Sydney South West Area Health Service

Aboriginal Health Plan 2010 - 2014

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Agendas for Action

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

Story behind the front cover art work:

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

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

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

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

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

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

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

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

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For additional hard copies, please contact Vicki Wade, Area Director Aboriginal Health, at the above address

Chief Executive's Message

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

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

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

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

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

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

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

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

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

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

Mike Wallace
Chief Executive

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1. Preamble

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

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

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

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

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

2. Format of Agendas for Action

The Agendas for Action that SSWAHS will be pursuing over the five years to 2012 are grouped within the priority health areas identified through consultation, review of the literature and steering committee advice and were developed by Priority Area Working Groups (PAWG) formed for each subject area:

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

For each priority health area a summary page is presented outlining:

- *Principles of Action* – what policy and listening to communities indicates are the important attributes of service delivery;
- *Model of Care* – up to ten main points summarising the way services will be delivered;
- *Action Initiatives* – the headline areas of action (specific actions are identified in templates for each).

For each *Action Initiative* a self-explanatory template format is used to identify the *goals* (target groups, benefits and performance indicator domains), *rationale* (history, data and best practice evidence), *responsibility* (roles of leaders and partners), specific *actions* (inc. timeframes and resource requirements) and the *links* to state and local policy (see Appendix 1 for the key to abbreviations used to notate the links to policy in State Plan, State Health Plan, *Two Ways Together* and the SSWAHS Strategic Plan).

SSWAHS will be challenging the gap through an integrated package of proposals that have been developed within a framework of *Principles for Progress* outlined in Volume 2 - emphasising holistic health, integrated responses by service providers, partnerships with communities and activities supportive to the primary care role of Aboriginal Community Controlled Health Organisations. A wide ranging set of initiatives are identified which build and expand on existing work and move forward into new areas of activity. Full impact on bridging the gap will require synergistic effect as an expanded Aboriginal health workforce engages with Aboriginal communities assisting them to build their capacity to address health issues, whilst at the same time SSWAHS makes the infrastructural, organisational culture and model of care changes necessary to ensure optimal results from service provision.

However, accountability for action requires a clear picture in each area of action of:

- *why* action is required (history, policy and health need);
- *who* will benefit (goals, target population, expected benefits, measures of success);
- *how* services will be provided (model of care, best practice, actions); and
- *responsibility* for action (leads, partners, timeframes and resource contingencies).

It is intended that each template can stand alone in the sense that it provides a story on the four issues above for each broad area of activity proposed. Only through clear delineation of intent and responsibility at this concrete level can there be any expectation that the synergistic impacts from application of the principles of holistic health, partnerships, integrated and supportive activities can be achieved.

3. Headline Areas of Action

Volume 2, *Principles for Progress*, outlines framework initiatives that will be applied across SSWAHS to ensure that closing the gap remains core organisational business. Those initiatives provide the supporting organisational infrastructure within which SSWAHS will focus on specific initiatives aimed at bridging the gap, both at a corporate level and in priority areas of health need. The headline areas of action include the following.

Corporate Initiatives (CI)

CI1 Audit protocol and checklist for mainstream services to assess access issues.
CI2 Embed cultural safety across services.
CI3 Embed use of Aboriginal Health Impact Statements (AHIS) across SSWAHS.
CI4 Implement the SSWAHS Aboriginal Workforce Strategy.
CI5 Enhancing mentoring frameworks and succession planning for senior SSWAHS Aboriginal staff.
CI6 Supporting and developing Aboriginal Health Worker networks across SSWAHS.
CI7 Ensure availability of transport does not impede the access of Aboriginal communities to SSWAHS services.
CI8 Coordinating extended support and social assistance to patients of SSWAHS facilities and their families over an episode of care to ensure they have the opportunity to fully benefit from the care offered.
CI9 Addressing data collection issues, gaps and opportunities to enhance research agendas.

Early Years, Children and Young People (EY)

EY1 Enhanced targeted support through pregnancy and during infant years (0-5) for Aboriginal children, their mothers and family units.
EY2 Integrated pathways – enhancing referral to mainstream services and providing supportive environments to ensure access and navigation across services.
EY3 Provide health education, health promotion, case management and streamlined referral pathways through an Aboriginal youth worker model outreaching to youth gathering places, with strong intersectoral links.
EY4 Support Aboriginal young people in schools, their families and broader communities through an intersectoral model for health education and promotion in high needs schools and at community venues for children and youth.

Chronic Diseases and Ageing (CA)

CA1 Implement Walgan Tilly solutions - culturally sensitive and effective discharge planning for Aboriginal patients 15+ years with chronic disease.
CA2 Implement the Aboriginal Chronic Care Program, including multidisciplinary, holistic chronic disease assessment, treatment and management through clinical outreach to primary care settings.
CA3 Health Promotion activities for Aboriginal people with or at risk of chronic disease.
CA4 Implement the SSWAHS Aboriginal Renal Health project.
CA5 Develop an electronic risk assessment and decision support tool for use in primary care settings with Aboriginal people at risk of developing cardiovascular disease.
CA6 Improving access of Aboriginal people to Aged Care Programs including TACP, ComPacks, CAPACS & ACATs - to optimise opportunities for their continued living at home within local communities.
CA7 Enhancing Healthy Ageing initiatives – improve access to health and human services and support for clients of Aboriginal day care centres.
CA8 Improved employment and training opportunities for Aboriginal people in Aged Care & Rehabilitation services in SSWAHS.
CA9 Implement the Sydney Diabetes Prevention Study (Aboriginal cohort) - lifestyle modification program for at risk people.

Mental Health

MH1 Expand partnerships and develop strong working relationships;
MH2 Develop accessible and responsive services;
MH3 Provide a skilled and supported workforce addressing Aboriginal mental health issues.

Drug Health

DH1 Prevention, health promotion and early intervention for Aboriginal people with substance use issues;
DH2 Develop and support partnerships between Drug Health Services (DHS), Aboriginal services and Aboriginal communities and other services within SSWAHS;
DH3 Enhance availability of clinical services for Aboriginal people with drug health issues;
DH4 Enhance the availability, skills level and organisational support for Aboriginal Health Workers in Drug Health Services (DHS).

Infectious Diseases and Sexual Health

IS1 Improving access for young Aboriginal people (16-24 years) through provision of outreach STI testing (urine only) at key gathering points for Aboriginal youth.
IS2 Provide comprehensive health information and education on sexual health issues to community groups at community based venues and support State & National campaigns at a local level.
IS3 Improve access and pathways to specialist care and associated services for people with Hepatitis C.
IS4 Strengthen the capacity of SSWAHS sexual health services through increased employment of Aboriginal staff and enhancement of their skills.
IS5 Enhance the participation of Aboriginal staff in the policy and planning development process for sexual health services in SSWAHS.
IS6 Advance issues of cultural safety and respect for identity of Aboriginal people within sexual health services.
IS7 Enhance surveillance of STIs in Aboriginal communities.
IS8 Engage more effectively with primary care providers of significance in Aboriginal communities.
IS9 Engage with Justice Health to provide post-release support on sexual health issues and engagement into treatment for former prisoners.

Oral Health

OH1 Increase access to mainstream publicly funded oral health services including engagement with the private sector through the Oral Health Fee for Service Scheme, the Pensioners Dental Scheme and the Medicare Enhanced Primary Care Scheme.
OH2 Emphasise oral health as an integral component of holistic care provision to Aboriginal communities within the context of preventative health measures (health promotion, education and early intervention).
OH3 Increase the number of SSWAHS workers and especially oral health professionals who have been trained in meeting the oral health needs of Aboriginal people in a culturally sensitive and supportive way.

4. Action Plans

Principles of Action

Aboriginal Workforce Development (WD)

WD1 Delineation of roles and competency frameworks for Aboriginal Health Workers;
WD2 Increase the use of Aboriginal designated specialty positions within clinical services, supplementing generalist AHWs;
WD3 Identification of skills, knowledge and experience of Aboriginal people in the public health system;
WD4 Participate in State networks of AHWs sharing a specialist interest e.g. sexual health, mental health, vascular disease;
WD5 Establish Area AHW networks to provide mutual support, access to management and a policy voice for AHWs;
WD6 Provide structured clinical supervision to support AHWs and ensure work is within competency levels;
WD7 Provide access to training and development focusing on Aboriginal health, both internally and externally;
WD8 Develop cross-agency training opportunities and placements including with ACCHS;
WD9 Increasing the number of Aboriginal Health Workers, meeting targets for % Aboriginal representation;
WD10 Work with the education sector to increase no. of Aboriginal students in health degree courses, incorporate Aboriginal health within curricula, support Aboriginal students;
WD11 Provide traineeship opportunities to contribute to the development of the Aboriginal Health workforce;
WD12 Provide mentoring to enhance work satisfaction, retain staff and foster career development;
WD13 Provide cultural awareness training to non-Aboriginal staff, including the line managers of AHW staff;
WD14 Develop strategies for workforce data collection, data improvement and performance indicators;
WD15 Apply the *Aboriginal Participation in Construction Guidelines* to tendered capital works projects.

Cultural Safety (CS)

CB1 Providing in-service training in Cultural Respect and Communication for staff in services seeing significant numbers of Aboriginal clientele;
CB2 Quality improvement activities to improve cultural awareness by service providers;
CB3 Inclusion of Aboriginal cultural competency as foundational content in training packages.
CB4 Organisational adoption of a strengths-based perspective of culture, diversity and identity;
CB5 Adopting processes for cultural self-assessment;
CB6 Providing culturally appropriate health education and promotion materials;
CB7 Involving family and carers in care planning;
CB8 Culturally appropriate protocols and models of care provided in culturally appropriate locations;
CB9 Community members as liaisons to optimise the benefit from mainstream services.

Access to Health Services (AH)

AH1 Creating culturally respectful and welcoming entry points to services;
AH2 Enhance cultural competency of non-Aboriginal staff working in services with significant numbers of Aboriginal clientele;
AH3 Increase Aboriginal designated positions in services with significant numbers of Aboriginal clientele;
AH4 Increase outreach of services to Aboriginal communities;
AH5 Coordinate non-emergency health transport needs of Aboriginal communities through consolidated Health Transport Units;
AH6 Establish Health Transport Networks to facilitate access to AHS and NGO health transport, NGO community transport and public transport;
AH7 Consider health transport needs of Aboriginal Communities in AHS Transport implementation Plans.

Extended Support to Patients and Families over a Course of Care (ES)

ES1 Support and expand capacity for ALO workforce in facilitating social support for Aboriginal clientele receiving care outside family networks;
ES2 Improve referral protocols for primary care providers in pre-admission preparation;
ES3 Enhance communication and referral links with human services agencies providing social support;
ES4 Enhance links with community support groups and NGOs engaged in the provision of social support.

Data Collection (DC)

DC1 Training for patient registration staff;
DC2 Identify key data items (inc. electronic) for Aboriginal Health and improve capture of Aboriginality;
DC3 Better profiling of SSWAHS Aboriginal workforce;
DC4 Improving measures of outcome in framework principles of holistic care, capacity building, partnership etc.

Corporate Initiatives (CI)

Model of Care

- Support expanded job opportunities, professional development, mentoring and networking of the Aboriginal workforce in SSWAHS;
- Expand training opportunities for Aboriginal students across SSWAHS;
- Improve cultural competency and cultural safety of mainstream service provision;
- Embed strengths based perspective in addressing Aboriginal Health;
- Increase outreach service provision to Aboriginal communities;
- Prioritise Aboriginal communities in AHS Transport Implementation Plans ;
- Expand liaison and linkages to social support for people in care without adequate supporting family networks;
- Identify and improve capture of Aboriginality in key data items for Aboriginal Health.

Action Initiatives

CI1 Audit protocol and checklist for mainstream services to assess access issues;
CI2 Embed cultural safety across services;
CI3 Embed use of Aboriginal Health Impact Statements (AHIS) across SSWAHS;
CI4 Implement the SSWAHS Aboriginal Workforce Strategy;
CI5 Enhancing mentoring frameworks and succession planning for SSWAHS Aboriginal staff;
CI6 Supporting and developing Aboriginal Health Worker networks across SSWAHS
CI7 Ensure availability of transport does not impede the access of Aboriginal communities to SSWAHS services;
CI8 Coordinating extended support and social assistance to patients of SSWAHS facilities and their families over an episode of care;
CI9 Addressing data collection issues, gaps and opportunities to enhance research agendas.

<table>
<tr><th colspan="2">CI1</th><th colspan="3">Audit protocol and checklist for mainstream services to assess access issues.</th><th>POA: CB2, CB5, AH1-4</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Mainstream clinical services i.e. those not necessarily targeting Aboriginal populations.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Self assessment and reflective consideration of whether services are making sufficient effort to attract Aboriginal clients.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">Services take up opportunity to audit their accessibility – no. audits undertaken.
Services make changes to improve accessibility – no. of initiatives identified to improve access.
Longer term – increases in use of services by Aboriginal communities.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Despite considerable policy attention nationally and at state level to increase access by Aboriginal communities to mainstream services, service use is generally considered to be sub optimal compared to health need. Nationally, expenditure on health services for urban Aboriginal people is less than for rural and remote counterparts and than for urban non-Aboriginal people. The barriers for urban Aboriginal communities in access have been well documented and relate to availability, affordability, acceptability and appropriateness. Surveys have shown that urban Aboriginal people were more likely than those in remote areas to report having not sought medical attention when needed. Overall Aboriginal people were more likely to have taken a health related action, with significantly higher rates reported for use of D&A, ED and mental health service usage. However, for hospital services, after adjustment for use of dialysis and for ambulatory care sensitive conditions the increased rate of usage by Aboriginal people is not as marked as the disparity in health need. Also, when hospitalised, Aboriginal Australians were less likely to receive a procedure e.g. 40% lower rate for key coronary investigations and procedures, such as coronary angiography and revascularisation.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">There is variation in the veracity of data collected on Aboriginality across mainstream services. Addressing Aboriginal access to mainstream services has not been approached in a systematic or formalised way at the individual service level. The focus on improving access has been through the enhancement of Aboriginal designated services and the placement of designated AHWs within clinical services of particular relevance to Aboriginal populations.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Improving access to mainstream services will require attention to all the barriers to access - availability, affordability, acceptability and appropriateness. Evolving paradigms of cultural safety and cultural competency would suggest that there is a role for services to undertake a self assessment and self reflective process to identify if access to their services by Aboriginal people is sub-optimal and what measures can be taken to improve access. This process could be structured in a way akin to use of the AHIS and undertaken formally in alignment with other quality improvement processes e.g. ACHS accreditation or performance review reporting.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Aboriginal Health Unit Bangala

Service Managers</td><td colspan="2">Develop audit tool, identify key criteria for assessing accessibility;
Undertake periodic accessibility audits in alignment with quality improvement programs.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Quality Improvement Officers</td><td colspan="2">Incorporation of process within quality improvement programs.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Identify the key criteria in assessing accessibility to mainstream services by Aboriginal populations.
Develop audit tool for self assessment of accessibility by mainstream services.
Pilot process in targeted mainstream services e.g. ACAT, CAPAC, cardiology, oncology, diabetes, rehabilitation, community health etc.
Review pilot and assess usefulness of process and validity of tool.
Incorporate self assessment process into quality improvement cycles.
Monitor, review and evaluate cost-benefit aspects of the process.</td><td>2009-10

2009-10

2010-11

2011
2011-12 onwards
2012-13 onwards</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Nil additional.</td><td>Internal</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, F3, F4, F5</td><td>1.2, 2.1, 2.2, 2.3, 2.5, 3.1, 3.2, 4.3</td><td>H, CH</td><td>4a.4, 2b.2, 1c.8, 3a.8.</td></tr>
</table>

CI2	Embed cultural safety across services.	POA: CB1-9
Goals	Who are we targeting	SSWAHS staff and service providers who engage Aboriginal and Torres Strait Islander people
	What benefit are we aiming for	To deliver an effective health service to Aboriginal and Torres Strait Islander people in SSWSAHS while respecting their cultural rights and values. To improve access to health services by Aboriginal and Torres Strait Islander people by ensuring services and facilities provide a culturally safe setting. Engaging the community to optimise utilisation of mainstream services.
	How will we know we have succeeded	**What we will measure (performance Indicators)** Cultural safety performance will be an integral part of the employee-provider performance evaluation system, and provider-organisation performance evaluation system. Cultural safety is embedded across all sectors of the system and at the corporate, organisational and care delivery levels. Feedback at the system and organisational levels on relevant key performance indicators and targets, continuous improvement of data and information collection and benchmarking to lift performance.
Rationale	What does current data tell us	Culture and the social behaviours surrounding it influence Aboriginal people's decisions about when and why they seek services, their acceptance or rejection of treatment, the likelihood of adherence to treatment and follow up, the likely success of prevention and health promotion strategies, the client's assessment of the quality of care and their views about services and staff. For many the hospitals and health centres are a reminder of inappropriate or substandard treatment of the past and are viewed as a continuation of the past. Building Cultural Safety reduces conflict, improves quality and outcomes, enhances efficiency and improves customer satisfaction. Management needs to change attitudes to facilitate changes in behaviour and ensure formal education and training as well as strong performance management processes to encourage good practice and culturally appropriate behaviour.
	The Story on what's happened till now	Cultural safety training has not been supported with change policy. Staff are often enthusiastic following training but have no opportunity to implement new skills.
	What do we know does or doesn't work	*What works* ▪ The needs and expectations of Aboriginal and Torres Strait Islander peoples are considered by mainstream policy-makers and planners during the planning, development, implementation, and evaluation of health services. ▪ Workplace management that is sensitive to cultural needs and risk management and that reflects cultural differences. ▪ It is important for workforce structure to reflect an appropriate balance of Aboriginal and skilled non-Aboriginal and Torres Strait Islander health professionals. *What doesn't work* ▪ Training non-Aboriginal staff in cultural safety with no opportunity to implement change in the workplace.

Responsibility		Who's Responsible	Their Role
	Who will lead?	Area Director Aboriginal Health Mainstream managers	Chair steering committee Implement and monitor framework objectives
		Who's partnering	**Their Role**
	Who will help?	Community representatives	

Actions		Our Actions	By when
	What we will do and by when	Cultural Safety Framework Working Group meets regularly	2010 onwards
		Development and integration of the framework with the participation and representation of top and middle management administrators, front line staff, consumers and/or their families, and community stakeholders	2010-11
		Development of a plan to integrate ongoing training and staff development into the overall Cultural Safety Framework	2010-11
		What additional resources do we need	**Source of funds**
		Nil additional.	Internal

Link	Plan	State Plan	State Health Plan	TWT	SSW Strategic Plan
	Reference	F1, P4	2.4, 2.5, 3.2, 4.3, 6.2, 6.3	H, CH, ED	4a.4, 6a.7, 2a.1, 2a.2, 2b.2

<table>
<tr><th>C13</th><th colspan="4">Embed use of Aboriginal Health Impact Statements (AHIS) across SSWAHS.</th><th>POA: CB2, CB5, CB8, CB9</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">SSWAHS staff and consultants involved in developing, implementing or evaluating policies or major health program initiatives in SSWAHS involving specifically targeted Aboriginal health initiatives.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Embedding use of AHIS across SSWAHS will ensure staff incorporate the health needs and interests of Aboriginal people in the development of new policies and major strategies. This will help ensure that the diverse health needs of Aboriginal people are respected and supported.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">AHU Bangala will keep a registry of completed AHIS. They will need to be completed for all processes impacting significantly on Aboriginal communities, including - clinical service plans; new service developments; funding submissions or proposals on Aboriginal Health in priority areas (child and maternal health; chronic disease e.g. diabetes, cardiovascular, renal, respiratory; sexual health; drug health; and mental health); new clinical service, health promotion projects, etc; research projects; new capital works developments/redevelopments; major policy developments inc. in employment strategies and eligibility criteria - applied at Area, zone or facility levels..</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Practical application of the NSW Government's recognition of Aboriginal peoples rights to self-determination and their role in determining where and how government responds to their needs and aspirations, requires communication and negotiation with Aboriginal people on how government services will be delivered. This is essential to ensure policies and programs are relevant to communities needs and can optimise access. Despite considerable policy attention on access to mainstream services, service use is generally considered to be sub-optimal compared to health need.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">In 2007 the NSW Health Aboriginal Health Impact Statement (AHIS) 2nd edition was implemented by NSW Health Department, it includes a checklist, identifies key stakeholders to be consulted and requires AHSs to identify the process by which consultation will occur.
SSWAHS has disseminated its own guidelines for completion of AHIS which mandate use across a wide range of processes (identified in performance indicators above).</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Good practice requires involvement of the AHU Bangala early in the process – identifying the best way for Aboriginal involvement and consultation to commence (may be through committee/working party representation and/or meetings throughout the development process). Ensuring the service/planning group is aware of what is in the AHIS checklist and identifying in writing consultation processes is important. AHIS are signed off by the Area Director Aboriginal Health and a copy retained by AHU Bangala. AHIS are mandatory for all major capital works developments which require a PDP.
Consultations need to take into account the real or potential impact on Aboriginal communities and the speed of the development process; at a minimum consultations are required with Area Director Aboriginal Health, Aboriginal organisations with which SSWAHS has a formal partnership with relevant to geographic catchment (currently Tharawal and Redfern ACCHS), local Land Councils and the SSWAHS Aboriginal Health Executive Committee. Consultation with Aboriginal community representatives and the broader Aboriginal community also where there is a significant impact on the community.
Consultation will only be adequate if it occurs as early as possible and if it is meaningful.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">AHU Bangala</td><td colspan="2">Provide education, advice and assistance on AHIS use to SSWAHS staff or consultants.
Keep a registry of completed AHIS.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS Health Services Planning Unit

SSWAHS Clinical Services</td><td colspan="2">Ensure AHIS are prepared for all planning processes impacting on Aboriginal communities.
Ensure AHIS are incorporated in new initiatives at the early stages of development.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">AHU Bangala to disseminate a local AHIS guide to SSWAHS Services.
AHU Bangala to develop and conduct AHIS education forums as required.
AHU Bangala to provide advice and assistance to staff that are required to undertake an AHIS.
Audit check of AHIS registry against reported developments meeting criteria for AHIS completion, to assess compliance rates.
Survey of AHIS users to identify scope for quality improvement</td><td>2009-10
2009-10 & ongoing

Ongoing

2010 & bi-annually.

2010 & periodically.</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">From within existing resources</td><td>Internal</td></tr>
<tr><td rowspan="2">Link</td><td rowspan="2">Plan Reference</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>F1, F4</td><td>2.1, 2.5, 3.2, 4.2, 4.3</td><td>H, CH</td><td>4a.4, 5b.2, 5b.5</td></tr>
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<tr><th>CI4</th><th colspan="4">Implement the SSWAHS Aboriginal Workforce Strategy</th><th>POA: WD1-3, WD7-14, DC3</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="4">All services funded by SSWAHS – mainstream and Aboriginal designated.
The existing and potential AHW workforce in SSWAHS.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Increased recruitment and retention of Aboriginal people to AHW and non-designated positions in mainstream services.
Training, skills enhancement and professional development for the Aboriginal workforce of SSWAHS.
Improved cultural awareness among the non-Aboriginal workforce of SSWAHS.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)
NSW public sector Aboriginal employment targets – 2.2% in 2008; 2.4% by 2013.
Numerical employment targets to be developed for each facility of SSWAHS.
Distribution of Aboriginal employment across salary ranges – target of 6% <$34K; 81% $34-63K; 13% >$63K.
Vacancy rate for designated and identified positions.
Retention rates for Aboriginal employees.
Rates of transition from traineeships to permanent employment.
Increased attendance at in-service training, increased professional development opportunities offered.
Increased cultural awareness training activities for non-Aboriginal staff of mainstream services.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">The degree of capture of Aboriginality within the employee database is unknown but may be under enumerated. In 2006-07, 1.3% (228 people) of SSWAHS staff identified as Aboriginal. At this level, to meet a 2.2% target would require up to an additional 160 Aboriginal staff to be identified i.e. a 69% increase in enumeration of Aboriginal staffing. Whole of organisation effort involving supportive and committed management action will be necessary to achieve the quantum increase in staff required.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">Aboriginal employment strategies were developed for the previously existing CSAHS and SWSAHS. These strategies were partly successful but were ineffective in establishing the workforce development momentum necessary to achieve the employment growth required to meet the NSW public sector targets.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">What works - supporting existing staff to achieve career goals, build skills and recruit new staff; highlighting opportunities and matching to talent identified through community networks; whole of organisation commitment to supporting initiatives; all managers taking a leadership role.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Facility and service managers
SSWAHS Centre for Education and Workforce Development.

Aboriginal Health Unit</td><td colspan="2">Leadership, commitment, identify opportunities.
Identify training needs and develop annual training agenda for Aboriginal employees or adapt current training courses for Aboriginal employees
Policy development, cultural awareness training</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Aboriginal employment and training organisations
SSWAHS Aboriginal staff
Schools and tertiary institutions</td><td colspan="2">Partner in identifying and nurturing recruitees.
Mentoring, identify talent in the community.
Partner in highlighting opportunities for students.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Implement the SSWAHS Aboriginal Workforce Strategy, including:
▪ employing Aboriginal people into vacancies, traineeships, apprenticeships and cadetships;
▪ advertising vacancies through local Aboriginal organisations and events and Aboriginal media;
▪ meeting recruitment targets;
▪ ensuring Aboriginal workforce distribution matches Aboriginal community health needs;
▪ establishing support infrastructure for all Aboriginal recruits;
▪ improving transition from traineeship to employment;
▪ encouraging identification;
▪ development of an Aboriginal employment website;
▪ conducting Healthwise career fairs for schools with high Aboriginal student populations using career ambassadors;
▪ training for existing AHWs and Aboriginal staff, including skills development, career coaching and mentoring;
▪ cultural awareness program and training for line managers.</td><td>Progressive implementation over period 2010-2013</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">From within existing resources.</td><td>Internal.</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, S5, P4</td><td>2.1, 2.5, 3.2, 4.2, 4.3, 6.1, 6.2, 6.3</td><td>H, CH, ED</td><td>6a.7, 6b.5, 6a.3, 6a.4, 6a.5, 6a.6</td></tr>
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<tr><th>CI5</th><th colspan="4">Enhancing mentoring frameworks and succession planning for senior SSWAHS Aboriginal staff</th><th colspan="2">POA: WD3, WD5, WD7, WD12</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="5">Aboriginal workforce in SSWAHS with leadership/seniority potential; Senior Aboriginal Officers Group (SAOG); Aboriginal Health Executive Team (AHET)</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="5">To promote and build a competent and skilled Senior Aboriginal Workforce within SSWAHS and to ensure leadership continuity through fostering an environment of continuous improvement and building of leadership skills and competence.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="5">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="5">▪ participation in Area-wide initiatives to promote Aboriginal Health;
▪ input into planning and evaluation of Area wide Aboriginal Health strategic directions;
▪ representation of SSWAHS Aboriginal Health at meetings, workshops and conferences;
▪ a higher skill level achieved by the SAOG and the AHET.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="5">The National Aboriginal Health Strategy aimed for a high level of participation in health decision-making processes and empowerment and self-determination are acknowledged as critical factors in achievement of health outcomes along with improved health information, health infrastructure, service provision, and access. Whilst passive community involvement in health and community support through fundraising or voluntary assistance is common, active leadership is required to influence program goals, implementation, or outcomes and make programs accountable to the communities they serve, inc. through articulation of their values and priorities. Real participation requires AHWs with management skills and tools in planning, implementation, monitoring, and evaluation.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="5">In October 2006 SSWAHS implemented a new Aboriginal Health Management Structure which included proposals for a SAOG comprising Senior AHWs and AHSMs working across SSWAHS. Separate to the AHET, this group will provide advocacy, leadership and cultural advice at the 'coal-face'. SAOG and AHET have developed a Succession Planning Action Plan aiming to promote and build a competent and skilled Senior Aboriginal Workforce within SSWAHS and to ensure leadership continuity through continuous improvement and building of leadership skills and competence. SAOG members will participate in Area-wide initiatives to promote, plan and evaluate Aboriginal Health strategic directions; communicate widely with SSWAHS AHWs and represent the SSWAHS Aboriginal workforce externally at meetings, workshops and conferences. Specifically, the Action Plan 2007-08 focuses on – a support structure of "critical friends"; culturally appropriate performance management systems; training opportunities, including leadership development programs; regular opportunities for staff to present their work internally and externally; establishment of trainee positions.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="5">Succession planning and mentoring involves partnerships which give employees the opportunity to share their professional and personal skills and experiences, and to grow and develop in the process. Mentoring is a cost effective powerful development strategy that contributes significantly to staff capacity development and organisational development. Mentoring can increase the representation of Aboriginal staff in mainstream management positions as well as:
▪ support the professional and career development of Aboriginal staff;
▪ establish activities and support strategies to enhance capacity of staff;
▪ build two-way learning partnerships between Aboriginal and non-Aboriginal staff;
▪ recognise and maximise the diversity and skills of staff;
▪ promote a culture of continuous and self-directed work based learning and leadership.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">Aboriginal Health Executive Team (AHET)

Senior Aboriginal Officers Group (SAOG)</td><td colspan="3">Sponsor SAOG, identify development opportunities, liaise with line managers.
Provide mentoring network, forum and structure for "critical friends".</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">Line Managers of AHWs
SSWAHS Centre for Education and Workforce Development.
External training agencies

Population Health</td><td colspan="3">Provide access to training and development.
Providing internal leadership development training opportunities
Providing access to external leadership development training opportunities.
Supporting mentoring network.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td colspan="2">By when</td></tr>
<tr><td colspan="3">▪ establish the SAOG in SSWAHS
▪ identify mentors from within SSWAHS
▪ develop Aboriginal mentoring package for SSWAHS
▪ Convene group meetings of mentors and Mentorees
▪ Undertake training need analysis for the SAOG and the AHET
▪ Develop training program for the SAOG and the AHET
▪ Implement training program for the SAOG and the AHET</td><td colspan="2">July 2009
July 2009
Aug 2009
2009-10 & ongoing
2009-10
2009-10
2010-11 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td colspan="2">Source of funds</td></tr>
<tr><td colspan="3">From existing resources</td><td colspan="2">NSW Health & Internal</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td colspan="2">SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, P4</td><td>3.2, 4.3, 6.1, 6.2, 6.3</td><td>H, CH, ED</td><td colspan="2">6a.7, 6b.5, 6a.9</td></tr>
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<tr><th>CI6</th><th colspan="3">Supporting and Developing Aboriginal Health Worker Networks across SSWAHS</th><th colspan="2">POA: WD3, WD4, WD5, CB4</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="4">SSWAHS Aboriginal Health Workers, SSWAHS Senior Aboriginal Officers Group and the Aboriginal Health Executive.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Ensure the Aboriginal Health Worker Forum provides an effective network for AHWs by providing:
▪ opportunities for Aboriginal Health Workers to present their work;
▪ a mechanism for consultation on a range of initiatives being planned for SSWAHS;
▪ a forum for the dissemination of new NSW Aboriginal Health policy;
▪ opportunities to improve collaborative efforts;
▪ a support group for Aboriginal health workers and managers.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)
▪ improved understanding of new Aboriginal Health policy;
▪ increased input into the development of new initiatives by Aboriginal health workers;
▪ increased collaborative activities.
▪ Forums conducted regularly i.e. 3 monthly.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">The 2006 review of management structures for Aboriginal health identified the following ;
▪ Networking across the Area is beneficial however workloads often prevent workers attending meetings
▪ Mainstream managers do not always understand the needs of the Aboriginal Health workers and Aboriginal community
▪ Some Aboriginal Health services and Aboriginal health workers had become isolated</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">Following establishment of SSWAHS, AHWs were able to provide input to development of a new SSWAHS Aboriginal health management model and structure. The Aboriginal Health Forum was established to provide professional support for Aboriginal health workers within the new management structure. There are 50 designated Aboriginal health Workers across SSWAHS. These positions in conjunction with mainstream services, provide a range of services to the Aboriginal people and communities including in mental health, AIDS/HIV/sexual health, Aboriginal aged day care, vascular health, health promotion, youth outreach program, Aboriginal family support, child and maternal health, drug health, hospital liaison and workforce development and employment.
The Aboriginal Health Forum played a key role in the review of management structures for Aboriginal Health in SSWAHS. The review looked into the critical work undertaken by AHWs across SSWAHS. Consistent with the recent Aboriginal Workforce Development Project (2006) report, AHWs are a dedicated workforce and the cornerstone to providing quality health care to their communities. Many of the AHWs have made significant inroads into breaking down the barriers to the provision of quality health care for Aboriginal communities. Their role also extends to activities that encourage cultural cohesion.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">What works – network arrangements facilitate peer support for AHWs and ensure all workers have a say in the development of Aboriginal Health services across SSWAHS.
What doesn't work – isolated AHWs working within clinical streams but without peer support or mechanisms for providing a united voice to management on the issues and required service responses in Aboriginal Health.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Aboriginal Health Executive</td><td colspan="2">Facilitate the Aboriginal Health Forum</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS Service Managers</td><td colspan="2">Support the Aboriginal Health Workers attendance</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Develop the Aboriginal Health Worker Forum yearly calendar</td><td>2009-10 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">No additional resources</td><td>Within existing</td></tr>
<tr><td rowspan="2">Link</td><td rowspan="2">Plan Reference</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>F1, S8</td><td>2.5, 3.2, 4.3, 6.1, 6.3</td><td>H, CH, ED</td><td>6a.7, 6b.5, 6a.9</td></tr>
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<tr><th>CI7</th><th colspan="4">Ensure availability of transport does not impede the access of Aboriginal communities to SSWAHS services.</th><th>POA: AH5-7</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal and Torres Strait Islander people with lack of access to private transport and patients and their families from rural NSW who travel to SSWAHS facilities for treatment.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">To improve access to hospital and community health services so that timely interventions can be made to improve the health outcomes of Aboriginal and Torres Strait Islander People.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)
• Improved knowledge and access to transport for patients
• Improved access to transport services by rural patients and families.
• A reduction in time spent by SSWAHS AHWs in providing transport for clients and patients, with corresponding increase in time spent on providing health programs.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Aboriginal communities on average have lower rates of car ownership and report at 3 times the rate of the broader community, difficulties getting to places they needed to go. Consultations identified considerable difficulties in the South West in using public transport to visit SSWAHS health facilities and in finding direct transport links in the Inner west, inc. from Redfern to RPAH. Navigating public transport can be particularly problematic for mothers with young children.
The Aboriginal Transport Conference held in Dubbo in 2004 with over 1000 AHWs attending identified critical transport issues for Aboriginal communities in access to renal and oncology services, coordination of the discharge process, ambulances, IPTAAS and the proportion of transport for health funding allocated to specific Aboriginal programs.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">Between 2003 and 2005, consultations with community transport providers identified needs for:
• discussions with the Ministry for Transport and government / non-government transport providers to ensure transport routes effectively link with hospitals
• grouping of patients to support growing numbers requiring health related transport
• a review of community transport within health
• better solutions to improve access for Aboriginal people to health services so staff can focus upon clinical care and promotion;
• improved transport options for Wingecarribee residents requiring regular hospital access;
• enhanced communication between transport providers and SSWAHS transport services
• a clearer picture of demand, recognising that services were unable to respond to many requests from the community for transport.
There are HACC funded Aboriginal community transport providers operating within SSWAHS e.g. Walomi Aboriginal Community Transport (around 30 clients and averaging 110 trips a month) covering the South West LGAs of Bankstown, Camden, Campbelltown, Fairfield, Liverpool and Wollondilly. Tharawal and Redfern ACCHS provide mini bus transport to SSWAHS facilities for medical appointments for some of their clients. NSW Ministry of Transport has employed a Statewide Aboriginal Transport Officer.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">No published good practice guidelines – a Statewide Aboriginal Transport Network has been tasked with identifying culturally appropriate best practice standards. The Aboriginal Transport Conference Dubbo 2004 recommended - regular meetings between ACCHS and mainstream transport providers; employment of Aboriginal transport development workers; permanent not pilot solutions supported by recurrent funding; develop partnerships, information sharing and networking; flexibility in funding, eligibility criteria and fees policies; cultural awareness training for admin and driver staff; improved MDS collection to reflect work undertaken e.g. to funerals.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS Transport Services

AHU Bangala</td><td colspan="2">Service review, strategy development, prepare information packages, provide transport directly.
Advice and assistance in developing culturally appropriate information.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">State Transit Authority, Private bus companies
Community transport services
ACCHS</td><td colspan="2">Partners in improving access to public transport.
Partners in improving access to community transport.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">• Review the provision of health related transport by Aboriginal health staff, identifying the ongoing transport demand that should be provided through SSWAHS Transport Services.
• Develop an Aboriginal TAG for all SSWAHS South West hospitals
• Advocate with NSW Health to review Aboriginal access to IPTAAS
• Develop IPTAAS information for rural and remote Aboriginal patients using SSWAHS facilities
• Develop strategies to improve patient access to services e.g. outreach clinics, improved public transport routes, coordinated group transport.</td><td>2009-10

2009-10
Ongoing
2009-10

2010 and ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">From within existing resources</td><td>Internal</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1</td><td>2.1, 2.4, 2.5, 3.2, 4.3</td><td>H, CH</td><td>2b.2, 2b.5, 3a.2, 2c.2.</td></tr>
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CI8	Coordinating extended support and social assistance to patients of SSWAHS facilities and their families to ensure they have the opportunity to fully benefit from the care offered.			POA: ES1-4
Goals – Who are we targeting	Aboriginal patients, their carers and family members travelling from rural and remote areas for treatment at SSWAHS health facilities.			
What benefit are we aiming for	Assisting patients, their carers and families to establish safe and healthy living arrangements whilst undergoing an episode of care at SSWAHS facilities.			
How will we know we have succeeded	**What we will measure (performance Indicators)**			
	Protocols/pathways established for dealing with the common support issues experienced by rural and remote patients, their carers and families. Increased identification and communication of support needs prior to commencement of care. Expanded range of accommodation options available including on hospital campus and in partnership with NGO and private providers.			
Rationale – What does current data tell us	Anecdotal evidence is that most Aboriginal patients from rural and remote areas require financial assistance in meeting the cost of their accommodation or that for their carers and family. IPTAAS can only meet a proportion of the cost of accommodation. Many patients require assistance in finding accommodation and in accessing financial resources for sustenance. Challenging aspects of these situations include lack of knowledge about IPTAAS, finding appropriate accommodation for children, providing meals and transport, helping multiple family members requiring support inc. those arriving without identity or beneficiary cards.			
The Story on what's happened till now	IPTAAS is available to Aboriginal patients and one escort travelling more than 100 km. IPTAAS meets only part of the cost of private accommodation and does not cover the cost of meals. Short term emergency accommodation may also be available under other arrangements e.g. DOH Rent Start Program, Hospital Samaritan funds, accommodation in Aboriginal Hostels or through approaching ACCHS for assistance. Until 2003, Aboriginal patients, families and carers could be accommodated at RPAH Queen Mary Building (QMB) Hostel and access hospital food. Following QMB closure discussions were initiated with the Ngadu Aboriginal Hostel Marrickville to reserve some accommodation but not finalised. From 2006, RPAH has leased Norland Hostel Ashfield Baptist Homes to provide hostel accommodation inc. bus transport to RPAH. Meals are not provided on site. In the longer term, culturally appropriate patient accommodation has been scoped within the RPAH Northwest Sector and Liverpool Hospital Stage 2 redevelopments. A brochure about RPAH services has been developed for rural Aboriginal patients and carers.			
What do we know does or doesn't work	A systematic response to these issues is required with organisational support to action within clear protocols and pathways. ALO and Social Work responses to complex and chaotic temporary living arrangements have been time consuming and sub-optimal. The time and pressure of responding to these issues has diverted ALOs from health enhancing aspects of their role and is responsible for significant burn-out, work dissatisfaction and retention difficulties.			
Responsibility – Who will lead?	**Who's Responsible**		**Their Role**	
	SSWAHS Corporate Services ALOs and Social Work Departments		Develop clear protocols and pathways for common support needs and include in SSWAHS Policy Manuals. Flexible application of protocols and pathways.	
Who will help?	**Who's partnering**		**Their Role**	
	Facility Managers DOH, NGO temporary accommodation providers, Govt welfare agencies, Aboriginal Hostels Ltd, ACCHS.		Flexible support to ALOS and social workers Partners in developing flexible approaches to temporary accommodation needs.	
Actions – What we will do and by when	**Our Actions**			**By when**
	Quantify and scope the ongoing level of support demand and the current resources devoted to meeting accommodation needs.			2009-10
	Identify degree to which needs will be met by newly constructed patient accommodation and develop a transition strategy till then.			2009-10
	Consult with rural AHS on needs of rural and remote people as identified in SSWAHS Carers Plan.			2010
	Improve IPTAAS packaging and communication with primary care providers.			2010
	Improve partnerships with Govt welfare agencies and emergency and temporary accommodation providers.			2010
	Develop clear protocols and pathways for ALOs and SW in addressing the commonly exhibited support issues.			2010
	Develop interagency MOU to address the collaborative activities required to address short term accommodation needs.			2010-11
	What additional resources do we need			**Source of funds**
	Address requirements for increased ALO presence cross SSWAHS facilities (+2) – also see CA1 Walgan Tilly initiative.			Internal.
Link – Plan	**State Plan**	**State Health Plan**	**TWT**	**SSW Strategic Plan**
Reference	F1, R4, S8	2.1, 2.4, 3.2, 4.3, 6.2	H, HO, CH	4a.4, 1b.4, 1b.5.

CI9	Addressing data collection issues, gaps and opportunities to enhance research agendas	POA: DC1-4

Section		
Goals	Who are we targeting	Health professionals and health service data collectors
Goals	What benefit are we aiming for	To improve the quality, comprehensiveness and scope of Aboriginal health information. To develop benchmarks to support continuous improvement in performance and outcomes and to support research.
Goals	How will we know we have succeeded	**What we will measure (performance Indicators)** ▪ Adoption of a standard question on indigenous status ▪ Improved identification rates ▪ Improved access to and accuracy of client information ▪ Training and support for data collectors ▪ Development / adoption of a data dictionary to support standardised data collection ▪ Data collection systems are compatible ▪ Development of a clear conceptual framework and a clear vision of the purpose of the performance ▪ measurement and research ▪ Standardised data collection systems ▪ Information governance.
Rationale	What does current data tell us	▪ Aboriginal people are under-identified. ▪ Development of analytical devices and capacity to help understand the data needs to be developed ▪ Lack of trend information of Aboriginal health status and risk behaviours ▪ Different data collection methods and systems across SSWAHS ▪ No coordinated analysis and interpretation of Aboriginal health data.
Rationale	The Story on what's happened till now	▪ Inconsistent collection practices when the data are collected ▪ Information is not easily transferred between eastern and western zones SSWAHS ▪ Data systems are not compatible with data not being transferable between systems ▪ Aboriginal people are 'over-researched' ▪ Research has occurred in a haphazard way with results not disseminated widely ▪ No Area-wide research agenda.
Rationale	What do we know does or doesn't work	*What works* ▪ Dedicated identified position to oversee data collection, analyses, interpretation and reporting of data

Responsibility		Who's Responsible	Their Role
	Who will lead?	Aboriginal Health Unit Clinical Stream/Program managers and AHW ISD	Coordinate audit of Aboriginal attendances Assess data / research needs Provide technical support
		Who's partnering	**Their Role**
	Who will help?	UWS / UNSW research facilities Population Health, CHETRE and REMS	Provide epidemiology and research expertise

Actions		Our Actions	By when
	What we will do and by when	▪ Audit Patient Information Systems to determine level of identification of Aboriginal and Torres Strait Islander people	2009-10
		▪ Clarify the minimum data set requirements for data collection	2010
		▪ Ensure all patient information systems have the capability and business rules in place to collect minimum data set on Aboriginality	2010-11
		▪ Incorporate the minimum data set across all streams of the Area Health service	2010-11
		▪ Establish data / research working group to develop strategies	2010
		▪ Establish research partnerships and collaborations with academic institutions and research stakeholders	2010-11
		▪ Develop and Implement a data management and research agenda	2010-11
		What additional resources do we need	**Source of funds**
		• Project Officer / epidemiologist	Internal
		• Infrastructure to support data collection systems	Internal

Link	Plan	State Plan	State Health Plan	TWT	SSW Strategic Plan
	Reference	F1	3.2, 4.3, 6.2, 7.2	H	7a.1, 7a.3, 7a.4, 7a.5.

4. Action Plans

Principles of Action (POA)

Planning and Protocols for Service Development (PP)

PP1 Community development approach emphasising capacity building and community participation
PP2 Early support and primary prevention approach
PP3 Reshaping mainstream and community services to be responsive to community priorities
PP4 Using evidence from culturally appropriate research and data collection to shape policy developments
PP5 Working within current Partnership arrangements

Capacity Building within Aboriginal Communities (CB)

CB1 Employ prevention approach
CB2 Engage communities in discussion about the issues they see as important for their children
CB3 Identify roles, responsibilities and actions to be taken by parents, young people and the whole community
CB4 Develop a communication strategy to inform families and the community about services available

Capacity Building of the Aboriginal Workforce (CBW)

CBW1 Identify skills and foster potential of Aboriginal health worker staff for career progression.
CBW2 Increase use of Aboriginal support workers in mainstream clinical services to support families

Integrated Pathways across Mainstream Services (IP)

IP1 Promotion of Aboriginal children as a priority focus for child health services
IP2 Training and guidelines for mainstream services on Aboriginal child and family health issues
IP3 Improved availability of culturally appropriate resources
IP4 Improved networking and pathways within health and with other human service agencies

Early Beginnings (EB)

EB1 Help parents to recognise potential or emerging child rearing issues and provide appropriate support
EB2 Continue implementation of joint home visiting programs (AHEOs, midwifes and ECH nurses) from pregnancy until at least first two years of life
EB3 Group and individual early literacy programs including book distribution
EB4 Provide mothers and families with access to smoking cessation programs
EB5 Educational strategies for Aboriginal parents on nutrition, immunisation, life skills etc
EB6 Strengthen partnerships to improve pre-schoolers access to support including childcare activities
EB7 Camps for young parents and babies
EB8 Strengthen partnerships with Housing Department

School Age Years (SA)

SA1 Provide support early in the emergence of problems to prevent issues becoming entrenched
SA2 Promote young people's social, emotional and cognitive development
SA3 Forge and reinforce young people's strong connection to families, schools and communities.
SA4 Strengthen agency partnerships to improve school connectedness and completion rates
SA5 Strengthen agency partnerships on provision of culturally specific information on relationships and lifestyle within the school curriculum
SA6 Provide resources on health areas of concern delivered through in-school education programs

Young People - High and Complex Needs (YP)

YP1 Support Aboriginal community elders to provide role models to Aboriginal youth
YP2 Develop and run groups for young men and women reinforcing community respect and pride.
YP3 Improve access for young mothers and fathers to "Schools as Community Centres" programs
YP4 Expand health promotion resources for youth
YP5 Strengthen partnerships with youth services
YP6 Expand availability of leadership and youth development programs
YP7 Expand availability of youth oriented cultural arts/music programs.

Model of Care

- Target Aboriginal families with children in gestation and up to 5 years, Aboriginal young people in school aged 8-18 and Aboriginal youth aged 15-24 with high and complex needs;
- Provide services within the context of community capacity building, fostering role modelling and leadership development;

Early Years, Children and Young People (EY)

- Provide services to strengthen connectedness of extended families;
- Early support and primary prevention focus in formative infant years;
- Early intervention and support to ameliorate emerging health impact issues
- Strengthen community knowledge and acceptability of, access to and supported navigation across mainstream services;
- Enhance the Aboriginal workforce within services for families, children and young people;
- Strengthen partnerships with ACCHS', NGOs and human services agencies;
- Expand culturally appropriate educational and health promotion programs;
- Engage with target populations in developing programs that reflect community needs and desires.

Action Initiatives

EY1 Enhanced targeted support through pregnancy and during infant years (0-5) for Aboriginal children, their mothers and family units.
EY2 Integrated pathways – enhancing referral to mainstream services and providing supportive environments to ensure access and navigation across services.
EY3 Provide health education, health promotion, case management and streamlined referral pathways through an intersectoral youth worker model outreaching to youth gathering places.
EY4 Support Aboriginal young people in schools, their families and broader communities through an intersectoral model for health education and promotion in high needs schools and at community venues for children and youth

EY1	Enhanced targeted support through pregnancy and during infant years (0-5) for Aboriginal children, their mothers and family units.	POA: PP 1-4, CB 1-4, EB 1-8

Goals	Who are we targeting	Women pregnant with Aboriginal babies, Aboriginal children 0-5 years, fathers and extended families.
	What benefit are we aiming for	Improved and/or increased - health of children, adoption of healthy lifestyles by families, social connectedness, childhood literacy skills, school retention, educational outcomes, and wellbeing in adulthood.
	How will we know we have succeeded	**What we will measure (performance Indicators)** **Antenatal** - no. attending antenatal care before 20 weeks gestation, tobacco smoking/alcohol use in pregnancy, no. breastfeeding at discharge, birth weights less than 2500gm, Infant mortality; **Postnatal** - no. of targeted women accessing antenatal sustained home visiting (two years), no. breastfeeding for 6-12 months, age-appropriate infant immunisation rates, under 5 years mortality; **Process** - availability of culturally accessible information, no. staff trained etc.
Rationale	What does current data tell us	46.6% of Aboriginal mothers single compared with 10.6% of all mothers; Perinatal death rate for Aboriginal babies of 29.6 per 1,000 compared to 8.4 for all babies (2001); 39.7% of Aboriginal women are breastfeeding compared to 72.4% of all mothers (Inner West); Aboriginal children in NSW three times more likely to be in care and protection orders; Preschoolers exposed to passive smoking through a higher incidence of adult smokers; Anecdotally – child behavioural problems, poor attendance at preschools and readiness for school; Internationally, 7 – 8 times higher diabetes among young urban Aboriginal people; "Food in Redfern Project" found poor access to cheap food supermarkets.
	The Story on what's happened till now	School completion by Aboriginal people is significantly lower than in the broader community. International research indicates that the mother's level of education has a significant impact on child mortality, baby birth weight, and the amount of language exposure children have. As a mother's education level increases, childhood mortality decreases, birth weight increases and the child's exposure to language increases. There is also a strong correlation between multiple disadvantage (including educational disadvantage) and predictors for sexual risk taking and personal safety. Currently sustained home visiting is available to all Aboriginal teenage mothers across SSWAHS, but restricted for other vulnerable Aboriginal mothers to Macarthur, Fairfield, Liverpool and Bankstown only. The SSWAHS Overweight & Obesity Prevention & Management Plan 08-12 (OOPM) focuses on infant & child weight.
	What do we know does or doesn't work	Intensive nurse home visiting programs in the antenatal period results in decreases in hypertension of pregnancy, smoking, prematurity and low birth weight, higher breast feeding rates and teenage mums are more likely to delay their next baby. Two years intensive postnatal home visiting increases rates of immunisation and breast feeding and decreases accidental injury, child abuse and behavioural problems. Impacts extend into adolescence with reductions in problems relating to drugs, and rates of running away from home, delinquency and arrests, substance abuse, dependency on welfare; and greater participation in the workforce. Strategies implemented in the early years (esp. <3 yrs) have a significant impact on development. Increased social connectedness decreases the level of child maltreatment and for youth reduces crime. Nutrition, otitis media and respiratory problems can be improved through breast feeding by mothers and by reduced smoking in pregnancy and in the home.

Responsibility		Who's Responsible	Their Role
	Who will lead?	Maternity Services	Antenatal assessment, promote healthy lifestyles, refer via pathway
		Child and Family Services	Sustained home visiting till 2 years for teenage and other vulnerable mothers, promote healthy lifestyles.
		Mental Health Services	Infant mental health programme and mainstream workforce training.
		Health Promotion	Providing support in developing resources and promoting relevant state-wide campaign resources to home visiting program teams. Develop programs promoting healthy weight in infants & children (A.1.2.4 of OOPM)
		Who's partnering	**Their Role**
	Who will help?	Redfern and Tharawal ACCHS'	Partner in providing sexual health and drug health resources, education programs & counselling for secondary school age children.
		DoCS	Early Literacy program
		Childcare Services	Parent engagement on nutrition and physical activity e.g. "Munch & Move"

Actions		Our Actions	By when
	What we will do and by when	Extend the joint home visiting program in first two years of life.	Funding dependant
		Establish an Early Literacy Program.	2010
		Offer smoking cessation and passive smoking education program	2010
		Develop a "Healthy and Happy Living Education Strategy" for Aboriginal parents on nutrition, breastfeeding, immunisation, active play, physical activity (inc. "Munch and Move"), lifestyle, life skills.	2010-11
		"Transition to School" programs to increase Aboriginal pre-schoolers enrolment in childcare, parental involvement in childcare activities, camps for young parents and babies.	2010-11 & ongoing
		With NSW DoH, implement the Pathways Project and AMIHS.	2009-10 & ongoing
		What additional resources do we need	**Source of funds**
		4 CFHNs: 2 SW; 1 AHEO to extend sustained home visiting to Inner West	External e.g. ACYFS
		Aboriginal Health Education Officer –South West	Internal

Link		State Plan	State Health Plan	TWT	SSW Strategic Plan
	Plan Reference	S3, F1, F4, F6, F7	1.1, 1.4, 3.2, 3.4, 4.2, 4.3, 5.1.	H, E, CH, FYP	3b.6, 4a.4, 3b.7, 6b.5, 3b.1, 3b.2.

<table>
<tr><th>EY2</th><th colspan="3">Integrated pathways – enhancing referral to mainstream services, providing supportive environments to ensure access and navigation across services.</th><th colspan="2">POA: CBW 1-2, PP 3-4, IP 1-4</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal communities of SSWAHS and the staff of mainstream services.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Improved community knowledge of service availability and capability of accessing these services, increased Aboriginal utilisation of mainstream and Aboriginal targeted services, increased understanding by mainstream services of Aboriginal cultural identity and improved service friendliness.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">Increases in utilisation by children of services such as oral health, speech pathology and counselling, community awareness of health options and pathways. For mainstream services Increased awareness of Aboriginal health services available, development of Aboriginal referral processes and pathways, understanding of Aboriginal cultural identity.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Child therapy and counselling services report few referrals and poor continuing attendance.
Child health services report little contact with and limited knowledge about the role of AHEOs.
Aboriginal health and non-health services report that they are often unaware of the range of SSWAHS services which could provide them with information and help and request contact names and numbers.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">There is a range of barriers to accessing mainstream health services - health staff use unfamiliar medical terminology, written information that families have difficulty reading, lack of understanding of family pressures or compassion when family is unable to cope; and many do not understand that more time is needed to explain health treatments and support the family than is customary. Families may feel isolated as the only Aboriginal person using the service, as the "poor" person in a group of wealthy parents or unaware of where to get help if in a LGA without Aboriginal infrastructure. There are insufficient Aboriginal health workers to develop sustained relationships or networks to support individual families. Many health services directed at preschool children are unaware of Aboriginal health staff available. In turn AHEOs and services are unaware of mainstream services available.
Workload management by mainstream services through geographical boundaries, waiting lists and reliance on centre based and time limited appointments, act as barriers to access for Aboriginal families who may have immediate needs, multiple and complex problems and transient living arrangements.
Parents report lack of communication or networking between services and that service "boundaries" limit their choice and may mean that they cannot get support if they move or live outside of the area of coverage of a hospital or community facility. Parents feel disempowered in approaching services and want help from staff who understand and are sympathetic to their needs, not judgemental.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Services which are flexible in referral processes and in the location and timing of intervention e.g.: screening and working at preschools, have higher referral levels and more success with intervention.
"Successful" mainstream services used by Aboriginal people - out-reach to Aboriginal communities rather than stay in a clinic; respond immediately; establish an ongoing and long term relationship with Aboriginal services and staff; waive service geographical restrictions; listen and respond without prescribed patter; accept that families cannot always keep to schedule; acknowledge anxieties by explaining in detail and accept that there are often multiple problems which will take longer to address.
Evidence based good practice for nutrition health programs emphasises community involvement, support and empowerment, multifaceted interventions and modifying strategies according to need.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who in SSWAHS will lead?</td><td>Who's Responsible</td><td colspan="3">Their Role</td></tr>
<tr><td>Aboriginal Health Unit
SSWAHS Facilities

Health Promotion Service
Human Resources</td><td colspan="3">Orientation/in-services to mainstream services and community services.
Promote TAG to Aboriginal patients and visitors & provide culturally appropriate resources in waiting rooms for Koori kids.
Advise and refer services in acquisition of culturally appropriate resources.
Recruitment of Aboriginal staff in key clinical services.</td></tr>
<tr><td rowspan="2">Who will help?</td><td>Who's partnering</td><td colspan="3">Their Role</td></tr>
<tr><td>Redfern & Tharawal AMS'
Dept of Community Services (DoCS)</td><td colspan="3">Develop promotional materials detailing services that AMS offer
Develop local directories of agencies (including contact details) which can support and assist Aboriginal families.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Develop guidelines/charter making Aboriginal children a "high" priority; requiring services implement practices responsive to Aboriginal families needs, covering intake, waiting list management, service location etc.
Extension early childhood counselling to South West and enhance AHP services
Ensure priority in provision of low cost/ loan equipment by all clinical services.
Audit and service redesign process to make all services more responsive to Aboriginal families' needs and cultural identity.
Increase availability of Aboriginal support workers in clinical services e.g. in EDs.
Pathways development within and between services/agencies inc. DoCS.
Develop directory and maps of local service availability
Promote TAG to Aboriginal patients and visitors
Provide cultural appropriate resources in waiting rooms for Koori kids.</td><td>2009-10

Funding dependant
2009-10
2009-10

2010
2009-10
2009-10
2009-10
2009-10</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">4 AHP to extend early childhood counselling to SW; 5 FTE to enhance AHPs</td><td>External e.g. ACYFS</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, F4, P4</td><td>2.1, 2.4, 2.5, 3.2, 4.3, 5.2.</td><td>H, CH, FYP</td><td>3b.6, 4a.4, 1b.2, 2b.2.</td></tr>
</table>

EY3	Provide health education, health promotion, case management and streamlined referral pathways through an Aboriginal youth worker model outreaching to youth gathering places, with strong intersectoral links.	POA: PP1-5, CB1-4, IP4, YP1-7

Section	Item	Detail
Goals	Who are we targeting	Aboriginal young people aged 15-24 with high and complex needs (AYHCN).
Goals	What benefit are we aiming for	Engagement of AYPHCN into culturally appropriate programs offering holistic case management inc. clinical, medical, nursing and counselling services, health promotion e.g. music program and focus on BBIs and STIs and programs on mental, physical, emotional, spiritual, cultural and social wellbeing.
Goals	How will we know we have succeeded	**What we will measure (performance Indicators)** No. accessing safer sex and harm minimisation resources; reduction in unplanned pregnancies, increases in youth networks and partnerships, access to clinical services inc. holistic case management, access to culturally appropriate youth programs, better Aboriginal identification on intake.
Rationale	What does current data tell us	A higher rate of Teenage births with almost 13% Aboriginal mothers aged 20 years and under, compared with 1.8 of all other mothers. Overrepresentation of Aboriginal people in health, Juvenile Justice (JJ) and adult judicial and welfare systems.
Rationale	The Story on what's happened till now	Many Aboriginal children, youth and families remain caught in a "vicious cycle of poverty" exacerbated by social justice issues (racial discrimination, pain, suffering, loss of land and cultural connectedness, disruption to family life, abuse, struggle for self-determination and self-governance) with poor education, health, housing and employment prospects. Younger age structures in Aboriginal communities (14% of the NSW Aboriginal population aged <5 yrs c.f. 7% of the total population) indicate high potential for Aboriginal youth disadvantage to be perpetuated (13% of families have 2 or more children, 40% of the pop. Is aged <14 years, 30% sole parent families, 6.3% of families receiving the Parenting Payment Support). Educational outcomes remain poor (26% of students achieve minimum reading levels in year 3 c.f. 92% of all students, 62% achieve minimum reading levels in year 5 c.f. 90% of all students). Youth leave school early - 33.3% <15 years c.f. 15% of all students, 86% complete year 10 c.f. 94% of all students, 36% complete year 12 c.f. 73% of all students.
Rationale	What do we know does or doesn't work	Young people grow to healthier adults and stand a better chance of avoiding risky behaviour when they experience and express strong connection to their families, schools and communities. Families need to form supportive relationships to networks of people they trust and can turn to for support and to a community that cares about what happens to them and their kids. Agencies need to work together, with the community and to empower Aboriginal communities and agencies. Partnerships to create connections to positive school environments ensure young people develop the resilience to avoid drugs use, violence and early sexual activity. Enhancement of as many individual, family and community strengths as possible instils a sense of connectedness and belonging. Collaborative approaches, evidence based with a focus on outcomes and using integrated service networks work best.

Responsibility

Who will lead? – Who's Responsible	Their Role
Youth Health Services SSWAHS	Delivery of health education programs to AYHCN in high needs schools, Youth Aboriginal Cultural Arts/Music programs, strengthen partnerships with NGO Youth Services and JJ, improve data collection, create and recruit Aboriginal Youth Health Education Officer positions, develop priority access strategy for AYHCN, provide case management of AYHCN, link with AMS..
Aboriginal Health Unit	Liaise with JJ, facilitate strategic planning, resource distribution to service providers, establish Working Group, help create and recruit Aboriginal Youth Health Education Officer positions.

Who will help? – Who's partnering	Their Role
SSWAHS sexual, mental & drug health services	Develop community programs/strategies, improve access to clinical services inc. outreach, provide case management, link to AMS.
Health Promotion Service	Work with youth health services on physical activity programs e.g. cycling.
Juvenile Justice, DOCS, Headspace	All these agencies facilitate AYHCN access to safer sex and harm minimisation resources and link to SSWAHS services.
DET	Facilitate referral links to "Schools as Community Centres" programs.

Actions – What we will do and by when

Our Actions	By when
Establish referral links to "Schools as Community Centres" programs	2009-10
Increase intra-service consultation for AYCHN strategic planning	2009-10
Health promotion campaign (what's available for youth within SSWAHS)	2009-10
Implement initiatives relevant to Aboriginal Youth from SSWAHS Youth Health Plan 2009-2013.	2009-10 & ongoing
Develop community programs/strategies based on needs analysis	Ongoing
Distribute Aboriginal appropriate resources to service providers	Ongoing
Partnership work with JJ to strengthen access to information and referral	2009-10 & ongoing
Partnership work with NGO Youth Services to reach AYHCN population	2009-10 & ongoing
Partnership work to develop Youth Aboriginal Cultural Arts/Music program	2009-10 & ongoing

What additional resources do we need	Source of funds
Aboriginal Youth Health Education Officer positions (2)	

Link

Plan Reference	State Plan	State Health Plan	TWT	SSW Strategic Plan
	S4, S5, F1, F4, P4	1.1, 1.6, 2.1, 3.1, 3.2, 3.4, 4.1, 4.3, 6.2	H, E, CH, FYP	3b.6, 4a.4, 6b.5, 1a.3, 1a.5, 2b.5, 3b.7

<table>
<tr><th>EY4</th><th colspan="5">Support Aboriginal young people in schools, their families and broader communities through an intersectoral model for health education and promotion in high needs schools and at community venues for children and youth.</th><th>POA: PP1-2, PP4-5, CB1-4, SA1-6</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="5">Aboriginal Young People In Schools (AYPIS), their families and broader communities</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="5">An increase in social and emotional wellbeing for Aboriginal young people in school by facilitating parents and caregivers engagement in the school community through school connectedness programs.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="5">What we will measure (performance Indicators)
Process indicators of Increases in no. of parents and caregivers engaging with schools, no. of schools developing connectedness programs and no. of school kids accessing breakfast and or lunch programs, accessing youth services and accessing health information and services in nutrition & lifestyle, drug, sexual, oral, mental health etc. Outcome indicators of improved transition to secondary school/tertiary study and employment, decreased rates of STIs and BBIs, Reduction of unplanned pregnancies amongst school aged young people.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="5">A higher rate of teenage births with almost 13% Aboriginal mothers aged 20 years and under, compared with 1.8% of all other mothers. Overrepresentation of Aboriginal people in health, judicial and welfare systems. Low literacy and numeracy rates among Aboriginal Young People in schools. High drop out rates of Aboriginal students between the ages of 10-18. Higher rates of unemployment for Young Aboriginal people.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="5">Many Aboriginal children, youth and families remain caught in a "vicious cycle of poverty" exacerbated by social justice issues (racial discrimination, pain, suffering, loss of land and cultural connectedness, disruption to family life, abuse, struggle for self-determination and self-governance) with poor education, health, housing and employment prospects. Younger age structures in Aboriginal communities (14% of the NSW Aboriginal population aged <5 yrs c.f. 7% of the total population) indicate high potential for Aboriginal youth disadvantage to be perpetuated (13% of families have 2 or more children, 40% of the pop. Is aged <14 years, 30% sole parent families, 6.3% of families receiving the Parenting Payment Support). Educational outcomes remain poor (26% of students achieve minimum reading levels in year 3 c.f. 92% of all students, 62% achieve minimum reading levels in year 5 c.f. 90% of all students). Youth leave school early - 33.3% <15 years c.f. 15% of all students, 86% complete year 10 c.f. 94% of all students, 36% complete year 12 c.f. 73% of all students.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="5">Young people grow to healthier adults and stand a better chance of avoiding risky behaviour when they experience and express strong connection to their families, schools and communities. Families need to form supportive relationships to networks of people they trust and can turn to for support and to a community that cares about what happens to them and their kids. Agencies need to work together, with the community and to empower Aboriginal communities and agencies. Partnerships to create connections to positive school environments ensure young people develop the resilience to avoid drugs use, violence and early sexual activity. Enhancement of as many individual, family and community strengths as possible instils a sense of connectedness and belonging. Collaborative approaches, evidence based with a focus on outcomes and using integrated service networks work best.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">SSWAHS Health Promotion Service

Drug Health, Mental Health, Youth Health Services

Drug Health & Sexual Health</td><td colspan="3">Assist with the distribution of youth health educational material e.g. Mind Matters and Community Matters youth educational resources.
Provide content material, up-skill school staff and consider co-delivery of educational sessions in high need schools, engage AYPIS into use of health services.
Liaise and work with school Aboriginal Liaison Officers utilising DET Aboriginal drug & sexual health teaching resources.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">AMS Redfern and Tharawal
Dept of Education and Training</td><td colspan="3">Co-deliver educational sessions in high need schools,
Identify, liaise with and facilitate sessions in high need schools, provide breakfast and gatehouse programs.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="4">Our Actions</td><td>By when</td></tr>
<tr><td colspan="4">Partnering with DET to address school connectedness in areas of:
▪ School environment and connectedness to the school e.g.: Gatehouse Project
▪ Access to on job training and job skills – with TAFEs, Unis and NGOs
▪ School education PDHPE programs through AHEOs and other AHWs
▪ Develop and extend social skills
▪ Young mothers completing education e.g. provide accessible child care
▪ Review curricula on life skills, relationship issues etc.
▪ Develop culturally specific information for young boys and girls
▪ Consider ways of providing free contraception.</td><td>2009-10 & ongoing</td></tr>
<tr><td colspan="4">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="4"></td><td></td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td colspan="2">TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>S5, S8, F1, F3,</td><td>1.1, 2.1, 3.1, 3.2, 4.2, 4.3, 5.1</td><td colspan="2">H, E, CH, FYP</td><td>3b.6, 4a.4, 1a.5, 1b.2, 1c.6.</td></tr>
</table>

Principles of Action (POA)

Self Management and Self Determination (SM)

SM1 Place individuals and the community at the centre of care.
SM2 Address health literacy, knowledge and cultural barriers to self management.
SM3 Enhance disease specific & generic self management skills
SM4 Encourage active patient involvement in decision making.
SM5 Comprehensive care planning developed in partnership between patients, families, carers and health workers.
SM6 Raise skill base and patient capacity to monitor symptoms, respond and cope appropriately.
SM7 Promote collaborative problem solving and goal setting.

Community Participation and Capacity Building (CP)

CP1 Ensure community members have knowledge of and ability to access health services.
CP2 Encourage those at risk of chronic disease to participate in effective community programs.
CP3 Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
CP4 Organize community resources to provide ongoing self-management support to patients
CP5 Advocate for improved interagency and intersectoral support for community interaction in healthy living activities.
CP6 Support community groups in access to health education and participation in healthy living programs.

Targeted Health Promotion across the Life Course (HP)

HP1 Tailor programs to affirm and reflect cultural values.
HP2 Build from the evidence base of what works in Aboriginal communities, informed by the translatable experience from other Indigenous communities.
HP3 Build on community strengths and enhance community capacity to create healthy living environments.
HP4 Community input at all levels of program planning, implementation, review and evaluation.
HP5 Reflect holistic health principles through a primary care focus on early intervention and prevention strategies.
HP6 Take a collaborative and partnerships approach.

Screening & Detection of Chronicity Precursors (SC)

SC1 Improve Aboriginal identification for SSWAHS service users and engage into screening for markers of chronic disease.
SC2 Increased screening activities in community settings.
SC3 Improved partnerships with primary care for early detection of precursors to chronic disease, inc. EPC.

Integrated Pathways across Mainstream Services (IP)

IP1 Improved discharge planning, assertive follow up and continuing management of chronic disease.
IP2 Improved access to mainstream support programs in the community inc. TACP, CAPAC etc.
IP3 Increased use of care planning, clinical pathways and case management where required.
IP4 Practical assistance in meeting appointments and navigating the health system.

Primary Health Care Approach (PH)

PH1 Support multifaceted interventions in communities.
PH2 Embed evidence-based guidelines into the daily clinical practice of primary care.
PH3 Ensure primary care providers can share evidence-based guidelines and information with patients to encourage their participation.
PH4 Integrate specialist expertise and primary care.

Coordination across Continuum of Care (CC)

CC1 For people with complex needs, case management that is goal directed and guideline based.
CC2 Regular, proactive planned contacts with a range of health workers reinforcing agreed care goals.
CC3 Patient registries, tracking, organised follow up and recall processes in place.

Enhanced Capacity of AHWs in Chronic Care (EC)

EC1 Training for AHWs in chronic care principles.
EC2 Support for AHWs in work to build the capacity of communities to create healthy living environments
EC3 Support initiatives to increase Aboriginal representation in the Aged Care workforce.

Model of Care

- Implement, consolidate and enhance spread of Walgan Tilly solutions, consistent with ACCAHSS.
- Enhance availability of screening for chronic disease and precursors in the community.
- Improve support to primary care providers in screening and disease management.
- Enhance community capacity to create healthy living environments and individual skills in chronic disease self management.
- Improve inter agency and inter sectoral coordination in continuity of care provision.
- Improve access to mainstream Aged Care support services in the community.

Action Initiatives

CA1 Implement Walgan Tilly solutions - culturally sensitive and effective discharge planning for Aboriginal patients 15+ years with chronic disease;
CA2 Implement the Aboriginal Chronic Care Program, including multidisciplinary, holistic chronic disease assessment, treatment and management through clinical outreach to primary care settings;
CA3 Health Promotion activities for Aboriginal people with or at risk of chronic disease;
CA4 Implement the SSWAHS Aboriginal Renal Health Project;
CA5 Develop an electronic risk assessment and decision support tool for use in primary care settings with Aboriginal people at risk of developing cardiovascular disease;
CA6 Improving access of Aboriginal people to Aged Care Programs including TACP, ComPacks, CAPACS & ACATs - to optimise opportunities for their continued living at home within local communities;
CA7 Enhancing Healthy Ageing initiatives - Improve access to health and human services and support for clients of Aboriginal day care centres;
CA8 Improved employment and training opportunities for Aboriginal people in Aged Care & Rehabilitation services in SSWAHS.
CA9 Implement the Sydney Diabetes Prevention Study (Aboriginal cohort) - lifestyle modification program for at risk people.

CA1	Implement Walgan Tilly solutions - culturally sensitive and effective discharge planning for Aboriginal patients 15+ years with chronic disease.	POA: SC1, IP1-4, CC1-3

Section	Item	Detail
Goals	Who are we targeting	Aboriginal patients 15+ with chronic disease using SSWAHS hospitals.
Goals	What benefit are we aiming for	Better outcomes for Aboriginal patients with chronic disease, their carers and families through improved - identification of Aboriginality, continuity of care and care planning, availability of culturally sensitive & effective discharge packages, quality of care by understanding reasons for EDD variances, reduced adverse events, satisfaction for ALOs. Meet the KPIs identified below.
Goals	How will we know we have succeeded	**What we will measure (performance Indicators)** Data to demonstrate key components of discharge planning have been achieved: • Preadmission – patients receive culturally appropriate info and TAGs, support needs assessed and conveyed to ALOs, IPTASS arranged; • Admission – Aboriginality identified, patient listing to ALOs, assessment for welfare & transport eligibility, ALO visit and inclusion in discharge team, EDD and potential problems documented <48 hrs, EDD tracked and variances to EDD documented; • Discharge – EDD confirmed with family/carer, education on medications, arrangement of transport, community services, equipment/consumables, assessment and referral rates to CAPAC, ComPacks and TACP; future bookings confirmed etc. • Post-discharge – follow-up phone call within 24 hrs, questionnaire completed, ensure linkage to primary care support in local community, decreased readmission rates <28 days.
Rationale	What does current data tell us	Aboriginal people remain under reported on admission or discharge forms from Hospital and once discharged are less likely to seek follow up care. Discharge planning is often poor with no referrals or late referrals to community and follow up services. Culturally appropriate information is not provided at time of discharge and continuing care arrangements are often fragmented.
Rationale	The Story on what's happened till now	In recognition that sub-optimal outcomes for continuing care post-discharge of Aboriginal people were occurring, NSW Health included this issue for consideration in the Walgan Tilly clinical redesign project on chronic care for Aboriginal people. The project reported during 2008 and SSWAHS has prepared a local implementation plan on this aspect of chronic care, to be overseen by a Project Management Committee.
Rationale	What do we know does or doesn't work	The COACH program on secondary prevention in cardiac disease (Melbourne) found that patients post-hospitalisation for cardiac care who received a package outlining their risk factor levels and the National Heart Foundation of Australia targets and structured telephone coaching by dieticians and nurses on working with their GP to meet targets in modifiable risk factors (cholesterol, smoking, blood pressure, glucose level, body weight, dietary saturated fat intake and physical activity) were able to decrease hospital admissions by 16% and bed days by 20% over a 4 year follow-up period. The Victorian Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) best practice information package on discharging planning for Aboriginal patients identifies core principles of – discharge planning commencing with accurate identification on admission, ALO involvement as essential, Aboriginal input to discharge information, cultural awareness training for staff, informed consent, case management model, notification of discharge to all care providers, ensure follow up is not sole responsibility of ALO.

Responsibility		Who's Responsible	Their Role
	Who will lead?	AHU Bangala Walgan Tilly Project Management Committee SSWAHS staff – ALOs, SW, Admissions, ward nursing, nurse educators etc.	Oversee the implementation plan. Implement pre-admission, admission, discharge and post-discharge protocols.
		Who's partnering	**Their Role**
	Who will help?	Primary care providers – ACCHS & GPs	Needs assessment and documentation per referral and post-discharge protocols.

Actions		Our Actions	By when
	What we will do and by when	Consult with key stakeholders and develop implementation plan	2009-10
		Undertake a literature review on other models (e.g. COACH study)	2009-10
		Develop form for 24hr phone follow up, discharge packages, list of Koori friendly GPs	2009-10
		Review existing discharge planning frameworks and strategies	2010
		Develop Koori information pamphlet for all larger hospitals; distribute with TAGs to Aboriginal primary care providers across NSW.	2010
		Implement preadmission, admission, discharge and post-discharge protocols – see *Walgan Tilly Project High Level Implementation Plan on Culturally Sensitive and Effective Discharge Planning* (summarised in performance indicators above).	2009-10 & ongoing
		What additional resources do we need	**Source of funds**
		Project officer Expanded ALO presence in SSWAHS (+2) – requirements under review.	Internal & State special purpose.

Link	Plan	State Plan	State Health Plan	TWT	SSW Strategic Plan
	Reference	F1, F5	1.2, 2.4, 2.5, 3.1, 3.2, 4.3, 5.2, 6.2	H, CH	3a.5, 2b.5, 3a.4, 3a.5

CA2	Implement the Aboriginal Chronic Care Program, including multidisciplinary, holistic chronic disease assessment, treatment and management through clinical outreach to primary care settings.	POA: CP6, SC2, IP2, PH1, CC2

Section	Question	Response
Goals	Who are we targeting	Aboriginal people with a chronic disease or at risk of chronic disease who attend community venues with significant Aboriginal patronage.
Goals	What benefit are we aiming for	To improve access to chronic disease services for Aboriginal clients through clinical outreach of integrated, multidisciplinary, culturally sensitive and holistic health services to community based primary health care settings. To reduce prevalence of high risk factors of chronic disease and provide a range of chronic disease services and referral to other services.
Goals	How will we know we have succeeded	**What we will measure (performance Indicators)** Improved access as indicated by increase in client contacts. Success in engagement into a culturally sensitive service/ model that reflects community views, including implementation of prevention strategies e.g.: nutrition, smoking health education. Improvements in early detection of risk factors. Improved referral pathways established that increase the continuum of care. Increased flexibility in appointment times. Increased use of care planning and monitoring of care plan in coordination with case manager. Improved communication links between government, NGOs and GP's. Clinical skill acquisition for AHWs Reduction in the burden of unmet transport needs of the community by providing outreach services at accessible locations.
Rationale	What does current data tell us	Aboriginal people have a poorer level of access to health services which places them at a greater risk of developing chronic conditions such as cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer which are major causes of morbidity and mortality. Risk factors for Aboriginal people that bring on an onset of chronic disease may include smoking approx. twice the rate of non-Aboriginal people, higher rates of obesity and overweight and poor nutrition.
Rationale	The Story on what's happened till now	SSWAHS has an Aboriginal Chronic Care Program (ACCP – formerly Aboriginal Vascular Health Program) recurrently funded from NSW Health, operating from two sites - RPAH and at Liverpool (Miller CHC). Both services have broad community support, with the Miller service model of location in a community health setting considered to offer a good model for expansion into other communities in SSWAHS. More recently there has been success at Miller in engaging SSWAHS specialist staff to outreach chronic care services to this community setting.
Rationale	What do we know does or doesn't work	It is known that the coordination of services required by Aboriginal people across a range of health and human service organisations is difficult for individuals, carers and families and problematic for their primary care providers. For people with complex needs, case management is difficult in absence of a loci where services can come together and truly address holistic care principles. Establishment of a 'one stop shop' provides opportunities for the practical application of holistic care principles by a range of service providers, including public and private sector health and other human service providers from Government and NGO sectors.

Responsibility		Who's Responsible	Their Role
	Who will lead?	AHU Bangala & Community Health Chronic Care (Vascular Health) committee	Oversee the implementation plan
		Who's partnering	**Their Role**
	Who will help?	Aboriginal community	Provide feedback and consultancy

Actions		Our Actions	By when
	What we will do and by when	Recruit workforce required to implement program	2009-10
		Review feasibility of replicating current chronic care model at Miller CHC.	2009-10
			2009-10
		Literature review on good practice in outreach health care models.	2010
		Strategic plan to guide roll out of Miller model elsewhere.	2010
		Detailed audit/mapping of services to be offered at outreach sites.	2010
		Assess financial impact and cost-benefit potential.	2010
		Business plan for roll-out of outreach packages to community settings	2010-11
		Ensure proposal is reflective of community needs through use of AHIS process; establish advisory committees with community representation.	
		Improve links with primary care providers, uptake of Medicare EPC items, use of AHP services, quality improvements in medication management.	2010-11 & ongoing
		Ensure continuing engagement of SSWAHS specialist service providers e.g. pop health, cardiac, dietetics, diabetes, renal, respiratory, cancer.	2010-11 & ongoing
		What additional resources do we need	**Source of funds**
		Project Manager (Area-wide); AHO (2); Equipment & transport funding Brokerage funding for allied health & specialist clinical outreach	Potential COAG & State special purpose

Link	Plan	State Plan	State Health Plan	TWT	SSW Strategic Plan
	Reference	F1, F5	1.2, 2.1, 2.5, 3.2, 4.3, 5.2, 6.2	H, CH, ED	3a.5, 2b.5, 3a.2, 3a.5

<table>
<tr><th>CA3</th><th colspan="4">Health Promotion activities for Aboriginal people with or at risk of chronic disease</th><th>POA: CP5-6, HP1-6, SM1-2</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal people who have contributing risk factors to chronic conditions such as smoking, obesity, poor physical activity and nutrition.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Reduction in Tobacco related disease such as cardiovascular disease and respiratory disease
Increase in the rate of physical activity for Aboriginal people living in non-remote areas
Increase in the rate of fruit intake to two or more serves per day
Increased birth weight due to better nutrition intake by Aboriginal mothers</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)
Tobacco control – reduction in prevalence of current smoking among Aboriginal people and smoking during pregnancy among Aboriginal mothers; increased proportion of AHWs trained in smoking cessation.
Injury prevention – decreases in injury rates; evidence of positive changes in safety related behaviours.
Healthy weight – decreases in overweight and obesity rates in children and adults; increased fruit and vegetable consumption rates; increased physical activity rates.
Social marketing support - high quality, evidence-based resources developed to facilitate behavioural change, with engagement of Aboriginal communities in program development.
Evidence of liaison with AHS and key NGO partners to strengthen their activities with Aboriginal communities in ways that are well integrated with the campaign and add value.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Tobacco - 45.9% of Aboriginal adults in NSW self-reported as current smokers, compared to 17.7% in the NSW adult population overall (NSW Health 2007); 55.3% of Aboriginal mothers reported smoking at some time during pregnancy compared with 13.1% of non-Aboriginal mothers(NSW Health 2007)
Nutrition - 37.2% and 10.2% of Aboriginal adults in NSW reported adequate levels of fruit and vegetable consumption respectively, c.f. 51.2% and 7.4% in the NSW adult population overall (NSW Health 2006)
Alcohol - 29.2% of Aboriginal adults in NSW reported high risk alcohol drinking, compared to 33.1% in the NSW adult population overall (NSW Health 2006);
Obesity - 51.6% of Aboriginal adults report adequate level of physical activity (NSW Health 2006); 55.3% of Aboriginal adults report being overweight or obese, c.f. 49.9% of NSW adults overall (NSW Health 2006).</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">Aboriginal Health Promotion Funding 07/08 – 09/10 - The Centre for Aboriginal Health, Chronic Disease Prevention and Health Advance has provided program funding to reduce morbidity and mortality amongst Aboriginal people attributable to chronic disease – addressing chronic conditions through initiatives in tobacco control, injury prevention and healthy weight. The SSWAHS Health Promotion Service Aboriginal Health Promotion Action Plan 2008-2010 and Funds Statement of Forward Intent 2009-10 provides the framework for this activity in SSWAHS, focusing on healthy weight and tobacco control.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">What works - programs need to be sensitive to the history of social injustice, discrimination and dispersal experienced by Aboriginal communities through working in a social model of health and with professional and community partners to achieve mutual goals. Good practice principles include focus on closing the gap between the health of Aboriginal and non-Aboriginal people; acknowledging Aboriginal health is everyone's business; use of a life-stage approach; promoting access to health services for all Aboriginal people; working with the community to develop long-term solutions; using strategies evidenced as effective in Aboriginal communities.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><th colspan="2">Who's Responsible</th><th colspan="2">Their Role</th></tr>
<tr><td colspan="2">SSWAHS Health Promotion Service</td><td colspan="2">Work in partnership to implement the SSWAHS Health Promotion Action Plan 2008-2011.</td></tr>
<tr><td rowspan="2">Who will help?</td><th colspan="2">Who's partnering</th><th colspan="2">Their Role</th></tr>
<tr><td colspan="2">Aboriginal Medical Service Redfern
Tharawal Aboriginal Corporation
AHU Bangala</td><td colspan="2">Work in partnership with SSWAHS Health Promotion Service to implement the SSWAHS Health Promotion Action Plan 2008-2011, through NSW Health, Aboriginal Health Promotion Funds, Statement of Forward intent on an annual basis.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><th colspan="3">Our Actions</th><th>By when</th></tr>
<tr><td colspan="3">Implement the Aboriginal Health Promotion Funds Statement of Intent 2008-2011 in coordination with the Aboriginal Chronic Disease committee and other Aboriginal priority area working groups/committees and relevant strategic plans internal to SSWAHS.
Implement in partnership with relevant organisations such as government and non-government organisations.</td><td>2009-10 & 2010-11</td></tr>
<tr><th colspan="3">What additional resources do we need</th><th>Source of funds</th></tr>
<tr><td colspan="3">Full implementation requires continued designated funding from NSW Health ($150,000-$200,000 p.a.).
Supplementary funding to expand program reach.</td><td>State

SSWAHS & external</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><th>State Plan</th><th>State Health Plan</th><th>TWT</th><th>SSW Strategic Plan</th></tr>
<tr><td>Reference</td><td>S3, F1, F4, F5</td><td>1.1, 1.2, 1.6, 2.1, 3.1, 3.2, 3.4, 4.3, 5.1, 6.2</td><td>H, CH</td><td>3a.5, 1a.2, 1a.3, 1b.2</td></tr>
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<tr><th>CA4</th><th colspan="4">Implement the SSWAHS Aboriginal Renal Health Project</th><th colspan="2">POA: SM5-7, SC1-3, IP3, PH3-4, CC1-3</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="5">Aboriginal people with early signs of renal disease.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="5">To identify Aboriginal people at risk of renal disease, provide diagnostic screening and engage in early treatment to prevent disease progression. If pilot is successful broader implementation would aim for sustainable reductions in attributable morbidity and mortality over time and enhancing workforce capacity to address early intervention in associated chronic diseases. Performance indicators will be derived from the baseline audit tool, focusing on:
▪ screening measures for early renal disease with adult Aboriginal community members.
▪ care management strategies for adult patients with renal and other chronic diseases.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="5">What we will measure (performance Indicators)
From the pilot - increased number of Aboriginal people screened; Increased number of referrals to early treatment inc. specialists; improved coordinated care of Aboriginal renal clients.
From longer term broader implementation - decreased prevalence of CKD in Aboriginal communities; decrease in current high incidence and prevalence of treated ESKD; decreased hospitalisation and mortality rates associated with renal disease.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="5">The burden of Chronic Kidney Disease (CKD) is a major concern for Aboriginal communities. Aboriginal people in NSW are 1.5 times more likely to be admitted to hospital than non-Aboriginal people, with renal dialysis accounting for the largest number of episodes. Aboriginal Australians have further been estimated to have a nine-fold increased risk of developing end stage kidney disease when compared to non-Aboriginal Australians.
Co morbidity and complications associated with CKD progression include but are not limited to renal bone disease, hypertension, anaemia and neuropathy (AIHW 2005, Howard et al 2006).
Risk factors include- smoking, overweight and obesity, Aboriginal people engaged in risk alcohol drinking as defined by the NHMRC Australian Alcohol Guidelines: significant greater proportions of male (54.2%) than females (37.8%), physical activity and nutrition. (p1 NSW project plan, Aboriginal renal health project)
Chronic Kidney Disease is defined as a Glomerular Filtration Rate (GFR) of less than 60ml/min./1.73m2 for three months or no change to the GFR but with no other evidence of CKD such as albuminuria, proteinuria, persistent haematuria, and pathologic or anatomic abnormalities (Howard et el 2006, Kidney Health Australia 2006).
CKD encompasses a range of kidney dysfunction: from asymptomatic disease through to End stage Kidney Disease (ESKD), at which kidney replacement therapy is required to sustain life. Such therapy includes but is not limited to dialysis and/or kidney transplant. (AIHW 2005).</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="5">NSW Health received enhancement funds in the 2007/2008 State Budget to reduce the morbidity and mortality arising from renal and vascular disease amongst Aboriginal people.
The Aboriginal Renal Health Project funds initiatives in the primary health care sector to optimise prevention, detection and treatment of early stage renal and vascular disease.
Essential components of these initiatives will include universal screening of all adult Aboriginal patients for albuminuria via urinalysis, hypertension and abnormal blood glucose tests, as well as assessment and intervention for modifiable chronic disease risk factors.
SSWAHS has been allocated funds to conduct an Aboriginal Renal Health Project.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="5">Factors associated with better outcomes include earlier home support through GPs and CHCs, timely access to specialist care, community involvement in program design, better patient health literacy, medication compliance and the embedding of evidence based clinical decision making.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">Community Health</td><td colspan="3">Implement and monitor project</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">Renal teams
Bangala AHU</td><td colspan="3">Assist in identification of at risk Aboriginal people and engagement into early treatment</td></tr>
<tr><td rowspan="9">Actions</td><td rowspan="9">What we will do and by when</td><td colspan="3">Our Actions</td><td colspan="2">By when</td></tr>
<tr><td colspan="3">Project steering committee established</td><td colspan="2">2009-10</td></tr>
<tr><td colspan="3">Establish partnership with other primary health care providers, such as ACCHS', Divisions of General Practice, and/or others;</td><td colspan="2">2009-10</td></tr>
<tr><td colspan="3">Link proposal to complementary actions under existing NSW Health and Commonwealth investments in chronic disease prevention and management for Aboriginal people inc. the Healthy for Life program;</td><td colspan="2">2009-10</td></tr>
<tr><td colspan="3">Participation in Statewide evaluation process, inc. baseline and follow up audits of clinician activity and patient health status – process likely to be led by an external provider with appropriate cultural and renal expertise;</td><td colspan="2">2010-11 & ongoing</td></tr>
<tr><td colspan="3">Provide program according to the project implementation plan provided to Centre for Aboriginal Health, NSW Health.</td><td colspan="2">2009-10 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td colspan="2">Source of funds</td></tr>
<tr><td colspan="3">$142, 000 recurrent funded</td><td colspan="2"></td></tr>
<tr><td colspan="5"></td></tr>
<tr><td rowspan="2">Link</td><td rowspan="2">Plan Reference</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td colspan="2">SSW Strategic Plan</td></tr>
<tr><td>S3, F1, F4, F5</td><td>1.2, 2.1, 2.5, 3.1, 3.2, 4.3, 5.1, 5.2</td><td>H, CH</td><td colspan="2">3a.5, 1b.2, 1c.1, 3a.5</td></tr>
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<tr><th>CA5</th><th colspan="4">Develop an electronic risk assessment and decision support tool for use in primary care settings with Aboriginal people at risk of developing cardiovascular disease</th><th>POA: SM3-7, CP2, SC1-3, IP3</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal people with or at risk of developing Cardio Vascular Disease in partnership with ACCHS, Divisions of GP and Vascular Health clinics across SSWAHS</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">An integrated model of care for Aboriginal people i.e. risk assessment is a routine primary care function. The system will build an evidence base for developing better care models</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">Clinical indicators e.g. blood pressure, Lipids, cholesterol levels, blood sugar levels, reduced number of recurrent hospitalisations, increased number of mod / high risk referrals to GPs, increased number of low risk management plans developed by AHVHW</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">There are gaps in risk calculations for Aboriginal people. There is no clear evidence around best models of care.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">There is no Electronic Risk Management or Decision Support Tools. Data collection and evaluation is ad hoc across incompatible systems. There are no area-wide systems.
Current systems do not build workforce capacity as AHW do not have the opportunity to develop assessment skills.
There has not been rigorous evaluation of models of care and Risk Assessment is often done opportunistically i.e. patients present for treatment of an unrelated condition, but this may be the only opportunity for a Risk Assessment / Risk management to be done.
Duplication of services will continue whilst there is no coordination of systems across agencies or one common Risk Assessment Tool.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">What does work – plain language, individualised advice for clients; Point of care assessment and referral; integration into mainstream systems; primary care based systems
What doesn't work – current data collection systems; communications across agencies, NGOs, patients do not access mainstream services that are not culturally appropriate, making an assessment tool designed for Aboriginal people a priority, transfer of information across agencies.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Cardio Vascular services
ISD
AHU Bangala

Aboriginal Health Workers</td><td colspan="2">Clinical design and evaluation of tool
Technical support
Coordinate partnerships, governance structures
Provide point of care assessments; roll out the assessment tool; data collection; referral pathways; develop management plans for low risk patients</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">ACCHS'
Divisions of GP</td><td colspan="2">Participate in assessment, data collection, referrals; develop management plans for high risk patients</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Identify partners / stakeholders
Establish the reference group, draft the TOR, scope the project
Secure ethics committee approvals
Develop / adapt Electronic Risk Assessment Tool
Develop / adapt performance indicators
Provide training to users of the tool
Roll out tool as a pilot
Evaluate pilot
Provide recommendations to the reference group re the appropriateness of the tool
Implement tool Area wide, including integration within Cerner IT environment</td><td>2009-10
2009-10
2009-10
2010
2010
2010
2010-11
2010-11
2011-12

2011-12</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Additional IT support is required
Funding to purchase / upgrade computers
Research support to assist with evaluations</td><td>Internal
Internal
Internal/External</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, F4, F5</td><td>1.2, 2.1, 2.5, 3.2, 3.4, 5.1, 7.2</td><td>H, CH</td><td>3a.5, 1c.1, 2b.5, 3a.5</td></tr>
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<tr><th>CA6</th><th colspan="3">Improving access of Aboriginal people to Aged Care Programs including TACP, ComPacks, CAPACS & ACATs - to optimise opportunities for their continued living at home within local communities.</th><th colspan="2">POA: CP3, IP1-2, CC3, EC3</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal and Torres Strait Islander people aged 45 years and older living in the community.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">To increase functioning for Aboriginal older people deconditioned following acute illness, through provision of specific therapy or other services after discharge from acute facilities. This may also assist those who wish to remain at home avoid RACF admission. Spin-off benefits to SSWAHS include more appropriate use of acute hospital beds, reduced readmissions and potential reductions in LOS. Benefits flow from Improved access of older Aboriginal people to mainstream transitional aged care services.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">Aboriginal aged people in SSWAHS, their carers and families will make a more informed choice about their long-term care needs and can prevent premature admission to residential aged care. KPIs will measure access of Aboriginal people to core aged and chronic care services such as ComPacks, CAPAC and cardiac rehabilitation.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Following acute illness, older people often lose some of their independence and functioning. A range of activities of daily living can be compromised at the same time as many older people their carers and family are required to make decisions about long term care requirements. Premature decisions to enter a RACF can occur, particularly following repeated hospital admissions for episodic care of chronic conditions. It is known that elderly patients recover medically before they recover functionally and that models of care like Transitional Aged Care, by providing the opportunity to optimise function in an appropriate environment, enable more informed choices about long-term care needs to be made.
Current data for transitional aged care services reflect very few Aboriginal older people accessing these programs.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">There has been no systemic approach to make the Aboriginal older community aware of the transitional aged care services available in SSWAHS. TACP services are yet to establish processes to ensure cultural appropriateness for Aboriginal older people. Liaison has been established between TACP services and Aboriginal Health teams inc. Marumali, to discuss roles, promote services and establish referral links. As at July 2009 referrals were yet to occur.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">TACP provides time-limited personal support and/or low intensity therapy in a residential or community setting. Aspects of TAC that have proved effective include provision of a goal oriented therapy program in home or a home-like environment and tailoring of services to individual requirements and adjustments as functioning improves. Access to case management, community care services and multidisciplinary therapy services are vital components. Evidence suggests that transitional aged care services make a difference and could be appropriate for Aboriginal people.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS Aged Care and Rehabilitation Services</td><td colspan="2">Service development and implementation
Publicity</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Bangala AHU

NSW Health</td><td colspan="2">Strategic and policy development
Publicity
NSW model for TACP & Aboriginal older community</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Develop & implement appropriate publicity for Aboriginal elder community & appropriate facility assessors/discharge planners/social workers etc.
Work with NSW Health to develop appropriate model for TACP across NSW to meet needs of Aboriginal older community
Investigate need for Aboriginal Transitional Aged Care worker dependent on NSW Model developed
Increase numbers of Aboriginal older people access to TACP</td><td>2009-10

2009-10

2009–10 & ongoing

2010-11 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Appropriate marketing & publicity
Aboriginal Transitional Aged Care worker</td><td>Transitional aged care services funding</td></tr>
<tr><td rowspan="2">Link</td><td rowspan="2">Plan Reference</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>F1, F5</td><td>1.2, 1.5, 2.1, 2.5, 3.1, 3.2, 4.3, 5.2, 6.2</td><td>H, CH</td><td>3a.5, 3a.6</td></tr>
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<tr><th colspan="2">CA7</th><th colspan="3">Enhancing Healthy Ageing initiatives - improve access to health and human services and support for clients of Aboriginal day care centres.</th><th>POA: SM1-5, CP3-6, IP2-3, PH1-4, CC1-2</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal people with chronic disease attending the Aboriginal Day Centres provided by SSWAHS.
People of Aboriginal and Torres Strait Islander background who are socially and financially disadvantaged.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">To improve access to chronic disease services for Aboriginal people by utilising the Enhanced Primary Care model at the Day Centre in conjunction with GPs and AHPs.
To increase access and affordability for leisure and recreational activities.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">Improved access to chronic care services by Aboriginal people as indicated by increase in client contacts.
Improvement in the early detection of risk factors.
Improved referral pathways for Aboriginal people accessing the service.
Reduction in the burden of unmet transport needs of the community by encouraging chronic care services/leisure/recreational activities to be provided at the centre.
Reduced social isolation.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Aboriginal people have a poorer level of access to health services which places them at a greater risk of developing chronic conditions such as cardio-vascular disease, diabetes, kidney disease, chronic respiratory disease and cancer which are major causes of morbidity and mortality. Risk factors for Aboriginal people that bring on an onset of chronic disease may include smoking, obesity and poor nutrition. These factors are compounded by social isolation and financial disadvantage.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">The Aboriginal Day Centre – Janangalee (Minto) is increasing access for Aboriginal People to chronic care services such as diabetes monitoring and podiatry, including hair dressing and massage services. Aboriginal artists assist clients with traditional paintings and other art work. These arrangements will be strengthened where EPC Care Plans are finalised for eligible clients and where practitioners are able to visit all clients at the one site. The Minto program also provides a home visiting, social support role for some Aboriginal people unable to attend the day centre. An outreach service (Aboriginal Chronic Care Program – Miller Program) is also provided. The Aboriginal Catholic Ministry and other religious groups visit the Minto site (with the approval of the Elders) to provide spiritual support.
The Hoxton Park Elders Group is transported to the Miller facility to engage in the Aboriginal Chronic Care Program. GP Division Aged Care Liaison Officer has promoted EPC/Dental services with clients with 2 referrals thus far. The Hoxton Park Elders Group utilise artists from Miller TAFE to facilitate art/craft programs. Hoxton Park Day Centre services have been actively promoted with other Aboriginal organisations and NGOs. Referral and liaison links have been established between the day centres and Marumali.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Providing chronic care and leisure based services at one site. The provision of home visiting services for Aboriginal people unable to attend the day centre. The number of clients attending the program (Minto) has grown by 100% since 2000.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Aboriginal Health Unit
Aged Care and Rehabilitation Services</td><td colspan="2">Oversee development of the day centres</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Aboriginal Community
SSWAHS clinical services in chronic care
Primary care providers and private allied health.
Partner agencies, NGO and community support.</td><td colspan="2">Provide feedback and consultancy
Specialist service inreach.
EPC care planning and service provision.
Service inreach.</td></tr>
<tr><td rowspan="11">Actions</td><td rowspan="11">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Increase client numbers at existing day care centres.</td><td>Ongoing</td></tr>
<tr><td colspan="3">Feasibility study on potential to increase Aboriginal day care centres across SSWAHS inc. in the Inner West.</td><td>2009-10</td></tr>
<tr><td colspan="3">Work with primary care providers to Increase the proportion of clients with EPC care plans.</td><td>2009–10 & ongoing</td></tr>
<tr><td colspan="3">Assess feasibility of expanding access to Medicare funded private allied health services</td><td>2009-10</td></tr>
<tr><td colspan="3">Expand medical, nursing and allied health clinical service inreach to centres in areas such as chronic care management.</td><td>2009–10 & ongoing</td></tr>
<tr><td colspan="3">Expand training and education in chronic care self-management for day centre clients</td><td>2009–10 & ongoing</td></tr>
<tr><td colspan="3">Expand access to service provision by partner human services agencies e.g. DADHC, Centrelink, and to NGO and other community support.</td><td>2009–10 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">From within existing State and Commonwealth funding arrangements</td><td></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, F5, E8</td><td>1.2, 1.6, 2.1, 2.5, 3.1, 3.2, 4.3, 5.2</td><td>H, CH</td><td>3a.5, 2b.5, 3a.2</td></tr>
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<tr><td>CA8</td><td colspan="5">Improved employment and training opportunities for Aboriginal people in Aged Care & Rehabilitation services in SSWAHS.</td><td>POA: EC1-3</td></tr>
<tr><td>Goals</td><td>Who are we targeting</td><td colspan="5">Existing Aboriginal Health workers within Aged Care & Rehabilitation; and Aboriginal people as potential employees;</td></tr>
<tr><td></td><td>What benefit are we aiming for</td><td colspan="5">Increased employment and training opportunities for people from an Aboriginal background. This will have a positive affect on access to Aged Care & Rehabilitation Services by Aboriginal people. It is also anticipated that links would be developed with local Aboriginal organisations, further increasing access.</td></tr>
<tr><td></td><td rowspan="2">How will we know we have succeeded</td><td colspan="5">What we will measure (performance Indicators)</td></tr>
<tr><td></td><td colspan="5">Increased number of Aboriginal people employed by Aged Care & Rehabilitation
Increased number of Aboriginal people referred to Aged Care & Rehabilitation services.</td></tr>
<tr><td>Rationale</td><td>What does current data tell us</td><td colspan="5">There are very few identified Aboriginal specific positions within Aged Care & Rehabilitation (all are within the South West of SSWAHS);
There is very limited access to Aged Care & Rehabilitation Services by Aboriginal people across SSWAHS.</td></tr>
<tr><td></td><td>The Story on what's happened till now</td><td colspan="5">The existing Aboriginal Health positions in Aged Care work in Day Centres in the South West. A program is underway for these positions to move to a nationally recognised qualification Certificate IV Aboriginal Health Worker – Aged Care. Traineeships may also be available for identified positions within Aged Care – these workers would be recruited with a criteria "Certificate IV or willingness to work towards". The SSWAHS Aboriginal Employment Coordinator is also available to work with Aged Care & Rehabilitation managers to identify positions which may be suitable to Aboriginal & Torres Strait Islander people, supporting potential staff through the recruitment period.</td></tr>
<tr><td></td><td>What do we know does or doesn't work</td><td colspan="5">It is known that increased training for workers improves the quality and appropriateness of service delivery to all clients. Traineeships also up-skill workers and introduce them to a potential employer. We are also very aware that Aboriginal & Torres Strait Islander employees in a service, and subsequent networks with other local Aboriginal services, increase the referral rate to that service from Aboriginal people.</td></tr>
<tr><td>Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="3">Their Role</td></tr>
<tr><td></td><td colspan="2">SSWAHS Aged Care and Rehabilitation Services</td><td colspan="3">Coordinate three strategies</td></tr>
<tr><td></td><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="3">Their Role</td></tr>
<tr><td></td><td colspan="2">Aboriginal Health
CEWD</td><td colspan="3">Provide expertise in training, support and consultancy</td></tr>
<tr><td>Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td colspan="2">By when</td></tr>
<tr><td></td><td colspan="3">▪ Form joint working group with representatives from Aged Care, Aboriginal Health and CEWD to progress three strategies:
▪ Identify positions within Aged Care & Rehabilitation (particularly Jane Evans Day Centre) suitable for Aboriginal Health traineeship positions, and work with Aboriginal Workforce Development Officer to progress
▪ Identify positions within Aged Care & Rehabilitation that when vacant may be appropriate for the SSWAHS Aboriginal Employment Coordinator's involvement in recruitment
▪ Increase training opportunities for existing and future Aboriginal Health Workers in Aged Care & Rehabilitation</td><td colspan="2">2009-10
2009-10 & ongoing
2009-10 & ongoing
2009–10 & ongoing</td></tr>
<tr><td></td><td colspan="3">What additional resources do we need</td><td colspan="2">Source of funds</td></tr>
<tr><td></td><td colspan="3">Traineeship wage
Training resources</td><td colspan="2">SSWAHS CEWD
Within existing funding arrangements</td></tr>
<tr><td>Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td colspan="2">SSW Strategic Plan</td></tr>
<tr><td></td><td>Reference</td><td>F1, P4</td><td>1.2, 2.1, 3.2, 4.3, 6.2, 6.3</td><td>H, CH, ED</td><td colspan="2">3a.5, 6a.3, 6a.4, 6a.6</td></tr>
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<tr><th>CA9</th><th colspan="4">Implement the Sydney Diabetes Prevention Study (Aboriginal cohort) - lifestyle modification program for at risk people.</th><th>POA: SM1-7, CP2-4, HP2-3, HP5-6, SC3, Ph1-4</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal Men and Women aged 18 and older who have been identified as being at risk of developing diabetes over the next decade.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Reduced risk of diabetes in Aboriginal men and women aged 18 years and older who have been identified as being at high risk of developing diabetes. The program aims to increase physical activity & fibre intake, decrease total and saturated fat intake and achieve a realistic weight loss over a period of 12-months.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">For Aboriginal men and women aged 18 and older at risk of developing diabetes over the next decade - increased physical activity; Improved nutrition; reduced smoking; reduced obesity and overweight.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Diabetes, a major and growing health problem in Aboriginal communities, is associated with reduced life expectancy and increased morbidity from cardiovascular diseases and other complications. Most lifestyle risk factors for Type 2 diabetes are modifiable - increased physical activity and improved diet can address the most important risk factors of obesity and physical inactivity. As chronic Type 2 diabetes develops gradually over time many at high risk will have undiagnosed pre-diabetes conditions, including higher blood glucose levels than normal. In New South Wales, one in four adults over the age of 25 has type 2 diabetes or is at high risk of developing it and for every person known to have type 2 diabetes there is another who has it without knowing. People with diabetes are at higher risk of - heart attack; stroke; kidney failure; blindness and amputation. Nevertheless, nearly 60% of cases of type 2 diabetes can be prevented by reaching and maintaining a healthy weight, being physically active and following a healthy eating plan.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">The NSW Health funded evidence-based Prevent Diabetes Live Life Well program is being run by the Macarthur Division of General Practice in collaboration with SSWAHS, Institute of Obesity, Nutrition and Exercise (Sydney Uni) and Diabetes Australia–NSW. GPs identify at-risk people aged 50-65 years who do not have diabetes and offer a 90-minute individual consultation and three 2-hour group sessions, run by qualified Divisional staff. Successful completion of these activities empowers people with the knowledge and skills to lead a healthier lifestyle.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Prevention of diabetes is achieved by maintaining a healthy weight, being physically active and following a balanced healthy eating plan. Follow-up phone calls and regular check ups with GPs are also important. Best results are achieved by reaching threshold levels of - at least 30 minutes per day of purposeful physical activity; reduced fat intake to 30% of total energy intake; reduce saturated fat to 10% of total fat intake; Increased fibre consumption to 15g per 1000kcal (approx. 30g per day); reduced weight by 5%.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Sydney Diabetes Prevention Program (SDPP) Aboriginal Working Group</td><td colspan="2">Advise on - intervention process; roles and responsibilities of partners; data collection systems to facilitate evaluation.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">▪ Divisions of General Practice
▪ Tharawal Aboriginal Corporation
▪ GPs
▪ Practice nurses
▪ SSWAHS Health Promotion Service</td><td colspan="2">Liaising with the Aboriginal Lifestyle Advisor and the Lifestyle Officers; Implementing individual and group based education; motivating and supporting participants to reduce their risk of developing Diabetes; supporting screening and recruitment processes.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Provide a culturally appropriate lifestyle modification support program to Aboriginal People referred to the Sydney Diabetes Prevention Program (SDPP) including group and individual contact, follow up and support.
Train and support General Practitioners in delivering the culturally appropriate lifestyle modification program
Recruit, evaluate and work to improve the health of Aboriginal people referred to the SDPP.</td><td>2009-10 & ongoing.
2009-10 & ongoing.
2009-10 & ongoing.</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Aboriginal Lifestyle Advisor – $60,000 recurrent</td><td></td></tr>
<tr><td rowspan="2">Link</td><td rowspan="2">Plan Reference</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>S3, F1, F4, F5</td><td>1.1, 1.2, 2.1, 2.5, 3.2, 4.3, 5.1, 5.2, 6.2</td><td>H, CH, ED</td><td>1a.3, 1b.2, 1c.1, 3a.4, 3a.5</td></tr>
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Principles of Action

Building Strong Enduring Partnerships (SP)

SP1 Interagency work on stable housing for Aboriginal people with mental health problems through the JGOS process;
SP2 Improved referral and consultation pathways between DoCS and CAMHS for parents, children and adolescents with mental health problems;
SP3 Expand School-Link to further incorporate Aboriginal mental health issues within training courses, health promotion and prevention programs in schools, TAFE, and justice services;
SP4 Develop HASI to meet the diverse needs of people with mental health problems, their families and the community;
SP5 establish interagency programs for Aboriginal family and carers of people with a mental illness;
SP6 include Aboriginal Mental Health and Well Being as a standing item on Aboriginal Health Partnership agendas.
SP7 Establish an Aboriginal Mental Health and Well Being Working Group at the Area level;
SP8 Establish cooperative agreements between AMHSs and AMS' addressing outreach services, consultation and clinical support to AMS staff; referral links; information management protocols; shared care; joint workforce development; other joint activities.

Providing Accessible and Responsive Services (AR)

AR1 Identify high level mental health managers to take direct responsibility for Aboriginal mental health issues;
AR2 Promote Aboriginal mental health as clinical specialisation;
AR3 Develop an Area Aboriginal mental health strategic plan;
AR4 Develop pamphlets, fact sheets and other resources on Aboriginal mental health, social and emotional well being;
AR5 Promote understanding of Aboriginal mental health and well being issues through Mental Health First Aid training;
AR6 Work with GPs and primary care staff to better advise the community and improve links to specialist services;
AR7 Friendlier Aboriginal environments in mental health facilities;
AR8 Offer clients access to Aboriginal MHWs or other AHWs, at critical points of care - initial assessment, crisis response, admission and discharge;
AR9 Ensure consultation with, and/or representation of, Aboriginal communities on Area working groups;
AR10 Guidelines on management of presentations – emergency assessment, treatment options and referral pathways;
AR11 Identify culturally appropriate local resources and services in the care plans of clients;
AR12 Increase early outreach of community mental health services to Aboriginal people with a mental illness;
AR13 Identify, develop, and implement rehabilitation options for Aboriginal people with a mental illness;
AR14 Develop, and implement accommodation support options for Aboriginal people with a mental illness.

Provide Services across the Lifespan (SL)

SL1 Employ holistic model of Aboriginal health;
SL2 Provide screening, assessment and treatment of co-occurring mental disorders and physical illness;
SL3 Training for mainstream staff on holistic assessment and culturally sensitive treatment responses;
SL4 **Children, adolescents, young people and families** – interagency action on mental health promotion, prevention and early intervention; competencies in partner agencies; clinical guidelines, intervention protocols and service pathways; involve families through clear diagnostic explanation, education, family conferences, support services;
SL5 **Social and emotional wellbeing** – work with other agencies to develop support programs in anger management, grief and loss and empowerment; choice of male or female worker, guidelines for those at risk of suicide; diversion programs and community justice initiatives; support on custodial release;
SL6 **Elders and older people** - work with other agencies to develop support programs on Stolen Generations issues; recognise possible early onset of dementia; respite needs of family and carers; recognise Elders as community leaders; coordinate AMHS and aged care service delivery; service pathways;
SL7 **Substance use and co-occurring needs** – collaboration between AMHS and drug health inc. joint screening and assessment; involve local Aboriginal networks; holistic approaches; treatment choices; respect cultural/community values in evidence based practice; assertive follow-up; cross training for mental and drug health staff.

Increased Expertise and Knowledge (EK)

EK1 Training on patient registration information to improve recording of Aboriginality;
EK2 Develop and review assessment and outcome tools
EK3 With partners evaluate effectiveness of mental health programs and services.

Supporting a Skilled Workforce (SW)

SW1 **Recruitment** - Expand AMHWs to 1/1,000 Aboriginal people; promote Aboriginal identified positions; clearly define AMHW roles; support Child & Adolescent AMHWs; expand specialist capacity in AMHWs; cadetships and scholarships;
SW2 **Training, mentoring and support** – employ locals, work and study program, peer support, Uni affiliations, clinical and management training, worker networks, training for non-professional partners in care
SW3 **Competencies** – diploma and degree courses, scholarships, career promotion in schools.

Model of Care

- In partnership provide outreach specialist medical services to Tharawal and Redfern;
- Improve knowledge, assessment protocols and links to specialist care among primary care providers to Aboriginal communities;
- Interagency work improving in-reach of mental health expertise to educational facilities, early childhood and family services, community services, housing, justice services etc.
- Work with Aboriginal communities to improve capacity to recognise precursors and early signs of mental health issues and initiate pathways to specialist care;
- Improve the interaction and relationships between AMHS and Drug health services through informal networking and formal joint protocol development and partnership action;
- Increase employment of AHMWs to levels mandated in State policy and provide a supportive workforce development structure for recruitment, training, mentoring, peer support and competency development.

Action Initiatives

MH1 Expand partnerships and develop strong working relationships.
MH2 Develop accessible and responsive services
MH3 Provide a skilled and supported workforce addressing Aboriginal mental health issues.

MH1 Expand partnerships and develop strong working relationships.	POA: SP 1-8, AR 4-5, SL4
Goals	
Who are we targeting	Government and NGO organisations providing support services to Aboriginal communities. Aboriginal Medical Services and other Aboriginal community controlled groups.
What benefit are we aiming for	Develop effective working relationships between SSWAHS AMHS and ACCHS Redfern & Tharawal. Establish effective partnerships with NGOs and relevant Government authorities. Increase in-reach of SSWAHS AMHS to Govt and NGO services for Aboriginal communities.
How will we know we have succeeded	**What we will measure (performance Indicators)** ▪ Cooperative working partnerships established with ACCHS. ▪ Aboriginal mental health as standing agenda item at SSWAHS/ACCHS Partnership meetings. ▪ Working arrangements developed reflect cooperation of each service and referenced within broader Partnership arrangement(s). ▪ In-reach services provided to ACCHS; information and education to community groups. ▪ Evidence (qualitative) of enhanced focus of NGOs on Aboriginal mental health and wellbeing.
Rationale	
What does current data tell us	The National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003) recognises shared responsibility requiring partnership between Aboriginal organisations, individuals and communities; across all levels of government; across and beyond the health sector. This is required to address complex and inter-related factors that contribute to the cause and persistence of health problems in aboriginal communities. The NSW Government's Two Ways Together initiative and interagency Action Plan for Better Mental Health are examples of whole-of-government strategies that aim to better coordinate responsibilities and programs for Aboriginal people and for all people with mental illness in NSW (NSW Aboriginal Mental Health and Wellbeing Policy 2006-2010).
The Story on what's happened till now	Working arrangements with ACCHS have been developed within the framework of broader Partnership arrangements with ACCHS. Although informal collaboration exists in the main formal service level agreements have not been seen as necessary. The Aboriginal mental health unit at Royal Prince Alfred Hospital has a working partnership with Redfern ACCHS.
What do we know does or doesn't work	Good practice suggests that most impact is achieved when arrangements are developed within broader overarching Partnership frameworks. Service level MOUs can be time consuming in conception and duplicative where the same ground is covered across numerous interactions.

Responsibility

Who will lead?	Who's Responsible	Their Role
	Area Coordinator Aboriginal Mental Health	Lead planning process and interagency liaison, coordinate partnerships with NGOs.
	AMHS Executive	Establish working arrangements with ACCHS, support activities of broad based Aboriginal Mental Health and Well Being Steering Committee.
	AMHS and HPU staff	Provide outreach services to ACCHS, men's and women's groups, school based programs.

Who will help?	Who's partnering	Their Role
	ACCHS	Enable in-reach mental health services
	NGOs	Increase focus on Aboriginal mental health and wellbeing within their services.
	Govt. agencies e.g. Housing, Education	Interagency work to facilitate in-reach of mental health services within their programs.

Actions

What we will do and by when	Our Actions	By when
	In establishing partnership relationships with ACCHS	
	Cooperatively plan and scope services to be provided at ACCHS	2009-10
	Pilot service provision arrangements	2010
	After piloting stage determine requirements for service expansion and additional resources required	2010-11
	Establish working arrangements between SSWAHS AMHS and ACCHS	2010-11
	In establishing partnerships with NGOs and government authorities:	
	Ensure housing issues are addressed at local JGOS meetings	2009-10 & ongoing
	Expand HASI program subject to funding availability	2009-10
	Engagement of Commonwealth and COAG funded NGOs into working with Aboriginal communities	2009-10 & ongoing
	Expand mental health promotion work with Aboriginal communities	2009-10 & ongoing
	↑ provision of AMH First Aid Training programs to partner organisations	Ongoing
	Expand input to school based programs such as school-link and MindMatters to ensure focus on Aboriginal students	2009-10
	Establish broadly representative Aboriginal Mental Health and Well Being steering committee	2009-10 & ongoing
	What additional resources do we need	**Source of funds**
	Achievable within 1:1,000 pop benchmark. Fill vacancies as they occur.	Internal

Link

Plan Reference	State Plan	State Health Plan	TWT	SSW Strategic Plan
	F1, F3, S4, R4	1.1, 1.6, 3.2, 3.3, 4.1, 4.3	H, HO, E, CH, FYP	4a.4, 1a.2, 1a.5, 1b.2, 1c.1, 1c.6, 2b.5, 3a.8

MH2 Develop accessible and responsive services		POA: AR 1-14, SL 3-7
Goals	Who are we targeting	AMHS to raise capacity to address Aboriginal mental health issues. Aboriginal communities to raise awareness and facilitate access.
	What benefit are we aiming for	Raise the profile of Aboriginal Mental Health as a specialist service within AMHS. Facilitate community knowledge and understanding of precursors and early signs of mental illness and improve access to and use of pathways to clinical care.
	How will we know we have succeeded	**What we will measure (performance Indicators)** ▪ Senior AMHS staff to lead Aboriginal mental health service development ▪ Aboriginal Mental Health First Aid courses delivered to communities ▪ Develop AMHS clinical protocols detailing priority responses for Aboriginal people ▪ All general Area MH services are accessible to and utilised by Aboriginal people when needed ▪ Aboriginal mental health workers are accessible to and utilised by Aboriginal people to support their contact with Area MH services.
Rationale	What does current data tell us	Aboriginal mental health is inextricably linked to overall health. The burden of grief, loss and trauma impacts on Aboriginal people, especially on members of the stolen generation and many Aboriginal people continue to live in conditions of social and economic disadvantage. Mental health and well-being issues impact on a whole range of health related indicators identifying poorer outcomes for Aboriginal people e.g. Aboriginal people are more likely to die at younger ages with those aged less than 25 years making up around 10% of deaths of Aboriginal people, compared with 2% of deaths among non-Aboriginal people; Aboriginal people are more than twice as likely as non-Aboriginal people to die as a result of injury; compared with rates for non-Aboriginal people, hospitalisation rates for Aboriginal people in NSW are 50% higher from injury and poisoning.
	The Story on what's happened till now	An Aboriginal Mental Health Training program has been developed. Aboriginal Mental Health staff have been trained to provide Aboriginal Mental Health First Aid training. AMHW positions across SSWAHS have been increased to equate to the 1:1,000 Aboriginal population mandated benchmark. Mental Health has been engaged within the Area framework to embed Aboriginal Health staff within Clinical Streams.
	What do we know does or doesn't work	*What works* – cultural awareness and cultural competency training across general AMH staff; focus on clinical outcomes and evaluation of work practices; developing work plans with line managers incorporating clear delineation of work roles and boundaries of practice. *What doesn't work* – isolated service provision without appropriate clinical support and links to other services.

Responsibility		Who's Responsible	Their Role
	Who will lead?	Area Coordinator Aboriginal Mental Health Area Mental Health Service Executive Area Mental Health Service line managers Bangala Aboriginal Health Executive	Oversee implementation of Aboriginal Mental Health strategies. Ensure strategies are well resourced and embraced as core business. Support strategy implementation on the ground.
		Who's partnering	**Their Role**
	Who will help?	ACCHS SSWAHS Drug Health Services Youth Health General Practice Other NGOs with Aboriginal clients	Collaborative support in implementing Aboriginal Mental Health strategies through committees, consultations and facilitating service provision. Participation in developing service level working arrangements.

Actions		Our Actions	By when
	What we will do and by when	Strengthen Aboriginal mental health as a specialised component of general AMHS programs	Ongoing
		Support clinical supervision and mentoring program for trainee AMHWs	Underway & ongoing
		Support a family centred approach to delivery of services	2009-10 & ongoing
		Train staff to deliver Aboriginal Mental Health First Aid (AMHFA)	Underway & ongoing
		Develop culturally appropriate Aboriginal health promotion material	Underway & ongoing
		Develop Aboriginal friendly and supportive environments in AMHS	2010 & ongoing
		Expand services to meet identified needs of Aboriginal communities in:	
		▪ The link between social and emotional wellbeing and physical health	2010 & ongoing
		▪ Assessment and care planning for substance misuse	2010 & ongoing
		▪ Isolation, depression and dementia for Elders	2010 & ongoing
		▪ Camp programs for children and adolescents	2009-10 & ongoing
		▪ Circle of security programs for families	2009-10 & ongoing
		▪ Adolescent programs linked with "headspace" services	2009-10 & ongoing
		▪ Other emerging needs utilising an early intervention care framework.	2009-10 & ongoing
		What additional resources do we need	**Source of funds**
		Achievable within 1:1,000 pop benchmark. Fill vacancies as they occur.	Internal

Link	Plan	State Plan	State Health Plan	TWT	SSW Strategic Plan
	Reference	F1, F3, F4, F6, F7, S5	1.1, 1.6, 3.1,3.2, 3.3, 3.4, 4.1, 4.3, 5.1	H, CH, FYP	3b.6, 4a.4, 1a.2, 1b.2, 1c.6, 2b.5, 3a.8, 3b.7

<table>
<tr><th colspan="5">MH3 Provide a skilled and supported workforce addressing Aboriginal mental health issues.</th><th colspan="2">POA: SW 1-3, AR 1-2, AR5, AR7</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="5">The workforce within SSWAHS AMHS including Aboriginal Mental Health workers and mainstream mental health workers.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="5">Increased support and skills enhancement for Aboriginal Mental Health workers; improved focus across all of SSWAHS AMHS on the mental health and wellbeing of Aboriginal communities; improved links with external organisations to enhance training opportunities and recruitment.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="5">What we will measure (performance Indicators)
▪ Aboriginal Mental Health Workforce in place across SSWAHS.
▪ Clear roles developed for Aboriginal mental health workers in specialist teams established by Area Mental Health Service.
▪ Scholarships and cadetships created in mental health professions in SSWAHS.
▪ AMHW trainees progressing well in competency development and academic training.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="5">Aboriginal people have poorer access rates to mental health services. AMHWs have an important role in supporting Aboriginal people in their contact with the AMHS. There is a need to target recruitment of Aboriginal people to positions across the general Mental Health Service.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="5">SSWAHS mental health workforce recruitment strategies include enhancement of the current 13 fulltime Aboriginal health positions and 2 Traineeships. Retention initiatives include - provide Aboriginal Mental Health First Aid Program (all AMHWS trained); cultural competency training program for mainstream AMHW staff; establish a professional supervision and support framework; establish an AMHW training structure internal to AMHS; facilitate access to skills development from sources outside AMHS; establish links with Universities for work experience and placements; support the SSWAHS Aboriginal health competencies program.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="5">What works - having an Aboriginal mental health workforce to support accessibility of mental health services; professional development for the Aboriginal mental health workforce; positive impact Aboriginal workforce has on cultural security of mental health services.</td></tr>
<tr><td rowspan="2">Responsibility</td><td>Who will lead?</td><td colspan="2">Who's Responsible
Coordinator Aboriginal Mental Health

AMHS Executive

AMHS Line Managers</td><td colspan="3">Their Role
Facilitate AMH First Aid program, cultural competency training, supervision and support framework for AMHWs, university links.
Facilitate AMH First Aid program
Facilitate specialised support for AMHWs, University links.
Implement supervision, support and training framework for AMHWs.</td></tr>
<tr><td>Who will help?</td><td colspan="2">Who's partnering
Aboriginal Workforce Development Manager

SSWAHS Health Promotion Service</td><td colspan="3">Their Role
Facilitate access for AMHWs to skill development outside AMHS.
Support AMHWs to roll out Aboriginal Mental Health First Aid program.</td></tr>
<tr><td rowspan="2">Actions</td><td rowspan="2">What we will do and by when</td><td colspan="4">Our Actions
Provide Aboriginal Mental Health First Aid Program (all AMHWS trained)
Provide cultural competency training for general AMHS staff
Develop specialised support for AMHWs e.g. child, adolescent, comorbidity
Establish professional supervision and support framework
Establish AMHW training structure internal to AMHS
Facilitate access to skills development from sources outside AMHS
Establish links with Universities for work experience and placements</td><td>By when
2009-10 & ongoing
2009-10 & ongoing
2010

2009-10 & ongoing
2009-10
2010 & ongoing
2009-10 & ongoing</td></tr>
<tr><td colspan="4">What additional resources do we need
Training resources to implement programs
Recruitment to specialised positions when established.</td><td>Source of funds
Internal
Internal</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td colspan="2">SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, F3, P4</td><td>3.2, 3.3, 4.1, 4.3, 6.1, 6.2, 6.3</td><td>H, E, CH, ED</td><td colspan="2">4a.4, 6a.7, 6b.5, 5a.3, 6a.3, 6a.4, 6a.6, 6b.4</td></tr>
</table>

Principles of Action

Enhance Community Capacity (CC)

CC1 Promote peer education programs;
CC2 Develop targeted educational resources for Aboriginal communities;
CC3 Use Koori media to convey health promotion messages;
CC4 Provide drug health educational resources for delivery within the context of broader Life Skills programs for Aboriginal youth;
CC5 Provide drug health educational resources in the context of Aboriginal community activities e.g. NAIDOC;
CC6 Develop brief intervention programs in drug health for use in primary care and to engage clients in community settings;
CC7 involve family and significant others in drug health prevention and treatment activities;

Collaborative Inter Agency Action (CA)

CA1 Strengthen collaboration between drug health and mental health services in addressing comorbidity issues;
CA2 Work with primary care providers inc. ACCHS on brief intervention strategies and engagement into treatment;
CA3 Interagency work on spread of early intervention initiatives;
CA4 Contribute to alcohol, tobacco and other drugs education activities in schools;
CA5 Include drug health messages within early childhood home visiting programs and parenting and life skills programs for children and young families;
CA6 Strengthen networks with law enforcement agencies inc. police, prisons and Justice Health;
CA7 Link drug health promotion to broader health promotion activities;

Improve Access to Services (IA)

IA1 explore provision of outreach drug health case management services;
IA2 Address transport difficulties in access to dispensing facilities;
IA3 Closely involve AHWs in the clinical intake process;
IA4 Contribute to post release programs for prisoners inc. relapse and aftercare programs;
IA5 provide screening and brief interventions for pregnant women;
IA6 early intervention programs for young people who do not attend school.

Holistic Approaches Across Spectrum of Care (HA)

HA1 Comprehensive care plans enabling engagement, stabilisation and management;
HA2 Incorporation of drug health messages within programs addressing injury, mental health and sexual health issues;
HA3 Develop culturally appropriate screening tools and brief interventions;
HA4 Work with primary health providers inc. ACCHS to improve capacity to provide early counselling, screening and brief motivational advice;
HA5 Promote culturally acceptable inpatient detoxification capacity;
HA6 increase access to culturally appropriate services for dual diagnosis.

Capacity Building in Drug Health Workforce (CW)

CW1 Expand the complement of AHWs within core drug health services inc. through recruitment to identified positions and traineeships and cadetships;
CW2 Enhance the support of AHWs within Drug Health inc. through in-house clinical training and education, mentoring, access to accredited courses, peer support and worker networks;
CW3 Enhance supervisory support for AHWs, within Drug Health and AHWs working elsewhere;
CW4 Increase awareness of Aboriginal cultural issues among DHS staff
CW3 Provide Drug Health training for AHWs in SSWAHS.

Strengthening Partnerships (SP)

SP1 Strengthen partnerships with Health Promotion to include drug health as a component of health promotion programs in Aboriginal communities;
SP2 Work with primary care providers to strengthen intake and assessment processes for entry to Drug Health services;
SP3 Strengthen clinical pathways linking to SSWAHS clinical services in areas such as mental health, sexual health, maternity etc.
SP4 Strengthen interagency partnership arrangements in areas such as law enforcement, post release prisoners, schools, youth and early childhood;
SP5 Improve the process of care coordination between SSWAHS and with other agencies.

Model of Care

- Focus on drug health prevention activities that are community driven or with community support within a perspective of enhancing culture, community empowerment and sense of belonging;
- Employ early intervention models that consider whole families or whole communities and move beyond one-to-one psychotherapy or behavioural intervention;
- Employ shared care models and care coordination processes to take account of underlying complex health and social needs;
- Work with primary care providers inc. ACCHS to provide early assessment, brief intervention and engagement into Drug Health care;
- Work with Aboriginal communities to improve capacity to recognise precursors and early signs of drug health issues and initiate pathways to specialist care;
- Improve the interaction and relationships between Drug Health, other SSWAHS Clinical Services and other Human services agencies through informal networking and formal joint protocol development and partnership action;
- Increase employment of AHWs in Drug Health and provide a supportive workforce development structure for recruitment, training, mentoring, peer support and competency development.

Action Initiatives

DH1 Prevention, health promotion and early intervention for Aboriginal people with substance use issues;
DH2 Develop and support partnerships between Drug Health Services (DHS), Aboriginal services and Aboriginal communities and other services within SSWAHS;
DH3 Enhance availability of clinical services for Aboriginal people with drug health issues;
DH4 Enhance the availability, skills level and organisational support for Aboriginal Health Workers in Drug Health Services (DHS).

<table>
<tr><th>DH1</th><th colspan="5">Prevention, health promotion and early intervention for Aboriginal people with substance use issues.</th><th>POA: CC1-7; CA2-3; IA1-2&6; HA3-4</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="5">Aboriginal communities in SSWAHS</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="5">Improved health and increased wellbeing of Aboriginal communities in SSWAHS
Reduction in drug related harms within the Aboriginal communities of SSWAHS
Increase community awareness of drugs, their effects and treatment services</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="5">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="5">Number of clients screened, treated and referred for BBVs
Number of syringes distributed
Number of service contacts recorded
Number of community interventions conducted for alcohol
Number of people receiving alcohol screening and brief intervention
Number education/information contacts with Aboriginal community services
Number and type of resources developed / distributed to communities</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="5">Effective health promotion in Aboriginal communities involves community driven approaches, and often broad initiatives which enhance culture, community empowerment and sense of belonging – to address underlying risk and protective factors and enhance the community's capacity to identify and address health issues.
Aboriginal Australians are less likely to access voluntary treatment of alcohol problems than they are to enter compulsory treatment. Late presentation to treatment is common. Brief intervention is cost-effective and typically provides earlier access to treatment.
Early intervention can be either community or health service based. Given that persons with substance use disorders may be more marginalised and be less likely to access health services, there is likely to be a role for outreach services.
Needle sharing appears to be increasing among some Aboriginal people who are injecting drug users - prevalence of HIV positivity among NSP users is marginally higher in SSWAHS (2.7%) c.f. State (2.1%). The rate of HCV prevalence for SSWAHS (68%) is similar to that of NSW (71%).</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="5">DHS has been a partner agency in health promotion initiatives with Aboriginal adolescents in South West Sydney. The recently establish Primary Health Care service in REPIDU, Redfern has successfully engaged new clients, providing health and BBV screening, treatment and referral. Provision of sterile injecting equipment to at-risk communities has contained rates of HIV.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="5">What works - employing Aboriginal staff within Drug Health services, low thresh-hold primary approaches that are client directed, community based services, working with families, allowing communities to identify priorities and develop strategies and messages.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">Drug Health Services SSWAHS</td><td colspan="3"></td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">SSWAHS Services in Aboriginal Health, Perinatal, Mental health, Sexual health, Youth Health.
ACCHHS' and NGOs</td><td colspan="3">Internal Clinical service partners.

External partner organisations.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="4">Our Actions</td><td>By when</td></tr>
<tr><td colspan="4">Identify and/or develop, distribute relevant resources to Aboriginal agencies and communities
Develop and deliver overdose education training for key stakeholders in the community
Implement alcohol brief intervention program
Participate in Aboriginal community activities (i.e. NAIDOC week)
Participate in youth health prevention initiatives
Facilitate community service visits to DHS clinical sites to increase understanding of treatment options
Provide new injecting equipment to 'at risk' communities
Provide brief intervention and referral in community settings
Establish DHS Primary Health Care services/clinics to at-risk communities.</td><td>2010 & ongoing
2010 & ongoing
2010 & ongoing
Ongoing
Ongoing
2010 & ongoing
Ongoing
Ongoing
2010-11</td></tr>
<tr><td colspan="4">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="4">Funding for the creation of positions for:
1. Drug Health Aboriginal Clinical Support Team; and
2. Primary Care Service in Macarthur
Goods and services budget to support population based prevention and education initiatives</td><td>NSW Health MHDAO

NSW Health MHDAO</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td colspan="2">TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>S3, F1, F4, F5</td><td>1.1, 2.1, 2.5, 3.1, 3.2, 3.4, 4.3, 5.1, 5.2, 6.2</td><td colspan="2">H, CH, ED, FYP</td><td>4a.4, 1b.2, 3a.2</td></tr>
</table>

<table>
<tr><th colspan="2">DH2</th><th colspan="3">Develop and support partnerships between Drug Health Services (DHS), Aboriginal services and Aboriginal communities and other services within SSWAHS</th><th>POA: CC6-7; CA2-3; HA3-4; SP2-3</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Drug Health Services, Aboriginal Health Services and other key stakeholders.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Improved continuity of care for Aboriginal clients within service networks.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">Number of clinical pathways implemented and evaluated.
Increase in referrals to DHS and retention in treatment for Aboriginal clients.
Increase in partnership contacts between all key stakeholder services</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Aboriginal Australians are less likely to access voluntary treatment of alcohol problems than they are to enter compulsory treatment.
Late presentation to treatment for substance use problems is common among Aboriginal Australians.
The potential for interactions between different risk factors for ill health in Aboriginal communities is large. Alcohol, smoking and adverse dietary choices lead to increased risk of coronary heart disease. Alcohol, obesity and hepatitis C are independent contributors to liver disease and two or more of these risk factors often coincide. Alcohol, obesity and smoking each contribute independently to risk of diabetes. In non-remote areas, Aboriginal adults are more likely than non-Aboriginal adults to be exposed to more than one of these risk factors.
Aboriginal Australians have:
▪ lower levels of alcohol use than general population but higher rates of risk drinking
▪ high rates of tobacco use and illicit drug use
▪ higher rates of BBV
▪ higher rates of foetal alcohol syndrome and neonatal abstinence syndrome.
Holistic approaches are reliant on high-levels of cooperation between health and other services.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">Aboriginal clients of Drug Health Services have complex health and social needs.
Holistic and client led approaches have proven to be more useful and effective than compartmentalised care.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Strong clinical partnership between the Aboriginal Medical Service Redfern and Drug Health Services RPAH has resulted in high level of engagement in treatment for Aboriginal people (approximately 25% of clients) in the OTP program.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Drug Health Services SSWAHS</td><td colspan="2">Engage relevant community organisations to improve pathways and referrals for Aboriginal people.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Aboriginal Health Services SSWAHS
ACCHS'
Aboriginal community services
NGOs
NSW Health</td><td colspan="2">Partner agencies</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Develop, implement and review:
▪ Intake and assessment processes;
▪ clinical pathways and service agreements between key services; and
▪ a care coordination model

Continue regular meetings between DHS, ACCHS', Aboriginal Health Services and Aboriginal community services.</td><td>
2010
2010
2010

Ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Positions for the Drug Health Aboriginal Clinical Support Team, which includes two people (male and female) in each stream.</td><td>NSW Health MHDAO</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>S3, F1, F5</td><td>2.1, 2.5, 3.2, 4.3</td><td>H, ED, FYP</td><td>4a.4, 2b.2, 2b.5, 5a.3</td></tr>
</table>

<table>
<tr><th colspan="2">DH3</th><th colspan="3">Enhance availability of clinical services for Aboriginal people with drug health issues</th><th>POA: IA1-6; SP1-5; HA3-5</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal Australians living or working in SSWAHS with substance use issues and/or problems</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Improved health outcomes for Aboriginal Australians in SSWAHS</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">▪ Number of Aboriginal people in treatment
▪ Number of Aboriginal people in treatment for more than 3 months
▪ Number of Aboriginal clients completing treatment.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Substance use disorders (alcohol, tobacco and to a lesser extent illicit drugs) contribute to:
▪ a high burden of mortality and morbidity experienced by Aboriginal people;
▪ domestic violence, assaults, injury, accidents and personal, family and community suffering;
▪ risk factors for future problems for children of the community.
Late presentation to treatment is common and Aboriginal Australians are less likely to access voluntary treatment for alcohol problems than they are to enter compulsory treatment.
Aboriginal Australians have:
▪ lower levels of alcohol use than the general population but higher rates of risk drinking;
▪ high rates of tobacco use and illicit drug use;
▪ higher rates of BBV;
▪ higher rates of foetal alcohol syndrome and neonatal abstinence syndrome.
Aboriginal Australians are over-represented among injecting drug users; and are also over-represented among the prison population.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">Aboriginal populations use DHS more commonly for opioid dependence (67.7% of presentations) than alcohol (17.4%) – in the inner West Aboriginal clients comprise 10% of Drug Health episodes of care and approximately 25% of clients on the Opioid Treatment Program at RPAH .
A higher proportion of Aboriginal clients left treatment without notice (32.4%) than clients overall (25.0%) and this was most likely to be in the first three months of treatment (41% of clients leaving for any reason, compared with 27% for clients overall).
It is evident that there is significantly stronger engagement in treatment in the Inner West than in South west with community primary drug health services in Redfern (REPIDU) having a high caseload and the Aboriginal Women's Group at RPAH successfully engaging female clients, family and children from 2005. The group is client directed and provides support and case management.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Evidence base on intervention for substance use disorders supports prevention, early intervention, treatment and harm reduction; however, data is lacking on effectiveness of these approaches in urban Aboriginal communities.
What Works - clinical partnerships with ACCHS', employing Aboriginal staff within DHS, community based services, flexibility in treatment planning, working with families, integrated services ('one stop shop'), low thresh-hold primary approaches that are client directed.
What Doesn't work - inflexible assessment and clinical services.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Drug Health Services</td><td colspan="2">Engagement of patients in treatment.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS - Aboriginal Health, EDs, Perinatal, Mental Health, Sexual Health, Youth Health.
ACCHS' & NGOs</td><td colspan="2">Partner services in provision of holistic care</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">▪ Develop an Aboriginal Clinical Support Team to work directly with clients and DHS staff across primary, secondary and tertiary settings
▪ Review intake and assessment procedures for Aboriginal people
▪ Develop individual treatment plans with an emphasis on flexibility
▪ Maintain and improve clinical pathways and service agreements within and between DHS and identified partner services
▪ Provide appropriate training to all Drug Health staff
▪ Review DHS models of care to support Aboriginal clients
▪ Provide opportunities for community based assessment and treatment in key identified communities.</td><td>Funding dependent

2010
Ongoing
Ongoing

2009-10 & ongoing
2010
2010-11 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">2 (male: female) X 3 settings = 6 positions for Clinical Support Team.
Traineeships from SSWAHS and NSW Health.
G&S to support groups (food, craft materials, educational resources)</td><td>NSW Health MHDAO

NSW Health MHDAO</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>S3, S4, S5, S8, F1, F3, F4</td><td>1.1, 2.1, 2.5, 3.1, 3.2, 4.3, 5.2, 6.2, 6.3</td><td>H, CH, ED, FYP</td><td>4a.4, 6b.5, 1c.1, 2b.5, 3a.2</td></tr>
</table>

DH4	Enhance the availability, skills level and organisational support for Aboriginal Health Workers in Drug Health Services (DHS).	POA: CW1-5; IA3

Section	Item	Details
Goals	Who are we targeting	Staff within Drug Health Services
	What benefit are we aiming for	A workforce that can work effectively with Aboriginal clients and their families Increased engagement of Aboriginal communities into DHS programs.
	How will we know we have succeeded	**What we will measure (performance Indicators)** DHS Aboriginal clinical support team established Aboriginal nursing cadetships and traineeships established across DHS. Number of cultural safety education sessions attended by DHS. Number of drug and alcohol related education sessions provided by DHS to SSWAHS AHWs, ACCHS' and other key stakeholder services. Number of continuing education sessions attended by DHS Aboriginal Health Staff. Number of DHS Aboriginal Health staff with access to supervision, appropriate to competencies.
Rationale	What does current data tell us	Employment of Aboriginal staff is not consistent across the DHS. Level of engagement with Aboriginal people varies considerably across the DHS programs. Engagement with Aboriginal people increases when Aboriginal staff works in the service.
	The Story on what's happened till now	Employment of Aboriginal staff in the Inner West is higher than in the South West with resultant higher engagement and retention of Aboriginal patients in treatment.
	What do we know does or doesn't work	Approaches whereby small numbers of Aboriginal staff work in isolation and without peer support are generally unsuccessful.

Section	Item	Who's Responsible	Their Role
Responsibility	Who will lead?	Drug Health Services	To improve the workforce in DHS that can engage aboriginal populations into treatment; and to increase and support Aboriginal staff.
		Who's partnering	**Their Role**
	Who will help?	Aboriginal Health SSWAHS Aboriginal Medical Services NSW Health	Partner services

Section	Item	Our Actions	By when
Actions	What we will do and by when	Establish an Aboriginal Drug Health clinical support team.	Funding dependent
		Develop and implement targeted recruitment strategies for Aboriginal staff across all of DHS.	Ongoing
		Increase awareness of Aboriginal cultural issues among DHS staff.	Ongoing
		Develop and deliver Drug Health related training for the Aboriginal Health workforce of SSWAHS.	2010-11 & ongoing
		Establish traineeships and cadetships for Aboriginal staff within DHS.	Funding dependent
		Provide clinical training and education for Aboriginal DHS staff.	Ongoing
		Provide supervision for Aboriginal Health staff (both DHS and SSWAHS Aboriginal Health staff).	Ongoing
		Provide opportunities for Aboriginal staff rotations within DHS and SSWAHS.	2010-11 & ongoing
		Provide student placement options for Aboriginal students.	2011 & ongoing
		What additional resources do we need	**Source of funds**
		Funding and resources for training, development and implementation	NSW Health MHDAO

Section	Plan	State Plan	State Health Plan	TWT	SSW Strategic Plan
Link	Reference	S4, S5, F1	2.1, 2.5, 3.1, 3.2, 4.3, 6.1, 6.2, 6.3	H, E, ED	6a.7, 6b.5, 5a.3, 6a.3, 6a.4, 6a.6, 6a.9

Principles of Action

Planning and Protocols for Service Development (PP)

PP1 Establish broad based local sexual health committees;
PP2 Local protocols and guidelines on contact tracing, access to young people, NSPs, correctional settings etc;
PP3 Use of Statewide protocols such as the AH&MRC Early Detection and Treatment manual;
PP4 Aboriginal representation and engagement in the preparation and distribution of resource materials;
PP5 Develop annual business plans for delivery of services;
PP6 Ensure the findings of research contribute to priority setting, strategies and service/program planning.

Capacity Building of the Aboriginal Workforce (CBA)

CBA1 Expansion, upskilling and support of ASHWs through focus on role definition, links with SSWAHS AES, career paths, training, mentoring, supervision, involvement in policy and other forms of capacity building;
CBA2 Increase the number of Aboriginal staff in HIV/AIDS, STI and Hepatitis C services;
CBA3 Promote relevant trainee and scholarship programs.

Capacity Building of the Mainstream Workforce (CBM)

CBM1 Training for mainstream health staff engaged in providing care to Aboriginal clients;
CBM2 Cultural awareness training addressing issues of sexuality, sexual identity and sexual health;

Partnerships (P)

P1 Partnerships supported by MOUs with mainstream services and AHCCS';
P2 Sustain provision of Aboriginal sexual health workers in AHS' and ACCHS' to strengthen partnerships;
P3 Support of GPs and pharmacies through education on issues relating to Aboriginal clients, information and resources on service availability and referral options;
P4 Partnerships, pathways, education and information exchange with Drug Health services, Sexual Assault services and correctional facilities including for custodial clients in the community and after discharge;

Service Orientation (SO)

SO1 Reorient service access through availability of male and female staff, outreach, flexibility, partnerships;
SO2 Continued provision of safe sex resources from service outlets;
SO3 Explore models of culturally sensitive care and treatment services involving partnership and linked services case management models.

Working in Aboriginal Settings (WA)

WA1 Promotion of programs at community events;
WA2 Engage community elders and other key community members;
WA3 Provide regular culturally sensitive services within Aboriginal settings through outreach and peer education;
WA4 Work with youth services to provide services within youth settings such as youth centres, entertainment precincts, Juvenile Justice, youth groups, school open days.

Targeting Population Sub-Groups (TP)

TP1 Build on support services and provide Aboriginal specific safe sex education resources and programs among those at risk of HIV and STIs including young people, gay men and sistagirls;
TP2 Raise awareness of the range of NSP outlets, including pharmacies.

Surveillance of Disease Transmission (SD)

SD1 Develop and adapt existing data collections to augment surveillance data, improve accuracy and completeness of Aboriginality data, form local AHS surveillance working groups;
SD2 Implement cross-area systems to improve diagnosis, care and treatment of Aboriginal people with syphilis.

Model of Care

- Target youth aged 16-30;
- Early intervention through "active outreach";
- Enhance the Aboriginal workforce within sexual health services;
- Strengthen partnerships with ACCHS';
- Deliver localise State community awareness campaigns;
- Enhance cultural safety aspects of sexual health service provision;
- Enhanced surveillance of STI infection;
- Enhanced voice of Aboriginal people in policy and planning;
- Improve the pathways across primary and specialist care – patient journey and referral mechanisms;
- Improve linkages with general practice – information, education and enhancement of continuity of care.

Action Initiatives

IS1 Improving access for young Aboriginal people (16-24 years) through provision of outreach STI testing (urine only) at key gathering points for Aboriginal youth.
IS2 Provide comprehensive health information and education on sexual health issues to community groups at community based venues and support State & National campaigns at a local level.
IS3 Improve access and pathways to specialist care and associated services for people with Hepatitis C.
IS4 Strengthen the capacity of SSWAHS sexual health services through increased employment of Aboriginal staff and enhancement of their skills.
IS5 Enhance the participation of Aboriginal staff in the policy and planning development process for sexual health services in SSWAHS.
IS6 Advance issues of cultural safety and respect for identity of Aboriginal people within sexual health services.
IS7 Enhance surveillance of STIs in Aboriginal communities.
IS8 Engage more effectively with primary care providers of significance in Aboriginal communities.
IS9 Engage with Justice Health to provide post-release support on sexual health issues and engagement into treatment for former prisoners.

<table>
<tr><th>IS1</th><th colspan="4">Improving access for young Aboriginal people (16-24 years) through provision of outreach STI testing (urine only) at key gathering points for Aboriginal youth.</th><th>POA: SO1, WA1, WA3, WA4, TP1</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal male and female youth (16-24 years) participating in formal and informal community gatherings.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Early identification of asymptomatic or minimally symptomatic sexually transmittable infection among Aboriginal youth who have not proactively sought care.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)
Occasions of outreach to community gathering places, the number of STI tests undertaken.
The number of positive tests reported, success of follow-up and engagement into treatment.
On-going surveillance of STI prevalence rates</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">2006 LRSHC – 237 OOS (3.19% of total activity)
2006 BPC – 197 OOS (1.84% of total activity)</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">There has been little success in enabling Aboriginal people's access to mainstream sexual health services operating from fixed outlets at Marrickville and Bigge Park.
Previous attempts to facilitate Aboriginal youth access to targeted clinics at SSWAHS outlets (Marrickville) has been unsuccessful attracting 1-2 clients per week only and very few males.
Evaluation of the SSWAHS (EZ) Aboriginal Sexual Health Strategy 2004-06 indicated that despite significant effort to ensure that the clinics were culturally sensitive, gender specific, walk-in, Aboriginal staffed, free and well advertised, attendance was disappointing. This is despite a community survey (97 respondents) that indicated that the model of targeted fixed site clinics had community support.
National strategy supports strategies to facilitate access, enhance and expand sexual health services, particularly to those aged 15-30 years.
There is inconclusive quantitative evidence that the prevalence of STIs in the youth of urban Aboriginal communities is higher than that in the general community e.g. a meta-analysis of the prevalence of Chlamydia trachomatis in Australia 1997-2004 indicated higher rates in Indigenous populations although this did not delineate urban/regional variations and it is likely that targeted screening practices impacted on routine surveillance data. Over the whole Australian community the highest rates were in pregnant adolescents and disadvantaged youth.
SSWAHS sexual health service advise that an alternative model of delivering clinical services to Aboriginal communities through "active outreach" is required, involving a packaged program of STI testing and associated health education and information, at venues where significant numbers of Aboriginal youth attend.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Targeted clinics at mainstream fixed sites do not work.
Qualitative expert advice that "active outreach" should be explored.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS Sexual Health Services</td><td colspan="2">Provide outreach testing, health education and information, follow-up of testing, engagement into treatment and surveillance.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS service venues seeing significant numbers of Aboriginal youth
Other government agencies facilitating community gatherings
Aboriginal Controlled Organisations facilitating community gatherings
Other NGOs facilitating community gatherings</td><td colspan="2">Providing and supporting venue for testing.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Identify the venues and frequency of attendance for "active outreach'
Prepare health education and information packages tailored to target population
Engage and establish enduring partnerships with partners in service provision
Pilot the process in selected venues
Expand reach and frequency consistent with demonstrated achievements.</td><td>2009-10
2009-10

2009-10 & ongoing

2009-10
2010-11 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Nil additional</td><td>Internal</td></tr>
<tr><td rowspan="2">Link</td><td rowspan="2">Plan Reference</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>R4, F1, F4</td><td>1.2, 1.6, 2.1, 3.1, 3.2, 3.4, 4.3, 5.1.</td><td>H, FYP</td><td>3b.6, 4a.4, 1c.4, 2b.5, 3a.2</td></tr>
</table>

<table>
<tr><th colspan="2">IS2</th><th colspan="3">Provide comprehensive health information and education on sexual health issues to community groups at community based venues and support State & National campaigns at a local level.</th><th>POA: PP4, PP6, WA1, WA2, WA3, WA4, TP1</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal communities in SSWAHS, with a focus on young people</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Increased Aboriginal community awareness and knowledge of sexual health issues.
Increased rates of screening for STIs and BBIs amongst Aboriginal people.</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="4">Measure rates of screening for STIs and BBIs amongst Aboriginal clients of SSWAHS services
Measure changes in of level of awareness and knowledge within selected Aboriginal community groups
Explore possibility of funding the Aboriginal Health & Medical Research Council of NSW (AH&MRC) to over-sample from SSWAHS when conducting surveys.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">NSW surveillance data on Aboriginal people are incomplete, but HIV, STIs and hepatitis B & C continue to be a significant source of morbidity among Aboriginal people in NSW.
Aboriginal people are under-represented as clients of SSWAHS sexual health and hepatitis C services.
The 2003 AH&MRC BBI project recommended building Aboriginal community awareness, understanding and ownership of BBI issues.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">Aboriginal sexual health workers in both the inner west and south west of the Area have undertaken community education for several years. This has taken a number of forms and has included involvement in:
• Aboriginal Women's Health Camps (Biyani and Mudjingal)
• Working with existing Aboriginal men's and women's groups
• Partnerships with youth services
▪ Involvement in public events including NAIDOC Week, Sorry Day, Youth Week, Sexual Health Week & World AIDS Day</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Taking a holistic approach e.g. raising sexual health in the context of reproductive health and relationships. Ensuring that community education programs are led by Aboriginal workers. Arts and sports-based events are often well-attended. Creating Aboriginal specific resources, including safe sex packs, is effective. A coordinated, Area-wide approach is ideal. Aboriginal Sexual Health Nurse and Aboriginal Sexual Health Promotion Officers working together is the best approach.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Aboriginal Sexual Health Promotion Officers.
Aboriginal Sexual Health Nurse.</td><td colspan="2">Design and deliver community education programs, in partnership with Aboriginal community organisations.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Aboriginal community organisations, including Aboriginal Medical Services.
Aboriginal health workers within SSWAHS.</td><td colspan="2">To advise and assist in designing and implementing programs for Aboriginal community groups.</td></tr>
<tr><td rowspan="9">Actions</td><td rowspan="9">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Develop an annual calendar of events, to be coordinated across the Area. Ensure that sexual health programs are included at these events. Key events for the calendar will be: NAIDOC Week, Sorry Day, Youth Week, Sexual Health Week & World AIDS Day.</td><td>2009-10</td></tr>
<tr><td colspan="3">Support recipients of Sexual Health Week grants to implement programs for Aboriginal youth.</td><td>2009-10</td></tr>
<tr><td colspan="3">Focus on continued partnerships with Glebe Youth Service and Marrickville Youth Resource Centre, building on the Memorandums of Understanding in place with these services.</td><td>On-going</td></tr>
<tr><td colspan="3">Develop similar partnerships with youth services in the south west which access large numbers of Aboriginal youth.</td><td>2009-10</td></tr>
<tr><td colspan="3">Continue to develop locally relevant Aboriginal-specific sexual health resources.</td><td>On-going</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Printed resources providing targeted information of relevance to Aboriginal communities in the areas of HIV, hepatitis B & C and STIs</td><td>HARP</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>R4, F1, F4, F5</td><td>1.2, 3.1, 3.2, 4.3, 5.1</td><td>H, E, CH</td><td>4a.4, 1a.2, 1b.2, 1c.4, 2b.5</td></tr>
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IS3	Improve access and pathways to specialist care and associated services for people with Hepatitis C.				POA: PP4, P3, TP1, CBA1, CBA2, SO1, SO3
Goals	Who are we targeting	Aboriginal people living with hepatitis C			
	What benefit are we aiming for	To improve knowledge of hepatitis C treatment options in the Aboriginal community. To improve the uptake of hepatitis C treatment by Aboriginal people within SSWAHS			
	How will we know we have succeeded	**What we will measure (performance Indicators)**			
		Increased Aboriginal community awareness of hepatitis C, including treatment options. Increased numbers of Aboriginal people accessing SSWAHS hepatitis C treatment services.			
Rationale	What does current data tell us	Of those individuals diagnosed with hepatitis C whose ethnicity was recorded in NSW, 10% were Aboriginal c.f. Aboriginal population in NSW being approximately 2.4% of the total population (NSW HIV/AIDS, STI and Hepatitis C Strategies Implementation Plan for Aboriginal People). Aboriginal people are under-represented as patients of SSWAHS hepatitis C treatment services.			
	The Story on what's happened till now	A partnership has been established between Redfern AMS and Gastroenterology and Liver Services (EZ), with an Aboriginal hepatitis C nurse providing services at the AMS. The groundwork has been laid for a partnership between Tharawal Aboriginal Medical Service and Gastroenterology and Liver Services (WZ). REPIDU's primary health clinics at Redfern and Canterbury offer hepatitis C testing and referral. Outreach clinics at Miller and other south western Sydney venues are being negotiated. The Aboriginal sexual health nurse will offer hepatitis C testing and referral as part of these clinics. "Chopped Liver" will be performed in Campbelltown and Glebe to raise hepatitis C awareness. The Aboriginal-targeted 'Play Your Cards Right' resource includes hepatitis C information and continues to be widely distributed to Aboriginal communities. 'Under Your Skin', a new deck of playing cards addressing blood borne viruses being developed by WZ Sexual Health Promotion, includes Aboriginal-targeted images and messages. A project for carers of people with hepatitis C is being developed in the EZ.			
	What do we know does or doesn't work	There is a lack of evidence about effective ways to support Aboriginal people to access hepatitis C treatment. Delivering services in an opportunistic and flexible way is considered necessary; there has been little success in successfully engaging people in unstable living situations, or current injecting drug users, into hepatitis C treatment.			
Responsibility	Who will lead?	**Who's Responsible**		**Their Role**	
		Aboriginal Sexual Health Workers (Sexual Health - HARP Health Promotion Teams)		Lead the development and implementation of the strategies.	
	Who will help?	**Who's partnering**		**Their Role**	
		Hepatitis C clinicians (Gastro & Liver Clinical Stream) Primary Care – ACCHS & GPs SSWAHS AHWs		Working in partnership with the Aboriginal Sexual Health Workers	
Actions	What we will do and by when	**Our Actions**			**By when**
		Identify outreach opportunities for the Aboriginal sexual health nurse e.g. Miller women's group, Hoxton Park CHC, Tharawal.			2009-10
		Evaluate success of retreat for Aboriginal people with hepatitis C held at Picton Healing Centre, with a view to further retreats being held.			2009-10
		Consult retreat participants about design of a hepatitis C resource.			2009-10
		Community education about hepatitis C to be provided by ASHWs.			2009-10 & ongoing
		Cultural awareness training for hep C treatment providers by ASHWs.			2009-10 & ongoing
		All SSWAHS programs designed to raise awareness of hepatitis C treatment will prioritise Aboriginal communities.			2009-10 & ongoing
		All ASHWs will undertake Mental Health First Aid training, and will train carers of Aboriginal people on hepatitis C treatment.			2009-10 & ongoing
		GPs with high Aboriginal caseloads targeted for ASHM hep C training.			2009-10 & ongoing
		What additional resources do we need			**Source of funds**
		Hepatitis C information resources specifically targeted at Aboriginal people.			AHMRC and/or NSW Health special purpose funding or local existing project funding.
Link	Plan	**State Plan**	**State Health Plan**	**TWT**	**SSW Strategic Plan**
	Reference	S8, F1, F4, F5,	1.2, 2.1, 2.5, 3.1, 3.2, 3.4, 4.3, 5.1	H, J, FYP	4a.4, 1b.2, 1c.1, 2b.5, 3a.2

IS4	Strengthen the capacity of SSWAHS sexual health services through increased employment of Aboriginal staff and enhancement of their skills				POA: CBA1, CBA@, CBA3, SO1
Goals	Who are we targeting	Sexual Health Service Managers ; Community Health Managers			
	What benefit are we aiming for	Increased access to sexual health services by Aboriginal communities Enhanced service delivery to Aboriginal communities			
	How will we know we have succeeded	What we will measure (performance Indicators)			
		Aboriginal designated positions remain filled; Aboriginal staff are supported in their positions; Aboriginal staff receive on-going training and career progression opportunities.			
Rationale	What does current data tell us	There are significant Aboriginal populations in the inner west and south west of SSWAHS. MDS data shows that Aboriginal people are under-represented as clients of sexual health services. Broader epidemiological data indicates higher rates of STIs and BBIs in Aboriginal communities, although local notification data does not consistently include information on Aboriginality.			
	The Story on what's happened till now	Two Aboriginal male and two Aboriginal female sexual health workers are employed in both the inner west and south west to cover men's and women's business. There is low turnover amongst SSWAHS Aboriginal sexual health workers and they have good access to training and support. An Aboriginal sexual health nurse commenced in an Area-wide position in April 2008 and is in the process of establishing outreach sexual health clinics. An Aboriginal Assistant in Nursing (AIN) has recently been appointed to work in hepatitis C with Gastroenterology and Liver Services in the inner west.			
	What do we know does or doesn't work	Previous success in retaining Aboriginal staff is due to support from management; the establishment of advisory committees; and having realistic work plans. Difficulties include overloading new staff with training commitments; finding a workable balance between the need for clinical skills development and community liaison work; and ensuring that permanent positions are available for Aboriginal trainees.			
Responsibility	Who will lead?	Who's Responsible		Their Role	
		Director, Sexual Health Service General Manager, Community Health Director, Aboriginal Health Manager, HIV/AIDS & Related Programs		Line management of Aboriginal staff Senior management of staff Monitoring and advisory role Reporting to NSW Health; funding distribution	
	Who will help?	Who's partnering		Their Role	
		SSWAHS Aboriginal Workforce Development Redfern and Tharawal ACCHS' Other Area Health Services		Monitoring and advisory role Mentoring, support and partnership Mentoring, support and partnership	
Actions	What we will do and by when	Our Actions			By when
		As Aboriginal outreach clinics are piloted in 2009, identify future staffing needs.			2009-10
		Ensure that the Aboriginal sexual health workers and sexual health nurse are well supported - by management and by a team based approach to their work.			2009-10 & ongoing
		Experienced Aboriginal Sexual Health workers will act as mentors to new staff (this may be part of a broader Aboriginal health mentorship program).			2009-10 & ongoing
		Support Aboriginal sexual health staff to undertake the AHMRC Diploma of Aboriginal Sexual Health.			2009-10 & ongoing
		Ensure all Aboriginal sexual health staff attend Aboriginal Mental Health First Aid training.			2009-10 & ongoing
		Explore options for establishing an Aboriginal sexual health nurse cadetship or graduate traineeship. This could possibly be done in partnership with another Area Health Service, to guarantee permanent employment at the end of the traineeship.			2009-10
		Maintain the existing training opportunities available to Aboriginal staff via the Workforce Development Program.			2009-10 & ongoing
		What additional resources do we need			Source of funds
		Possible need for additional Aboriginal identified positions, to be determined in 2009-10.			Potential Commonwealth &/or State special purpose funding.
Link	Plan	State Plan	State Health Plan	TWT	SSW Strategic Plan
	Reference	F1, P4	1.2, 2.1, 2.5, 3.2, 4.3, 6.1, 6.2, 6.3	H, E, ED	4a.4, 6a.7, 6b.5, 5a.3, 6a.3, 6a.4, 6a.6, 6b.4

IS5	Enhance the participation of Aboriginal staff in the policy and planning development process for sexual health services in SSWAHS			POA: PP1, PP5, CBA2, CBM2
Goals				
Who are we targeting	Sexual Health Service management and staff Aboriginal Sexual Health Workers			
What benefit are we aiming for	Improving service delivery to Aboriginal people. Improving engagement and consultation with Aboriginal communities. Improving advocacy for Aboriginal issues.			
How will we know we have succeeded	What we will measure (performance Indicators)			
	Aboriginal Health Impact Statements completed for all Sexual Health Service initiatives. Regular meetings of all Aboriginal Health Workers and their line managers. ASHWs are represented at all Aboriginal Sexual Health Advisory Group meetings. Infectious Diseases and Sexual Health is a standing agenda item at AHWs Forum meetings. Senior ASHWs participate in the Senior Aboriginal Officers Group.			
Rationale				
What does current data tell us	Best practice evidence points to involvement of Aboriginal staff in planning and delivering sexual health services, to ensure that planning models meet community needs and reflect Aboriginal values, customs and cultural expectations.			
The Story on what's happened till now	Aboriginal Sexual Health Workers have been involved at various levels in the planning of sexual health service delivery but to date there has been no formalised approach to engagement in these processes.			
What do we know does or doesn't work	What doesn't work – ASHWs working in isolation in mainstream services; ASHWs advocating for Aboriginal communities without support from senior management; sexual health service delivery developed with inadequate input from Aboriginal workers and Aboriginal communities.			
Responsibility				
Who will lead?	Who's Responsible		Their Role	
	Aboriginal Health Director & HIV/AIDS & Related Services Manager		Co-chairs, Aboriginal Sexual Health Advisory Group.	
	Aboriginal Health Director		Oversee mentoring and support arrangements for Aboriginal Sexual Health Workers.	
	Sexual Health Director		Aboriginal Health Impact Statements; supporting Aboriginal staff to participate in relevant meetings and mentoring/support.	
Who will help?	Who's partnering		Their Role	
	Aboriginal Sexual Health Workers		Providing expert input into service planning	
	AHMRC		Supporting and resourcing activities	
	AIDB – NSW Health		Supporting and resourcing activities	
Actions				
What we will do and by when	Our Actions			By when
	Aboriginal Health Impact Statements will be mandatory for all Sexual Health Service planning, research and program development activities.			2009-10 & ongoing
	Key Sexual Health Service staff required to attend workshops on Aboriginal Health Impact Statements.			2009-10
	Regular meetings of all Aboriginal Sexual Health Workers and their line managers will be established (based on a successful model used by Aboriginal Mental Health Workers).			2009-10 & ongoing
	Cultural management by Bangala will be maintained for Aboriginal Sexual Health Workers.			2009-10 & ongoing
	ASHWs will be represented on the Area-wide Aboriginal Sexual Health Advisory Group.			2009-10 & ongoing
	Updates on Aboriginal Health Plan PAWGs, including Infectious Diseases and Sexual Health, will be on the agenda of all AHWs Forum meetings.			2009-10 & ongoing
	Senior Aboriginal Sexual Health Workers will participate in the Senior Aboriginal Officers Group.			2009-10 & ongoing
	Other actions relevant to this strategy - IS3 which includes cultural awareness training for hepatitis C treatment providers IS4 involving mentoring support for Aboriginal Sexual Health Workers.			
	What additional resources do we need			Source of funds
	Nil additional			N/A
Link				
Plan Reference	State Plan	State Health Plan	TWT	SSW Strategic Plan
	S8, F1	2.5, 3.2, 4.3, 5.2	H, CH	4a.4, 6a.7, 6a.9

<table>
<tr><th>IS6</th><th colspan="4">Advance issues of cultural safety and respect for identity of Aboriginal people within sexual health services</th><th>POA: PP4, CBM1, CBM2, SO1, SO3</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal clients of sexual health services.
Aboriginal staff of sexual health services.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">To make sexual health services accessible and culturally appropriate for Aboriginal clients and staff.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)
Increased numbers of Aboriginal people accessing SSWAHS sexual health services.
Retention of Aboriginal staff.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Nationally, the prevalence of STIs amongst Indigenous People is reported to be up to eight times higher than for the non-Indigenous population, due in part to poor access to services experienced by many Aboriginal people (NSW HIV/AIDS, STI and Hepatitis C Strategies Implementation Plan for Aboriginal People).
Aboriginal people are under-represented as clients of SSWAHS sexual health services.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">Aboriginal cultural awareness training for sexual health staff
Clinics targeted specifically for Aboriginal community attendance
Open days for the Aboriginal community.
Outreach activities from sexual health clinics
Availability of Aboriginal staff to support aboriginal clients.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Aboriginal-specific clinic times have not been successful in attracting significant client numbers. Creating a culturally appropriate and respectful environment in the clinics is effective, as is having Aboriginal staff available to support clients if required. Promoting sexual health clinics to Aboriginal communities and providing outreach to Aboriginal community venues is considered effective.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Director, Sexual Health</td><td colspan="2">To oversee the implementation of this strategy</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Director, Aboriginal Health</td><td colspan="2">To support the implementation of this strategy</td></tr>
<tr><td rowspan="13">Actions</td><td rowspan="13">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">Audit sexual health services to ensure that they comply with NSW Aboriginal Health Cultural Safety Standards.</td><td>2009-10</td></tr>
<tr><td colspan="3">Complete an Aboriginal Health Impact Statement for all proposed sexual health clinical and health promotion programs.</td><td>Ongoing</td></tr>
<tr><td colspan="3">Ensure that all sexual health service staff attend annual Aboriginal cultural awareness training.</td><td>Ongoing</td></tr>
<tr><td colspan="3">Ensure that all new sexual health staff meet with senior Aboriginal Sexual Health Workers as part of their orientation.</td><td>Ongoing</td></tr>
<tr><td colspan="3">Ensure that Aboriginal-specific resource material is clearly displayed at sexual health services.</td><td>2009-10 & ongoing</td></tr>
<tr><td colspan="3">Wherever possible, Aboriginal sexual health staff to be available to support Aboriginal clients at sexual health clinics.</td><td>2009-10 & ongoing</td></tr>
<tr><td colspan="3">Aboriginal Sexual Health Nurse and Aboriginal Sexual Health Workers will conduct outreach to Aboriginal community venues.</td><td>2009-10 & ongoing</td></tr>
<tr><td colspan="3">Promote to Aboriginal communities the days that the Aboriginal Sexual Health Nurse works at RPAH and Bigge Park Centre Sexual Health Clinics.</td><td>2009-10 & ongoing</td></tr>
<tr><td colspan="3">Provide additional clinical services to Aboriginal clients (e.g. Gardisil vaccination, pap smears).</td><td>2009-10 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">More Aboriginal-targeted sexual health and BBV resources.</td><td>Seek special purpose funding where available.</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="2">Link</td><td rowspan="2">Plan Reference</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>S8, F1, F4</td><td>2.1, 2.4, 3.1, 3.2, 3.4, 4.3, 6.2</td><td>H, CH, ED</td><td>4a.4, 6a.7, 1c.4, 2b.5, 3a.2</td></tr>
</table>

IS7	Enhance surveillance of STIs in Aboriginal communities				POA: PP2, PP3, P3, SD1, SD2
Goals	Who are we targeting	SSWAHS sexual health services General Practitioners Laboratories			
	What benefit are we aiming for	For service planning to be informed by more accurate Aboriginal STI data.			
	How will we know we have succeeded	What we will measure (performance Indicators)			
		By conducting on-going annual reviews of STI notification data for Aboriginal people and using this information to inform service goals.			
Rationale	What does current data tell us	There are small but concerning rates of syphilis transmission in Aboriginal people in SSWAHS. There are significant rates of latent syphilis in Aboriginal communities. The syphilis epidemic amongst gay men has the potential to spread into the Aboriginal community. The younger demographic of the Aboriginal community means that Chlamydia is an issue, as young people are over-represented in Chlamydia notifications. There is no reliable data about rates of gonorrhoea in NSW Aboriginal communities, but it is known that rates are higher in rural areas and that gonorrhoea is usually a marker of poor access to health care.			
	The Story on what's happened till now	Most notifications are made by laboratories and Aboriginality is not specified on their forms. The SSWAHS Public Health Unit conducts enhanced syphilis surveillance. This has been very beneficial, for example by ensuring proper follow-up for young pregnant women with syphilis. The PHU does not currently undertake enhanced surveillance for hepatitis B, but follow up acute cases. This acute case follow-up has not so far revealed a significant problem in the Aboriginal community. RPAH Sexual Health Service is involved in the HIV observational database, a 10 year project of the National Centre in HIV Epidemiology and Clinical Research (NCHECR), which includes the collection of Aboriginality data.			
	What do we know does or doesn't work	Labs and GPs often don't identify Aboriginality on notification forms. Follow-up with Aboriginal patients can be difficult as they may change doctors. Short term enhanced surveillance projects are not useful. Such projects should be conducted over at least five years.			
Responsibility	Who will lead?	Who's Responsible		Their Role	
		SSWAHS Public Health Unit		Collection and analysis of notification data. Enhanced surveillance for syphilis and gonorrhoea.	
		RPAH Sexual Health Service and Aboriginal Sexual Health Advisory Committee (ASHAC)		Participation in Access Project	
	Who will help?	Who's partnering		Their Role	
		SSWAHS Sexual Health Clinics Laboratories General Practitioners		Refine procedures to improve recording of Aboriginality.	
Actions	What we will do and by when	Our Actions			By when
		▪ Continue enhanced surveillance for syphilis.			On-going, long-term
		▪ Commence enhanced surveillance for gonorrhoea amongst women, Area-wide, for a minimum of five years.			From 2009-10 for at least 5 years
		▪ Commence enhanced surveillance for gonorrhoea amongst men in Western Zone only (south west).			From 2009-10 for at least 5 years
		▪ PHU to continue to liaise with laboratories and GPs regarding inclusion of Aboriginality on notification forms. This issue is being taken up at a national level by the National STI Working Group.			On-going
		▪ Analyse SSWAHS syphilis and gonorrhoea data from the last five years			2009-10
		▪ RPAH Sexual health service to participate in the "Access" project, a database on Chlamydia risk factors for clients of sexual health services., GPs and Aboriginal Medical Services (this project has AH&MRC approval).			On-going, commenced late 2008
		What additional resources do we need			Source of funds
		Nil			N/A
Link	Plan Reference	State Plan	State Health Plan	TWT	SSW Strategic Plan
		F1, F4	1.2, 3.1, 3.2, 3.4, 4.3, 5.1	H, FYP	4a.4, 1c.1, 1c.4

<table>
<tr><th colspan="2">IS8</th><th colspan="3">Engage more effectively with primary care providers of significance in Aboriginal communities.</th><th>POA: P1, P2, P3, P4, SO3, TP2</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="4">General Practitioners, Redfern and Tharawal ACCHS, pharmacotherapy providers</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Increased levels of STI testing for Aboriginal clients of GPs and Redfern and Tharawal ACCHS. Enhanced capacity of these health care providers to provide STI clinical care. Increased rates of vaccination against hepatitis A & B for Aboriginal clients of these services. Improved referral pathways for Aboriginal clients of these services to specialist sexual health and BBV services.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)
Levels of STI testing and treatment at ACCHS'
Numbers of in-services provided to relevant service providers including AMS & pharmacotherapy services
Numbers of GPs with high Aboriginal caseloads attending training
Numbers of GPS with high Aboriginal caseloads taking up RPAH Sexual Health Clinic clinical attachments
Increased referrals of Aboriginal clients to SSWAHS sexual health, HIV and hepatitis C services</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Aboriginal STI notification data is incomplete & unreliable.
Aboriginal people have less access to appropriate health care, including sexual health services
Approximately 30 – 40% of RPAH methadone clinic clients are Aboriginal</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">There have been some successful initiatives including Hepatitis C clinics at Redfern and Tharawal AMS'; sexual health training for Redfern AMS clinicians and STI partnerships with Tharawal AMS.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Working with GPs is known to be most effective when engagement is through Divisions of General practice. In working with AMS' successful practice includes engagement within the context of respectful partnerships and acknowledgement of the leadership role of the AMS.</td></tr>
<tr><td rowspan="6">Responsibility</td><td rowspan="3">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS HARP Health Promotion Teams</td><td colspan="2">Identify GPs; coordinate training; distribute resources. Establish relationships with relevant SSWAHS Aboriginal Health teams.</td></tr>
<tr><td colspan="2">SSWAHS Sexual Health Services</td><td colspan="2">Provide clinical attachments. Be involved in the provision of training to GPs and other service providers.</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">ASHM, Divisions of General Practice, ACCHS', Aboriginal community groups, SSWAHS Aboriginal Health teams</td><td colspan="2">Participate in design and delivery of training & in-services. Support staff to attend.</td></tr>
<tr><td rowspan="10">Actions</td><td rowspan="10">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">▪ HARP Health Promotion teams will identify GPs with significant Aboriginal caseloads, through consultation with the Australasian Society of HIV Medicine (ASHM), Divisions of General Practice, Aboriginal Medical Services and the Aboriginal community. Work with ASHM to provide 'category 1' training to these GPs, based on the STIGMA GP training project model.</td><td>2009-10 & on-going</td></tr>
<tr><td colspan="3">▪ Encourage GPs with high Aboriginal caseload to undertake RPAH Sexual Health Clinic's program of paid clinical attachments. The clinical attachments include work in HIV and sexual health clinics and attract category 1 CME points.</td><td>2009-10 & on-going</td></tr>
<tr><td colspan="3">▪ Provide identified GPs with Aboriginal-specific sexual health promotion materials.</td><td>2009-10 & on-going</td></tr>
<tr><td colspan="3">▪ Incorporate Aboriginal specific information into existing in-services for public and private pharmacotherapy providers.</td><td>2009-10 & on-going</td></tr>
<tr><td colspan="3">▪ Explore possibilities for providing sexual health in-services for SSWAHS Aboriginal mental health and Aboriginal early childhood workers</td><td>2009-10 & on-going</td></tr>
<tr><td colspan="3">▪ Provide annual sexual health in-services for ACCHS GPs and nurses</td><td>2009-10 & on-going</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Approximately $10,000 for ASHM GP Aboriginal sexual health training course (based on previous STIGMA project)</td><td>HARP
NSW Health</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, F3, P4</td><td>2.5, 3.2, 3.3, 3.4, 4.3, 6.3</td><td>H, E, FYP</td><td>4a.4, 1a.2, 1b.2, 1c.1, 1c.4, 3b.7</td></tr>
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<tr><th>IS9</th><th colspan="3">Engage with Justice Health to provide post-release support on sexual health issues and engagement into treatment for former prisoners.</th><th colspan="2">POA: PP4, P4, SO1, SO3, WA4</th></tr>
<tr><td rowspan="3">Goals</td><td>Who are we targeting</td><td colspan="4">Aboriginal people (men and women) leaving prisons and Juvenile Justice Centres and returning to postcodes in Sydney South West Area Health Service.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="4">Aboriginal ex-prisoners and detainees will be aware of and linked into SSWAHS HIV/AIDS, STI and hepatitis C testing, treatment and support services.</td></tr>
<tr><td>How will we know we have succeeded</td><td colspan="4">What we will measure (performance Indicators)
We will evaluate information resources and programs to determine their reach and the level of uptake by the target group.</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="4">Hepatitis C prevalence amongst prisoners is very high and Aboriginal people are significantly over-represented in the prison system. Of those individuals diagnosed with hepatitis C whose ethnicity was recorded in NSW, 10% were Aboriginal. This compares with the Aboriginal population in NSW being approximately 2.4% of the total population (NSW HIV/AIDS, STI and Hepatitis C Strategies Implementation Plan for Aboriginal People). Nationally, the prevalence of STIs amongst Indigenous People is reported to be up to eight times higher than for the non-Indigenous population, due in part to poor access to services experienced by many Aboriginal people (NSW HIV/AIDS, STI and Hepatitis C Strategies Implementation Plan for Aboriginal People).

The 2006 NSW Inmates Census (NSW Department of Corrective services 2006) showed that the last known address of inmates included:
* Fairfield/Liverpool 8.6% * Canterbury/Bankstown 5.7%
* Outer South Western Sydney 4.0% * Inner Western Sydney 1.6%

There are a number of halfway houses for ex-prisoners in the inner west of Sydney. It is reported that many Aboriginal ex-prisoners return to Redfern and other inner west locations upon their release.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="4">There are is one adult women's jail (Berrima) and one male Juvenile Detention Centre (Reiby) in SSWAHS boundaries. Both have a large proportion of Aboriginal inmates. In the past Traxside Youth Health Service and Bigge Park Sexual Health Service have separately provided staff training and education to detainees at Reiby. Yasmar Juvenile Detention centre for girls used to be based in the inner west and a partnership project produced a sexual health resource for young detainees. It is hoped that this resource will be reprinted.
The Sexual Health Promotion Team in the inner west has run a program with Aboriginal male clients of the Newtown Probation and Parole office. Aboriginal sexual health workers from the inner west team have provided interviews for the Jailbreak radio program. An Aboriginal sexual health worker from the south west sexual health promotion team currently runs a fortnightly program at Berrima Women's Correctional Centre.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="4">Previous successes include the arts based programs run at Berrima and through Newtown Probation and Parole; Youth-focused programs run at Reiby by Traxside Youth Health Service; and the partnership project with Yasmar which produced a useful and popular resource.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">SSWAHS Director of Aboriginal Health</td><td colspan="2">Arrange a meeting with Corrective Services and Justice Health to establish a way forward to support Aboriginal ex-prisoners returning to SSWAHS</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="2">Their Role</td></tr>
<tr><td colspan="2">Sexual Health, Justice Health, Corrective Services, Probation and Parole, Drug Health, Mental Health, Sexual Health, the Public Health Unit and Community Restorative Centre.</td><td colspan="2">To partner in producing a resource for Aboriginal ex-prisoners and other projects identified.</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td>By when</td></tr>
<tr><td colspan="3">At a minimum, we will produce a resource for Aboriginal ex-prisoners with information and referrals about sexual health, hepatitis and HIV. Possibilities for other projects will be explored in collaboration with partners listed above.</td><td>2010-11</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td>Source of funds</td></tr>
<tr><td colspan="3">Project worker may be required to work on continuity of care, referral links and information needs of prisoners post-release.</td><td>HARP</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td>SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, F4</td><td>1.2, 2.1, 2.5, 3.2, 3.4, 4.3</td><td>H, E, J, FYP</td><td>4a.4, 1c.1, 2b.5, 3b.7</td></tr>
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Principles of Action (POA)

Improving Oral Health Promotion (HP)

HP1 Promote access to Commonwealth funded oral health programs targeting Aboriginal people inc. continuing Enhanced Primary Care initiatives and other evolving initiatives.
HP2 Improve capacity of general health care providers to identify oral health conditions, refer appropriately and provide basic oral health promotion messages.
HP3 Broad based oral health promotion through media targeted to Aboriginal communities.
HP4 Include an oral health component in broader health promotion, health education, preventative health care and health literacy activities undertaken with Aboriginal communities.
HP5 Support advocacy for oral health through community support groups operating in Aboriginal communities.
HP6 Provide chair side oral health promotion advice, including on smoking cessation, hygiene and dietary advice etc
HP7 Provide culturally appropriate oral health information targeting pregnant women, parents, school aged children and adolescents, young adults, women's and men's groups, Elders.

Integration and Partnerships (IP)

IP1 Develop partnerships with stakeholders (including primary care providers) of relevance to priority populations including maternal care, infants and preschool children, school aged children, adolescents, young adults and elders
IP2 Improve care coordination with primary care providers for people with chronic conditions and complex needs and Elders
IP3 Integrate oral health within broader policy initiatives (inter-agency) including early childhood, school and curriculum, youth, aged care, healthy ageing, carers.

Strengthening the Oral Health Workforce (HW)

HW1 Expand workforce and professional development opportunities for Aboriginal oral health/dental health staff
HW2 Increase workforce available to provide assessment, follow up and early intervention for priority populations including in maternal care, infants, preschool, youth adults with diabetes and elders.

Improve Access to Oral Health Services (AO)

AO1 Identify and address barriers to access including transport issues and the provision of mobile services.
AO2 Strengthen school assessment programs.

Improving Data Collection (DO)

DO1 Support oral health research in Aboriginal communities

Creating an area Focus (AF)

AF1 Establish Aboriginal oral health steering committee
AF2 Develop AHS Strategic framework action plan for Aboriginal people

Model of Care

- Population health focus emphasising provision of culturally appropriate oral health promotion and education widely across Aboriginal communities;
- Target population health approaches to children, youth and young families;
- Include an oral health component in broader health promotion and preventative health programs within Aboriginal communities;
- Provide oral health messages and education to Aboriginal community groups;
- Raise the profile and improve service linkages and referral pathways for oral health with other SSWAHS clinical services provided within Aboriginal communities inc. chronic care, drug health, mental health, diabetes etc.
- Strengthen partnerships with AMS' to facilitate improved access for Aboriginal communities to general and specialist dentistry;
- Tailor Commonwealth initiatives to local environments to ensure optimal impact for initiatives to facilitate access into clinical care;
- Enhance the Aboriginal workforce within oral health services;
- Enhance knowledge of oral health among AHWs and AHEOs working within Aboriginal communities;
- Enhance cultural safety aspects of oral health service provision;
- Enhanced voice of Aboriginal people in oral health policy and planning;
- Improve linkages with general practice – provision of culturally appropriate oral health information, education and enhancement of early detection and referral to clinical care.

Action Initiatives

OH1 Increased access to mainstream publicly funded oral health services including engagement with the private sector through the Oral Health Fee for Service Scheme, the Pensioners Dental Scheme and the Medicare Enhanced Primary Care Scheme.
OH2 Emphasise oral health as an integral component of holistic care provision to Aboriginal communities within the context of preventative health measures (health promotion, education and early intervention).
OH3 Increase the number of SSWAHS workers and especially oral health professionals who have been trained in meeting the oral health needs of Aboriginal people in a culturally sensitive and supportive way.

OH1	Increased access to mainstream publicly funded oral health services including engagement with the private sector through the Oral Health Fee for Service Scheme, the Pensioners Dental Scheme and the Medicare Enhanced Primary Care Scheme.	POA: HP1, HP6, IP1, AO1, HW2.

Goals	Who are we targeting	All members of the Aboriginal Communities of the SSWAHS that are eligible to receive dental care through publicly funded oral health programs.
	What benefit are we aiming for	Improved oral health of the Aboriginal communities in the SSWAHS by improving access to general and specialist primary oral health care services.
	How will we know we have succeeded	**What we will measure (performance Indicators)** A reduction in the prevalence of the common oral diseases among Aboriginal people including reductions in the rates of dental caries and periodontal disease. (DMFT, CPITN).
Rationale	What does current data tell us	The 2004 NACOH report tells us that Aboriginal children have twice the caries experience and a higher proportion of untreated dental caries than non-Aboriginal children. Aboriginal adults have more missing teeth than their non-Aboriginal counterparts and Periodontal Disease is significantly worse throughout the Aboriginal population.
	The Story on what's happened till now	All people wishing to access publicly funded dental services in NSW are initially triaged using the NSW State-wide Priority Oral Health Program and appointed for treatment according to need. Urgent cases are seen within defined timeframes. When the treatment required is not considered urgent patients are advised that they have been placed on a waiting list. Patients identified to be of Aboriginal or Torres Strait Islander descent are accelerated within these waiting lists. Eligible patients may be referred for treatment in the private sector using the OHFSS and the PDS Patients wishing to access dental care through the Commonwealth Medicare Enhanced Primary Care Scheme are referred to the private sector through their Medical Practitioner. It is reported that both Bankstown and Fairfield LGAs in particular, have limited culturally appropriate dental health service availability.
	What do we know does or doesn't work	Oral hygiene instruction, dietary advice, pit and fissure sealants, fluoride treatments and early restorative and reparative treatment of carious lesions are proven to be effective in improving oral health status.

Responsibility			
Who will lead?	**Who's Responsible**	**Their Role**
	SSW Oral Health Services	Provision of general and also specialist dental services to SSWAHS and NSW.
Who will help?	**Who's partnering**	**Their Role**
	Redfern and Tharawal ACCHS Private practitioners Centre for Oral Health Strategy	Additional general dental services OHFSS, PDS and EPC State-wide coordination of Aboriginal Oral Health Programs

Actions		
What we will do and by when	**Our Actions**	**By when**
	Provision of a full range of general and specialist dental services to the Aboriginal people residing in the SSWAHS	2009-10 & ongoing
	Explore opportunities to enhance the provision of culturally appropriate dental health services in Bankstown and Fairfield LGAs	2009-10 & ongoing
	Encourage eligible patients to seek care under the Medicare EPC whilst the program remains in operation	2009-10 & ongoing
	What additional resources do we need	**Source of funds**
	Increased Oral Health Workforce to provide more comprehensive and timely service	Internal and explore under C'wealth Dental Health Program

Link	State Plan	State Health Plan	TWT	SSW Strategic Plan
Plan Reference	F1, F5	1.3, 2.1, 2.5, 3.2, 3.4, 4.3	H	4a.4, 1c.1, 2b.2, 2b.5

OH2	Emphasise oral health as an integral component of holistic care provision to Aboriginal communities within the context of preventative health measures (health promotion, education and early intervention).				POA: HP3, HP4, HP7, IP1, IP2, IP3, HW2.
Goals	Who are we targeting	Aboriginal communities and the staff of mainstream health services within the SSWAHS			
Goals	What benefit are we aiming for	Improved general health of Aboriginal people by improving oral health status through a better understanding of the ways to prevent dental caries and periodontal disease			
Goals	How will we know we have succeeded	What we will measure (performance Indicators)			
		Demonstrated increased awareness of Aboriginal people and health staff of the important linkages of poor oral health to poor general health and also the causes of poor oral health.			
Rationale	What does current data tell us	Dental Caries and Periodontal Disease are almost entirely preventable maladies that affect Aboriginal people more than the general population. The adoption of a Population Health Approach will dramatically limit the effects of these diseases.			
Rationale	The Story on what's happened till now	Like many members of the general population many Aboriginal people remain unaware of the aetiology of dental disease. They also remain insufficiently aware that poor oral health can cause or accelerate many serious general health problems. There has been a reliance on treating dental disease rather than preventing it, or minimising its health impact			
Rationale	What do we know does or doesn't work	Targeting oral health promotion messages to new Aboriginal parents and young people should eventually have a dramatic flow-on effect to the entire Aboriginal community. Oral health promotion, in partnership with other activities such as Smoking Cessation Programs are proven to have cumulative effects.			
Responsibility	Who will lead?	Who's Responsible		Their Role	
		SSWOHS Aboriginal Health Unit Health Promotion Service Mainstream Clinical Services		Dissemination of oral health information to Aboriginal people and general health personnel.	
Responsibility	Who will help?	Who's partnering		Their Role	
		Redfern and Tharawal ACCHS		Collaborate in development of culturally specific community programs and strategies to promote oral health.	
Actions	What we will do and by when	Our Actions			By when
		Increased oral health promotion activity with strategies targeted at specific populations within Aboriginal communities.			2009-10 & ongoing
		Integration into other health promotion activities with particular emphasis on diabetes, cardiovascular disease, tobacco and alcohol, nutrition and drug health.			2009-10 & ongoing
		Targeted focus on integrating oral health into Child and Youth health promotion programs.			2009-10 & ongoing
		Implementation of the NSW Early Childhood Oral Health Program (ECOH – NSW Health PD2008_020) in all Aboriginal communities throughout the SSWAHS.			2009-10 & ongoing
		What additional resources do we need			Source of funds
		Recruitment of a Health Promotion Officer with special knowledge of Oral Health Promotion to join the Health Promotion Service			Explore Commonwealth funding opportunities
Link	Plan	State Plan	State Health Plan	TWT	SSW Strategic Plan
Link	Reference	F1, F4	1.3, 2.1, 2.5, 3.1, 3.2, 3.4, 4.3, 5.1	H, E, FYP	4a.4, 1a.2, 1b.2, 1c.5

<table>
<tr><th>OH3</th><th colspan="4">Increase the number of SSWAHS workers and especially oral health professionals who have been trained in meeting the oral health needs of Aboriginal people in a culturally sensitive and supportive way.</th><th colspan="2">POA: HP2, HP7, IP3, HW1, HW2, AO1.</th></tr>
<tr><td rowspan="4">Goals</td><td>Who are we targeting</td><td colspan="5">Aboriginal Health Workers, SSWAHS oral health staff and staff of mainstream clinical services.</td></tr>
<tr><td>What benefit are we aiming for</td><td colspan="5">Improvement in the oral health status of the Aboriginal people of the SSWAHS by developing a culturally aware workforce that is skilled in prevention, identification and management of oral diseases in the context of the Aboriginal community's special identity</td></tr>
<tr><td rowspan="2">How will we know we have succeeded</td><td colspan="5">What we will measure (performance Indicators)</td></tr>
<tr><td colspan="5">Increased utilisation of oral health services as a response to appropriate referrals of Aboriginal patients by other health disciplines
Increased awareness of all health workers of the special oral health risk factors endemic in the Aboriginal community e.g. diabetes</td></tr>
<tr><td rowspan="3">Rationale</td><td>What does current data tell us</td><td colspan="5">Insufficient health staff and oral health staff have undergone training in awareness of the special cultural needs of the Aboriginal community
Frontline staff from other health disciplines does not routinely include an oral health assessment when treating their Aboriginal patients.</td></tr>
<tr><td>The Story on what's happened till now</td><td colspan="5">Appropriate training in the identification of oral diseases has not been included in the education programs of medical, nursing and allied health personnel.
Paediatric specialist services have been engaged in the SSWAHS with the "Lift the Lip" Program but this needs to be expanded more widely.
Maternity and Early Childhood programs for Aboriginal mothers and families do not always include oral health training.</td></tr>
<tr><td>What do we know does or doesn't work</td><td colspan="5">Early dietary advice and training in oral hygiene procedures that is provided in a culturally sensitive way has been proven to reduce dental caries in Aboriginal children with flow-on effects into adolescence and adulthood.</td></tr>
<tr><td rowspan="4">Responsibility</td><td rowspan="2">Who will lead?</td><td colspan="2">Who's Responsible</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">Oral Health Services
Aboriginal Health Unit
SSWAHS Human Resources CEWD</td><td colspan="3">Facilitate educative programs in Aboriginal Health and cultural awareness</td></tr>
<tr><td rowspan="2">Who will help?</td><td colspan="2">Who's partnering</td><td colspan="3">Their Role</td></tr>
<tr><td colspan="2">Child and Family Services
Redfern and Tharawal AMS
Centre for Oral Health Strategy</td><td colspan="3">Provide input into program development and evaluation</td></tr>
<tr><td rowspan="4">Actions</td><td rowspan="4">What we will do and by when</td><td colspan="3">Our Actions</td><td colspan="2">By when</td></tr>
<tr><td colspan="3">Increased cultural awareness training for relevant personnel
Publicise and implement Early Childhood Oral Health (ECOH) Program with Aboriginal Health Workers</td><td colspan="2">2009-10 & ongoing
2009-10 & ongoing</td></tr>
<tr><td colspan="3">What additional resources do we need</td><td colspan="2">Source of funds</td></tr>
<tr><td colspan="3">From within existing resources</td><td colspan="2">Internal</td></tr>
<tr><td rowspan="2">Link</td><td>Plan</td><td>State Plan</td><td>State Health Plan</td><td>TWT</td><td colspan="2">SSW Strategic Plan</td></tr>
<tr><td>Reference</td><td>F1, P4</td><td>1.3, 2.1, 2.5, 3.2, 4.3, 6.3</td><td>H, E, CH, ED, FYP</td><td colspan="2">4a.4, 1b.2, 6a.4, 6a.5</td></tr>
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5. Implementation, Monitoring and Evaluation

The responsibility for implementation of the initiatives outlined within this Plan lies broadly across the organisational structure of SSWAHS. Some initiatives will remain the corporate responsibility of SSWAHS whilst many others will be the responsibility of individual clinical services operating within SSWAHS and the facilities within which clinical services are provided.

Each initiative allocates leadership responsibility in implementation and the key partners that will need to be involved for successful implementation. In addition, the domains in which performance will be measured and the performance indicators that will be developed to help evaluate the success of implementation are identified. Often, the target level of performance against these indicators will require further work and refinement as the initiatives are put in place.

There are a number of accountability mechanisms built in to ensure that SSWAHS can continue to monitor the extent to which the initiatives proposed are implemented across SSWAHS. An important aspect of this will include the ongoing mechanisms by which SSWAHS involves the Aboriginal communities of SSWAHS, including its Aboriginal Health workforce in advising on the best means of addressing Aboriginal Health Issues. These mechanisms include use of existing mechanisms such as:

- The Partnership Arrangements with the ACCHS at Redfern and Tharawal;
- The Aboriginal Health Worker Forum within SSWAHS that meets on a regular basis;
- The Senior Aboriginal Officers Group;
- Monitoring arrangements under existing plans and strategies which address Aboriginal health needs including the SSWAHS Aboriginal Employment Strategy;
- Ongoing operations of a fully supported Aboriginal Health Unit (AHU) and Aboriginal Health Executive Team (AHET).

Hierarchy of Performance Indicators

Higher level monitoring will be continued through performance indicators SSWAHS has committed to in the context of the NSW State Plan, NSW State Health Plan and SSWAHS Health Service Strategic Plan, as reflected in the Area's Performance Agreement with the NSW Health Department and also through indicators developed within the inter-agency plans SSWAHS participates in through multilateral Senior Officers Group and other whole of Government arrangements, including progressing of the *Two Ways Together* agendas.

The headline indictors in Aboriginal Health are included within the NSW Health Dashboard Indicators which form the major part of the Area Performance Agreement. There are also Aboriginal specific indicators in the Area Sustainable access Plan Agreement. Of necessity they represent a selection only of the many indicators that have been and continue to be developed nationally in the context of COAG and AHMAC and in NSW through the whole of Government *Two Ways Together* initiatives.

Dashboard Indicators Referencing Aboriginality – Area Performance Agreements 2008-09

Performance Agreement 2008/09

- Potentially avoidable deaths – persons aged <75 years (age adjusted rate per 100,000 population);
- Avoidable hospital admissions for conditions suitable for management in the home (number);
- Antenatal visits – confinements where first visit was before 20 weeks gestation (%);
- Low birth weight babies – weighing less than 2,500g (%);
- Aboriginal staff as a proportion of total (%);

Sustainable Access Plan Agreement 2008/09

- Reduction in bed days for Aboriginal people >45 years;
- Commence implementation of Aboriginal Chronic Disease Management Walgan Tilly Project solutions;
- PAS identification of Aboriginal people consistent with PD2005_547;
- % of Aboriginal people with a chronic disease participating in and completing rehabilitation, ComPacks and CAPAC programs;
- % of Aboriginal people with chronic disease followed up within 24-48 hours of discharge from hospital, by any member of the agreed health provider team;

Source: SSWAHS Performance Agreement 2008/09 and Sustainable Access Plan Agreement 2008/09.

A much broader range of indicators have been adopted at the State level under the auspices of Two Ways Together and these indicators have most recently been reported on in the 2008 publication *Two Ways Together Report on Indicators 2007*. These indicators are consistent with the indicators developed nationally through COAG and the Productivity Commission work. The indicators have been categorised within the TWT

priority areas and some are reported on at state level and others at regional level. The following table outlines these indicators.

Table 5.1 Performance Indicator Domains Identified in TWT Reports on Indicators 2005 & 2007

State Wide reported Indicators

Health
Life expectancy
Infant mortality
Birth weight
Disability and/or core activity restriction
Hospital admissions for infectious diseases
Otitis media and conductive hearing loss
Alcohol and tobacco consumption
Alcohol related crime and hospital statistics
Drug and other substance use
Children with tooth decay
Mental health
Access to primary care
Hospitalisation rates
Injury and poisoning
Ambulatory care sensitive conditions

Education
Literacy and numeracy
School attendance and retention
Years 10 and 12 attainment
Post-secondary education and training
Aboriginal cultural studies in schools
Transition from school to work
Preschool education

Economic Development
Unemployment and employment
Household and individual income
Training
Enterprises
Aboriginal owned or controlled land
Governance capacity and skills

Justice
Deaths from homicide and hospitalisations for assault
Victim rates for crime
Imprisonment and detention rates
Repeat offending
Bail for Aboriginal defendants
Juvenile diversions
Criminal court appearances

Families and Young People
Suicide and hospital separations for suicide attempts by youth and adults
Victimisation rate for domestic violence for Aboriginal young people
Substantiated child abuse and neglect
Suicide and hospital separations for suicide attempts by youth and adults
Victimisation rate for domestic violence for Aboriginal young people
Substantiated child abuse and neglect
Children and young people on long term care and protection orders
Out-of-home care
Participation in early childhood activities
Participation in organised sport, arts or community group activities
Reported child abuse and neglect
Supported Accommodation

Culture and Heritage
Access to traditional Aboriginal lands
Aboriginal community control and/or management of Country and resources
Protection of culturally significant lands, objects and intellectual property
Participation in contemporary and traditional cultural expression

Housing and Infrastructure
Overcrowding in Housing
Access to social housing
Housing standards and conditions
Home ownership
Homelessness
Water, sewerage and waste collection
Environmental health
Transport
Information technology

Regional reported Indicators

Health
Low birth weight
Hospitalisations for diabetes
Hospitalisations for cardiovascular disease
Hospitalisations for pertussis, measles and influenza among children
Hospitalisations attributable to alcohol
Hospitalisations for trauma attributable to alcohol
Hospitalisations for injury and poisoning
Hospitalisations for ambulatory care sensitive conditions

Education
Basic Skills Test Literacy Yr3 and Yr5
Basic Skills Test Numeracy Yr3 and Yr5
Apparent retention rates Yrs 7-10 and Yrs 7-12
Attainment of Yr10 and Yr12 certificate
TAFE enrolments
ACE contact hours
Cultural studies students
Attendance rates Yrs K-6
Attendance rates Yrs 7-10

Economic Development
Unemployment
Non-school qualifications
Weekly Income
Self employment and Aboriginal businesses
Home ownership
Public sector employment

Justice
Hospitalisations for assault related injuries
Rate of assault victimisation
Adults on remand
Adult imprisonment
Criminal court appearances
Bail refusals
Juvenile diversions

Families and Young People
Victimisation for domestic violence among young people
Substantiated child abuse/neglect reports
Out-of-home care
Child protection reports referred for further investigation

Housing and Infrastructure
Overcrowding
Social housing
Home ownership
Hospitalisations for respiratory infection
Hospitalisations for gastrointestinal infection
Hospitalisations for skin infection
Home use of computers
Access to internet

Nationally a range of indicators have been developed under the auspices of AHMAC to provide the basis for measuring the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health. These are reported on bi-annually by AIHW, with the latest report in 2008. The Performance Measures are provided in three domains:

- Tier 1: Health Status and Outcomes;
- Tier 2: Determinants of Health;
- Tier 3: Health System Performance.

The performance measures identified within these domains are as follows.

T1 Health Status & Outcomes

Health Conditions
1.01 Low birth weight infants;
1.02 Top reasons for hospitalisation;
1.03 Hospitalisation for injury & poisoning;
1.04 Hospitalisation for pneumonia;
1.05 Circulatory disease;
1.06 Acute rheumatic fever & rheumatic heart disease;
1.07 High blood pressure;
1.08 Diabetes;
1.09 End stage renal disease;
1.10 Decayed, missing, filled teeth;
1.11 HIV/AIDS, Hepatitis C & sexually transmissible infections
1.12 Children's hearing loss.

Human Function
1.13 Disability;
1.14 Community functioning.

Life Expectancy & Wellbeing
1.15 Perceived health status;
1.16 Social and emotional wellbeing;
1.17 Life expectancy at birth;
1.18 Median age at death.

Life Expectancy & Wellbeing
1.19 Infant mortality rate;
1.20 Perinatal mortality;
1.21 Sudden infant death syndrome;
1.22 All causes age standardised death rates;
1.23 Leading causes of mortality;
1.24 Maternal mortality;
1.25 Avoidable and preventable deaths.

T2 Determinants of Health

Environmental Causes
2.01 Access to functional housing with utilities;
2.02 Overcrowding in housing;
2.03 Environmental Tobacco Smoke.

Socioeconomic Factors
2.04 Year 3, 5 and 7 literacy;
2.05 Years 10 and 12 retention & attainment;
2.06 Educational participation & attainment of Aboriginal and Torres Strait Islander adults;
2.07 Employment status including CDEP participation;
2.08 Income;
2.09 Housing tenure type;
2.10 Index of disadvantage.

Community Capacity
Demography
2.11 Dependency ratio;
2.12 Single-parent families by age group;
Safety and Crime
2.13 Community safety;
2.14 Contact with the criminal justice system;
2.15 Child protection.
Other
2.16 Transport;
2.17 Indigenous peoples access to their traditional lands.

Health Behaviours
Tobacco, alcohol, other drug use
2.18 Tobacco use;
2.19 Tobacco smoking during pregnancy;
2.20 Risky and high risk alcohol consumption;
2.21 Drug & other substance use including inhalants.
Physical activity
2.22 level of physical activity.
Physical activity
2.22 Dietary behaviours;
2.23 Breastfeeding practices;
Other health behaviours
2.24 Unsafe sexual practices

Person-related factors
2.25 Prevalence of overweight & obesity

T3 Health System Performance

Effective, Appropriate, Efficient
3.01 Antenatal care;
3.02 Immunisation, child and adult;
3.03 Early detection and early treatment;
3.04 Chronic disease management;
3.05 Differential access to key hospital procedures;
3.06 Ambulatory care sensitive hospital admissions;
3.07 Health promotion.

Responsive
3.08 Discharge against medical advice;
3.09 Access to mental health services;
3.10 Aboriginal and Torres Strait Islander Australians in the health workforce;
3.11 Competent governance.

Accessible
3.12 Access to services by types of service compared to need;
3.13 Access to prescription medicines;
3.14 Access to after hours primary health care.

Accessible
3.15 Regular GP or health insurance;
3.16 Care planning for clients with chronic diseases;

Capable
3.17 Accreditation;
3.18 Aboriginal and Torres Strait Islander people in Tertiary Education for health related disciplines;

Sustainable
3.19 Expenditure on Aboriginal and Torres Strait Islander health compared to need;
3.20 Recruitment and retention of clinical and management staff (including GPs).

These National performance measures, along with the State Aboriginal Health performance measures identified within the Area Performance Contract and whole of Government Aboriginal welfare indicators under the TWT framework, provide an indication of the priority areas of action for closing the gap in health status for Aboriginal populations. The majority of the areas identified are addressed by one or more initiatives within the SSWAHS Aboriginal Health Plan. Areas emphasised within the performance measures and addressed by initiatives include chronic disease (e.g. cardiovascular, diabetes, renal); oral health; sexually transmissible infections; disability; working with partners to improve literacy and school participation; health issues for those in contact with the justice system; transport; health-risk behaviours in smoking, alcohol consumption and other drug use; health promotion; access to mental health services; access to primary care; screening and early detection; care planning and coordination; employment prospects and enhancing the Aboriginal health workforce.

Other priority performance measures are addressed by targeted strategies for Aboriginal communities within whole of population Plans that are being implemented concurrent with the SSWAHS Aboriginal Health Plan e.g. SSWAHS Overweight and Obesity Prevention and Management Plan 2008-2012 and SSWAHS Maternity Services Plan 2009-2013.

Monitoring of progress in bridging the gap will also be facilitated by the proposal that the Priority Area Working Groups (PAWGs) established as part of the planning process continue in a monitoring and review capacity for the life of the Plan. It is expected that these groups would need to meet on a bi-annual basis to ensure that service development is proceeding on track with the directions established through the extensive consultative processes undertaken within the Plan. PAWGs and others assessing implementation will be able to reference the detailed information provided for each initiative on implementation responsibility, partnerships required, timeframes and performance indicators. PAWGs will have an important role in ensuring the initiative templates are updated and refined over time to reflect any changed emphasis that arises and in developing many of the target levels of performance to be aimed for.

Monitoring Local Initiatives Contribution to Meeting National and State Policy Directions

Progress in bridging the gap in Aboriginal Health in SSWAHS will be assessed against the policy directions developed nationally and bilaterally through COAG, and at a State level as reflected in the NSW State Plan, State Health Plan, Healthy People NSW (population health initiatives) and Two Ways Together planning processes undertaken through REGs. The higher level policy directions and performance indicators identified at national and state levels will be supplemented by the targeted actions and more operational based performance indicators developed locally within SSWAHS, as identified in each template. These predominately process indicators will help in assessing the degree to which action has been initiated within SSWAHS to address the health gap experienced by Aboriginal communities and provide sentinel indicators of eventual positive impact on the health outcome indicators identified for Aboriginal communities nationally and across the State.

The following provides examples of how the local SSWAHS initiatives will contribute to achievement of National and State priorities and the performance indicators underlying these. Some of the priorities identified are targeted towards Aboriginal communities in particular, whilst other priorities apply equally across the Australian community including Aboriginal communities as equal partners in health improvement. For example the State Plan priorities selected include most of those identified by NSW Department of Aboriginal Affairs as priorities of relevance to Aboriginal people even though only a few directly refer to Aboriginal health.

The priorities are coded by their source, as follows:
COAG: Bilateral Priorities referenced in National Healthcare Agreement (December 2008)
NSSP: NSW State Plan (November 2006)
NSHP: NSW State Health Plan (February 2007)
HPNS: Healthy people NSW: Improving the health of the population (February 2007)

For ease of reference back to the templates the priorities identified Nationally and at State level in the above documents have been themed under the PAWG categorisation used in the SSWAHS Aboriginal Health Planning process.

Framework Initiatives

Addressing Healthy Communities and the Social Determinants of Health

COAG: Provision of incentives for workplaces and local communities to provide physical activity and other risk modification and healthy living programs.
COAG: increased access to services for children to increase physical activity and improved nutrition.
NSSP: Increased participation and integration in community activities
NSSP: More people using parks, sporting and recreational facilities and participating in the arts and cultural activity.
NSSP: Improved health through reduced obesity, smoking, illicit drug use and risk drinking
COAG: Reduced smoking rate among Aboriginal and Torres Strait Islander peoples.
NSHP: Continue to reduce smoking rates by 1% each year to 2010, and then by 0.5% to 2016 – we aim to exceed this target for the Aboriginal population.
HPNS: Provide additional targeted programs to support populations with high smoking prevalence to quit smoking.
NSHP: Stop the growth in childhood obesity by holding it to the 2004 level of 25% by 2010, and then reduce levels to 22% by 2016.
NSHP: Prevent further increases in levels of adult obesity which are currently at 50%.
HPNS: Implement coordinated programs, services and infrastructure across the priority areas of schools, community, parents and childcare promoting healthy weight through increasing physical activity and encouraging healthy eating habits.
HPNS: Work with other government and non-government agencies to develop and implement strategies to address the social determinants of health, including education, employment and income, housing and urban environments.
HPNS: Support the NSW Collaborative Centre for Aboriginal health Promotion.

See F1 for the framework of action on capacity building in Aboriginal communities. See F2 on implementation of the SSWAHS Aboriginal Health Promotion Action Plan and incorporation of Aboriginal specific modules within broader health promotion programs. See CA3 for health promotion activities for those at risk of chronic disease and OH2 for oral health promotion initiatives. See EY1 *Healthy and Happy Living Education* strategy and transition to school programs for young children and parents. See EY3 for youth initiatives including partnering in cultural, arts and music programs. See DH1 for prevention programs in excessive alcohol use including with youth and DH3 for access to clinical care for illicit and other drug use. See F9 and F10 for health prevention work targeting men's and women's groups. See F3, F4 and F5 for the framework for coordinated action across agencies and health providers. See EY2 for integrated service pathways for Aboriginal children. See the SSWAHS Overweight and Obesity Prevention and Management Plan for targeted initiatives for Aboriginal communities on obesity prevention.

Partnerships Development

HPNS: Develop strategic partnerships between agencies and Aboriginal organisations and communities, to build an environment that affirms and respects Aboriginal heritage and cultural values.
HPNS: Work with Divisions of General Practice, Aged Care Facilities and Aboriginal Community Controlled Health Organisations to increase uptake of influenza and pneumococcal vaccine and prevention of chronic disease risk factors.
HPNS: maintain and enhance a collaborative working relationship with a range of organisations including (but not limited to) government and non-government agencies, local government, Aboriginal Community Controlled Health Organisations, industry, universities and the Department of Environment and Conservation.
HPNS: work with research centres in the University sector to deliver evidence in line with NSW Health priority areas.

See F3, F4 and F5 for the framework for coordinated action across agencies and health providers. See F8 for the framework for recognising Aboriginal heritage, culture, identity and richness across SSWAHS. See CI2 for cultural safety initiatives. See CA8 for healthy ageing initiatives in Aboriginal communities. See MH1, DH2, IS8, CA4 and OH1 as examples of partnership work proposed within clinical streams. See CI9 for research agenda proposals.

Contributing to Issues where primary action lies with agencies outside Health

NSSP: *Reduced rates of crime, particularly violent crime.*
NSSP: *Reduced levels of antisocial behaviour.*
NSSP: *Reduced re-offending.*
NSSP: *Reduced rates of child abuse and neglect.*
HPNS: *Implement programs targeted at reducing injury among Aboriginal communities.*

See F3, F4 and F5 for the framework for coordinated action across agencies and health providers. See F1 for the framework for SSWAHS support of capacity building in Aboriginal communities. See F6 for the framework for SSWAHS contribution to community renewal agendas. See F9 and F10 for work with men's and women's community groups on social and emotional issues including precursors to violence. See EY1, EY3 and EY4 for work with parents, children and young people enhancing safe and healthy environments for child development. See IS9 for agency partnership work proposed with Aboriginal ex-prisoners and detainees.

Improving Models of Care

NSSP: *Embedding the principle of prevention and early intervention into Government service delivery in NSW.*

HPNS: *Implement whole of government early intervention framework with families and individuals addressing antenatal care, midwifery availability, home visiting, parenting support, childhood health and development surveillance, early childhood education, early detection screening for breast, cervical and bowel cancer and childhood middle ear inflammation.*

COAG: *Significantly improved coordination of care across the care continuum.*

See EY1, EY2, EY3 and EY4 for early intervention work with families, young children and youth. See F2 for prevention activities within a health promotion framework. See CA3, CA6, MH1, DH1, IS1, IS2 and OH2 for targeted prevention and early intervention work within clinical streams. See F7 for the framework for improving holistic care across SSWAHS services. See CA6, MH2, DH2, IS3 and OH1 for improved coordination of care within and between clinical streams.

Corporate Initiatives

Improving Access to Primary Care

COAG: *Increased uptake of Medicare Benefits Schedule-funded primary care services to Indigenous people with half of the adult population (15-65 years) receiving two adult health checks over the next four years.*

COAG: *To expand primary health care and targeted prevention activities to reduce the burden of chronic disease on Indigenous Australians.*

COAG: *Timely access to GPs, dental and primary health care professionals.*

See F3 and F4 for the framework for improving access and coordination with primary care providers. See CA2, CA4, CA5 and CA8 specifically targeting work with primary care providers and in primary care settings addressing the burden of chronic disease. See DH1, IS8 and OH1 for initiatives in other clinical streams addressing access to and support of primary health care.

Increasing Employment Opportunities and Workforce Development

COAG: *Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade and to increase Indigenous public sector employment to reflect Indigenous working age population share by 2015 - Indigenous workforce strategies will be built into implementation plans for all reforms contributing to the closing the gap targets.*

NSHP: *Increase the proportion and distribution of Aboriginal staff in order to meet the demand for services.*

NSSP: *More people participating in education and training throughout their life.*

COAG: *Strengthen current procurement policies to maximise Indigenous employment, skills development and business creation.*

HPNS: *increase Aboriginal employment, professional learning, cadetships and career development opportunities within population health.*

See CI4, CI5 and CI6 for the framework for workforce development initiatives for Aboriginal employees in SSWAHS. See CA9, MH3, DH4, IS4, IS5 and OH3 for initiatives within clinical streams to enhance the Aboriginal workforce and improve the workforce development opportunities available to these positions.

Early Years, Children and Young People

Educational Preparedness, Participation, Achievement and Retention

COAG: *Improving literacy and numeracy for primary school students, especially Indigenous students.*

COAG: *Give all children the opportunity to access quality early childhood education addressing significant under-representation of Indigenous children in preschool programs.*

NSSP: *Increased proportion of children with skills for life and learning at school entry.*

HPNS: *Evaluate the effectiveness of targeted programs for early childhood, up to four years of age.*

See EY1, EY2, EY3, and EY4 for interagency and collaborative work with partners to improve educational outcomes for infants, children and young people.

Maternal and Babies

NSHP: *Increase the proportion of mothers starting ante-natal care before 20 weeks gestation.*
NSHP: *Reduce the proportion of Aboriginal babies weighing less than 2,500g at birth.*
NSHP: *Increase the proportion of families offered and receiving a post natal home visit within two weeks of birth.*
HPNS: *Target antenatal programs and provide training and support to midwives and Aboriginal Health workers.*

See the SSWAHS Maternity Services Plan 2009-2013 for initiatives targeting improvements in antenatal care for Aboriginal mothers. See EY1 for early childhood home visiting initiatives. See DH4, MH3, IS8 and OH2 for initiatives to enhance clinical specific skills for early childhood workers.

Chronic Diseases and Ageing

COAG: *A reduction in the average length of hospital stay and reduction in readmissions.*
COAG: *A reduction in selected potentially avoidable GP type presentations to emergency departments.*
NSSP: *Reduced avoidable hospital admission.*
NSHP: *Reduce hospital admissions over five years for Aboriginal people with conditions that can be appropriately treated in the home by 15%.*
HPNS: *Pilot community-based diabetes prevention strategies including intensive lifestyle interventions for those at high risk (i.e. pre-diabetes).*
HPNS: *Enhance chronic disease risk factor management in General Practice.*
HPNS: *Fund the Aboriginal vascular Health Program to increase access to and use of culturally appropriate services by Aboriginal people with or at risk of vascular disease.*
HPNS: *Enhance early detection and management of chronic disease in Aboriginal communities, through programs like the well-person check.*

See CA1, CA2, CA3, CA4, CA5 and CA6 for chronic disease initiatives seeking to reduce unnecessary hospital admission, enhance prevention and early detection of chronic disease and precursors and improve the management of chronic disease through primary care settings. See F1, F2 F9 and F10 for framework initiatives to provide increased opportunity for prevention and health promotion work on lifestyle modifications in Aboriginal communities.

Mental Health

NSSP: *Improved outcomes in mental health.*
HPNS: *Develop a strategic approach for consistent mental health promotion, prevention and early intervention across NSW for all age groups, sectors and settings addressing community awareness, mental health literacy, stigma attenuation, strengthening resilience and early intervention.*
HPNS: *Build on early intervention initiatives for young people with mental health problems.*

See MH1, MH2 and MH3 for initiatives specifically targeting mental health promotion, prevention and early intervention, access to specialist care and the cultural appropriateness of care for Aboriginal communities.

Drug Health

NSHP: *Reduce total risk drinking to below 25% by 2012.*
NSHP: *Hold illicit drug use below 15%.*

See DH1, DH2, DH3 and DH4 for initiatives specifically targeting drug health prevention, health promotion and early intervention and availability of culturally appropriate clinical services for Aboriginal communities.

Infectious Diseases and Sexual Health

Infectious Diseases

COAG: Increased immunisation rates for vaccines in the national schedule.

NSHP: Increase the rate of influenza immunisation among people aged 65+ from 75% to 80% and pneumococcal immunisation from 55% to 60%.

NSHP: Improve and maintain the rate of children fully immunised at one year of age above 90%.

NSHP: Increase screening for Otitis Media in Aboriginal children aged from zero to six years to 85%.

HPNS: Develop and implement child and adult vaccination interventions to increase immunisation rates particularly among high-risk groups.

HPNS: Implement strategies to increase immunisation coverage for Aboriginal children so that it is equal to coverage for non-Aboriginal children.

See F3 and F4 for the framework for improving access and coordination with primary care providers who are the prime providers of vaccination to Aboriginal communities. Other initiatives such as DH1 and CA8 provide the opportunity to ensure improved access for adults to primary care including vaccination interventions.

Sexual Health

COAG: Reduced incidence and prevalence of sexually-transmitted infections and sentinel blood borne viruses (for example, Hepatitis C, HIV) for Indigenous and non-Indigenous Australians.

HPNS: implement strategies to respond to HIV/AIDS, STIs and Hepatitis C within Aboriginal communities, in partnership with the Aboriginal Health and Medical Research Council.

See IS1 and IS2 for sexual health promotion, prevention and early detection initiatives; IS3 for engagement into specialised Hepatitis C care; IS4, IS5 and IS6 to improve access to sexual health services; IS7 for enhanced surveillance initiatives and IS8 and IS9 for partnership work with primary care providers and in engaging ex-prisoners.

Oral Health

NSHP: *Increase the proportion of five year old children without dental decay (caries free) from 70% in 2000 to 77% in 2010.*

HPNS: *Enhance oral health, delivering an increased focus on prevention, health promotion and early intervention initiatives through greater population coverage by fluoridated water, and more effective oral health promotion programs.*

See OH1 for increasing access into oral health services and OH2 for initiatives to increase oral health promotion and prevention work including within broader health promotion programs.

Evaluating the Success of Implementation

A frequent concern expressed by Aboriginal communities and commentators on Aboriginal health policy agendas is that although policy and planning proceeds to close the gap, progress is stymied by lack of services on the ground and poor coordination of agency action. Post planning evaluation of the extent to which Aboriginal Health strategies developed in the previous SWSAHS and CSAHS had been implemented had identified barriers to implementation. Among the most important of those identified included lack of a clear Aboriginal Health infrastructure, high turnover of Aboriginal staff internally and in external organisations and problems of engaging mainstream health services in taking action to improve Aboriginal Health. This Plan includes specific initiatives addressing these previously identified barriers to implementation, particularly among the framework and corporate initiatives. Structuring of initiatives within Priority Working Areas has also focussed on the engagement of mainstream clinical services in these areas.

Evaluation of previous Plans had recommended that future plans address the need to:

- Set clear directions and achievable goals;
- Integrate Aboriginal health issues into all parts of the organisation;
- Invest in infrastructure;
- Develop and strengthen partnerships.

These recommendations have been explicitly addressed within the various initiatives that form the core of this Plan. For example the approach to developing initiatives taken within the Plan is considered to be totally consistent with the Commonwealth approach to identifying Indigenous Health initiatives outlined within the 2008-09 Budget papers:

- policy-making based on the analysis of available evidence;
- approaches to be rigorously and regularly evaluated
- Using evidence and evaluation as the key to determining where funds and policies are targeted;
- Involving Aboriginal people in the design and delivery of programs;
- Solutions developed on the ground driven by the communities that will ultimately determine their success or failure

- Building the trust between communities and government agencies required for working together on getting results.

Each initiative outlines the available evidence on what works and doesn't work for Aboriginal communities. The approach and performance indicators to be used are clearly delineated. Consultation for the Plan and ongoing consultative and partnership work with Aboriginal communities and the core Aboriginal controlled organisations ensures Aboriginal participation in service design and delivery (assisted also by initiatives to expand and enrich the SSWAHS Aboriginal workforce). The partnership framework within which the initiatives have been developed and will be implemented also ensures that they have community support and have the best opportunity for success. Partnership arrangements and community capacity building activities which are at the core of the framework initiatives outlined in this Plan will build on the trust and close working alliances necessary to ensure community ownership of these strategies to improve Aboriginal health.

In the first years of the Plan the PAWGs will focus on establishing baseline levels of indicators where they are not currently available and the process for regular collection of the data required. In most instances this will be through established data collections such as the Inpatient Statistics Collection, Midwives Data Collection, NSW Health Survey etc. Midway through the Plan there will be a review of implementation progress including performance indicator data analysis where there is robust data available, process indicator analysis and qualitative assessment of progress. By 2014 a broader summative assessment of the Plan will commence, focussing on an assessment of the approach taken and the appropriateness of the initiatives identified. This will include assessment of the structural arrangements put in place to ensure flexibility in the approach to initiatives to take account of changing policy parameters, priorities, community preferences and emerging evidence of positive fresh approaches.

Responsibility for actions is identified within each initiative. This will vary between mainstream program managers and dedicated Aboriginal Health positions. In some instances higher level Executive positions will have prime implementation responsibility. There are many and varied performance indicators identified across the initiatives. Therefore, there may be value in identifying a core set of the most potent performance indicators for regular reporting to the Area Executive as a supplement to the headline indicators included in the Area Performance Contract and REG workplans. If this is seen as beneficial, it would be a role for the Aboriginal Health Unit and Aboriginal Health Executive Team to undertake. These core indicators could where relevant be reflected in Performance contracts.

6. Resourcing the Initiatives

Implementing the initiatives outlined in the Plan implies increased and expanded emphasis on priority activities to close the gap in health disadvantage experienced by the Aboriginal communities of SSWAHS. The aim will be to maximise the extent to which available resources are targeted towards Aboriginal Health. This implies that SSWAHS in collaboration with NSW Health will need to continue to proactively pursue a range of funding sources for Aboriginal Health initiatives to maintain momentum in closing the gap. This includes not only the financial allocation made available to the Area by NSW Health under Program 1.2 Aboriginal Health Services but also efforts to secure an appropriate share of the COAG agreed funding 2009-2012 of an Indigenous Health package worth $1.6 billion over four years (Commonwealth contributing $806 million and the States $772 million). Where a potential funding source has been identified it is included within the initiative template.

This Plan through clearly linking proposed initiatives to the evidence base and policy directions, national and State (including the COAG closing the gap priority targets of prevention activities to reduce the burden of chronic disease, expanded primary care, improved coordination of care and reduced requirements for hospitalisation), places SSWAHS in a good position to press the case for expanded funding of Aboriginal health initiatives.

The core focus of SSWAHS service provision in Aboriginal Health will be through supporting the health workforce employed in Aboriginal health worker dedicated positions. Consultations, existing policy frameworks and good practice evidence emphasise that a focus on employing Aboriginal staff has synergistic impacts on improving access, promoting cultural safety and empowering communities to address health need. It can also be a key component of SSWAHS strategies to meet targets for the proportion of staff identifying as Aboriginal. A key component in this strategy will be through identifying trainee positions across SSWAHS which will equip Aboriginal people with the requisite skills to be able to take up on-going full time positions within a range of services.

Priority areas for workforce enhancement to address the health needs of Aboriginal populations across SSWAHS have been identified within the Plan. Ideally, as opportunities in these areas are able to be met through available resources, they would be targeted towards Aboriginal people, enhancing the Aboriginal health workforce within SSWAHS. The areas in which potential for workforce enhancement have been identified can be summarised as follows.

Table 6.1 Priority Areas with Potential for Identified Aboriginal Health Positions

No. Positions	Position Description	Initiative Ref.
1	Project Officer/Epidemiologist for Aboriginal Health Information Strategy	CI9
6	4 CFHNs: 2 SW; 1 AHEO to extend sustained home visiting to Inner West	EY1
1	Aboriginal Health Education Officer – Early Years (South West)	EY1
4	AHPs to extend early childhood counselling to South West & enhance AHPs	EY2
5	Expansion of physiotherapy, occupational therapy & speech pathology	EY2
2	Aboriginal Health Education Officer – Youth	EY3
4	Walgan Tilly & Chronic Care Program Managers (2) & AHEOs (2)	CA1-2
2	Enhanced ALO presence across SSWAHS facilities	CI8, CA1
4	AHEO Aboriginal Health Promotion Strategy implementation	F2, CA3
1	Project Officer Aboriginal Renal Health Project	CA4
1	Project Officer Aboriginal Transitional Aged Care	CA7
6	Aboriginal Drug Health Clinical Support Team	DH2-3
2	Aboriginal Sexual Health Workers	IS4
1	Project Officer Referral/Continuity of Care Prisoners Post Release	IS9
1	Oral Health Promotion Officer	OH2
41 Total		

The potential for workforce enhancement in these areas will be further assessed as the detailed implementation pathways for the proposed initiatives are further developed. These areas of potential will also be identified within updates of the SSWAHS Aboriginal Employment Strategy. Workforce enhancement in these areas would also be a tangible demonstration of the SSWAHS commitment to working with partner agencies within the *Two Ways Together* framework to improve employment opportunities for Aboriginal people.

Appendix A

This Appendix outlines the abbreviations used to identify within each template the links between the proposed initiative and key overarching plans and strategic frameworks of relevance to Aboriginal Health within which SSWAHS operates i.e. State Plan and State Health Plan, Two Ways Together and SSWAHS Health Service Strategic Plan.

State Plan

The CEO Group on Aboriginal Affairs identified in 2007 the State Plan Priorities of relevance to Aboriginal People, categorised under the five areas of activity of the NSW Government identified within the Plan:

Rights, Respect and Responsibility

R1 Reduced rates of crime, particularly violent crime
R2 Reduced re-offending
R3 Reduced levels of anti-social behaviour
R4 Increased participation and integration in community activities

Delivering Better Services

S3 Improved health through reduced obesity, smoking, illicit drug use and risk drinking
S4 Increasing levels of attainment for all students
S5 More students complete Year 12 or recognised vocational training
S8 Increased customer satisfaction with Government services

Fairness and Opportunity

F1 Improved health and education for Aboriginal people
F3 Improved outcomes in mental health
F4 Embedding prevention and early intervention into Government services
F5 Reduced avoidable hospital admissions
F6 Increased proportion of children with skills for life and learning at school entry
F7 Reduced rates of child abuse and neglect

Growing Prosperity across NSW

P4 More people participating in education and training throughout their life
P7 Better access to training in rural and regional NSW to support local economies

Environment for Living

E1 A secure and sustainable water supply for all users
E4 Better outcomes for native vegetation, biodiversity, land, rivers and coastal waterways
E7 Improve the efficiency of the road network
E8 More people using parks, sporting and recreational facilities, and participating in the arts and cultural activity

State Health Plan

The State Health plan identifies a range of actions of relevance to Aboriginal People, including actions targeting Aboriginal populations and more broadly across the whole of the population, categorised under the seven strategic directions that also apply to the 20 year Futures Plan. Measures of success are included under each strategic direction:

1. Make prevention everybody's business

1.1 Improved health through reduced obesity, smoking, illicit drug use and risk drinking
1.2 Improved survival rates and quality of life for people with potentially fatal or chronic illness through improvements in health care
1.3 Improved dental health
1.4 Reduced vaccine preventable conditions through increased immunisation
1.5 Reduced fall injuries among older people
1.6 Increased participation and integration in community activities and increased participation in recreation, sporting, artistic and cultural activity
1.7 Reduced levels of anti-social behaviour and reduced re-offending

2. Create better experiences for people using health services
2.1 Improved access to quality health care
2.2 improved access to hospital care through emergency departments
2.3 improved access to elective surgery
2.4 Increased customer satisfaction with health services
2.5 Ensuring high quality care

3. Strengthen primary health and continuing care in the community
3.1 Reduced avoidable hospital admissions through early intervention and prevention and better access to community based services
3.2 Improved health for Aboriginal communities
3.3 Improved outcomes in mental health
3.4 Increased focus on early intervention
3.5 Reduced rates of crime, particularly violent crime

4. Build regional and other partnerships for health
4.1 Improved outcomes in mental health
4.2 Implement key plans and frameworks
4.3 Improved health outcomes for Aboriginal communities

5. Make smart choices about the costs and benefits of health services
5.1 increase the share of the health budget allocated to prevention and early intervention
5.2 Increase the effectiveness of resource allocation through the continuum of care

6. Build a sustainable workforce
6.1 Reduce staff turnover
6.2 Increase the proportion and distribution of Aboriginal staff in order to meet the demand for services
6.3 Improvement in education and training of the health workforce

7. Be ready for new risks and opportunities
7.1 Implementation of an integrated risk management framework
7.2 Assess research outputs to ensure they are driven by health priorities and policies

Two Ways Together

Many initiatives will have impact on most or all of the key focus areas of *Two Ways Together*. Notated in each template is the prime TWT Focus Area(s) in which it is considered the initiative will have impact using the following abbreviations:

H Health
HO Housing
E Education
CH Culture & Heritage
J Justice
ED Economic Development
FYP Families & Young People

See Volume 1 for further explanation as to the intent and contents of the NSW Government's Two Ways Together ten-year plan to improve the wellbeing of Aboriginal people and communities.

SSWAHS Health Service Strategic Plan Towards 2010

The Area Strategic Plan provides broad level programs and initiatives SSWAHS will undertake through to 2010 structured within the 7 Strategic Directions adopted by NSW Health. The Plan does not attempt to address in detail targeted activities to individual communities within SSWAHS. Those initiatives targeted particularly to Aboriginal communities include:

1b.1 In collaboration with community members and other agencies, develop and implement an Aboriginal Health Plan.
3a.5 Continue to implement the NSW Aboriginal Chronic Conditions AHS Standards.
3b.6 Actively participate in the Families First, Better Futures and Aboriginal Child, Youth and Family Strategy initiatives to improve the health and wellbeing of young people and families and reduce child abuse and neglect.

4a.4 Enhance and strengthen partnerships with Aboriginal people and other key groups to achieve measurable health improvements for Aboriginal people.
6a.7 Implement key findings of the Aboriginal and Torres Strait Islander Workforce Development Program project.
6b.5 Expand the Aboriginal Health workforce to ensure representation of Aboriginal people across all key clinical and non-clinical areas.

Aboriginal communities will also benefit from other strategic direction and initiatives identified within the Area Strategic Plan, with initiatives within the Aboriginal Health plan contributing to achievement of these objectives within Aboriginal communities. Key initiatives include:

1a.2 Create strategic linkages between population health and other clinical services in developing health promotion initiatives.
1a.3 Implement existing health promotion plans and expand health promotion programs addressing smoking, obesity, healthy eating and drinking, food security, physical activity and falls prevention.
1a.5 Expand the Health Promoting Schools Program.
1b.2 Tailor health promotion programs to the needs of specific communities.
1b.4 Investigate options to provide accommodation for patients who are geographically isolated and require treatment at SSWAHS facilities.
1b.5 Continue to support carers (including staff who are carers) through a range of initiatives including carer education, respite and carer coordination units.
1c.1 Work closely with GPs, pharmacies and other health care service providers to implement prevention activities and services.
1c.2 Maintain and establish programs to support the increased uptake of immunisation.
1c.4 Review and further develop programs addressing communicable disease control and environmental health.
1c.5 Trial and evaluate programs to improve the awareness of oral health management during pregnancy and early life with parents and early childhood settings.
1c.6 Further implement and evaluate prevention initiatives in Mental Health including Mind Matters, Parenting Support and Depression in Older People.
1c.8 Improve access to the Perinatal and Family Drug Health Service.
2a.1 Measure health service satisfaction.
2a.2 Review and further develop quality systems through a Patient Safety and Quality Plan.
2b.2 Continually monitor and refine initiatives aimed at improving patient access and patient flow, with particular attention to Emergency Departments (EDs) to achieve national benchmarks for timely access to EDs and surgical treatment.
2b.5 Develop networks of services to support increased access for residents to health services e.g. the provision of outreach clinics.
2c.2 Develop a SSWAHS Transport for Health Plan to improve access to and between SSWAHS facilities in conjunction with stakeholders.
3a.2 Expand the current range of services available in the community, including outreach services, which reduce demand on acute services.
3a.4 Provide patients with chronic and complex care needs and their primary health care providers with individualised Care Plans on discharge from hospital.
3a.5 Continue to implement the NSW Aboriginal Chronic Conditions AHS Standards.
3a.6 Expand the availability of post acute and transitional care services across the Area e.g. ComPacks and Transitional Aged Care Packages.
3a.8 Improve access to mental health services.
3b.1 Support the provision of universal health home visits on postnatal discharge from hospital.
3b.2 Expand Families First initiatives, particularly sustained home visiting program for vulnerable families.
3b.7 Strengthen relationships between services to identify and provide programs to children and young people in need of mental health services.
5a.3 Increase the number of clinical staff employed to provide direct service to clients.
5b.2 Prepare strategic clinical service and/or clinical stream plans/strategies as required to support the allocation of resources.
5b.5 All units develop Business or Operational Plans consistent with the Strategic Plan to strengthen strategic decision making and planned, progressive improvement.
6a.3 Promote career and employment opportunities (including school based traineeships) to the local community through a range of mechanisms.
6a.4 Deliver in-house workforce development programs through the SSWAHS Centre for Education and Workforce Development and undertake program evaluation.
6a.5 Expand the provision of more flexible delivery methods e.g. E-learning.

6a.6 Provide career and study pathways through nationally recognised on the job training.
6a.9 Investigate opportunities to continually improve the work environment, including work-life balance, recognising performance and supporting staff through employee assistance and health living programs.
6b.4 Work with tertiary institutions to develop workforce capabilities in identified areas and to ensure the provision of high quality clinical placements.
7a.1 Develop a Research and Teaching Plan for SSWAHS.
7a.3 Build effective academic partnerships through the appointment of academic leaders.
7a.4 Increase the number of grants and fund raising activities.
7a.5 Improve the profile of research activities within SSWAHS.

The templates identify where the Aboriginal health initiative is expected to make a prime contribution to achieving the Area Strategic objective among Aboriginal communities.

Abbreviations

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

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

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