

# Tracking the Circle: A Report from the Blue Mountains Aboriginal Health Coalition

Blue Mountains Aboriginal Sharing and Learning Circle Report



*"Healing Country" - Leanne Tobin, Darug 2011*



Health  
Nepean Blue Mountains  
Local Health District



This consultation was commissioned by the Blue Mountains Aboriginal Health Coalition and coordinated by the two lead agencies for this project, Nepean-Blue Mountains Medicare Local and Nepean Blue Mountains Local Health District.

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# Dedication

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Tracking the Circle 2013 is the follow up to the 2008 Sharing and Learning Circle. In 2008 the Sharing and Learning Circle was dedicated to local Aboriginal community leaders past and present and to the local Aboriginal community. Our 2013 Sharing and Learning Circle is dedicated to Darug and Gundungurra Elders past and present who have passed on their leadership and entrusted those who have come to the circle to continue to work to improve our future. Their gift continues through the circle in the younger members of the community who continue to engage for the community, and work to improve Aboriginal health and well-being.

# Acknowledgments

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Without the engagement, participation and commitment of the Aboriginal community locally, the broader community and local service providers Tracking the Circle 2013 would not have been possible. It is important to acknowledge the ongoing support and commitment of the Nepean-Blue Mountains Medicare Local (NBMLL) and the Nepean Blue Mountains Local Health District (NBMLHD) and other members of the Blue Mountains Aboriginal Health Coalition/Consortium (The Coalition), in working together as partners to influence positive change in health outcomes for Aboriginal people locally.

The willingness and commitment of key community groups and organisations has been essential for the success of this initiative. The Coalition, formed in response to and as a strategy of the 2008 Circle, has been instrumental in bringing about significant change in local Aboriginal health service delivery. The strength of the Coalition in driving positive change is reflected in the words of an Aboriginal community member:

*The Blue Mountains Health Coalition is unique in my experience, every local Aboriginal organisation and service is represented, it enables the broad voice of our community to be given a place and heard...this model lends itself to the participation of the community, their voice is central and change is owned by them.*

The Blue Mountains Aboriginal Health Coalition consists of:

- Darug Tribal Aboriginal Corporation – Darug Mountains Group
- Gundungurra Tribal Council Aboriginal Corporation
- Gundungarra Aboriginal Heritage Association
- Blue Mountains Aboriginal Culture and Resource Centre
- Link-Up New South Wales
- Blue Mountains City Council
- Primary Care and Community Health, Nepean Blue Mountains Local Health District
- Nepean-Blue Mountains Medicare Local

The Coalition wish to express sincere thanks to attendees to the Tracking the Circle 2013:

- Aboriginal Elders
- Aboriginal community participants
- General Practitioners and other health professionals
- Non-Aboriginal community participants
- Nepean-Blue Mountains Medicare Local Staff
- Primary Care and Community Health, Nepean Blue Mountains Local Health District Staff
- Community agencies and organisations (government and non-government)

Medicare Locals gratefully acknowledge financial and other support from the Australian Government Department of Health.

## Cultural Safety

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The objective of the sharing and learning circles is to draw in community voices to improve Aboriginal health and to move towards cultural safety within health and other services.

The 'safety' in cultural safety refers to a standard that must be met in health care development and delivery. Anything less than this standard is considered culturally unsafe (Polaschek 1998). The concept introduces a different way of looking at the inequalities that lie embedded in the health care system. Importantly, it seeks to challenge health professionals and health systems to critically examine the way they view Indigenous health and how they engage with Indigenous peoples.

Put simply, where the old standards stated that people be nursed *regardless* of colour or creed, cultural safety advocates that people be nursed *regardful* of those things that make them culturally distinct or different (Papps and Ramsden 1996:493). Cultural safety, it is argued can increase the likelihood of positive outcomes in relation to patients' health because it identifies the information that is important and endeavours to deliver it in a way that it will be understood (Larson et al 1996) In addition, cultural safety has the potential to not only empower the client but also the health practitioner (Richardson and Williams 2007), Bin Sallik (2003), sees cultural safety as extending beyond cultural sensitivity and cultural awareness in that it empowers the clients to contribute to the achievement of positive outcomes. It is perhaps this emancipatory aspect of cultural safety that can contribute most to self-determination.

Communities must and will certainly have a role to play. Coffin (2007) believes that cultural awareness in the health system alone, will not achieve better delivery or outcomes and that health services need to include community opinions in choosing the directions they take. Coffin adds that communities in turn must be clear on what they want from the service providers and the health care system. While much has been written about cultural safety from the viewpoint of power relationships between health care professionals and patients, it is invariably the institutions (hospitals, government departments, schools etc.) which need to adhere to the cultural safety formula in order to 'effect cultural change in the design and delivery of policy (Brascoupe and Waters 2009).

*National Aboriginal and Torres Strait Islander Health Worker Association Cultural Safety Forum, Adelaide, 7-8 May 2013 Information booklet: Creating Cultural Safety in Health Workplace Environments for Aboriginal and Torres Strait Islander Health Workers, pp.13-14.*

# Introduction - Tracking the Circle 2013

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## **Blue Mountains Aboriginal Community Sharing and Learning Circle**

*14 November 2013*

In November 2013, the Blue Mountains Aboriginal Community Sharing and Learning Circle again came together to track the achievements in working to improve the health and well being of the local Aboriginal community; identify those areas of remaining need; discuss new challenges and develop potential strategies to meet those existing and emerging needs. This circle continued in the spirit of the first sharing and learning circle held in 2008 – the creation of a vision for improving access, services and ultimately improved outcomes for members of the local Aboriginal community.

The 2013 Circle was commissioned by the Blue Mountains Aboriginal Health Coalition.

Blue Mountains Aboriginal community members were invited to attend by word of mouth, Aboriginal specific media, and flyers. All members of the Coalition were invited, along with previous attendees of the 2008 Sharing and Learning Circle.

Note: Blue Mountains Aboriginal Health Coalition has advised the use of 'Aboriginal' to indicate Aboriginal and Torres Strait Islander people in the Blue Mountains area.

# Executive Summary

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## General Comments

Community members indicated that there had been significant improvements in access to Aboriginal specific services locally since the original 2008 Sharing and Learning Circle with the development of a significant number of programs now available to the community (Blue Mountains Aboriginal Healthy for Life Program (HFL); Mootang Tarimi Outreach bus; Aboriginal men's groups; eye clinic, dental clinic, Moving On programs).

There was confirmation from the community members that local health services were responding in part to their needs and that some services had become more Aboriginal friendly since the 2008 Sharing and Learning Circle.

Generally community members felt that some GP practices had improved their performance in making Aboriginal community members more comfortable and safe when attending practices. It was felt that there remained room for ongoing improvement across practices in the Blue Mountains.

Whilst acknowledging the cited areas of improvement the community voiced the need for continued commitment from the local health services to deliver appropriate, accessible, culturally safe health services to the local Aboriginal community, by culturally competent health staff.

The Blue Mountains Aboriginal Health Coalition was cited as a major strength and key factor locally in the development, implementation and evaluation of programs aimed at improving Aboriginal health and well-being locally.

There was a clearly identified need from the community members and service providers present to vastly improve the flow of information and communication on new and beneficial services available to the Aboriginal community. Suggestions were made as to possible avenues of communication such as Koori radio, Blackmail, Koori Mail and Indigenous Times as well as Facebook and Twitter.

Regular scheduled information days or an Aboriginal Health and Wellbeing Expo for the community on available services, changes to services and so on with the potential to involve a range of service providers not just health focussed services, was raised as a potential strategy to improve access and health and well-being outcomes generally. Services suggested for potential inclusion were Centrelink, Family and Community Services and Housing.

The need to increase the numbers of designated Aboriginal specific clinical positions in mental health, aged care and drug and alcohol services was identified as a community priority.

Transport was identified as a significant problem relating to a number of issues, particularly community participation, social inclusion, getting to appointments, for ageing community members maintained in their homes, and for families and children.

Tracking the Circle 2013 identified six priority areas impacting on the health and well-being of Aboriginal community members locally:

1. Mental health
2. Aged Care

3. Drug and alcohol
4. Workforce
5. Community access to information
6. Transport

Comments and suggestions related to these and other areas are outlined in the following.

## 1. Mental Health

- Aboriginal specific mental health and drug and alcohol support workers were identified as necessary to improve outcomes for community members.
- The need to increase the numbers of designated Aboriginal specific clinical positions in mental health was identified as a community priority.
- Community members noted the need for better follow up after discharge for all conditions, but specifically important in mental health.
- Improvements to providers' understanding of stressors affecting Aboriginal mental health, particularly intergenerational trauma and associated post-traumatic stress disorders was cited as critical to improved health outcomes for the local community.
- The lack of mental health service engagement in key community events, forums and committees was raised as an ongoing and long standing issue.
- The need for improved and enhanced services concerning dual diagnosis for mental health and substance abuse in Aboriginal community members was identified as an area needing attention and strengthening.
- The potential to develop a mentoring program approach matching a mentor to an individual, enhancing support for community members undergoing treatment and therapy.
- The issue of the need to revisit a specific Aboriginal Mental Health Well Being Centre was again raised. This was raised in previous consultations and Circles as a culturally appropriate strategy to improve mental health and emotional well-being .

## 2. Aged Care

- There was identified need for Aboriginal community volunteers to visit and support older community members at home and in residential aged care facilities,
- Specific need for Aboriginal workers in Aged Care Assessment Teams and liaison in Residential Aged Care facilities was identified as a priority issue.
- Aboriginal people referred to aged care facilities in the Blue Mountains from other areas so that they are in unfamiliar country without access to family and communities was raised.
- The lack of facilitation of Aboriginal specific activities for Aboriginal people in residential care was also a concern.
- The need for an Aboriginal aged care facility in the Blue Mountains was stated.

### 3. Drug and Alcohol

- Education needs to focus on the legal and long term effects of drugs and alcohol using peer to peer approaches rather than authority and include mentoring for young people, role models and stories on adverse outcomes for children, relevant, discrete information and awareness, attendance at AA meetings for a 'glimpse of their future' and the Salvation Army's rehabilitation tour for example.
- More appropriate Aboriginal specific detoxification centres, more culturally relevant information and education, and Aboriginal counsellors and mentors through enhanced funding were raised as strategies they would like to see discussed.
- Gender specific youth cultural mentoring camps were suggested as an appropriate strategy for the community when working with young people around substance use issues
- Better referral processes are also required - Aboriginal safe driver and safe drug use programs and youth song and rap competitions were all raised as potential approaches to be explored

### 4. Aboriginal Workforce

- Community members identified that Aboriginal workers (both paid and volunteers) and specific support services were needed in the areas of mental health, substance abuse and aged care.
- Mentor programs were raised in the context of mental health and drug and alcohol service delivery. Using purpose recruited community members to support community members and work with the professional teams
- Community concern was expressed regarding the excessive time taken to fill Aboriginal specific positions in local health services. This was seen as unacceptable to the community.

### 5. Community access to information

- There was a clearly identified need from the community members and service providers present to vastly improve the flow of information and communication on new and beneficial services accessible available to the Aboriginal community.

### 6. Transport

- Transport was identified as a significant problem relating to a number of issues, particularly community participation, social inclusion, getting to appointments, for ageing community members to be maintained in their homes, and for families and children.

Other areas identified:

#### Cultural Safety

- Need for and commitment by health services at all levels to ensure that health providers have much greater awareness and better practical understanding of Aboriginal culture, their specific health issues and the effect of past trauma on their well-being.
- Discussion around the need for the local health service providers to extend cultural awareness to the deeper practice of cultural safety in delivering and developing Aboriginal health services

#### Pharmacy

- The need for further education of pharmacists nationwide on Closing the Gap initiatives and

the entitlements for community members covered by Closing the Gap strategies, particularly entitlement to Closing the Gap medication costs.

- Another issue noted was related to methadone programs and pricing and access under the PBS with pharmacists determining their own price making it too costly for many people.

### Cultural Processes and Practices

- Strengthening of Aboriginal cultural processes such as integrating traditional healing approaches was identified as having the potential to improve outcomes when planning care for individuals and families, and promotion and prevention of disease development in those at risk e.g. connection to country, corroborees and storytelling.
- Scope for investigating a local forum or symposium has been raised e.g. Aboriginal Holistic Health Forum showcasing successful programs and services and inviting input from across the region and State.
- All health services need to ensure Aboriginal representation and or input into planning committees around service development

### Family Centred Approaches

- Holistic family centred approaches to care involving whole families (extended family members) was felt by participants to be particularly important to outcomes for mental health, including post-natal depression and substance abuse issues.

### Interagency

- A need for an Aboriginal interagency, an increase in Family and Community Services Aboriginal specific services, an Aboriginal mental health and/or liaison officer at Blue Mountains Anzac Memorial Hospital (Katoomba Hospital) and Aboriginal family workers to work with whole families for family restoration were identified.

# The Process

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*In considering Indigenous health it is important to understand how Indigenous people themselves conceptualise health. There was no separate term in Indigenous languages for health as it is understood in western society. **The traditional Indigenous perspective of health is holistic.** It encompasses everything important in a person's life, including land, environment, physical body, community, relationships, and law. Health is the social, emotional, and cultural wellbeing of the whole community and the concept is therefore linked to the sense of being Indigenous. This conceptualisation of health has crucial implications for the simple application of biomedically-derived concepts as a means of improving Indigenous health.*

*MacRae A, Thomson N, Anomie, Burns J, Catto M, Gray C, Levitan L, McLoughlin N, Potter C, Ride K, Stumpers S, Trzesinski A, Urquhart B (2013). Overview of Australian Indigenous health status, 2012.*

## **The Sharing and Learning Circle format allows each participant to speak, listen and exchange ideas**

In planning the provision of services to a community, or to improve and redesign services it is imperative that the community themselves are involved and have a voice. The Aboriginal Community have a distinct voice that needs to be recognised within the specific geography of the Blue Mountains. The sharing and learning circle, an Aboriginal oral tradition for sharing information and stories, was considered to be the culturally appropriate format for engaging the community and formed the basis for the 2008 Sharing and Learning Circle and Tracking the Circle 2013.

The sharing circle is a traditional Aboriginal custom and is designed so that, where possible, no one has their back to another and everyone is equal, that all opinions are respected and all stories valued. It allows all participants to speak, listen and exchange ideas. It provides a culturally safe space to talk and gives diverse voices opportunity to speak. The learning circle is a mechanism for organising and honouring the collective wisdom of the group.

## **Tracking the Circle 2013**

All local Blue Mountains Aboriginal services and organisations were represented giving a broad voice to the community through the unique Blue Mountains Aboriginal Health Coalition formed to progress health concerns in the Aboriginal community. An open invitation was sent to all who have an interest in improving the health and well-being of Aboriginal people.

Both individual Aboriginal Community members and service organisations were invited to attend the forum. Tracking the Circle 2013 was a follow up to the 2008 Sharing and Learning Circle attended by community and local organisations.

Invitations were again extended to Aboriginal focused organisations, Aboriginal Community members, General Practitioners, Community health staff and other service providers within the Blue Mountains. Response notification was via Nepean-Blue Mountains Medicare Local offices at Hazelbrook. Tracking the Circle 2013 was held at Mid Mountains Community Centre on 14 November 2013, with 43 Circle participants from various organisations and sectors of the community.

# Background

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The Nepean-Blue Mountains Medicare Local covers Penrith, Hawkesbury, Blue Mountains and Lithgow Local Government Areas.

The unique geography, ribbon (one track) development and availability of services, and transport limitations means that access to services is limited, often costly and requires extended periods of time to access due to distance.

Within the Nepean-Blue Mountains Medicare Local catchment, 2.2 per cent of the population identify as being of Aboriginal or Torres Strait Islander descent and 10.7 per cent of this population are aged 65 years or above.

In the 2011 census there were 1,324 people who identified as Aboriginal in the Blue Mountains an increase of 380 from 2006 (Blue Mountains City Council, key statistics). There are still some issues with people not wishing to identify as Aboriginal, and within the Aboriginal community the population is regarded as higher than census numbers indicate.

## **Blue Mountains Aboriginal Health Coalition**

Formed in 2008 as a result of the Blue Mountains Aboriginal Community Sharing and Learning Circle this community-based health program operates as a Consortium of eight Blue Mountains organisations:

- Darug Tribal Aboriginal Corporation – Darug Mountains Group
- Gundungurra Tribal Council Aboriginal Corporation
- Gundungarra Aboriginal Heritage Association
- Blue Mountains Aboriginal Culture and Resource Centre
- Link-Up New South Wales
- Blue Mountains City Council
- Nepean Blue Mountains Local Health District – Primary Care and Community Health
- Nepean-Blue Mountains Medicare Local

The Coalition was successful in securing Round One Funding from the Office of Aboriginal and Torres Strait Islander Health in 2008. Phase One of this program focused on establishing baseline information on the health of Aboriginal mothers, babies and children, the quality of life of Aboriginal people with a chronic condition and the incidence of adult chronic disease. The Coalition then formed a Healthy for Life Steering Committee of all eight members to develop the phase two of the Healthy for Life proposal. The second proposal was funded and has enabled a virtual primary health care model of care to operate for Aboriginal people in the Blue Mountains. The model was developed by the Healthy for Life Steering Committee in conjunction with the three general practices and two community health sites.

# Aboriginal Health – Nepean Blue Mountains

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## Nepean Blue Mountains Medicare Local

Nepean-Blue Mountains Medicare Local (NBMML) is proud to offer a range of services supporting and working with the Aboriginal and Torres Strait Islander communities for better health. The Closing the Gap Program, through the Aboriginal and Torres Strait Islander Outreach Workers, links community members to appropriate health services. This includes attending medical appointments with clients, arranging healthcare and transport, promoting Aboriginal and Torres Strait Islander specific primary health care initiatives e.g. health checks, PBS co-payment and encouraging self-identification via local schools, parent groups and other community groups and organisations.

The percent of the total population who are Aboriginal and Torres Strait Islanders is 3.8% in Lithgow, 2.6% in Hawkesbury, 2.4% in Penrith and 1.3% in Blue Mountains Local Government Areas. The NBMML needs assessment identified health related issues for our region such as transport to health services, Aboriginal & Torres Strait Islander health, GP shortages, aged care and nursing home bed availability. Eight consumer forums were held across the region in 2012 which confirmed these issues of concern.

The Blue Mountains Aboriginal Healthy for Life Program (HFL), is an initiative of the Blue Mountains Aboriginal Health Coalition, and is managed by NBMML. This community-based health program works in partnership with five primary health care sites and offers services aimed to improve health for Aboriginal Australians. The Program focuses on chronic, complex and aged care; men's and boy's health; and mums, bubs and kids health & wellbeing.

At 31 December 2013 Blue Mountains Aboriginal Healthy for Life had 16% of the Blue Mountains Aboriginal population registered with the Program, and 32% of this population was actively registered at one of the five Healthy for Life Primary Care Partner Sites (3 GP Practices and 2 Nepean Blue Mountains Local Health District Community Health Centres). The number of Aboriginal patients accessing these Sites increased by 27% between February 2012 and December 2013.

In 2013, 336 patients were assisted through Closing the Gap. In addition, 220 Aboriginal & Torres Strait Islander patients with chronic health conditions were referred by their GP to the Care Coordination & Supplementary Services (CCSS) program. As part of this program, the NBMML Care Coordinators provided 829 care coordination services consistent with their GP care plan and provided financial support to ensure access to specialists, in Penrith, Hawkesbury, Blue Mountains, and Lithgow (with over 100 Aboriginal community members accessing these programs), transport and some medical/equipment supplies.

NBMML coordinates a Specialist Paediatric Outreach Clinic in Lithgow, and commenced a new Psychiatric Outreach Clinic in Katoomba in March 2013. This provides affordable, accessible specialist services to Aboriginal families and families from low socioeconomic backgrounds. NSW Rural Doctors Network provides funding to cover the specialists and clinic costs through the Urban Specialist Outreach Assistance Program. 239 patients were seen through these clinics in 2013-2014.

## **Nepean Blue Mountains Local Health District (NBMLHD)**

The Nepean Blue Mountains Local Health District (NBMLHD) is responsible for providing primary, secondary and tertiary level health care for people living in the Blue Mountains, Hawkesbury, Lithgow and Penrith (LGAs) and tertiary care to residents of the Greater Western Region. The NBMLHD covers an area of approximately 9,000 square kilometres from Portland in the west to St Marys in the east, sharing the same boundaries as the NBMML. The District is diverse with a mix of metropolitan, regional and rural areas. The vision of the NBMLHD is: Together, Achieving Better Health. This vision has been reflected in the Primary Care and Community Health (PC&CH) service of NBMLHD working with key partners through the Blue Mountains Aboriginal Coalition and the local people to provide services to Aboriginal communities. Since the original Blue Mountains Sharing and Learning Circle in 2008, PC&CH have worked with a number of partners to secure funding and establish services including:

- Working with NBMLHD Oral Health services to provide the Blue Mountains Aboriginal Dental Clinic at Katoomba Hospital
- As lead agencies with NBMML, working with the Aboriginal Coalition members to secure Department of Health (Office for Aboriginal and Torres Strait Islander Health funding for the Healthy for Life program
- Primary Care and Community Health services worked in partnership with the Aboriginal Coalition to progress and support Medicare Locals 'Healthy For Life' program
- Establishing three year funding for the Strong Father, Strong Families Program, a program to support parenting for significant men in Aboriginal families such as husbands, partners and uncles
- Aboriginal Men's Parenting information and resource packs provided to both Katoomba and Lithgow hospitals
- Health screening in 'Health Tents' with Diabetic Educators, Drug and Alcohol counsellors, Child and Family Health nurses, Chronic and Complex nurses, Oral Health, in addition to offering immunisation and flu vaccines at significant Aboriginal events such as NAIDOC and Family Fun days across the Blue Mountains and Lithgow
- Presence of the Health Screening bus Mootang Tarimi (Living Longer) at events and planned locations throughout the Blue Mountains and Lithgow
- Three day Aboriginal Young Men's camps at both Yarramundi and Mt Victoria held twice yearly, Aboriginal Men's Yarn Up Sharing circle at Mt Victoria
- Involvement of Aboriginal Project worker in Harmony days at local high schools to promote and support Aboriginal culture
- Aboriginal Cultural Awareness training of all PC&CH staff provided through NSW health and locally by the NBMML Healthy for Life team
- In November 2013 the Aboriginal Project worker, for Strong Fathers, Strong Families, Mathew Tempest, was proudly nominated as the Blue Mountains City Council Mayoral Ambassador

against domestic violence.

- Within the NBMLHD there are a number of initiatives to promote Aboriginal health and to engage employees of Aboriginal heritage, through initiatives such as the NBMLHD Aboriginal Network Meetings.

In summary, the information from the 2013 Tracking the Circle: Blue Mountains Aboriginal Sharing and Learning Circle, will continue to inform and influence health service delivery throughout the NBMLHD, and the ongoing work of the Blue Mountains Aboriginal Coalition.

# Tracking the Circle 2013 Outcomes

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This report presents the outcomes from the 2013 Sharing and Learning Circle, Tracking the Circle. The full account of proceedings of the day and discussions is contained in the appendices attached.

Tracking the Circle utilised both large group and small group targeted discussion and feedback to generate priority issues. Outcomes presented here are based on analysis of discussions, identification of priority areas and small group discussion of identified priorities.

There was some confirmation from the community members that the health services were responding to their needs and that services had become more Aboriginal friendly since the 2008 Sharing and learning Circle.

## Priority Areas Identified

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Based on the large group discussion the following priority areas were identified:

Drug and alcohol
Aged Care
Mental health
Workforce
Community access to information
Transport

Small groups were conducted on the basis of the issues prioritised from the previous session. Each group moved on every ten minutes to the next priority area in order to maximise input on all priorities.

Groups were divided on the basis of community members (3 groups), health organisations and Aboriginal health organisations. Each group had a scribe to write down on butchers paper comments and ideas generated by the group on each priority.

All community groups discussed Drug and Alcohol, two discussed Workforce issues, one

discussed mental health and one discussed Aboriginal kids and community information. Issues identified under Aboriginal kids have been incorporated into the main topics ensuring that all were included.

Both health service groups discussed aged care, mental health, drug and alcohol and workforce issues, one group discussed community information and transport and the other postnatal depression.

When the priority areas were identified, the Circle participants were asked to indicate which issues were the most important in improving and addressing the health and well being of the local Aboriginal community. The review of this breakdown between community members and service providers indicates that there is significant alignment between the community and services providers for the top priority issue (Mental health), that both groups agree with the second priority in ranking (Aged Care), however it could be interpreted that this is an issue of higher importance and pressing need for community members than service providers. That both groups again agree in ranking for the third priority issue (Drug and alcohol), however again this issue appears to resonate more strongly with the community participants than the service providers present. Workforce is clearly a shared priority area for both the community and the service providers. Though this is based on raw numbers and the numbers of community members and service people who voted is not known, it does give some idea of the priorities as identified by the different groups.

Identified Priority Areas	Aboriginal Community Members	Services	Total
Mental health	21	18	39
Aged Care	22	12	34
Drug and alcohol	13	6	19
Workforce	10	11	21
Transport	10	6	16
Community access to information	7	6	13

Each priority area will be presented with the major areas of discussion from the groups.

# Priority Area One: Mental Health

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*The extent of mental illness and mental health problems has been recognised as ‘a major difficulty for most Indigenous communities’...after age-adjustment, Indigenous people aged 18 years or older were more than 2.6 times as likely as their non-Indigenous counterparts to feel high or very high levels of psychological distress. A significantly greater proportion of Indigenous people reported feeling sad and without hope than did their non-Indigenous counterparts. In 2010-11, Indigenous people were more than twice as likely to be hospitalised for ‘mental and behavioural disorders’ than were other Australians.*

MacRae A, Thomson N, Anomie, Burns J, Catto M, Gray C, Levitan L, McLoughlin N, Potter C, Ride K, Stumpers S, Trzesinski A, Urquhart B (2013). Overview of Australian Indigenous health status, 2012; *Australian Indigenous Health*. InfoNet (2013) Summary of Australian Indigenous Health, 2012.

## Response from community members

One community group considered mental health. They noted the difficulty in getting mental health service attention, and the need for more information on mental health services in the Mountains as well as the lack of Aboriginal mental health physicians and professionals. Aboriginal specific mental health and drug and alcohol support workers were identified as improving outcomes for community members. The potential to develop a mentoring program approach matching a mentor to an individual, enhancing support for community members undergoing treatment and therapy was raised. Aboriginal community members would be trained as mentors and matched to clients working with the case managers. The suggestion was these positions could work with clinical staff to ensure appropriate and culturally sensitive plans of care involving and reflecting the needs of the whole family unit were developed and implemented, whilst also offering greater levels of support. The need to increase the numbers of designated Aboriginal specific clinical positions in mental health was identified as a community priority.

Community members noted the need for better follow up after discharge and for ‘filling the gaps’ whilst in care such as clean clothes, visiting and shopping. Destigmatising was needed and clear information about understanding mental health (both mental illness and psychological problems) and well-being, particularly intergenerational trauma and associated post-traumatic stress disorders amongst Aboriginal people.

They felt that there was an underestimation of the cultural/spiritual healing through culture and identity and recognition was needed of culture – purri purri, gurda, Kadachi medicine and impacts both positive and negative.

Mental health services require proper guidance from community members, and need to show more commitment to Aboriginal mental health locally by being more engaged with the community and key forums and structures.

## Response from service groups

It was emphasised that strong advocacy was needed for Aboriginal mental health and a key voice was required on the NBMLHD Board. Greater cultural awareness is required especially on admission, treatment and discharge planning. An Aboriginal Liaison Officer and/or an Aboriginal Mental Health Worker and an adolescent mental health outreach worker are required. It was also

suggested that an Aboriginal specific crisis mental health team be established and an increase in the numbers of Aboriginal mental health and substance abuse workers. Staff are needed for both issues to enhance continuity for dual diagnosis patients.

The lack of availability of specialised mental health treatment/care in the local area, especially acute care, follow up of stable clients who are becoming acute and support for concerned family and neighbours was noted.

Brain injury was further noted as an area of concern.

The need for improved and enhanced service around dual diagnosis in Aboriginal community members was identified as an area needing attention and strengthening.

The lack of Mental Health service engagement in key community events, forums and committees was noted and raised as an ongoing issue.

## Priority Area Two: Aged Care

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*Expectation of life at birth for Indigenous people is 67.2 years for males (11.5 years less than for non-Indigenous males), and 72.9 years for Indigenous females (10 years less than for non-Indigenous females). The median age at death in NSW for Indigenous men was 58.5 years and 66.2 years for women (around 20 years less than those for the non-Indigenous population).*

*Australian Indigenous Health InfoNet (2013) Summary of Australian Indigenous Health, 2012.*

The realities of life expectancy for Indigenous community members brings specific challenges around ageing and the provision of culturally sensitive, accessible and appropriate services for Indigenous community members in the Blue Mountains as they age. The Blue Mountains ribbon geography and lack of transport and support infrastructure compounds issues of inclusion, access and service provision. The challenges posed in providing care and support to Indigenous community members in residential aged care facilities locally was raised, particularly the social exclusion felt by Indigenous community members in care who are often 20 years younger than other residents.

### Response from community members

A major concern with aged care was with transport especially for social outings and social inclusion. The age difference and differences in care level between 45-55 and 65-75 were also a concern with a noted lack of funding for under 55s. Mention was made of the lack of inclusion of cultural medicines in the medications list.

Suggestions included more activities such as bowls, darts and golf and a transport directory for the frail and aged. More respect for Elders (Aboriginal Liaison services) and cultural sensitivity allowing for access to country were also mentioned, and a Koori specific visitors scheme that could provide massages, sunshine, walks and outings. More identified positions were needed in aged care.

Suggested service strategies were for services to work more collaboratively, more services like LinkUp, more Aboriginal carers and education for GPs and pharmacists. There was a noted need for access to care alert resources, explanation of medicines being given and for the hospital to

give patients a medication list and explanation of medicines on discharge. More needed to be done about accessing Closing the Gap benefits.

Discussion around aged care needs also identified the potential for Aboriginal community volunteers to visit and support older community members at home and in residential aged care facilities, and the need for Aboriginal workers in Aged Care Access Teams.

## **Response from service groups**

Service groups stated that there was no Aboriginal specific aged care facility in the whole Western Sydney area, there was a need for more support workers for Aboriginal aged people and that there needed to be cultural awareness for all carers of Aboriginal elders and cultural training and Aboriginal workers for Aged Care Access Teams.

There is a lack of advocacy on the part of Aboriginal aged people, a lack of awareness of Closing the Gap benefits (Nursing Homes lack of awareness – GP 715 Aboriginal assessments) and community equipment and supplies. More aged care Home and Community Care packages for the 45+ age group and more user friendly staff environments when accessing health services. Transport limitations for aged people getting out were also noted.

Information distribution about available benefits in hard copy needs to be improved on all levels – interagency, consumers and providers. It was suggested that Blue Mountains Aboriginal Culture and Resource Centre services be expanded ensuring provision of appropriate care through liaison with Healthy for Life, community services and package providers.

The group cited the need for a specific Aboriginal Liaison Officer position covering Nursing Homes, Aged Care Assessment Teams and the community.

# Priority Area Three: Drug and Alcohol/Substance Abuse

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*Tobacco use was the leading cause of burden of disease and injury among Indigenous people. Tobacco use accounted for one-in-five deaths in the Indigenous population, with almost one-half (47%) of Indigenous people aged 15 years or older reporting that they were current smokers...the burden of disease attributable to alcohol among Indigenous people was more than twice that among other Australians with alcohol as the fifth leading cause of the burden of disease among Indigenous people with the highest levels of alcohol related disease burden for injury (22%) & mental disorders (16%)... almost one-quarter (23%) of Indigenous people aged 15 years or over reported that they had used an illicit substance in the 12 months prior to interview-1.6 times higher than the non-Indigenous population aged 14 years. Cannabis, pain killers and amphetamines are the illicit substances used most commonly by Indigenous Australians aged 15 years or over.*

*MacRae A, Thomson N, Anomie, Burns J, Catto M, Gray C, Levitan L, McLoughlin N, Potter C, Ride K, Stumpers S, Trzesinski A, Urquhart B (2013). Overview of Australian Indigenous health status, 2012;*

## Response from community members

Drug and Alcohol use and abuse was clearly identified as a significant issue within the community. It was noted that the problem with drugs and alcohol was starting earlier with children and that there was a negative impact on Aboriginal culture, family and relationships with accompanying lack of respect for Elders, and increase in violence and in mental health issues.

Smoking (yarndi) was identified as a particularly big issue amongst Aboriginal community representatives in the Circle. There was concern about brain damage from drug and substance use. Community groups also noted the use of metho, glue, petrol and nitro sniffing with “kids” abuse of parents, both physically and verbally, becoming a big issue. In addition, intergenerational use and dealing were noted within the discussion with anecdotal concern around high school kids known to be dealing. Kids use of yarndi was more of a problem than alcohol. The Circle discussed that “kids had grown up with alcohol and alcohol is more socially accepted”.

The strategies for dealing with drugs and alcohol for community member groups fell into three main areas – education, culturally specific services and cultural strengthening processes.

### 1. Education

Education needs to focus on the long term effects using peer to peer approaches rather than authority and include mentoring for young people, role models and stories on adverse outcomes for children, relevant, discrete information and awareness, attendance at AA meetings for a ‘glimpse of their future’ and the Salvation Army’s rehabilitation tour.

### 2. Culturally specific services

Culturally specific services mentioned included more appropriate Aboriginal specific detox centres, more culturally relevant information and education and Aboriginal counsellors and mentors through more funding. Better referral processes are also required. Aboriginal safe driver and safe drug use programs and youth song and rap competitions were also suggested.

### 3. Cultural strengthening

Cultural strengthening ideas included holistic approaches to include whole families and communities, regular healing camps on country, corroborees, storytelling for kids in primary school and increased skill and resilience building and sport participation for kids.

### Response from service groups

Service groups also discussed drug and alcohol as a priority area noting that it had become a more significant issue and now included harder line drugs and caffeine and synthetic marijuana, being taken up at a younger age with implications for mental health. Concerns were noted about doctor shopping and over prescribing of addictive drugs as well as lack of pain management services. A link between trauma including chronic long term intergenerational trauma and substance abuse was noted.

Strategies came under three main areas – education, service issues and culturally specific approaches.

#### 1. Education

It was noted that there was a lack of education and awareness of the legal implications for young people of the use of alcohol and use and dealing of drugs.

#### 2. Service issues

Service issues included people having to repeat their history or story for no benefit and an overlap of services with lack of communication between services and privacy barriers. There were problems noted with the Mental Health access team of little or no continuity or engagement with key care providers, lack of clarity about what services are provided and fragmentation of services which were short term in most cases, not helpful and merely 'do no harm' approaches. There was a perceived lack of active pursuit of Aboriginal clients by some Drug and Alcohol workers and a reluctance of Drug and Alcohol workers to home visit. Aboriginal people face additional stigma through prejudice when accessing services.

Another issue noted was that coming off methadone programs was not covered under the PPS and pharmacists can determine their price making it too costly for many people.

Suggested strategies for improving the services offered were to have a Drug and Alcohol counsellor from community health connected to ACRC and Healthy for Life, and the development of a Drug and Alcohol resource, education and support service for the Aboriginal community.

#### 3. Culturally specific approaches

Working within the whole family context was strongly emphasised. The need for family based work to give parents and family members a capacity to respond and draw on the strong resilience in the Aboriginal community was noted. This would include a mobile service with specialist experts adopting an interfamily approach to help break down barriers and invite family involvement to build family strength. It was also noted that a better response to dual diagnosis was needed and Aboriginal and gender specific Drug and Alcohol services and support groups that were culturally friendly such as Aboriginal AA and activities such as the disco run by the Police that was discontinued. Early intervention and follow up programs to prevent relapse are also needed.

Overall a restrictive justice approach rather than a punitive one was recommended that could be delivered in a non-judgemental, safe, community supportive and culturally appropriate form.

The need for improved and enhanced services around dual diagnosis in Aboriginal community members was identified as an area needing attention and strengthening.

## Priority Area Four: Aboriginal Staff/Workforce

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*Having Indigenous Health Workers on staff, increasing the number of Indigenous people working in the health sector (doctors, dentists, nurses), having culturally competent non-Indigenous staff working in services and designing health campaigns especially for Indigenous people makes health services more accessible for Indigenous people.*

*Australian Indigenous HealthInfoNet (2013) Summary of Australian Indigenous Health, 2012.*

In addition to discussing and identifying specific Aboriginal positions felt to be needed as new positions or extended in existing services across a range of services and health issues, Circle participants identified the positive change that a program like Healthy for Life program makes. Concerns about the impact of potential funding discontinuation to programs such as this, and the potential or expectation that mainstream services like community health could pick up from such services was unacceptable to participants given their experience if a targeted program with identified Aboriginal workers and culturally competent non Aboriginal workers.

### Response from community members

There was a clear statement that more Aboriginal health workers were needed. A number of strategies were noted including more training through TAFE and funded places through Centrelink, on the job training with adequate funding and opportunities for on the job reskilling.

The need for cultural safety in workplaces, lack of cultural understanding by employers, board members, management and other staff and a glass ceiling for Aboriginal workers were noted. Racism, both overt and covert, exist in the workplace along with outdated myths (equal wages – ensuring this is upheld). Employment codes of ethics should be applied equally.

Better motivation and mentoring, better pay and incentives and equal opportunities for the local community are needed.

Generally, community members identified that Aboriginal workers (both paid and volunteers) and specific support services, were needed in the areas of mental health, substance abuse and aged care. Discussion around aged care needs identified the potential for Aboriginal community volunteers to visit and support older community members at home and in residential aged care facilities, and the need for Aboriginal workers in Aged Care Access Teams.

Aboriginal specific mental health and drug and alcohol support workers were identified as central to improving outcomes for community members. Specifically the potential to develop a mentoring program approach matching a mentor to an individual, enhanced support for community members undergoing treatment and therapy. Aboriginal community members would be trained as mentors

and matched to clients working with the case managers. The suggestion was these positions could work with clinical staff to ensure appropriate and culturally sensitive plans of care involving and reflecting the needs of the whole family unit were developed and implemented, whilst also offering greater levels of support.

## **Response from service groups**

Cultural awareness training run by local Aboriginal people taking people on a journey for all workers and affirmative action to offer support, training, apprenticeships or scholarships for Aboriginal people are considered important for improving Aboriginal workforce issues. Stigmatisation of Aboriginal people in government roles was noted and a need to increase the qualifications of people in Aboriginal specific roles. Staff understand that the available resources were not enough.

A need for an Aboriginal interagency, an increase in Family and Community Services Aboriginal specific services, an Aboriginal mental health and/or liaison officer at Blue Mountains hospital and Aboriginal family workers to work with whole families for family restoration were identified. Along with more effort in training and education of Aboriginal people, particularly young people more support and acknowledgement was needed for Aboriginal people in non-identified roles.

Suggestions included government services and community agencies working collaboratively, healing provision for community and individuals and narrative therapy to be offered at community forums and smoking ceremonies.

*“Aboriginal health for Aboriginal people” (Circle 2013 Participant)*

# Priority Area Five: Information for Community

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*A lot of health services are not as accessible and user-friendly for Indigenous people as they are for non-Indigenous people, adding to higher levels of disadvantage...Sometimes health services are not culturally appropriate (do not consider Indigenous culture and the specific needs of Indigenous people).*

*Australian Indigenous HealthInfoNet (2013) Summary of Australian Indigenous Health, 2012.*

There was a clearly identified need from the community members and service providers present to vastly improve the flow of information and communication on new and beneficial services accessible available to the Aboriginal community. Available and easily accessible information and effective communication channels to support the distribution of critical information across and within services and Aboriginal community networks was felt by Circle participants to be an area for improvement and an area that would improve health and well-being outcomes . A need to convey further information about services to the community was identified at the sharing and learning circle.

One community group and one service group discussed the issue and provided ideas.

## **Response from community members**

A number of methods for provision of information were suggested by one of the community groups. Print ideas included Black Mail pamphlets, flyers and booklets, a council directory, school newsletters for students, school bus stop pickup, the Koori Mail and Indigenous Times. Other methods were TV and radio such as Tracker and Koori radio Living Black, Facebook and Twitter. Using prominent personalities through Vibe for families and carers, community expos, presentations at schools and word of mouth were also suggested as suitable ways to convey relevant information.

## **Response from service groups**

Suggestions for information provision by service groups included newsletters, distribution of hospital information through Healthy for Life newsletters for new clinics and services such as hydrotherapy, compiling a directory for community and workers of all services in the Blue Mountains and continuing to educate providers on new and existing services ie. Closing the Gap Care Coordination and Supplementary Services (CCSS).

It was also suggested that explanation of medical jargon and services was needed through an Aboriginal liaison officer at Blue Mountains Hospital and Aboriginal people need to be prioritised in the dental service at Nepean so they are not coming to the Blue Mountains clinic for dental services.

# Priority Area Six: Transport

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Transport was identified as a significant problem relating to a number of issues, particularly community participation, social inclusion, getting to appointments, for ageing community members to maintained in their homes, and for families and children.

## Major Issues

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*Compared with the stressors reported by the general population in the 2010 General Social Survey (GSS), many more Indigenous people reported stressors like: the death of a family member or friend; alcohol or drug related problems; trouble with the police; and witness to violence...Almost one-in-five Indigenous people also reported that either themselves, a family member, or friend had been sent to jail in the previous 12 months, but this stressor was not reported by the general population.*

*Australian Indigenous HealthInfoNet (2013) Summary of Australian Indigenous health, 2012.*

A number of major issues were discussed in the key priority areas identified as integral to improving health and well-being outcomes for local Aboriginal and Torres Strait Islander community members. Addressing these issues was felt by Circle participants as necessary if further improvement in access to and improved experiences when using health and related services for the local community was to occur. General issues identified have been categorised as:

### **1. Increased awareness and cultural sensitivity by Health Service providers of culturally sensitive issues that impact on Aboriginal service users.**

Community members present felt that there was real need for and commitment by Health Services at all levels to ensure that health providers had much greater awareness and better practical understanding of Aboriginal culture, their specific health issues and the effect of past trauma on their well-being.

### **2. Application of Closing the Gap strategies and entitlements by private health service providers.**

Circle participants specifically identified and discussed the need for further education of pharmacists on Closing the Gap initiatives and the entitlements for community members covered by Closing the Gap strategies. Particularly around entitlement to Closing the Gap prescription costs.

### **3. Holistic family centred approaches to care.**

Participants emphasised the need to take a whole of family approach, involving whole families (extended family members). This approach was felt by participants to be particularly important to outcomes for mental health, including post-natal depression and substance abuse issues.

#### **4. Strengthening of Aboriginal cultural processes.**

Integrating traditional healing approaches was discussed as necessary to include in plans of care for individuals and families and health promotion for at risk community members around disease development. Traditional methods for healing such as connection to country, corroborees and storytelling were named.

#### **5. Coordination and collaboration between services and service organisations.**

Significantly improved coordination and collaboration between Aboriginal specific, government and non-government general health services, service providers and health and social programs is required at all levels to improve access and uptake of programs and services aimed at improving health and well-being outcomes for the local Aboriginal community. Lack of coordination, collaboration and information flow is seen as restricting or potentially denying members of the local Aboriginal community access to appropriate resources.

#### **6. Enhanced resources and Aboriginal workforce in mental health, substance abuse and aged care.**

Community members and service providers identified that Aboriginal workers (both paid and volunteers) and specific support services, were needed in the areas of mental health, substance abuse and aged care. Discussion around aged care needs identified the potential for Aboriginal community volunteers to visit and support older community members at home and in residential aged care facilities, and the need for Aboriginal workers in ACAT teams.

Aboriginal specific mental health and drug and alcohol support workers were identified as improving outcomes for community members. Specifically the potential to develop a mentoring program approach using matching a mentor to an individual, enhancing support for community members undergoing treatment and therapy.

Aboriginal community members trained as mentors and matched to clients working with the case managers is a model put forward. The suggestion was for these positions to work with clinical staff to ensure appropriate and culturally sensitive plans of care involving and reflecting the needs of the whole family unit were developed and implemented, whilst also offering greater levels of support.

The need to increase the numbers of designated Aboriginal specific clinical positions in mental health, aged care and drug and alcohol services was also identified as a community priority.

#### **7. Available and easily accessible information and communication across networks of available and new services beneficial to Aboriginal community members.**

It was suggested that a forum could be held or working party formed to make formal suggestions around how to improve communication and information flow through existing services and networks employing new and innovative approaches.

#### **8. Transport was identified as a significant problem relating to a number of issues, particularly community participation, getting to appointments and aged care and for families and children.**

# Recommendations

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*What makes health services more accessible for Indigenous people?:*

- *having Indigenous Health Workers on staff*
- *increasing the number of Indigenous people working in the health sector (doctors, dentists, nurses, etc)*
- *designing health promotion campaigns especially for Indigenous people*
- *having culturally competent non-Indigenous staff*
- *making important health services available in rural and remote locations (so Indigenous people living in rural and remote areas do not have to travel to cities, away from their support networks)*
- *funding health services so they are affordable for Indigenous people who might otherwise not be able to afford them.*

*Australian Indigenous Health InfoNet (2013) Summary of Australian Indigenous Health, 2012.*

A number of key recommendations can be put forward as a result of the 2013 Tracking the Circle process:

1. Forums twice yearly to bring Aboriginal and non-Aboriginal services together including other relevant services such as CentreLink, Family and Community Services and Housing to:
  - share information and feedback on successes and challenges of new and existing programs
  - report on innovative programs and new initiatives that have been implemented or that may benefit the local Aboriginal community
  - identify emerging needs and gaps as a continuous process of review, development and improvement
2. Explore alternative means of information distribution through Aboriginal networks as suggested in Priority Area Five.
3. Forums be held annually to inform community members of changes and new services involving all services including CentreLink and Housing to be held in convenient locations in Upper and/or Mid Mountains with costs shared between services and service agreements to work together for improvements to Aboriginal health.
4. Accountability of services to be evident to community in the form of data showing indicators of improvement in Aboriginal health and access to services to demonstrate shared responsibility.
5. Consolidation of resources to reduce duplication and increase use of and access to available resources. The current Aboriginal men's groups were cited as an example of duplication and an opportunity to strengthen outcomes for the community if these resources were consolidated and to "go with the one, the approach that works". The Coalition was cited as central to addressing this recommendation.
6. Reduce competition between services and dedicated Aboriginal health and well-being programs, ensuring that programs address needs rather than focus on individual service ownership. The Coalition is central to addressing this recommendation.

7. Mental Health Services locally need to ensure that they are engaged, participating and present in all relevant local forums and committees related the health and well-being and improved outcomes for the Aboriginal community locally.
8. Nepean Blue Mountains Local Health District Mental Health Services (inpatient and community) must engage or be directed to engage as a standing member of the Blue Mountains Aboriginal Health Coalition.
9. The Blue Mountains Aboriginal Health Coalition have a voice in recommendations related to the Aboriginal specific health worker positions raised by Tracking the Circle 2013 participants and make recommendations to NBMML and NBMLHD.
10. Blue Mountains Aboriginal Health Coalition review membership and consider extending membership to relevant Blue Mountains NGO community services funded to provide complementary community support and volunteer resources to the aged and people with a disability. Inclusion of these services would broaden access to and information on local services able to be accessed by the local Aboriginal community.
11. Ensure continuation of funding of existing programs to reduce uncertainty in the Aboriginal community of access to services and medications.
12. Address access to Closing the Gap prescriptions by officially identifying entitlements of participants on prescriptions so that Aboriginality and entitlements to Closing the Gap benefits are not subject to the judgments of pharmacists.
13. Coverage of methadone under PBS needs to be clarified for health workers, community and with pharmacists re pricing.
14. Create formal agreements with relevant organisations for both primary and secondary schools and the relevant services for Aboriginal health workers to go into schools to talk to Aboriginal young people about risks of drug and alcohol and to encourage local Aboriginal storytelling for Aboriginal kids.
15. Investigate drug and alcohol programs for young people such as the Salvation Army's youth prevention and rehabilitation programs
16. Aged care referrals from other areas/country be considered before accepting and make provision for eventual return to country and/or visits in the meantime to enable family and community visits.
17. Aged care facilities for Aboriginal people within their own country and access to community need to be established, including in the Blue Mountains.
18. Fill vacancies in Aboriginal health in a timely manner and reach quotas to keep the confidence of the community and continue to look for ways to provide support and upskilling for existing Aboriginal staff.
19. Consider where services can be decentralised to make them more accessible.
20. The potential for funding the Building Strong Foundations program in the Mountains be investigated.
21. Compulsory one day training for all services to improve cultural safety for Aboriginal people working within and accessing services.
22. Ensure services are adopting holistic and whole family approaches to Aboriginal health.

# Appendices

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## Appendix One: Forum Program

10.00 – 10.15	Welcome to & Acknowledgement of Country
10.15 – 10.30	Overview of the purpose of the day, privacy and confidentiality, photos and recording
10.30 – 11.00	Update of the impact and evidence of key initiatives
11.00 – 12.00	Large Group Discussion <ul style="list-style-type: none"><li>- 30 mins Evaluation - community view on achievements and continuing issues</li><li>- 20 mins New areas for improvement</li><li>- 20 mins Identification of priorities for future</li></ul>
12.00 – 1.00	Small group discussion on top priorities – rotate all identified priorities across groups for maximum input with a scribe for each group. Purpose of the small group work: <ul style="list-style-type: none"><li>- How can you see these issues being addressed?</li><li>- What is your preferred outcome around the priority issue?</li></ul>
1.00 – 1.45	Lunch
2.15 - 2.30	Sum up and Evaluation/survey of community perceptions
2.30	Close

## Appendix Two: Tracking the Circle November 14<sup>th</sup> 2013

### Process Overview

#### Mid Mountains Neighbourhood Centre Commenced 10.40am

- Acknowledgement to country: Clarke Scott
- Clarke introduced the day and the purpose of today's circle and introduced the service speakers who would speak to the group, the big circle to look at the recommendations from the last circle and if the group felt they had been achieved, and the process of priorities being discussed in small groups
- Group members introduced themselves in the large circle
- Attendee numbers: 43
- Members asked if they were OK with their photo being taken or their voices being recorded – all members agreed that this was OK
- Group members thanked, moved to updates from the services from the initiatives put in place

### *Reports - Achievements to date*

#### Coalition update provided by Brad Moore

Acknowledged that the Coalition consists of:

- Link Up
- Tribal Councils
- NBMLHD
- Medicare Local
- BMCC
- ACRC
- Community members

Major initiatives of Coalition acknowledged by Brad Moore as:

- Healthy for Life
- Dental clinic BMADMH
- Specialist clinics
- Closing the gap initiatives and employment of Ellie and Clyde Chatfield
- 2 current men's projects
  - Aboriginal men's group
  - Strong Fathers Strong Families project
- Spoke to the Coalition meeting monthly and seeking to improve outcomes

- Acknowledged there is always work to be done and issues to be identified and support to the community

### **Healthy for Life update from Chris Haslam**

- Identified that the HFL would not be successful without Aboriginal governance.
- HFL 3 years in operation
- Closing the Gap (Lithgow BM's, Hawkesbury)
- CCSS Closing the Gap program
- 2 MovingOn Programs to support self-empowerment of managing health issues when you have a chronic condition. Hoping to find funds to employ and train Aboriginal community leaders as facilitators of the program
- Chronic health care forum
- Funding through rural doctors for a paediatric clinic in Lithgow accessible to BM's community
- Psychiatric clinic
- 2 women's camps run on country as a partnership project with HFL
- Tobacco cessation in home program

### **NBMLHD update from Dawn Williamson**

- Acknowledged the importance of the community input into the program and that there are processes for members being able to input both today at the circle or by speaking to Clarke Scott or Sarah Redshaw to capture their issues, concerns, suggestions and that a report will come from today. Dawn spoke to a number of NBMLHD community health initiatives targeting our local Aboriginal community:
- Dental clinic very successful, Lithgow now asking for the program
- Strong Fathers Strong Families program outlined
- Parenting groups
- Yarn up groups
- Info kits for new dad's
- Strong links to child and family health nurses
- Building strong foundations program not running in Mountains but hope that there is room to extend so it can run up here
- Assisting identification of Aboriginality for community members when using a health service, and detailed that Aboriginal and Torres Strait Islander community members will be prioritised for the service they require
- Health days/health screening and information events
- Dawn acknowledged that mental health and D&A services were not present today. She spoke to general Community Health services for information for group members. Dawn assured the group that she would ensure that D&A and mental health service issues raised by the

community today would be fed back to those services.

### **Nepean Blue Mountains Local Health District Aboriginal Health Unit outlined by Trish Heal**

- Currently operating with 4 to 5 permanent staff.
- HEO position discussed and the input in NAIDOC events.
- 30-40 Aboriginal staff across the NBMLHD, first network meeting occurred, new employment coordinator on to boost Aboriginal employment opportunities.
- Programs running, chronic care program-the outreach bus now managed by NBMLHD, they are re-engaging to ensure the bus is accessible in the mountains, as this was an initiative from the original circle.
- 48 hour follow up ensures that community will be followed up within 48hrs of discharge to ensure that the community member has what they need, medications, follow up appointments etc.
- Quit for Life program specifically targeting and encouraging Aboriginal women and pregnant women to give up smoking.
- Outreach days at Wentworth Falls and Hartley were successful.
- The NBMLHD Aboriginal Health Unit is now an active member of the coalition. Major focus for the Aboriginal health unit is rebuilding relationship in the mountains; establishing an Aboriginal Governance Committee with the community encouraged to attend and contact the unit for further details

Clarke acknowledged the work of all organisations and their attendance today and that they have come today to take back feedback or areas for improvement.

Clarke then went through some of the short, medium and long term outcomes from the 2008 Sharing and Learning Circle asking people if they thought these had been addressed.

## Appendix Three: Large Group Discussion

Large group exercise conducted based on the issues prioritised at the 2008 circle, contained in the original report. Short term, intermediate and long term issues were prioritised in the original report and these were reviewed and discussed in the large group to see if they were still valid, what had been addressed and achieved directly related to them.

### Coalition

- Request for more information on the coalition. Brad Moore fielded the question and gave a brief overview. Original purpose was to improve health locally and bring all relevant services stakeholders together – Health to respond to needs and advocacy from local community
- Coalition has worked to the original issues raised in the 2008 Sharing & Learning Circle as the basis of their strategic plan/directions
- Brad outlined the strength of all the services coming together. Gave example of the BMCC involvement –the only local council engaged in H4L program across NSW, as an example of the import and engagement
- Question around the broadening of the coalition membership over time as well as H4L working with a community steering mechanism.
- Stated that they attempt always to have a predominant Aboriginal membership
- Highlighted need to get contact details of the community members present today, and the ability to use the Coalition to feed back issues, ideas – Brad asked that a mechanism be developed through the Coalition to capture the grass roots needs of the community
- Culturally specific information, training for GP's
- Group asked by facilitator if they felt that GP attendance a better experience. GP Dr Sam Critchley present spoke to the cultural awareness training undertaken for GPs and staff - that it has made a difference in terms of raising awareness and needs to continue. Understanding by staff of the importance of Aboriginal health programs and initiatives has been improved - strengthening and positive.
- Spoke to local cultural awareness training developed through the Coalition and approved by the GP college
- Uncle Graham Cooper spoke to his attendance at the 3 cultural awareness programs, and his belief that the programs have facilitated change and improvement in care – feedback extraordinary and respect in the Aboriginal community for those who have attended has grown, warmly received
- HFL staff members spoke to the GP practices across the mountains who have engaged – training has increased the work practices in those surgeries with community members, contacting HFL where concerned for a client and understanding of the complex issues that affect Aboriginal and Torres Strait Island community members.
- Transport remains a big problem.
- Question relating to pharmacists and chemists and paramedical services engaged in the loop of care as this is currently a weak link

- Refusal of CtG entitlement for filling prescriptions in other areas
- Chemists' awareness of Aboriginal health services and treatment of Aboriginal people/cultural awareness – need for training
- Need for identification of Closing the Gap entitlement on the record or prescriptions

### Communication of available services

- Sue Tate raised her concerns that the BMADMH has a number of initiatives that are accessible to the Aboriginal community, and that their Reconciliation Community is working to ensure improved service provision and cultural awareness
- The importance and good work of the Reconciliation Committee at the Hospital was acknowledged from the floor

### After hours care and follow up outside GP hours

- Confirmed as 'huge gap' by Tilly (HFL) that all programs are aware of – 'massive problem' with many clients on books having mental health/trauma related problems
- Not part of funding model

### Involvement of Mental Health Services and mental health illness

- This was identified as a huge gap particularly around chronic care programs, mental illness not being included in physical chronic care initiatives and the impact of mental illness not being part of the funding model.
- Discussion about the need for mental health services to be present in all partnerships, forums and discussions. Discussion that the issues raised are not isolated to our community.
- Coalition – Brad – saying this from the start - easier to deal with things that can be seen than things that are behind the scenes
- Medicare local spoke to the Partners in Recovery program aimed at chronic mental health sufferer's and that the program will have an Aboriginal focus, for people with a chronic mental illness and linking up services.
- Community member raised their concerns about the "fear" factor with mental illness and mental health issues, another community member raised the poor follow up after an issue or service engagement.
- Chris Okunbor spoke to HFL existing in limited practices across the mountains but they have seen large increases in client numbers. Also spoke to the need for community members to be really candid about the big issues to be addressed as gaps

### Access to service information

- Clarke asked if people are getting the information around what services are out there. Deb Dare spoke to the need for the community to be aware of MCRN (Mountains Community Resource Network) as a resource for Aboriginal services to get information to and from the broader network of community sector services

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- Feedback opportunities
  - a. Aboriginal health workers to be networked into community
  - b. Employ more network into services – question if that has been achieved, and recognition of need – Health rep spoke to the largeness of the Health bureaucracy and the need for an Aboriginal workforce – Brad spoke to this as being critical locally also spoke to the need for the services to be respectful of the community and the community to be respectful of the worker.

## Appendix Four: Small Group Work

Small groups were conducted on the basis of the issues prioritised from the previous session. Each group moved on every ten minutes to the next priority area in order to maximise input on all priorities.

Groups were divided on the basis of community members (3 groups), health organisations and Aboriginal health organisations. Each group had a scribe to write down on butchers paper comments and ideas generated by the group on each priority.

All community groups discussed Drug and Alcohol, two discussed Workforce issues, one discussed mental health and one discussed Aboriginal kids and community information.

### Responses from community group

Community 1	Community 2	Community 3
Drug and Alcohol	Substance Abuse - complex factors	Drug and Alcohol
Education - long term effects peer to peer (rather than authority)	Issues from stolen gen - transgenerational trauma	More appropriate Aboriginal specific detox centres
Drug and alcohol prevalent in community	Aboriginal person - negative impact on culture, family relationships - little respect for elders, violence, mental issues	More culturally relevant information and education
More Aboriginal counsellors/mentors	Starting young	Relevant discrete information and awareness
Attend AA/NA meetings for a glimpse of their future	Underlying issues drugs kick off - diagnosis re substance abuse, mental health issues	Change for children Role models/stories on adverse outcomes
Salvos rehab tour	Smoking massive amongst Aboriginal (yarndi) people	Holistic approaches
Teach life skills - cooking, finances, dancing, art	Long term brain damage	Cultural strength to avoid substances
More mentoring for young people to identify (and be proud)	Metho (9 years taking) Sniffing glue/petrol/nitro/ flavours	Regular healing camps on country
Keep culture alive	Spray paint	Lack of funding for culturally appropriate services

	Inter-generational 'dealing', 'use' - High school kids dealing	Better referral system
	Kids abusing parents (physical and verbal) - big issue	
	Kids not as much alcohol abuse - more jarndi Grown up with alcohol	
	Alcohol socially accepted	

Community 1	Community 3
Workforce	Aboriginal workers
More training - TAFE more Aboriginal workers in services - Centrelink	More of them
More motivation/ mentoring/lead by example	On the job training with adequate funding
Lobby employers/industry	Opportunities for people, to get on the job reskilling
Better pay/incentives	Cultural safety for workers
	Lack of cultural understanding by employers/board members/management/other staff
	Equal application of code of ethics
	Mentors for Aboriginal workers
	Barriers/glass ceiling for Aboriginal workers
	Outdated myths - equal wages, ensuring that this is upheld
	Racism (overt and covert) in the workplace
	Equal opportunities for local community

Aged Care	Aged Care
More transport - provide directory	What is aged care? Is there a difference of carer between ages 45-55 and 65-75?
Services work more collaboratively	Transport for aged, frail and sick - social outings, cultural inclusion
More services like LinkUp	Cultural sensitivity - accessing country
More Aboriginal carers	Respect for Elders i. A L services
More activities - bowls, darts, golf	Explanation of medications being administered
Closing the Gap - access to benefits	Cultural medicines not included in medications list
More education of GPs and pharmacists	Hospital giving patients medication list upon discharge and explanation of medicine given
	Access to care alert for patients
	Lack of funding for aged care under 50 years
	Caring and social support for aged (awareness)
	Koori specific visitors scheme for massages, sunshine, walks, outings
	More identified positions
<b>Community 2</b>	<b>Community 3</b>
Aboriginal kids	Mental health
Increasing ice in mountains - reports of dealers' spice 'pot'	Follow up after discharge
Kids come to HS tanked up - gone importance of song line/ancestry	Fill the gaps whilst in care - clean clothes, visiting, shopping ok
Got to direct / engage youth early	Getting the mental health attention
Youth hard to see dangers - vulnerability	More information on mental health services in mountains
Kids in PS actively sexual (sexual abuse, pornography) - oral sex - favours	Clear information around understanding mental health
Commission on child abuse	Destigmatising

Gambling - kids from young age	Intergenerational trauma and associated PTSD
Risk of unsafe sex	Lack of ATSI mental health physicians
Culture of silence	Underestimation of cultural/spiritual healing through culture and identity Recognising culture - purri purri, gurda, Kadachi medicine - and impacts it has positive and negative
Physical abuse	Transference of energies
More cultural programs	Proper guidance for mental health services from community members
Increase cultural awareness on country/culture	Funding - more please!!!
Corroboree - all go to - service and community (Moree Shire Council support)	
Increase pride in Aboriginality	
Start in primary schools - skills, resilience	
Adequate funding	
Culturally appropriate services	
Getting "part of system" for acknowledgement	
Appropriate referrals	
Increase sport - footy	
Combat accepted culture of drinking/smoking pot	
Offer/identify positive alternatives through life cycle	
Ensure culturally appropriate - Aboriginal AA	
Identify culturally appropriate supports for whole family - stronger fathers/mothers	
Ensure referral pathways/interagency	
Aboriginal safe driver, youth song/rap competitions, safe drug use	
Increase self determination	
Primary kids - storytelling	

Comic book - Streetwise	
Community Info	
Black Mail - pamphlets, flyers, booklets	
Mailing list	
Council directory	
School newsletter - students	
Family and carers - Vibe - prominent personalities	
Aboriginal organisations Website	
Community expos	
Word of mouth	
Newspaper	
School bus stop pick up	
Presentations at school Koori Mail/Indigenous Times	
Tracker (NSW land) - TV, radio	
Koori radio/living black Facebook, Twitter, phone directory, posters	

## Responses from service groups

Both health service groups discussed aged care, mental health, drug and alcohol and workforce issues, one group discussed community information and transport and the other postnatal depression

Aboriginal Health Workers group	Health Services
Aged Care	Aged Care
No Aboriginal specific aged care facility in whole of Western Sydney area	CTG – NH lack of awareness – GP 715 Aboriginal Assessments
Support workers for Aboriginal aged people	User friendly staff/environment
Cultural awareness for all carers of Aboriginal Elders	Lack of advocacy
Expand ACRC services for Elders ensuring provision of appropriate care – liaise with H for L and community	Cultural events – community connections

services, packages etc	
	Transport limitations – getting out
	ALO covering NH/ACAT/community
	45+ aged care HACC packages
	Information distribution - hard copy IT – interagency, consumers, providers
	Community – equipment, supplies
	ACAT – Aboriginal workers/cultural training
<b>Information for Community</b>	
Newsletters valuable	
Distribute hospital information through H for L newsletters ie. new clinics and services, hydrotherapy	
Compilation of directory for community and workers of ALL services in BM	
Prioritise Aboriginal people in dental service at Nepean so not coming to BM clinic	
Explanation of medical jargon and services – another reason for Aboriginal liaison officer at hospital	
Continue educating providers on new and existing programs ie. CCSS	
<b>Mental Health</b>	
Cultural awareness, especially on admission, treatment and discharge planning	MH for Aboriginal people needs <u>strong</u> advocacy – Clarke on NBMLHD Board – key voice for issues – table this report
Availability of specialised mental health treatment/care in local area, esp acute care	Aboriginal specific crisis mental health team – increase numbers of Aboriginal MH and substance abuse workers – staff for <u>both</u> issues to enhance continuity for dual diagnosis
Follow up of stable clients becoming acute – who follows them?	Support for concerned family/neighbours
Aboriginal liaison worker AND/OR Aboriginal Mental Health worker	Brain injury

Adolescent mental health outreach worker	
Aboriginal Staff/Workforce	Workforce
Aboriginal health for Aboriginal people	Cultural awareness training – run by local Aboriginal person – taking people on a journey
Staff understand available resources- not enough	Affirmative action to offer support/training/ apprenticeships/scholarships for Aboriginal people
Working collaboratively between govt services and comm agencies	Workforce colleagues
Aboriginal mental health AND/OR liaison workers at BM Hospital	ALO – increase capacity
Culturally appropriate training for ALL workers	Aboriginal family workers – working with family as a whole – family restoration
Healing provision for community and individuals	Aboriginal interagency
Narrative therapy offered at community forums/smoking ceremonies	Increase FACS Aboriginal specific
	Support and acknowledgement of Aboriginal people in non-identified roles
	More effort into training/education for Aboriginal people – part young people
	Stigmatisation of Aboriginal workers in govt roles
	Increase quals for people in Aboriginal specific roles – mentoring, support
Drugs and Alcohol	Drug and Alcohol
D & A counsellor through community health – to connect with ACRC and H4L	Significant issue – become more so
D & A resource/education /support service for Aboriginal community	Different/harder line drugs – caffeine, synthetic marijuana – younger age – link to mental health – youth services aware of this?
Need for early intervention and follow up programs to stop relapse	Better response to dual diagnosis
Non-judgemental, safe community support, culturally appropriate	Need for family based work – parents/family capacity to respond – strong resilience in Aboriginal community

D&A and Mental Health – reluctance to home visit – this helps break down barriers and invites family involvement – builds family strength	Concern re Dr shopping and over prescription of addictive drugs
AA Aboriginal specific GP – disco discontinued but was needed	Lack of pain mx services – auxiliary
Gender Specific	Workers to work within whole family context
Acknowledgement of chronic conditions – long term intergenerational trauma	Link between trauma and substance abuse
Fragmented services – not helpful and most care short term – ‘do not harm’ – needs specialist, expert, ‘mobile’, interfamily approach	Methadone – coming off this – not covered under PPS – pharmacists can determine price
People repeating history/story for no benefit	Lack of Aboriginal specific D&A services/support groups
What services do MH access team provide? – little/no continuity/engagement with key care providers	Difficulty in accessing culturally friendly D&A services
	Overlap of services – lack of communication/privacy barriers
	Lack of active pursuit by some KCH D&A workers
	Lack of education/awareness of legal implications for young people – need to break down fear
	Stigma as prejudice – part in reference to Aboriginal people
	Restrictive justice approach as opposed to punitive
Post-natal depression	Transport
Need for family approach – cultural safety	Child and family
Exclusion from Aboriginal specific services	Nursing home

## Appendix Five: Identified Priority Areas

Participants were given coloured dots and asked to place these next to the areas they thought were the most important priorities for the Aboriginal communities in the BMs.

The identified priorities were listed on sheets of butcher's paper and placed around the walls of the meeting hall and people were able to place as many dots as they wished. Aboriginal community members were given red and yellow dots and health service personnel were given blue and green dots in order to highlight any differences in priority between community and services.

The dots were then tallied according to the identified priority areas and are shown in the table below.

Identified Priority Areas	Aboriginal Community Members	Services	Total
Mental health	21	18	39
Aged Care	22	12	34
Drug and alcohol	13	6	19
Workforce	10	11	21
Transport	10	6	16
Community access to information	7	6	13

## Appendix Six: Summary of progress from the 2008 Blue Mountains Sharing and Learning Circle

The Blue Mountains Sharing and Learning Circle took place in March, 2008 as a consultation process and was attended by over 60 people. From the forum the Blue Mountains Aboriginal Health Coalition was formed with representatives from Aboriginal Community members and organisations, Sydney West Area health Service (now the Nepean Blue Mountains Local Health District) and the Blue Mountains GP Network (now the Nepean-Blue Mountains Medicare Local).

Issues and strategies were identified with timeframes including: immediate, short term and long term. The formation of the Blue Mountains Aboriginal Health Coalition has become the driving force for these issues and strategies to be implemented and addressed.

The following indicates progress on the 2008 identified strategies.

### Short Term Strategies

SHORT TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
<b>Culturally appropriate training for GPs</b>	<p>Contact Aboriginal Cultural Resource Centre</p> <p>Market the need</p> <p>Link into existing education</p> <p>Ensure GPs see the training as a priority</p> <p>Educate all services and workers not just GPs</p>	<p>Sessions conducted:</p> <ul style="list-style-type: none"> <li>• Two Cultural Awareness sessions were conducted initially in 2011 in both Katoomba and Springwood with 61 professionals attending in total.</li> <li>• Three experiential cultural awareness workshops for both GP staff and Mental Health providers were conducted in 2008 onwards.</li> <li>• One education session was held in 2012 for Community Health staff.</li> </ul> <p>Each Blue Mountains General Practice was then visited to run in-house mini training sessions on cultural awareness. Cultural awareness training is a regular part of the Nepean- Blue Mountains Medicare Local training calendar. These sessions are advertised and open to all health workers, GPs and administrative Practice staff.</p>	<p>Continue to promote and conduct cultural awareness training</p>

SHORT TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
<p><b>Making Aboriginal health services friendly</b></p>	<p>Awareness campaign</p> <p>Pamphlets available with flag/ sticker of Aboriginal colours</p> <p>Aboriginal Liaison Officer at facilities.</p> <p>Copies of Koori Mail or health workers journal Available</p> <p>Surveys /feedback with colours</p> <p>Health professionals education</p>	<ul style="list-style-type: none"> <li>• Two posters were developed with input from the local community in 2009 to indicate that a health facility was Aboriginal friendly. These posters were printed and distributed to GPs and Community Health Centres in the district for display. Posters were developed with Sydney West Area Health Service and the Blue Mountains GP Network logos, however, now both organisations have changed their names.</li> <li>• Newspapers were purchased for a limited time period for waiting rooms in Community Health Centres and discontinued as they were not utilised.</li> <li>• Aboriginal specific workshops and forum flyers have, in most cases, displayed an Aboriginal logo or border for easy identification.</li> <li>• A number of Blue Mountains GP Practices have linked with local artists via the Healthy for Life program and have purchased and prominently displayed these works of art in their Practices.</li> <li>• The Healthy for Life program has extensively used Aboriginal art for its program brochures.</li> </ul>	<p>These Aboriginal friendly posters need to be revisited with the new organisations logos reflected; Nepean Blue Mountains Local Health District and Nepean-Blue Mountains Medicare Local. Prominent display of the new Aboriginal friendly service posters should then occur at each health facility/GP Practice</p> <p>Development of protocols and guidelines are required within the Nepean Blue Mountains Local Health District and Nepean Blue Mountains Medicare Local to encourage the use of the Aboriginal colours on appropriate documentation.</p>
<p><b>Increase awareness of what services are available</b></p>	<p>Use community radio</p> <p>Aboriginal newsletter with list of services</p> <p>Pamphlets</p>	<ul style="list-style-type: none"> <li>• Community radio talks were undertaken in 2009 however not utilised extensively since 2010.</li> <li>• The Blue Mountains Aboriginal Cultural Resource Centre has been the conduit for enhancing communication of services to the local Aboriginal Community via their newsletter. The Blue</li> </ul>	<p>A schedule is required to ensure these methods of information sharing continues.</p>

SHORT TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
	Interface strengthened between health professionals and the community  Bulk billing signs  GP list	Mountains Aboriginal Coalition members also ensure relevant information is provided to the Community. <ul style="list-style-type: none"> <li>Awareness and access to services has been reinforced through the Healthy for Life team involvement in the local community. The Healthy for Life Program also produces a quarterly newsletter for the Blue Mountains Aboriginal community.</li> <li>Services that were identified as lacking in 2009 such as Dental services have subsequently been established in Katoomba and advertised widely through GPs, agencies and the community together with advertisements in the Gazette.</li> </ul>	

### Medium Term Strategies

MEDIUM TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
<b>Importance of Aboriginal health workers in services- Aboriginal health workers to be well networked into community</b>	Review workers roles and look at opportunities to employ more Aboriginal workers	<ul style="list-style-type: none"> <li>The Blue Mountains GP Network established a new position employing an Aboriginal outreach worker in 2009.</li> <li>Discussions were undertaken with Human Resources at the Local Health District to encourage employment of Aboriginal workers. This resulted in local advertisements stating the encouragement of Aboriginal workers.</li> <li>Local Health District, Mental Health Services commenced a program of training Aboriginal workers and supporting them to complete a mental Health worker qualification.</li> <li>Specific staff members from local services were involved in an organisation looking at improving workplace training and education for Aboriginal staff.</li> <li>A submission for program funding in 2011 was successful resulting in the Healthy for Life program. This program employed a Program Manager, Child and Family Health Nurse, Chronic Care</li> </ul>	Continued promotion of opportunities for Aboriginal workers.

MEDIUM TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
		<p>Nurse, Aboriginal Outreach Workers and has had a 100% retention rate.</p> <ul style="list-style-type: none"> <li>• Healthy for Life staff engage with the Aboriginal Community to ensure services are linked for Aboriginal community members and cultural needs are being considered in care.</li> <li>• In 2012 Sydney West Area Health Service launched the Strong Fathers, Strong Families program employing an Aboriginal project worker. This position worked alongside similar roles within Blue Mountains City Council and the Aboriginal Cultural Resource Centre.</li> <li>• Local Health District Mental Health and Drug &amp; Alcohol services have both employed Aboriginal Liaison officers.</li> <li>• A Cadetship for a nursing position (Aboriginal specific) at Katoomba Hospital has been established.</li> <li>• The Nepean-Blue Mountains Medicare Local has increased the number of Aboriginal workers supporting the Close the Gap program.</li> </ul>	
<p><b>How to justify the numbers for funding of positions</b></p>	<p>Encourage identification at hospitals, GP practices etc.</p>	<ul style="list-style-type: none"> <li>• Education and training of GP staff was undertaken by all Blue Mountains GP Practices relating to cultural awareness and the promotion and encouragement of cultural identification.</li> <li>• The establishment of the Healthy for Life program also assisted in the promotion of identification in the community and has a presence on the Blue Mountains Hospital Reconciliation Committee where this issue is discussed frequently.</li> </ul> <p>There has been a steady increase in Aboriginal Community members accessing services and Aboriginal health checks. In 2014 The Australian Institute of Health and Welfare released a report tabling an increased usage rate for the MBS 715 Aboriginal Health Assessment from 8.7% to 13.1% over a three year period – for the Nepean- Blue Mountains Medicare Local area.</p> <p>In 2014 28% of the Blue Mountains Aboriginal population had identified and were registered as patients/clients of the 5 primary health care sites signed up to</p>	<p>Yearly updates for training of GPs to continue.</p> <p>Ongoing awareness and encouragement of the Community to identify.</p>

MEDIUM TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
		the Blue Mountains Aboriginal Healthy for Life Program (3 GP sites and 2 Community Health sites contributing to National Key Performance Indicator data).	
<b>Health programs in the mountains</b>  <b>Funding (Aboriginal Medical Service)</b>  <b>Flexible appointments system</b>	Look at services extending to Mountains e.g. Aboriginal Medical Service	<ul style="list-style-type: none"> <li>Investigation and discussions were undertaken with the Aboriginal Medical Service.</li> </ul> <p>The Blue Mountains Coalition felt that local programs and projects would need to be more tailored to the Blue Mountains. This resulted in;</p> <ol style="list-style-type: none"> <li>A dedicated day per week at the Katoomba hospital dental clinic for Aboriginal patients. A direct phone number and flexible appointment times were built into clinic service delivery.</li> <li>The Healthy for Life program has also continually developed local health targeted initiatives such as those specifically for young men and women focussed upon cultural activities, yarn up and hydrotherapy program.</li> <li>Programs such as Strong Fathers, Strong Families program, and Aboriginal youth program at council, Men and Boys camps and conference.</li> </ol>	Continue to be open to new opportunities for service development and expansion to meet gaps.
<b>GP training through Division</b>	Engage Aboriginal services/workers to provide education to both GPs and their staff	<ul style="list-style-type: none"> <li>Aboriginal staff and consultants are engaged to conduct training sessions on cultural awareness. This continues today sponsored by the Nepean-Blue Mountains Medicare Local throughout the region.</li> </ul>	The Nepean-Blue Mountains Medicare Local to review education calendar to include opportunities for continued Cultural Awareness Training.
<b>Transport Special fitted out bus –</b>	To address one stop shop and accessibility	<ul style="list-style-type: none"> <li>Mootang Tarimi was established as a mobile bus screening service for chronic disease. The mobile service was booked monthly across the Mountains and</li> </ul>	The utilisation of Mootang Tarimi for

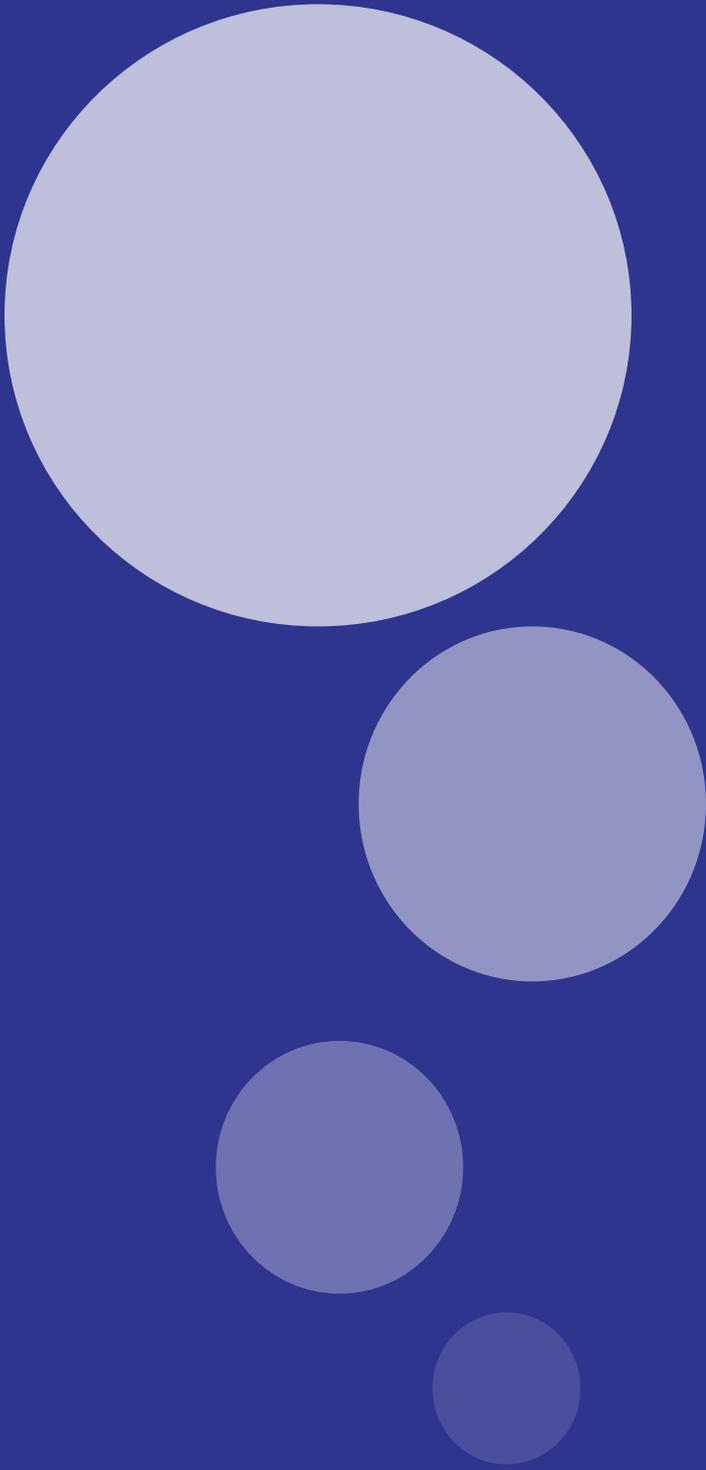
MEDIUM TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
<b>mobile bus service</b>	for the community.  Needs to be accessible across mountains and not just in one location	Lithgow with varying attendance rates. Changes to bus schedule means that Mootang Tarimi is now booked for key local events such as NAIDOC, family fun day events etc.	screening and referrals to specialists must continue to be promoted. A set schedule of venues, times and dates that are advertised will further enhance usage of the bus as a positive method for health screening.

### Long Term Strategies

LONG TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
<b>Aboriginal Culture and Resource Centre relocated</b>	Lobby council for location in an accessible location	On hold	
<b>One stop shop for Aboriginal Health</b>	GP clinic proposal	<ul style="list-style-type: none"> <li>Due to the ribbon development of the Blue Mountains this strategy was seen to be one that required a different approach. Establishment of Mootang Tarimi services and specific Blue Mountains programs such as dental and Healthy for Life have</li> </ul>	The Blue Mountains Aboriginal Health Coalition to continue to provide leverage and lobby for services

LONG TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
		provided an alternative to date.	identified as lacking
<b>Aboriginal health worker at Katoomba Hospital</b>	Lobby for worker 24/7	<ul style="list-style-type: none"> <li>A newly appointed Aboriginal Liaison Officer in Community Health will provide inreach into Katoomba hospital during working hours, as required.</li> </ul>	
<b>Holistic approach to health Transport Housing Medical Cultural /spiritual</b>	Enhance recognition of needs in the Blue Mountains/increase numbers through identification	<ul style="list-style-type: none"> <li>The establishment of the Blue Mountains Aboriginal Health Coalition has provided a more holistic approach to health and an avenue to facilitate cultural appropriateness of service planning and delivery. Strategies to increase identification continue to give weight to the need for Aboriginal specific approaches to service development and service availability locally.</li> </ul>	
<b>Blue Mountains identified funding</b>		<ul style="list-style-type: none"> <li>Healthy for Life was the result of a submission by the Coalition members for specific Commonwealth funding for the Blue Mountains.</li> <li>The Coalition has supported other funding applications such as Strong Fathers Strong Families and the Blue Mountains City Council Aboriginal youth program.</li> </ul>	Opportunities for new funding sources need to be sought through successful applications for funding supported by the Coalition.
<b>Collective approach to lobbying for change</b>	Voice through a joint planning committee with Blue Mountains Division of GP and Sydney West Area Health Service to coordinate a united voice	<ul style="list-style-type: none"> <li>The Blue Mountains Aboriginal Health Coalition was established in 2009 following the 2008 Sharing and learning circle. The Coalition is recognised as a model of partnership and engagement that has given a voice to the Community in the Blue Mountains and has</li> </ul>	The Coalition has been instrumental in advocating for additional services and change to mainstream systems. The Coalition initially led by

LONG TERM	STRATEGY	PROGRESS	FUTURE DIRECTION NEEDED
		<p>forged collaborative initiatives. The coalition not only operates to provide advice to service providers but has actively worked in partnership to advocate for change.</p> <p>Members include:</p> <ul style="list-style-type: none"> <li>• Aboriginal Cultural Resource Centre</li> <li>• Darug Mountains Group</li> <li>• Gundungurra Tribal Council Aboriginal Corporation</li> <li>• Gundungurra Aboriginal Heritage Association</li> <li>• Link-Up NSW</li> <li>• Blue Mountains City Council</li> <li>• Nepean- Blue Mountains Medicare Local (formerly, Blue Mountains GP) Network Inc.</li> <li>• Nepean Blue Mountains Local Health District ( formerly, Sydney West Area Health Service) Community Health</li> </ul>	<p>the Nepean-Blue Mountains Medicare Local and Local Health District is now chaired by an Aboriginal member of the committee.</p>



A Report from the Blue Mountains Aboriginal Health Coalition.  
A joint initiative from Nepean-Blue Mountains Medicare Local and Nepean Blue Mountains Local Health District.

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*Border by L & S Tobin*

