Working with other Government Departments to address economic and social conditions effecting ATSI health
- Improving career development and management structures for Aboriginal health staff
- Reviewing, standardising and resourcing training of staff in cultural awareness and ATSI health issues
- Reviewing funding sources for ATSI programs to increase the number of positions on long term funding in SWSAHS
- Developing organisational infrastructure to support ATSI health improvement

Table 1- Extent of Implementation of the Goals and Strategies of the 1993 SWS Aboriginal Health Plan

1993 Plan Goal	Number Of Strategies	Number Fully Implemented	Number Partly Implemented	Number Not At All Implemented
1. To improve the health and wellbeing of Aboriginal people in South Western Sydney	4	2	2	2
2. To meet the primary health care needs of Aboriginal people in South Western Sydney through appropriately resourced, Aboriginal owned and controlled services and structures	11	6	5	5
3. To improve the accessibility and appropriateness of mainstream health services to Aboriginal people in partnership with Aboriginal communities	15	0	9	9
4. To develop community consultation mechanisms and processes that actively encourage Aboriginal participation and control of health care	4	3	0	0
5. To incorporate Aboriginal health advancement into the corporate objectives of the South Western Sydney Area Health Service through collaboration with the Tharawal Aboriginal Corporation and the Office of Aboriginal Health of the NSW Department of Health	6	4	1	1
6. To identify and maximise intersectoral contributions to Aboriginal health advancement	3	1	1	1
7. To ensure that Aboriginal community of South Western Sydney receives an equitable share of all resources available for Aboriginal advancement	2	1	1	1
<b>TOTAL</b>	<b>45</b>	<b>17</b>	<b>20</b>	<b>20</b>

## 9. IDENTIFIED HEALTH PRIORITY AREAS

The ATSI community identified seven priority issues. The data analysis supported these priorities and suggested a further issue- Infectious Diseases. From these 8 priority health issues, the Aboriginal Steering Committee agreed that 7 areas should be the final priorities- Child and Youth Health, Mental Health, Drug and Alcohol, Diabetes, Cardiovascular health, Infectious Diseases and Oral Health. However, it is expected that all area plans and strategies will incorporate ATSI needs and issues and will collaboratively translate these issues into agreed strategies.

### 9.1 Child and Youth Health

#### Background

- The health and nutrition status of children and youth of Aboriginal and Torres Strait Islander (ATSI) origin is worse than that of other Australians and available evidence suggests that this inequity begins prenatally (NH&MRC 2000). ATSI infants are more likely to be delivered prematurely (10.0% cfd 6.6%), and record a low birth weight (11.0% cfd 5.8%) than non-ATSI babies (MDC 1998). Differences in health status with non-ATSI children are reflected in higher mortality (Alessandri et al 1999) and hospital admission rates (Read et al 1994; Gracey and Gee 1994) during childhood. Gastrointestinal and respiratory diseases and social admissions are the most frequent reasons for admission (Read et al 1994).
- Low birthweight is caused by short gestation and/or restricted intrauterine growth (Kramer 1987) which in turn are related to pre-pregnancy weight, inadequate pregnancy weight gain, diabetes, alcohol intake and cigarette smoking (Sayers and Powers 1997). ATSI mothers often have multiple risk factors for low birthweight and slow growth rate in the first 2 years of life (Gracey 1992). However, outcomes can be improved with attention to maternal health during pregnancy, regular antenatal supervision, avoidance of alcohol and cigarettes, and personal and family hygiene (Gracey 1992; Najman et al 1994).
- Smoking both during and after pregnancy has also been implicated in the rates of otitis media and SIDS. Data from the NSW Midwives Data Collection indicate that pregnant ATSI mothers were more likely to smoke during pregnancy (60% cfd 20%) than non-ATSI mothers (MDC 1998). The rate of SIDS was 3.5 times higher among infants (Alessandri et al 1996) with young maternal age, high parity, small-for-gestational age and exposure to tobacco smoke (Alessandri et al 1996; Eades and Read 1999).
- The poverty and family disruption that are more likely in ATSI families continue to exact a high cost on ATSI children and youth as they grow older with lower school retention rates and literacy levels, higher teen pregnancy rates and higher likelihood of involvement with the juvenile justice system being found.
- There is growing interest in the development of interventions to address poor health outcomes of Indigenous children and youth. One model involves ongoing home visiting by health workers to provide prevention and education about parenting issues including nutrition, hygiene and protection from tobacco smoke (Olds et al 1998; Reifsnider 1998). Positive evidence supports this role in the short-term effects on growth and development, the home environment and mother's perceived stress. Visiting of low income unmarried mothers by early childhood nurses improved maternal outcomes such as the number of subsequent pregnancies and use of welfare (Olds et al 1998) and reduced the incidence of behavioural and other social problems in adolescents (Olds et al 1997).
- South Western Sydney Area Health Service (SWSAHS) has one of the highest ATSI populations in the Sydney metropolitan area, with over 1000 ATSI children under 5 years of age. A very large proportion (43.7%) of the total SWS ATSI population is aged under 15 years, compared with 24.5% of the total SWS population. Approximately half of this population resides in the Campbelltown sector with the remainder scattered across Bankstown, Fairfield and Liverpool. Approximately 200 ATSI babies are born in SWSAHS each year. Available data suggest that ATSI mothers access health services less effectively than do non-ATSI people. For example, the SWSAHS Midwives Data Collection (MDC) indicates that ATSI women are more likely to present later than 19 weeks gestation for their first antenatal visit.

#### Current Strategies

- A pilot Aboriginal Home Visiting (AHV) Program has been established as a conjoint project with TAC in the Campbelltown sector of SWSAHS, commencing operation in November 2000. Pregnant women of ATSI origin or with a partner of ATSI origin are offered regular visits at home before and after birth until the infant reaches 2 years of age. The AHV Program has been well accepted in the community, with only one refusal among 35 women contacted.

- A Paediatric clinic is held at Tharawal Aboriginal Corporation (TAC) each fortnight .
- ENT specialists from The Children's Hospital – Westmead visit TAC each month to review children with serous otitis media.
- Hearing screening of all ATSI children in Macarthur.
- Vision screening offered by Royal Blind Society and an optometrist at TAC.
- A Speech Pathologist from Macarthur Health Service visits Ooranga Wandarrah Preschool once a fortnight.
- Tharawal Aboriginal Corporation Child Development Team. An intersectoral multi-disciplinary team assesses ATSI children attending Ooranga Wandarrah preschool identified by preschool staff as having developmental problems.

### **The Way Forward**

1. Home Visiting for all pregnant ATSI women and infants in SWSAHS.  
The ATSI Home Visiting program needs to be consolidated as an ongoing program funded by SWSAHS for a further 5 years. Evaluation of its impact on the health of ATSI children should also be continued.
2. Expansion of Early Child Development program for ATSI infants, prior to school entry.
3. Expansion of early intervention programs for ATSI children with identified developmental delay.  
The present child assessment service run through Ooranga Wandarrah Preschool should be expanded to provide assessments and referral for all ATSI infants and preschoolers in SWSAHS with identified developmental delay. This could be run through preschools in the area or children could be recruited through the ATSI Home Visiting program.
  - SWSAHS needs to support more community-based delivery of therapy services. Therapists would attend preschools, playgroups and parent groups to provide education and individual therapy.
  - A psychologist needs to be employed to support and develop culturally sensitive parenting programs for ATSI children.
  - Continued liaison with the Department of School Education would assist ongoing support of these children and youth into their school years.
4. Enhancement of medical services for ATSI children and youth.  
Present acute medical care for ATSI children needs to be expanded to provide greater flexibility for intervention at times of crisis. This could be provided by:
  - Improved links with local general practitioners, including education about ATSI issues.
  - Employment of a full-time child health medical officer through Tharawal Aboriginal Corporation, or SWSAHS, to become part of ATSI Child and Youth Health Team.
  - Extension of the current paediatric clinic at Tharawal Aboriginal Corporation to other sites.
  - Improved links between SWSAHS Emergency Departments and ATSI Child and Youth Health Team.
  - Enhanced ENT services targeting ATSI children.
5. Development of mental health improvement strategies for ATSI children and youth  
Currently mental health services in SWSAHS are not providing the level of services needed by ATSI children, youth and families. A project needs to be developed, in consultation with the community, to provide or support culturally appropriate, outreach mental health services for ATSI children and youth, specifically to address behavioural and emotional problems.
6. Establishment of ATSI Child and Youth Health Team  
Given the existing commitment of staff and resources by SWSAHS, TAC and Families First to ATSI child health in SWSAHS, it is proposed that a focussed ATSI Child and Youth Health Team be established initially in Macarthur. The ATSI Child and Youth Health Team would:
  - work with local ATSI communities to promote the health and well being of ATSI children and youth.
  - develop health services that meet the needs of ATSI mothers, babies, children and youth through the provision of appropriate and high quality preventive and direct services using a collaborative approach.
  - work with other ATSI community-controlled and non-ATSI organisations and government departments to develop services and strategies that will address underlying social and economic disadvantage in the local ATSI community.
  - evaluate the effectiveness of the ATSI Child and Youth Health Team in improving ATSI child and youth health in SWSAHS.
  - It is anticipated that the ATSI Child and Youth Health Team would extend its operations in 2002 to include all ATSI children in SWSAHS.

## 9.2 Mental Health

### Background

Mental health and mental health service provision has been highlighted as a key challenge in consultations with ATSI people and health and community workers in south western Sydney. Key issues are:

- the impact of generations of trauma and loss, family separation and the history of dispossession. For example, ATSI people are generally confronted with mortality and illness more often than non-ATSI people. Aboriginal families attend more funerals and experience greater numbers of deaths and serious illnesses within their extended family networks than do non-ATSI people.
- the importance of prevention and improved access, especially targeting young children and families. The 1997 and 1998 NSW Health Surveys show a higher level of psychosocial distress, as measured by a standard questionnaire (K10), among Indigenous people compared with non-Indigenous people. This was particularly apparent among younger and older Indigenous people. However, there is evidence that ATSI people do not use mainstream mental health services.
- the importance of specific ATSI mental health services, particularly with an outreach focus. When ATSI people are experiencing a mental health problem, misdiagnosis and issues arising from late presentation to services are common (Action Plan 2000 & SWSAHS consultations).

These issues have also been consistently raised in a number of important reviews, royal commissions, policies and plans e.g: Report of the Royal Commission into Deaths in Custody (1991); Report of the Inquiry into Mental Illness by the Human Rights and Equal Opportunity Commission (Burdekin) (1993); NSW Family Health Strategy (1995); NSW Aboriginal Mental Health Policy (1997)).

Most protective and risk factors for mental health derive from conditions in the everyday lives of individuals and communities. They often relate to income and social status, education, working conditions, social environments and connectedness, personal health practices and coping skills, physical environments and availability of opportunities including sport and recreation. Substantial evidence exists that ATSI peoples are seriously disadvantaged in comparison with the general population in relation to most of these conditions, experiencing greater poverty, lower levels of education, poorer housing and facilities, higher levels of unemployment, imprisonment, racism, discrimination and oppression.

As many of these protective and risk factors lie outside the domain of mental health services and mainstream health services, it is essential that programs are developed, owned and evaluated by local communities and that joint planning occurs across organisations which impact on conditions of everyday lives. The National Action Plan for Promotion, Prevention and Early Intervention (Action Plan 2000) identifies an urgent need to develop and evaluate the effectiveness of strategies that are holistic and culturally valid. Policy, planning and broad resource allocation decisions need to support the strategies and programs determined by ATSI communities.

### Current Strategies

Following Burdekin funding, eight Aboriginal mental health workers were appointed in SWSAHS. The workers have a mental health, community development, drug and alcohol and advocacy focus and are based in Divisions of Community Health, in Liverpool and Macarthur and with the Mental Health Service in Bankstown; specifically:

- Liverpool Health Service  
Child Mental Health Worker  
Mental Health Worker  
Mental Health Drug and Alcohol Worker
- Macarthur Health Service  
Youth Support Worker  
Youth Drug and Alcohol Worker  
Mental Health Access Worker  
Development Worker
- Bankstown  
Mental Health Worker

There is a need to review the adequacy and progress of this level of infrastructure for ATSI mental health. Extension of development opportunities is required to increase the education and training available to Aboriginal workers in mental health and non-Aboriginal workers in working in a culturally appropriate way.

### **The Way Forward**

In summary, key strategies for improving the mental health of ATSI people in south western Sydney during the next 3-5 years will include :

- Joint planning and evaluation at the local level between Aboriginal Community Controlled organisations, mental health, mainstream health and other community organisations. Of particular importance is the partnership with Tharawal Aboriginal Corporation.
- Increase in culturally appropriate mental health promotion, prevention and early intervention initiatives which are developed with, and owned by the local community.
- Improved treatment by mainstream and specialised mental health services through identification of early signs and symptoms, improved access points, appropriate referral and culturally appropriate interventions.
- Increase in ATSI people professionally trained in mental health improvement and service provision, and non-Aboriginal health workers who have gained skills in working with ATSI people.

## **9.3 Drug and Alcohol**

### **Background**

Smoking is twice as common amongst ATSI people than the general population. This puts people at increased risk of heart disease, cancer, respiratory disease, and other conditions. Whilst drinking is less prevalent amongst ATSI communities overall, the prevalence of heavy drinking is higher amongst ATSI people. Related issues of family violence, injury and sexual abuse have been long recognised. The use of illicit drugs and other harmful substances, particularly amongst youth, is also of concern (AIHW 2000) The SWSAHS Drug and Alcohol Plan (2001) has identified ATSI communities as a priority for prevention and treatment.

Consultations undertaken for this plan identified substance misuse and mental health as priorities to address. The consultation process identified the need for more effective partnerships to tackle the problems, the need for more drug and alcohol and mental health workers and culturally appropriate drug and alcohol services.

The Western Sydney Aboriginal Substance Misuse Regional Plan of the Marrin Weejali Aboriginal Corporation based in Western Sydney has consulted regarding the needs of ATSI people across the greater Western Sydney. Their plan identifies the need for halfway houses and rehabilitation places for ATSI people in the greater Western Sydney and identified the need for additional Aboriginal Drug and Alcohol Workers in each of the Area Health Services.

Of the total individuals seen by the Area Drug and Alcohol Centre staff for the calendar year of 1998, 2.7% or 22 people were from an Aboriginal or Torres Strait Islander background. A survey of existing public methadone services indicates comparatively high access of the services by people of Aboriginal and Torres Strait Islander background ie 7.7% indicating a substantial level of need for these communities. The ATSI Health planning group noted the need to provide adequate staffing and program resources to meet the differing needs of both genders and to address the complicated mental health issues associated with substance misuse in ATSI communities.

The following issues have been identified as significant in SWS:

- Difficulties in referring clients to mainstream services
- Need for the development of prevention programs with ATSI young people, particularly focusing on the senior primary years and intervening early with young people identified as at risk
- The prohibitive cost of services especially detoxification and rehabilitation services
- The lack of local or ATSI- specific treatment and rehabilitation services
- Need for increased collaboration between the AHS and NGOs (eg. Tharawal Aboriginal Corporation, Odyssey House) in the development of prevention strategies
- Integration with Corrections Health Services around key issues (drug courts, drug trials, infectious diseases)
- Increased focus on early intervention with the Aboriginal community - safe using, needle exchange, safe sex
- Need for improved data collection
- Training of Aboriginal staff in D & A issues.
- Need to improve access to AHS services, particularly to appropriate detoxification services
- A need to assess the adequacy/appropriateness of rehabilitation/ongoing support services

## **The Way Forward**

- Partnerships need to be developed between mainstream drug and alcohol services, other government and non-government organisations and Aboriginal controlled and managed services
- Development of effective health promotion and harm minimisation strategies in consultation with ATSI communities
- Increase in AHW specialising in drugs and alcohol. There is a need for a male and female ATSI D&A Counsellor in Macarthur and two extra AHWS in the northern sectors (Liverpool and Bankstown)
- Cultural appropriateness and re-orientation of the current treatment and rehabilitation services to improve their referral links and accessibility

## **9.4 Diabetes**

### **Background**

The onset of diabetes has been related to a number of risk factors: poor nutrition in foetal and early infant life; increased body fat; ageing; and, genetic factors. Physical activity is protective of diabetes onset. Diabetes can lead to a variety of conditions and complications including heart disease, stroke, blindness, kidney failure and neurological problems (AIHW 2000). Diabetes contributes to the high degree of circulatory disease encountered by Aboriginal and Torres Strait Islanders, which is the leading cause of death for non-communicable disease among Aboriginal and Torres Strait Islanders (Guest and O'Dea 1992). In Aboriginal and Torres Strait Islander adults, death due to circulatory disease occurs up to 10 times more than in the rest of the population. Prevalence of diabetes mellitus in Australian Aborigines is uncertain, but according to the National Diabetes Strategy (1998) prevalence rates among adults is between 10-30%, which is at least 2-4 times higher than for non-Indigenous Australians. Furthermore, younger Aboriginal and Torres Strait Islanders, that is, people aged between 15-30 years are developing Type 2 diabetes compared with the non-Aboriginal and Torres Strait Islander population between the ages of 40-60 years old.

### **Current Strategies**

The Aboriginal and Torres Strait Islander diabetes service within the south west of Sydney is presently located at Tharawal Aboriginal Corporation, Campbelltown and Hoxton Park Community Health, Liverpool. There are specialist clinics that operate from the Liverpool Local Lands Council (Gandangara), the Miller Community Health Centre and Hoxton Park Community Health Centre. Education and health promotion are fundamental components of the current strategy.

### **The Way Forward**

There is a need to fully evaluate the current diabetes service and strategies. There is a need to provide more expansive, community-oriented strategies with the capacity to prevent and intervene early in diabetes (London and Guthridge 1998). Imposed solutions are likely to increase dependency and powerlessness, without producing change (Reath and Usherwood 1998). Fundamental to a positive approach is the collaborative development of strategies which address the known risk factors and which focus on population health gain. It is important to re-orientate the current range of services so that they are culturally appropriate to ATSI people. There is also a need to transform the current service into a Diabetes/Cardio-vascular service. It is estimated that this would require up to three full-time AHW, a part-time community podiatrist, a community dietitian, a community midwife and additional equipment.

## **9.5 Cardiovascular Health**

### **Background**

The major cause of death amongst ATSI people is from cardiovascular disease (including heart, stroke and vascular disease). Whilst this is also true for the general population, deaths from cardiovascular disease occur in ATSI communities at about twice the rates of the general population. Whilst death rates for ATSI women have nationally been declining, death rates for ATSI men have not changed. Cardiovascular disease has a number of major risk factors such as: smoking, physical inactivity, poor nutrition and high consumption of alcohol, together with physiological risk factors such as high blood pressure, elevated blood lipids, obesity and diabetes (AIHW 2000). ATSI populations have known risk factors related to cardiovascular disease including:

- higher rates of obesity,
- twice as likely to smoke cigarettes
- whilst less drink alcohol, those who do drink are more likely to drink to excess
- twice the rate of diabetes of the general population
- less physical activity

Perhaps the clearest risk marker however is socio-economic status.

### **The Way Forward**

The promotion of cardiovascular health relates to reducing risk factors (smoking, weight loss, physical activity etc) and influencing the social, economic and environmental conditions related to risk factor development. In order to develop broad and sustainable prevention strategies, it is necessary to have strong partnerships with Aboriginal community organisations as well as with other government departments and agencies. The focus of cardiovascular health in SWS ATSI communities will be on primary and secondary prevention.

Comprehensive primary prevention would seek to promote risk factor assessment, improve access to primary prevention (via reminder systems, providing transport, provision of AHW). Secondary prevention would seek to modify risk factors and control symptoms. Positive primary care networks are therefore essential to foster.

Access to appropriate management and treatment services is also essential to reduce deaths, morbidity and improve the quality of life. Emergency treatment is crucial for acute events. Hospital services need to work with AHWs to ensure that staff practices support the access and care of ATSI peoples.

Fundamental to any change in ATSI cardiovascular health is the improvement of overall social health through community development and empowerment. The foundation for these is the partnership with TAC and with other government departments and organisations.

## **9.6 Infectious Diseases**

### **Background**

Data on comparable rates of infectious disease between ATSI and non-ATSI people derive from various sources. The available evidence suggests that rates of tuberculosis, haemophilus influenzae type B, meningococcal infection, salmonellosis, syphilis and gonococcal infections are higher for Indigenous people. Hepatitis is also a significant issue in Indigenous health (AIHW 2000).

The overall rate of notification of HIV for ATSI people is similar to that of non-ATSI people. However, whilst the rate for non-ATSI people has declined, the rate for ATSI people has not. In addition, the rate of infection of ATSI women was higher than for non-ATSI women (AIHW 2000).

### **The Way Forward**

There is a need for a comprehensive approach to reducing infectious diseases amongst ATSI people in SWS. Key components include:

- Building on the Partnerships with Tharawal Aboriginal Corporation and with other Aboriginal controlled organisations and groups
- Developing community agreed plans and strategies for prevention, early intervention and health promotion
- Developing an Aboriginal Sexual Health Service networked to the Liverpool Health Service
- Developing the expertise and understanding of AHWs
- Linking services with General Practitioners and other primary care providers

## **9.7 Oral Health**

### **Background**

Factors which may affect ATSI dental health include: age, exposure to fluorides, diet, preventive dental behaviours, smoking, alcohol consumption, stress, infection and immunity and access to services. Dental health is usually measured in terms of the number of decayed, missing or filled teeth. ATSI children and adults have been shown to have a greater burden of oral disease than the rest of the population (AIHW 2000).

## Current Strategies

The Tharawal Aboriginal Corporation dental service is situated in Campbelltown and is available to all people of an ATSI background in SWS. There is one Dental Officer and one Dental Assistant. The current waiting list for general treatment is around six months. The service is funded through the Commonwealth.

A partnership agreement exists between SWSAHS and Tharawal Aboriginal Corporation with the partnership committee meeting monthly. Campbelltown Community Health Centre Dental Clinic provides backup services when the dental service at Tharawal Aboriginal Corporation is unavailable.

ATSI referrals are automatically listed as priorities for all dental services in SWS.

## The Way Forward

There is a need for greater emphasis on prevention and early intervention dental services.

Key to developing optimally accessible services is the early appointment of ATSI dental assistants through the state funded program which pays 75% of salaries and wages for the first year whilst training is being undertaken. In the second year, these positions would be sustainable on full pay as they could be absorbed in vacancies.

There is also a need to develop ATSI-specific dental session(s) (2-3 hours) in selected clinics in SWS. This would provide greater access to ATSI peoples and would be developed in collaboration with the local ATSI community and TAC.

## 10. KEY CHALLENGES TO IMPROVE ATSI HEALTH

The consultations and evaluation raise a number of common issues as key challenges to improving Aboriginal Health: These challenges or goals are also consistent with the state-wide Aboriginal health plan and policy.

### 10.1 Key Challenge 1: Partnerships

Partnerships with Aboriginal communities and organizations in developing policies, plans and in providing services is the most powerful underlying theme of the SWS community consultations and is also the foundation of the NSW Government's policy commitments.

The local Partnership Agreement between Tharawal Aboriginal Corporation and SWSAHS recognizes the holistic approach of health service delivery to Aboriginal people and supports the principles of:

- *Aboriginal self-determination-allowing Aboriginal people to determine policy and service direction for themselves*
- *Partnership between Aboriginal and non-Aboriginal people*
- *Intersectoral collaboration*

### 10.2 Key Challenge 2: Addressing Identified Priority Health Issues

Local consultations and epidemiological research clearly identify a number of critical health problems that are leading to high rates of illness, disability and premature death amongst Aboriginal people. However, the need for agreed priority areas and a realistic number of outcomes is recognized, as expressed in the Evaluation of the 1993 Strategic Plan:

*“The first strategic plan was visionary in the goals and strategies that it proposed with twenty-one priority issues identified. The lack of measurable objectives and targets coupled with poor monitoring and reporting mechanisms means it is difficult to assess if progress has been made in improving Aboriginal health in SWS. It will be important in developing the next strategic plan to set a number of measurable objectives and targets in a smaller number of health areas. A routine monitoring and reporting mechanism should be put in place to enable progress to be tracked.”*

The priority health issues for those consulted include child and youth health, mental health, diabetes, drug and alcohol, cardiovascular health, infectious diseases and oral health. This is supported by epidemiological findings documented at Appendix 2 in this document.

To significantly improve Aboriginal health in these priority areas there must be commitment to prevention and early intervention. A framework for working has been outlined in Diagram 1.

As stated in the goals of the local partnership Agreement with Tharawal Aboriginal Corporation, this requires an enhancement of primary health care services for the Aboriginal community. Health improvement will also necessitate tackling some of the social determinants of health through community development and intersectoral collaboration.

### **10.3 Key Challenge 3: Improving Access**

The community consultations emphasized difficulty in accessing health services and this is confirmed in the major NSW policy and planning documents.

*"The range of primary health providers in NSW comprises ACCHs, health services provided through the public health system and GPs. Studies reveal that whilst Aboriginal people under-utilise the public health system and GP services their use of inpatient services is high. A range of issues impact on the access to and utilisation of primary health care services, including distance, cost, lack of information and cultural insensitivity" NSW Aboriginal Health Strategic Plan 1999.*

The evaluation of the previous Strategic Plan emphasizes the need to integrate Aboriginal health into all parts of SWSAHS activity.

*"As the Aboriginal population in SWS represents a small proportion of the population the needs of Aboriginal people are often invisible in mainstream services...however, if effective action is to be taken to address Aboriginal health then the involvement of mainstream service is essential."*

Engagement of the wider health care system will need to focus on providing opportunities and resources to adapt or develop services to meet the needs of Aboriginal people.

### **10.4 Key Challenge 4: Organisational Commitment**

The evaluation of the 1993 plan for Aboriginal health identified increased levels of activity in the past two years that

*"appears to be the result of increased levels of organizational commitment and an expanded Aboriginal health workforce."*

However, as was also raised in the community consultations, a number of areas of supportive infrastructure need to be put in place if the current rate of progress is to be sustained:

- A practical commitment to monitoring and evaluation so as to measure the effectiveness of health improvement strategies. Progress must be monitored to sustain improvement, drive necessary changes and to identify "Better Practices" that work well in addressing Aboriginal health issues.
- A funding base for Aboriginal staff and programs that is not predominantly one-off or otherwise short term. Funding needs to be part of the mainstream budget and be long term and equitable.
- A human resource strategy that leads to skilled and supported workforce.
- Clarification of the roles of Aboriginal Health Workers in SWSAHS and Tharawal Aboriginal Corporation in relation to mainstream services.
- A leadership approach to Aboriginal health by Senior Managers through a long- term commitment to measurable health improvement and equitable resource allocation.
- A commitment to developing senior Aboriginal health management in SWSAHS.
- A full evaluation of this health plan. Through the Partnership, indicators with which to evaluate structures, processes and outcomes of the Strategic Plan will be developed. A working party comprising Aboriginal community representatives and staff, senior members of the Division of Population Health and the Area Director, Planning will be convened. It is the intention of the Evaluation component of the Strategic Plan first to measure utilisation of appropriate structures and adherence with specified processes and, second, to identify potential surrogate indicators of progress towards better health.

## 11. STRATEGIC DIRECTIONS

### KEY CHALLENGE 1: PARTNERSHIPS

Links: Ensuring Progress in ATSI Health – NSW ATSI Health Policy 1999, Strategic Direction 2.1  
NSW ATSI Health Strategic Plan, Supportive Strategy A  
SWSAHS Strategic Directions Statement and Implementation Plan 1998-2003, Key Challenge 3

Rationale: The aim of the NSW Health ATSI Partnership Agreement is to ensure that the expertise of ATSI people is brought to health care processes in NSW.  
*“ATSI community collaboration is essential for understanding the community context and for planning, delivering and monitoring services that are appropriate for ATSI people. It is widely accepted that service delivery will be most effective when ATSI participation has occurred” Ensuring Progress in ATSI Health – NSW ATSI Health Policy 1999.*

	Objective	Strategy	Time Frame	Performance Indicator	Responsibility	Resources
1.1	To support and improve partnerships between all levels in SWSAHS and the ATSI Community Controlled Sector	Continued development and support for the Partnership Agreement  Initiate innovative arrangements between AHS clinical programs, GPs and Tharawal Aboriginal Corporation to integrate primary health care with specialist services to improve:  - the coverage and quality of service - the continuity of care from primary health care to specialist services	Annually  March 2002	Existing partnership is reviewed annually and improvements planned  A number of joint services and strategic alliances are established in priority health areas	Aboriginal Partnership Committee  Aboriginal Partnership Committee, Division of General Practice	
1.2	To have an acceptable and appropriate process of ATSI community participation	Develop and implement a policy for ATSI community participation across SWS  Integrate community participation within existing arrangements  Develop and support an appropriate community accepted reference group focusing on ATSI Children to promote: - Effective consultation - Effective community involvement - Effective ownership of services and data	June 2002  ongoing  June 2002	Policy adopted by Partnership Committee and Board  Area/Sector Plans to implement the approach in place  Evidence that community based reference group is established	Manager Community Participation  Director, Division of Planning  Area Director Population Health	

1.3	To address social and economic determinants affecting ATSI Health	Establish formal arrangements with key Government departments, ATSI community controlled sectors including outside area agencies.	December 2002	Evidence of intersectoral participation	CEO, Aboriginal Partnership Committee,	
				Participation in a number of intersectoral projects	CEO, Aboriginal Partnership Committee	
				Evidence of increased local community development projects	CEO, Aboriginal Partnership Committee	
		Develop Partnership action plans to address social issues that affect the health of ATSI people.	December 2001	Action plans developed and agreed by Partnership Committees and Division of General Practice	CEO, Aboriginal Partnership Committee, Division of General Practice	
		Strengthen the local approach to Disease prevention through Health Promotion (HP) and community development.	Ongoing	Evidence of best practice approaches and increased resources, including availability and accountability of SWSAHS staff	Aboriginal Partnership Committee, GM's	
1.4	To work in Partnership with GPs, Tharawal Aboriginal Corporation and SWSAHS	Develop a service agreement between Division of GPs, Tharawal Aboriginal Corporation and SWSAHS including: <ul style="list-style-type: none"> <li>- Policies and protocols</li> <li>- Cooperative projects</li> <li>- Mutual training opportunities</li> </ul>	June 2003	Formal agreements documented	Aboriginal Partnership Committee, GM's, ATSI Health Coordinator, Division of General Practice	
				Number of cooperative efforts		
				Number of exchanges of training opportunities		



		Commit to longer term, relevant and sustainable holistic and culturally relevant health promotion programs with local communities	2001 - 2006	Evidence of Increased investment in longer term program development and action, in relation to ATSI Health needs	Director Health Promotion, CEO, GM's	
<b>CHILD and YOUTH HEALTH</b>						
2.3	To improve the Health of ATSI Children and Youth living in South Western Sydney.	Develop and support home visiting for all pregnant ATSI women and infants living in South Western Sydney.	December 2002	Macarthur Health Service Pilot Model evaluated. Preferred model implemented throughout SWSAHS.  Recommended model operational with required resources.	GM Macarthur, Director Community Paediatrics	ATSI Child Maternal Health Team  ATSI Child Maternal Health Team
		Development of Early Child Development Program for ATSI infants, prior to school entry in partnership with Families First Community Kids Program	June 2002	Evidence of established programs	GM's and Developmental Paediatricians, Paediatric Mental Health, Division of General Practice	
	To improve the Health of ATSI Children and Youth living in South Western Sydney (contd)	Expansion of early intervention programs for ATSI children with identified developmental delay	December 2002	Evidence that increased numbers of children with developmental delay are seen by early intervention program	GM's and Developmental Paediatricians, Division of General Practice	
		Enhancement of medical services for ATSI children and youth	December 2001	Evidence of increased access to ENT and other child development services.	Director Health System Reform, Division of General Practice	
		Development of mental health services for ATSI children and youth	June 2002	Evidence of established mental health services for ATSI children and youth	Area Director Mental Health	
		Establishment of ATSI Child and Youth Health Team in SWSAHS	June 2002 June 2003	Macarthur team established Northern Sector Team established	GM Macarthur CEO, G.M's	

<b>MENTAL HEALTH</b>						
2.4	Develop and implement Area-wide and local strategies to ensure the delivery of appropriate Mental Health Services (including Early Intervention and Promotion/Prevention Interventions) to ATSI people	Provide a framework in SWS for service provision and health improvement that achieves the goals of the National and NSW ATSI Mental Health plans and policies	June 2002	Framework exists and review conducted of existing services and programs based on the strategies presented in National, State and SWSAHS plans and policies	Area Director of Mental Health, Division of General Practice	National Mental Health Funding (NMH)
			June 2002	Sub Committee of the Area Mental Health Advisory Committee established to support the review	Area Director of Mental Health	
			December 2002	Review recommendations and framework endorsed by appropriate bodies such as the SWS Partnership Committee for ATSI Health (Tharawal Aboriginal Corporation and SWSAHS)	Area Director of Mental Health	
		Establish a planning process at Sector level based on the issues documented in the review	December 2002	All stakeholders involved in the development of Sector action plans	Area Director Mental Health, Division of General Practice	NMH Funding
				ATSI people are involved in the planning and development of mental health services to ATSI communities	Area Director of Mental Health	
				Sector working parties are established to support the planning process	Area Director Mental Health, GM's	
	Develop Sector Action Plans that determine priorities for health improvement and service development	December 2002	Sector plans developed that are endorsed by the local ATSI communities	GMs	NMH Funding	

2.5	Provision of Mental Health Services to ATSI people in accordance with Sector Action Plans	Develop program plans for submission to the SWSAHS Mental Health Advisory Committee, the SWS ATSI Partnership Committee and the Centre for Mental Health	December 2002	Detailed program plans completed which include a summary of the proposed initiative, performance indicators/evaluation process and funding requirements	Area Director Mental Health	NMH Funding
		Implement funded programs and establish evaluation framework	June 2004	Increase the number of programs which are needs based, effectively implemented and evaluated	Area Director Mental Health	Enhancement Funding
	Develop ATSI specific Mental Health Services	Research a culturally appropriate best practice model of service, which includes appropriate care for dual diagnosed clients.	December 2002	Evidence of research models presented to Aboriginal Partnership Committee for endorsement.	Area Director of Mental Health, ATSI Partnership committee.	
		Services and model developed and implemented	2005	Funding allocated for development.	Area Director of Mental Health, Aboriginal Partnership Committee	
			2004	Facility plan (PFP) for mental health service completed	Director , Division of Planning	
2.6	Improved access for ATSI people to a range of Mental Health services.	Document current and required utilisation of general mental health services	December 2001	Clinical pathways for each service determined	Area Director Mental Health, Division of General Practice	NMH Funding
		Assess referral process and facilities for acceptability to ATSI people	December 2002	Recommendations implemented regarding referral process and facilities	Area Director Mental Health, Division of General Practice	NMH and Enhancement Funding
		Develop and implement culturally appropriate provision of services to ATSI people in community settings	June 2003	Service Agreements developed and implemented between mental health services and ATSI health services in accord with the Partnership Agreement between Tharawal Aboriginal Corporation and SWSAHS	Area Director Mental Health	Enhancement Funding

			June 2003	Evidence that early identification and treatment services are provided in relevant settings	Area Director Mental Health, Division of General Practice	
			June 2002	Evidence of increase in number of ATSI people accessing mental health services	Area Director Mental Health	
			December 2002	Evidence of increased number of conjoint interventions	Area Director Mental Health, Division of General Practice	
			June 2002	Specialist consultation/outreach services developed if required	Area Director Mental Health	
2.7	Improved provision of Mental Health Services to ATSI Workers and non-ATSI Mental Health Workers through Workforce Development, Education and Training Initiatives	Identify and provide education and training programs and work opportunities for ATSI health workers  Identify and provide education and training programs and work opportunities for non-ATSI health workers  Review the workforce infrastructure for ATSI mental health and develop workforce development strategies accordingly	June 2002	Skills and qualifications gained in mental health improvement and provision of services	Area Director Mental Health, Manager Area HR Development	NMH Funding
			June 2002	Skills and qualifications gained in mental health improvement and provision of services to ATSI Community.	Area Director Mental Health	NMH Funding
			June 2003	ATSI workers and non-ATSI workers are working collaboratively and effectively together, feel supported and valued  Service approaches match changing organisational and mental health service delivery trends	Area Director Mental Health, Manager Area HR Development	

<b>DRUG AND ALCOHOL</b>						
2.8	To reduce the impact of Drug and Alcohol harm within the ATSI community.	Review and develop appropriate referral links	July 2002	Evidence of improved referral links	Area Director of Drug and Alcohol, Division of General Practice	Projects and training costs
		Develop formal agreements between the Department of Corrections Case Management Strategy, Area and Sector D & A services for ATSI people	December 2002	Evidence of improved access to D & A prevention and treatment services by post-prison release ATSI people	Area Director of Drug and Alcohol	
		Develop formal partnership links between the Youth Drug Court Project and Tharawal Aboriginal Corporation for the provision of support services	April 2002	Evidence of improved access to support services for ATSI Drug Court Project clients	Area Director of Drug and Alcohol	
		Include ATSI young people as specific target group in the AHS Agreement developed with the Department of Education and Training and in Sector Agreements with DET, DOCS and Juvenile Justice regarding cooperation and support for JJ establishments and school based prevention and education programs (refer Strategy 2.1.6 of the Area D & A Strategic Plan)	June 2002	Agreements developed include specific reference of support for ATSI focused programs	CEO	
			February 2002	Agreement with JJ, DOCS, and DET regarding the cooperation and support for prevention programs in JJ and DET established.	CEO	Project/Program Costs
2.9	To develop prevention programs in drug and alcohol	Work with schools and JJ to pilot and implement prevention and health education programs in relation to Drug and Alcohol use targeting <ul style="list-style-type: none"> <li>• ATSI children in the senior primary years</li> <li>• ATSI young people who have been identified as at risk</li> </ul>	December 2002	Evidence of programs being developed, piloted and evaluated	Area Director of Drug and Alcohol  Area ATSI Health Coordinator	Project costs
2.10	Increase access to a greater range of high quality and appropriate rehabilitation and treatment Services	Investigate the appropriateness of current models of Ambulatory Detoxification for ATSI clients and develop protocols for ATSI access which may include employment of ATSI staff, staff training and collaboration with other relevant services such as Tharawal Aboriginal Corporation and GPs.	December 2002	Evidence of improved access to ambulatory services and rehabilitation services by ATSI clients	Area Director of Drug and Alcohol, Division of General Practice	

		Investigate the impact of the current charging policies on ATSI access to detoxification and rehabilitation services	June 2002	Report on costs of services provided to Area Partnership Committee	Area Director of Drug and Alcohol	
		Work with Marrin Weejali (ATSI D & A Referral Centre) and Tharawal Aboriginal Corporation in the planning and development of appropriate D & A rehabilitation services for South Western Sydney including post-rehabilitation community support	February 2002		Area Director Drug and Alcohol, Area ATSI Health Coordinator	
2.11	Improve the level and standard of Data Collection relating to D & A Issues and Services for the ATSI Community	Assess the adequacy of the D & A Minimum Data Set and advise the Department of Health of any gaps for inclusion in the CHID model to be developed	June 2002	Report on drug and alcohol minimum data set provided	Area Director of Drug and Alcohol, Area ATSI Health Coordinator	
<b>CARDIO-VASCULAR HEALTH</b>						
2.12	Develop and Provide services and program which address CVD within the ATSI Community of SWS	Chronic and Complex Care Cardiovascular Sub-committee to ensure strategies are developed to enable greater access to this program for heart failure for ATSI and Torres Strait Islander people via Specialist Liaison Nurse.  Develop and implement ATSI appropriate health promotion and prevention strategies for coronary heart disease for ATSI health.  Work to address key determinants of health for coronary heart disease issues identified with ATSI communities.	December 2002  June 2002  June 2002	Evidence of Increased access to Chronic and Complex Care Program for heart failure.  Evidence of Accurate data/statistics collected and provided in CVD annual report  Health promotion and prevention strategies funded  Evidence of strategies developed and implemented that address key determinants.	Area Director Medical and Clinical Services Chronic and Complex Care Cardiovascular Sub-committee  Coronary Heart Disease Advisory Committee  Coronary Heart Disease Advisory Committee	Funds for Nurse

<b>DIABETES</b>						
2.13	To improve the Health of ATSI people who are at risk of Diabetes and who have Diabetes.	Evaluate the appropriateness and effectiveness of the current ATSI diabetic strategy.	December 2001	Evaluation of services documented.  Submission for proposed resources submitted to the Area ATSI Health Partnership Committee.	Director, Diabetes Clinic, Liverpool Hospital, Aboriginal Partnership Committee.	
		Develop and implement a strategy to address diabetes risk factors, which includes strategies to address structural problems.	June 2002	Strategy documented	Director of Diabetes. Director Health Promotion	
		Reorientation of existing mainstream staff and resources in providing culturally appropriate Diabetic care.	Ongoing	Evidence of improved acceptability	Director of Diabetes, Division of General Practice	
<b>INFECTIOUS DISEASES</b>						
2.14	Establish ATSI specific Sexual Health Services	Develop formal links between AHS, NGOs and Tharawal Aboriginal Corporation for appropriate STD service provision	June 2002	Evidence of Service Agreements developed	Area Director Public Health Unit	Funds for ATSI specific staff.
		Create and employ ATSI Sexual Health Workers	June 2002	Workers employed	Area Director Public Health Unit	
		Develop policies and procedures for training of staff to provide services	June 2002	Policies and procedures developed and training provided for staff	Area Director Public Health Unit	
	Develop a ATSI plan for infectious diseases	June 2003	- Review current documents - Establish committees that involve ATSI people - Plan accepted by Partnership Committee	Area Director Public Health Unit,		
	Develop and implement area wide strategies to prevent and Intervene in the early treatment of infectious diseases					

<b>ORAL HEALTH</b>						
2.15	Improve ATSI oral health through improved access to services	Increased the number of identified ATSI positions within SWSAHS Dental services	December 2002 Ongoing	Evidence of increased ATSI people employed in dental health	Area Director of Dental Services	
		Increase dental health promotion programs targeting ATSI children	June 2003	Number of ATSI specific oral health promotion programs	Area Director of Dental Services	
		Establish links between Tharawal Aboriginal Corporation Dental Services and SWSAHS providers through the existing partnership agreement.	June 2002	Evidence of service agreements developed with Tharawal Aboriginal Corporation and SWSAH	Area Director of Dental Services Area Aboriginal Health Coordinator	
		Develop ATSI specific sessions in existing dental clinics in each sectors	June 2002	Number of ATSI specific clinics.	Area Director of Dental Services	

**KEY CHALLENGE 3: IMPROVING ACCESS**

Links: NSW ATSI Health Policy 1998, Strategic Direction 2.1  
 NSW ATSI Health Strategic Plan 1999, Key Priority 1  
 SWSAHS Strategic Directions Statement and Implementation Plan 1998-2003, Key Challenge 3

Rationale: *“ATSI people’s access to mainstream services can be limited by their cost, location, availability and continuity. The conflict that can occur between the cultural values that underpin the delivery of mainstream health services and the cultural practices and values of ATSI people may also be further barriers to access”* (Ensuring Progress in ATSI Health – NSW Health Policy 1999).

	<b>Objective</b>	<b>Strategy</b>	<b>Time Frame</b>	<b>Performance Indicator</b>	<b>Responsibility</b>	<b>Resources</b>
3.1	Reorientate Mainstream Services to meet the requirements of ATSI people	Increase outreach clinics  Develop innovative and culturally appropriate models of health care  Undertake an assessment of opportunities to the improve community transport to health facilities for ATSI people.	2001 - 2006  Annually  December 2001	Plan establishment of outreach clinics and joint projects in targeted health issues  Evidence of adaptations to mainstream services  Report on transport issues and health access submitted to Partnership Committee	Aboriginal Partnership Committee  CEO, GM'S  CEO, Aboriginal Partnership Committee	

3.2	To promote the critical role that ATSI staff play in improving ATSI people's access to services and the ability of services to address ATSI cultural issues	<p>Implement the NSW Health System's ATSI Employment strategy with particular attention to improved employment, retention and career development of ATSI people at all levels and in all occupations.</p> <p>Sector General Managers and Divisional Heads to monitor that all plans have input from the ATSI Health Coordinator and/or other ATSI staff and resource people.</p>	<p>June 2003</p> <p>Annually</p>	<p>Evidence of progress against NSW Strategy including numbers employed, staff turnover rates, and numbers in training</p> <p>Evidence that the SWS ATSI Strategic plan is incorporated into all plans across SWSAHS and that ATSI issues and concerns are considered and incorporated in all Area plans</p>	<p>CEO, GM's</p> <p>Director of Planning, GM's</p>	
3.3	To have skillful and knowledgeable non-ATSI staff to provide culturally sensitive services and to work in partnership with the ATSI community	<p>Improve recruitment, selection and induction of new staff in ways that encourage better service delivery for ATSI people</p> <p>Review, update and standardise an approach to cultural awareness training</p> <p>Compulsory cultural awareness education incorporated into induction packages and specific in-service training for all SWSAHS staff</p>	<p>Ongoing</p> <p>June 2002</p> <p>June 2002</p>	<p>Meeting held to determine key issues.</p> <p>Evidence of Improvement in agreed issue areas</p> <p>Review undertaken</p> <p>Evidence of implementation of review findings</p> <p>Cultural awareness education is implemented</p>	<p>CEO, GM's, Director Human Resources, ATSI Health Coordinator</p> <p>Director of Business Services, Area Aboriginal Health Coordinator</p> <p>Director of Business Services, GM's</p>	
3.4	To measure and improve the satisfaction level of ATSI people as consumers of Area health services	<p>Implement an accessible, fair and culturally sensitive complaint resolution process</p> <p>Incorporate feedback from patients and the community into action</p>	<p>December 2002</p> <p>Ongoing</p>	<p>Evidence of complaint mechanism is operational</p> <p>Evidence that consumer survey/complaints actioned</p>	<p>CEO, GM's</p> <p>CEO, GM's</p>	

**KEY CHALLENGE 4: ORGANISATIONAL COMMITMENT**

Links: *Ensuring Progress in ATSI Health*, NSW ATSI Health Policy 1998, Strategic Directions 3.1, 3.3, 4.1, 4.2  
 NSW ATSI Health Strategic Plan 1999, Supportive Strategies D and E, Key Priority 4  
 SWSAHS Strategic Directions Statement and Implementation Plan 1998-2003, Key Challenge 5

Rationale: *"The evaluation identified increased levels of activity in the past two years, which appears to be the result of increased levels of organisational commitment and an expanded ATSI health workforce. However, a number of issues need to be addressed if the current rate of progress needs to be sustained"* (Evaluation of the 1993 Strategic Plan for ATSI Health in SWSAHS 1999).

	<b>Objectives</b>	<b>Strategy</b>	<b>Time Frame</b>	<b>Performance Indicator</b>	<b>Responsibility</b>	<b>Resources</b>
4.1	To measure the effectiveness of all ATSI Health Improvement Strategies	<p>Include monitoring and evaluation processes in the implementation of all ATSI health plans, programs and strategies.</p> <p>Evaluation of SWSAHS 2006 Aboriginal Health Strategic 5 year Plan</p>	<p>Ongoing</p> <p>2006</p>	<p>Evidence that performance indicators are in place and reporting requirements followed</p> <p>Evaluation Report completed.</p>	<p>CEO, Aboriginal Partnership Committee, GM's</p> <p>CEO, Area Aboriginal Health Coordinator, Aboriginal Partnership Committee</p>	
4.2	To better inform the Area Health Service about ATSI Health Status and Needs	<p>Implement the NSW ATSI Health Information Strategy as it pertains to AHS activities</p> <p>Design and implement a strategy to increase identification of ATSI people using SWS services</p> <p>To research and prepare an Area specific ATSI epidemiological profile</p>	<p>December 2002</p> <p>December 2001</p> <p>June 2003</p>	<p>Evidence of Area progress against the NSW Strategy</p> <p>Evidence that strategies are implemented. Improved identification rates.</p> <p>An ATSI epidemiological profile is published two yearly</p>	<p>GM's, Aboriginal Health Coordinator, Division of General Practice</p> <p>GMs, ATSI Health Coordinator, Division of General Practice</p> <p>Director Epidemiology Unit, Division of General Practice</p>	
4.3	Support ATSI Health Staff in leading the Agenda in ATSI Health.	<p>Implement the NSW Health System's ATSI Employment Strategy with specific attention to:</p> <ul style="list-style-type: none"> <li>- developing skills and knowledge through a range of training and accredited educational opportunities</li> <li>- improving employment, retention and career development of ATSI people at all levels and in all occupations</li> <li>- facilitating the reciprocal transfer of skills between the AHS and ACCHS</li> </ul>	<p>June 2003</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>	<p>Evidence of Area progress against NSW Strategy</p> <p>Number of ATSI staff enrolled in training and education courses</p> <p>Report on ATSI employment, retention &amp; career development completed</p> <p>Report on skills transfer completed</p>	<p>Director of Business Services, Area Human Resources</p> <p>GM's, Area Human Resources</p> <p>Area Human Resources, ATSI Health Coordinator</p> <p>Partnership Committee</p>	

4.4	Provide secure and equitable funding for ATSI Health Positions and Programs in SWSAHS	Expenditure on ATSI health by SWSAHS monitored with an indication as to the source of all ATSI funds. Address in Area Resource Allocation Policy	December 2002	Evidence of designated ATSI health initiatives over 5 years	CEO, GM's	
4.5	To provide leadership and Commitment to ATSI Health Improvement over the long term	Establish a mechanism for determining separate roles and responsibilities for ATSI health for Managers, ATSI health staff and mainstream staff. Include areas in performance agreements related to ATSI Health	2001 - 2006	Evidence that roles and responsibilities in ATSI health are incorporated into job descriptions and performance agreements	CEO, GM,s	
		Establish a position of Director of ATSI Health at Senior Management level within SWSAHS	2002	Position established	CEO	Funding for position
4.6	Develop service capacity for effective health promotion with ATSI people living in south western Sydney	Provide resources to support ATSI health workers for ongoing expenses associated with ATSI health promotion and community development.	June 2002	Evidence of a secure and equitable goods and services budget for everyday programs.	GM's	Education Resources
		Improve capacity building of ATSI Staff throughout SWSAHS	June 2002	Evidence of workplace mentoring	CEO, GM's, Director of Business Services	
			Ongoing	Evidence of ATSI staff Health Promotion training	Area Director Health Promotion	
		Develop an ATSI health promotion program at area and sector level.	December 2002	Services and Programs are developed coordinated and supported across sectors	Area Director Health Promotion	
4.7	Evaluate the 2001 SWSAHS Aboriginal Health Plan	Undertake a full utilisation and health improvement evaluation of the plan	June 2002	Evaluation Working Party established - Develop utilisation baseline data - Develop surrogate indicators of improved health	CEO, Area Partnership Committee, Area ATSI Coordinator	Program Resource

	Evaluate the 2001 SWSAHS Aboriginal Health Plan (cont'd)		Annually	Compare baseline with available utilisation statistics	Area Director of Epidemiology	
			Annually	Apply surrogate indicators of progress	Area Director of Epidemiology	
			June 2004	Report on the mid-term implementation of the plan	Area ATSI Coordinator, Area Partnership Committee	
			February 2006	Full evaluation of the plan submitted	Area ATSI Coordinator, Area Partnership Committee	

**APPENDIX 1: DEMOGRAPHIC PROFILE OF ATSI COMMUNITIES IN SWS**

The data in this section is primarily based on the 1991 and 1996 Census of Population and Housing for New South Wales (NSW).

SWSAHS accounts for around 12% of the NSW population, or 3% of Australia's population. In the 1991 Census, the enumerated population for SWSAHS was 651,050 and in 1996 Census it increased to 705,789 people. Data related to SWSAHS resident populations, comprises seven Local Government Areas namely, Camden, Bankstown, Campbelltown, Fairfield, Liverpool, Wingecarribee and Wollondilly.

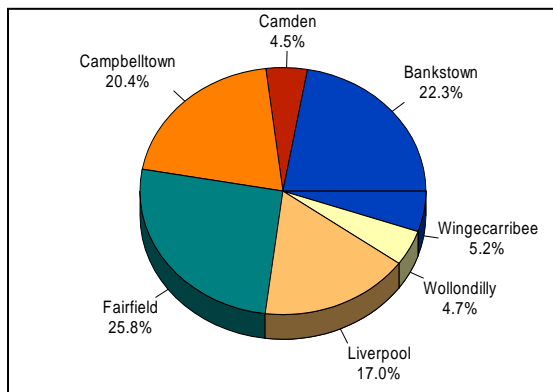
In 1996 there were 8,696 persons of Aboriginal or Torres Strait Islander (ATSI) background in SWSAHS representing 1.2% of the total population. This is the second highest population of ATSI by AHS region in NSW. During the period 1991-96, the number of persons of ATSI origin increased in both NSW (1.2% to 1.7%), SWSAHS (0.9% to 1.2%) and across SWSAHS LGAs (Table 1). It is not clear what has contributed to this increase, but it could include increased self-identification (increased reporting of Aboriginality), increased in-migration in NSW, or increased fertility in this population group. The highest proportion of ATSI was reported in Campbelltown (2.3%), followed by Liverpool (1.6%) and the lowest was in Bankstown. In total, SWSAHS has 8.6% of the ATSI population of NSW. In SWSAHS the largest ATSI communities are located in Campbelltown, followed by Liverpool and Fairfield. In SWSAHS, Campbelltown is the third most populated LGA (20.4% of SWSAHS population) and has the highest number SWSAHS ATSI population (37.4%). (Table 1, Figure 2 & Figure 3).

In SWSAHS, the ratio of males to females in the ATSI population and total population was 93.4:100 and 98.5:100 respectively (in NSW 97.4 for ATSI, 97.7 for total population). This indicates that there were more female than male ATSI people in SWSAHS. The age distribution of the ATSI and total population differs in that the ATSI in both SWSAHS and NSW are much younger. This reflects the high fertility and mortality rates of the ATSI population (Figure 4).

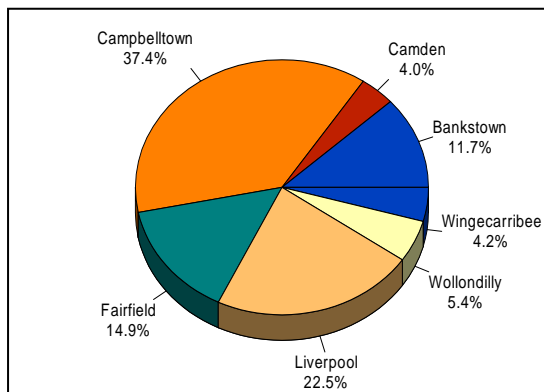
**Table 1. Percentage of Aboriginal and Torres Islander People in SWSAHS and NSW 1991-96**

LGA	1991		1996	
	Number	% Of total population	Number	% of total population
Bankstown	817	0.5	1018	0.6
Camden	103	0.5	347	1.1
Campbelltown	2148	1.6	3248	2.3
Fairfield	1074	0.6	1292	0.7
Liverpool	1271	1.3	1956	1.6
Wollondilly	247	0.8	473	1.3
Wingecarribee	184	0.6	362	1.1
<b>SWSAHS</b>	<b>5844</b>	<b>0.9</b>	<b>8696</b>	<b>1.2</b>
<b>NSW</b>	<b>70069</b>	<b>1.2</b>	<b>101485</b>	<b>1.7</b>

**Figure 2. Distribution of SWSAHS Population**



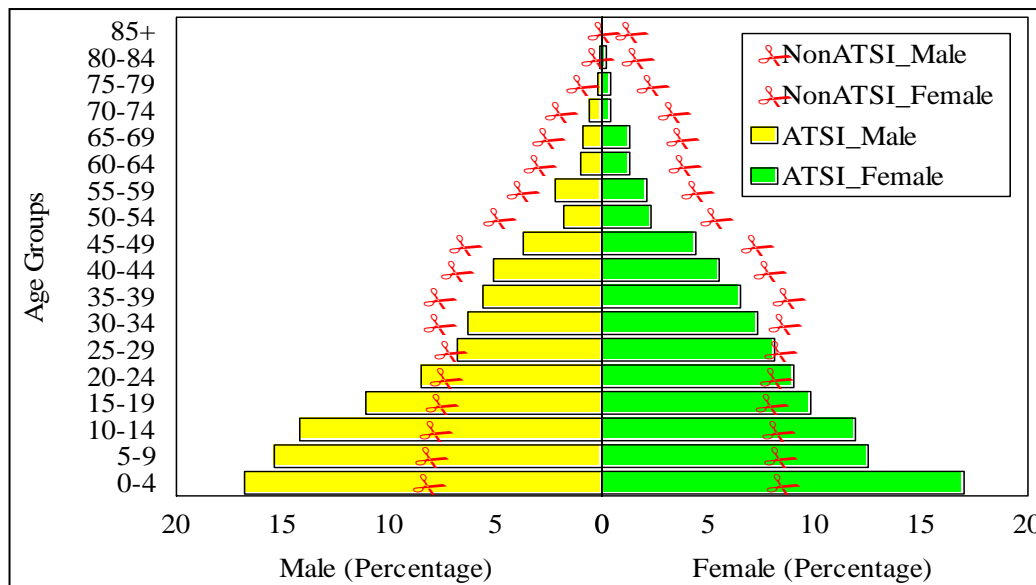
**Figure 3. Distribution of ATSI Population**



In SWSAHS, 43.7% (40.5% for NSW) of the ATSI population is under 15 years compared with 24.5% of the total population (21.4% for NSW). About 2% of the SWSAHS ATSI population are 65 years and over compared with 9.1% of the total population. This also indicates that the ATSI population in SWSAHS is younger than the NSW ATSI population (Figure 4).

These figures reflect the higher death rates and shorter life expectancy of the Indigenous population.

**Figure 4. Age-Sex Distribution of SWSAHS ATSI and Non-ATSI 1996**



ATSI people leave school at an earlier age than the total population. The proportion of ATSI persons by age left school showed that 43.3% of the SWSAHS and 40.6% of the NSW ATSI population left school before 16 years of age compared with 32.8% of the total population in SWSAHS and 32.3% for NSW (Table 2). The attained level of education indicates that ATSI population is less likely to hold formal qualifications than the total population. In SWSAHS, 66.3% of the ATSI populations had no formal qualifications compared with 55.2% of the total population (Table 2).

**Table 2. Selected Demographic Features of ATSI Population in SWSAHS Compared with NSW Population 1991 and 1996**

Selected Characteristics	ATSI Population		Total Population	
	SWSAHS %	NSW %	SWSAHS %	NSW %
The ratio of Males to Females	92.5	97.0	98.5	97.6
Age <15 years	43.7	40.5	24.5	21.4
Age 65 years +	2.0	2.4	9.1	12.7
Never Married	52.3	56.0	29.0	29.4
Age left school at 15 years or younger	43.3	40.6	32.8	32.3
Yearly Individual Income \$31,200 or above	10.4	8.0	17.1	20.8
Unemployed	15.4	11.2	10.8	8.8
Dwellings owned	34.6	29.9	67.4	67.6

Only 0.1% of ATSI hold postgraduate qualifications compared with 0.7% of the total population. The unemployment rate for ATSI population in SWSAHS was 15.4%, which was much higher than the unemployment rate in the total population (10.8%). The average individual income of the ATSI population is lower than that of the total population. About 67% of the ATSI population earned less than \$31,200 per annum compared with 58.4% of the total population (Table 2). ATSI occupied dwellings were less likely to be owned/purchased than the dwellings of the total population. In SWSAHS 34.6% of the ATSI population reside in owned/purchased dwellings compared with 67.4% of the total population. A higher percentage, (40.5%) of the SWSAHS ATSI population were living in housing commission/authority dwellings compared with 10.1% of the total population.

In summary, these figures show that Aboriginal people are socially disadvantaged compared to the rest of the community, with higher rates of unemployment, lower family weekly income and higher rates of families living in rented accommodation. This profile is similar to the ATSI profile across NSW.

## **APPENDIX 2: HEALTH PROFILE OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE.**

Health to Aboriginal people is not merely the absence of sickness. Rather, health is related to the broader concept of the spectrum of the social, spiritual, emotional and cultural well-being of the whole family and the whole community. The health of ATSI people also cannot be considered independently of the history of dispersal, dispossession, assimilation, loss and trauma. Policies of successive governments have contributed to the relatively poor health status of ATSI people. Thus, self-determination, the ongoing relationship to the land and community control is inextricably linked with the positive health of ATSI peoples. Positive strategies need to work from this social view of health, need to recognise the importance of intersectoral reform and community empowerment and development.

Due to difficulties in obtaining accurate or reliable data in relation to the health of Aboriginal and Torres Strait Islander people, area specific information is not reproduced. Where possible, data used describes the differences between the morbidity and mortality of people of Aboriginal people and the general population in NSW or in Australia where reliable NSW data is not available. Sources of the data have been the Australian Bureau of Statistics (ABS), 1999, the Report of the NSW Chief Health Officer, 2000 and the National ATSI Health Clearinghouse Summary of Indigenous health status, June 2000.

In determining the health priority areas for future strategic directions in SWS the following data was considered particularly relevant:

### **❖ Cardiovascular disease (CVD)**

Indigenous status is believed to be substantially under-reported in NSW hospital morbidity data so there is insufficient information at present to comment on the patterns or causes of death. However National figures from the ATSI Clearinghouse found the following differences in death rates between Indigenous people and the total population in 1995-97:

- . Overall cardiovascular deaths twice as high
- . Coronary heart disease-1.7 times higher
- . Stroke-3 times higher for males and 1.77 times higher for females
- . Rheumatic heart disease- 10 times higher for males and 13 times higher for females.

### **❖ Respiratory disease**

National ATSI Clearinghouse figures note that deaths from respiratory disease were 5 to 6 times more common for Indigenous people. Infective conditions were responsible for almost half the indigenous deaths from respiratory disease, and were 9-11 times more common than among non-indigenous Australians. Deaths from chronic respiratory disease were 3-5 times more common than expected from total Australian rates.

Indigenous hospitalisation rates were more than twice those of non-Indigenous people.

### **❖ Injury**

Nationally, death from injury is 3 to 3.5 times more common for Indigenous than non-Indigenous people and is the most common cause of hospitalisation for Indigenous males (excluding renal dialysis). The most common causes of injury-related hospital separations among Indigenous people were falls, interpersonal violence, transport accidents, suicide and self-inflicted injury and poisoning.

### **❖ Maternal and perinatal health**

Due to poor reporting of Indigenous status on perinatal death certificates in NSW, the most reliable source of information on Indigenous perinatal mortality in NSW is the NSW Midwives Data Collection (MDC). As the MDC only collects information on the Indigenous status of mothers, this is an underestimate of the total number of Indigenous babies. Over the period 1990-97 the perinatal mortality rate for babies of Indigenous mothers was about twice that for babies overall. The rate of low birth-weight babies has been over 10% since 1991. It was 10.5% in 1998 which is substantially higher than the rate for NSW overall, which was 6.0% in 1998. Similarly, the rate of prematurity in Indigenous babies has been over 10% since 1991 and was 10.6% in 1998. The overall rate for prematurity in NSW was 6.8%.

### **❖ Cancer**

The ATSI Clearinghouse found reasonable data for the incidence of cancer as only available for WA, SA and the NT. Overall between 1987 and 1996, the incidence of cancer was lower for Indigenous than non-Indigenous males, but rates for Indigenous and non-Indigenous females were very similar. In marked contrast, the death rates for cancer were generally much higher for Indigenous than for non-Indigenous people. A detailed analysis undertaken by the SA Cancer Registry concluded that the higher death rate among Indigenous people were due to the more advanced stage of the tumours at diagnosis and a lower survival rate for primary cancers matched by site, age at diagnosis, sex, year of diagnosis and, where possible, histological type.

#### ❖ **Diabetes**

The Report of the NSW Chief Health Officer 2000 found that:

Age-adjusted separation rates for diabetes mellitus amongst Indigenous people were about six times higher than for non-Indigenous people over the period 1993/4 to 1997/98. Estimates of diabetes prevalence among Indigenous people vary from 5 to 19%, compared with 2 to 7 % among Caucasian Australians. High rates of diabetes coupled with often-limited access to appropriate services results in high rates of hospital admissions for complications such as infection and kidney disease.

#### ❖ **Renal Disease**

The NSW Chief Health Officer reports in 1997/98 there were higher rates of haemodialysis in Indigenous males in rural NSW and Indigenous females in both rural and urban NSW than non-Indigenous people. While Indigenous people with end-stage renal disease (ESRD) tend to be younger than non-Indigenous people with ESRD, the survival of Indigenous people on dialysis is low (median 3.3 years compared with 6.5 years for non-Indigenous people).

#### ❖ **Drug and Alcohol Misuse**

Results of the 1997 and 1998 NSW Health Surveys indicate that there were higher rates of smoking and hazardous or harmful alcohol consumption in the Indigenous as compared to the non-Indigenous people of NSW.

#### ❖ **Mental Health**

The 1997, 1998, 1999 and 2000 NSW Health Surveys also show a higher level of psychosocial distress, as measured by a standard questionnaire (K10), among Indigenous people compared with non-Indigenous people. This was particularly apparent among younger and older Indigenous people.

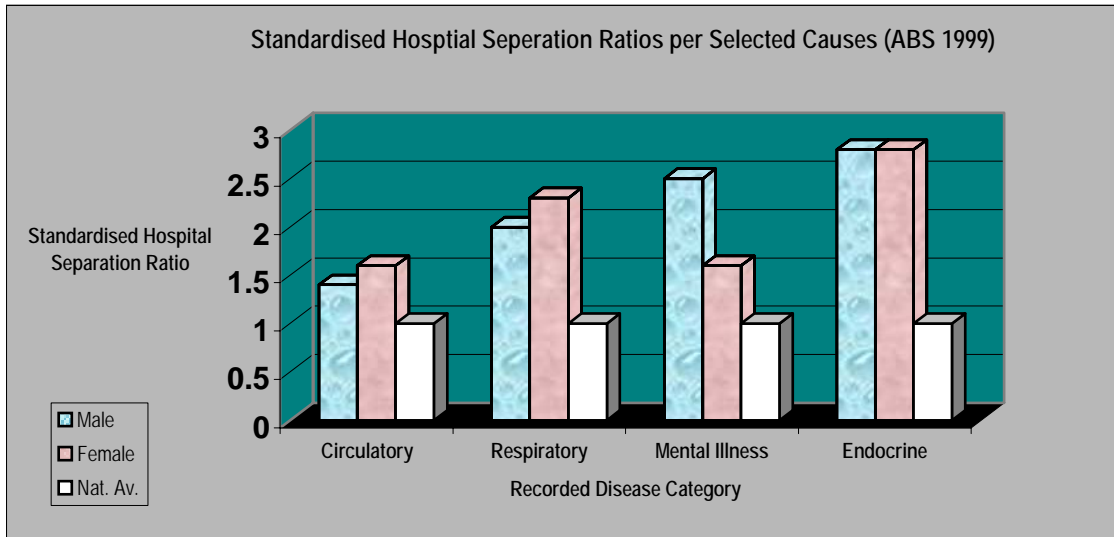
#### ❖ **Infectious diseases**

While Indigenous status is not reported for large portions of notifications for most disease, the ATSI Clearinghouse have collated information about specific communicable diseases from a variety of sources. Data for a number of diseases relevant to SWS, for 1996-98 follows:(when known, the proportion for which the question on Indigenous status was not answered is shown in parentheses)

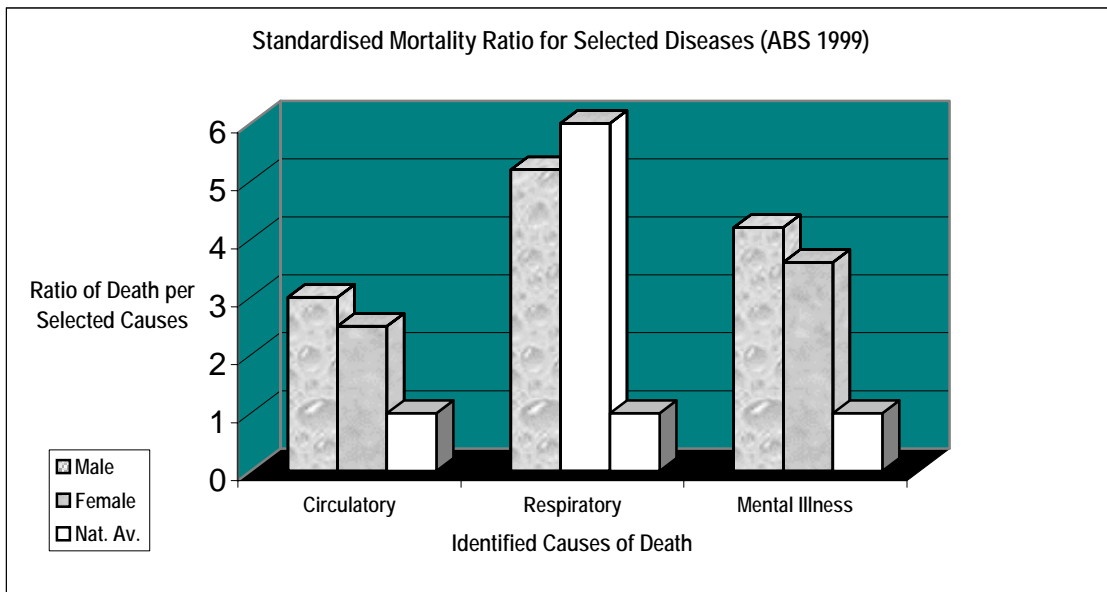
- Haemophilus influenzae type B- the notification rate for Indigenous people was 1.7 per 100,000, compared with 0.3 per 100,000 for the total Australian population (69%)
- Meningococcal infection- the notification rate for Indigenous people was 7.9% per 100,000, more than three times the all-Australian rate of 2.5% (48%)
- Salmonellosis- the notification rate for Indigenous people was 102 per 100,000, more than three times the all-Australian rate of 2.5 (48%)
- Syphilis- the notification rate was 115 per 100,000, compared with 6.9 per 100,000 for the total Australian population
- Gonococcal infection- the notification rate for Indigenous people was 619 per 100,000, compared with 33 per 100,00 for the total Australian population (38%)

The following graphs show ABS 1999 data for some of the most common causes of morbidity and mortality.

**Graph 1: Aboriginal SSRs for Selected Diseases (ABS 1999)**



**Graph 2: SMRs per Selected Causes (ABS 1999).**



In summary, in relation to overall mortality rates, the NSW Chief Health Officer reports some grim statistics,

*“In 1998, the reporting of indigenous status on death certificates improved, making it possible to examine indigenous mortality rates for the first time in NSW. After taking age into account, the death rate of indigenous people was 42% higher than non-indigenous people.”*

## **APPENDIX 3: CURRENT SWSAHS SERVICES**

### **ABORIGINAL HEALTH SERVICES**

#### **Area Aboriginal Health Coordinator**

Responsible for the co-ordination of Aboriginal Health Policy and program development across SWSAHS

#### **Area Aboriginal Employment Co-coordinator** (Temporary 12 months)

Responsible for the development and the implementation of the SWSAHS Aboriginal Employment Strategy

#### **Liverpool Health Service**

Team Manager, Child Mental Health Worker, Mental Health Worker, Mental Health Drug and Alcohol Worker, Health Education Worker, Hospital Liaison Officer and Aged Care Co-coordinator.

#### **Macarthur Health Service**

Team Manager, Program Coordinator, Youth Support Worker, Youth Drug and Alcohol worker, Child Protection Worker, Mental Health Access Worker and Development Worker, Otitis Media Co-ordinator (Temporary). The pilot Families First Aboriginal Home visiting program is currently being established.

#### **Fairfield Health Service**

Three Health Education Officers- Generalist, Youth, Outreach.

#### **Bankstown Health Service**

Three Health workers with a focus on Health Promotion and Women's Health

#### **Elsa Dixon Aboriginal Employment Project**

Fifteen Aboriginal people have been placed in a range of mainstream positions, for example Clerk, Administration Officer, Security Officer and Food Services Assistant.

There are currently no ATSI services in Wingecarribee.

### **MAINSTREAM HEALTH SERVICES**

#### **South Western Sydney Area Health Services**

SWSAHS is divided into 5 sector health services: Macarthur, Liverpool, Fairfield, Bankstown and Wingecarribee. Public sector health services in SWS are provided by hospitals, community health centres, nursing homes and specialist centres providing services such as rehabilitation, mental health and family and child.

There are six acute hospitals in SWSAHS- Liverpool, Fairfield, Bankstown-Lidcombe, Campbelltown, Camden and Bowral.

There are community health centres at Narellan, Campbelltown, Rosemeadow, Tahmoor, Bowral, Bankstown, Liverpool, Cabramatta, Carramar, Prairevale, Ingleburn, Yagoona, Moorebank and Hoxton Park. These centres provide community and outreach services.

There is one Aboriginal Hospital Liaison officer employed in SWS (Liverpool).

#### **Private and Charitable Hospitals**

There are 5 private hospitals in SWS. There are four day procedure centres and 28 nursing homes.

#### **General Practitioners**

There are 975 General Practitioners across the south west of Sydney. These are organised into five Divisions of General Practice – Fairfield, Liverpool, Bankstown, Macarthur and Southern Highlands. National data indicates an under-utilisation of GP services by ATSI people.

There are 5 Division of General Practice covering SWSAHS. These Divisions have specific programs targeting key health issues in their local areas

LGA	Number of General Practitioners
Bankstown	155 FT GPs 31 PT GPs 20 casual GPs
Camden	29 FT GPs 6 PT GPs 2 casual GPs
Campbelltown	120 FT GPs 10 PT GPs 7 casual GPs
Fairfield	FT GPs 9 PT GPs 11 casual GPs
Liverpool	111 FT GPs 13 PT GPs 12 casual GPs
Wingecarribee	T GPs 6 PT GPs 6 casual GPs
Wollondilly	12 FT GPs 2 PT GPs

Source; Health Insurance Commission 1997/98  
NSW Aboriginal Health Regional Plan

#### **APPENDIX 4: ABORIGINAL HEALTH COMMITTEE MEMBERSHIP**

- Christine Carriage- Aboriginal Program Co-ordinator Macarthur
- Jennifer Collins- General Manager Macarthur Health Service (Chair)
- Elizabeth Harris- Director, Centre for Health Equity, Training, Research and Education
- Pamela Garrett- Senior Planner
- Bin Jaludin- Deputy Director Epidemiology Unit
- Brendon Kelaher- SWSAHS ATSI Health Co-ordinator
- Karen McNulty- Senior Aboriginal Health Education Officer
- Kay Mundine- Chief Executive Officer Tharawal
- Victor Nossar- Director of Community Paediatrics
- Sharon Nicholson- Aboriginal Health Team Manager- Macarthur
- Mark Thornell- Business Manager, Division of Population Health
- Alison Sneddon- Deputy Director/Program Management Mental Health Promotion
- Dorothy Shipley Aboriginal Health Team Manager-Liverpool

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