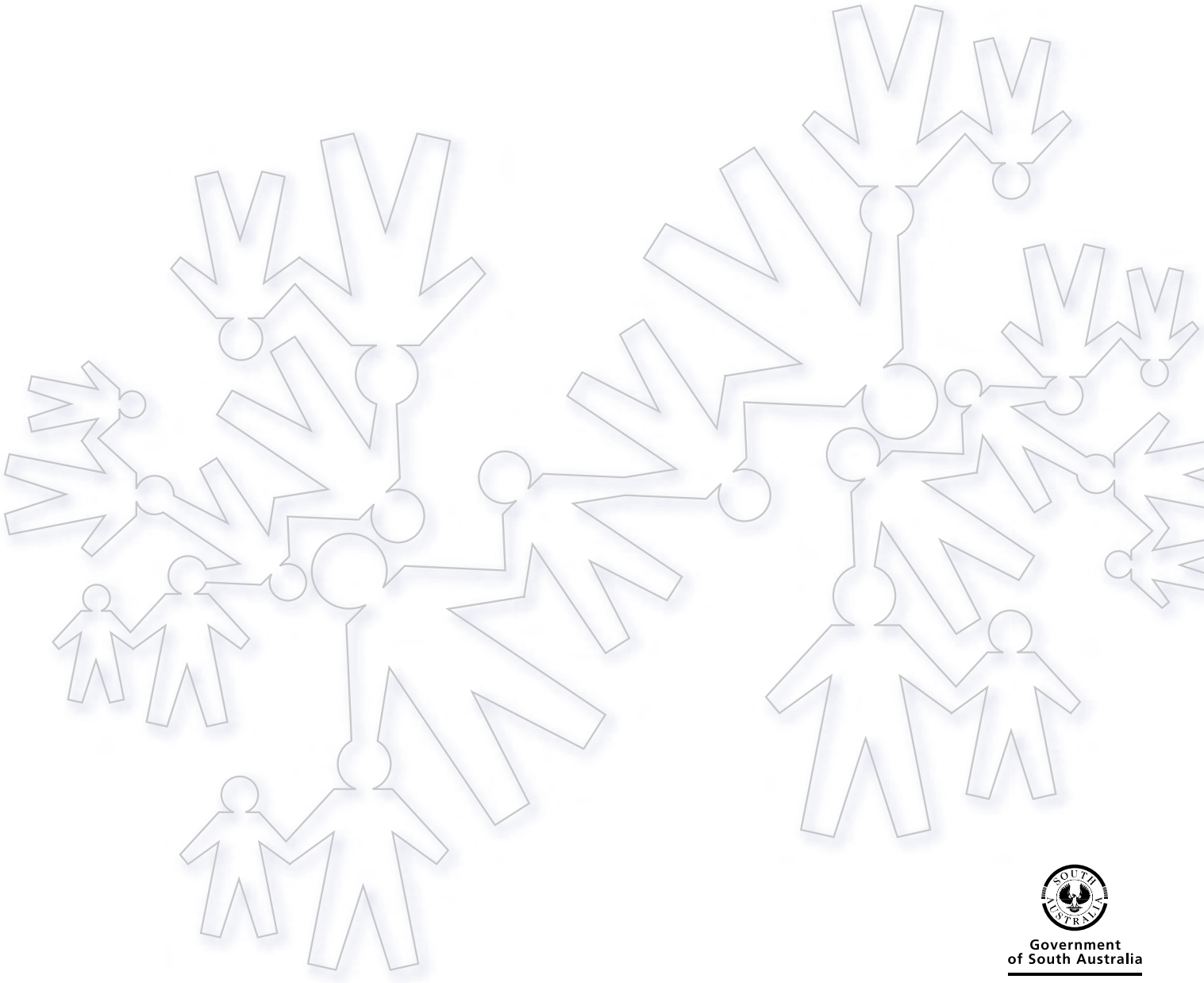
Towards a Fairer Society

Community Case Studies

VOLUME 2 | 2006

Previous volume:
Inequality in South Australia - key determinants of wellbeing (2004)



Government of South Australia
Department of Health

Towards a Fairer Society:
Community Case Studies
Volume Two: 2006

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Minister's foreword

Towards a Fairer Society: Community Case Studies outlines a range of programs to address inequality in South Australia.

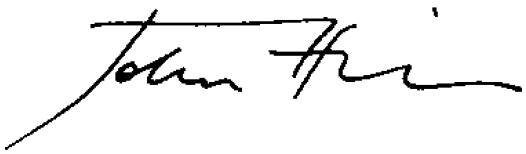
In recent years the overall health and wellbeing of people living in South Australia has improved, including increases in life expectancy. However, these benefits are not being shared equally. For those people living in poverty and hardship, the outcomes are much less promising, with higher rates of illness, injury and premature death. In many instances increases in morbidity and mortality could be avoidable.

The South Australian Government is strongly committed to dealing with the issue of inequality. In 2004 we released South Australia's Strategic Plan, Creating Opportunity, which outlines the vision for a prosperous and environmentally sustainable state, and sets targets to achieve this vision. A number of the targets in the Strategic Plan require a strong focus on reducing inequality, for example reducing income inequality and improving Aboriginal infant mortality.

There are many complex factors creating inequality and the solutions are not simple. Addressing the underlying social determinants of health and well being requires a coordinated approach from numerous sectors, both government and non-government, from the community and from individuals. The case studies detailed in Working Towards a Fairer Society provide examples of how this can be done.

This resource contains a rich source of stories about positive efforts in South Australia to tackle inequality. It includes case studies from the education, justice, housing, health and non-government sectors. It highlights the commitment from many agencies to work to prevent the adverse consequences of inequality.

I trust the case studies will be a useful guide for action, as we continue to work collaboratively to reduce inequality in South Australia..



John Hill
Minister for Health

Chapter 1: Introduction

Background

In March 2004 the Government released South Australia's Strategic Plan which made explicit that a systematic approach to reducing inequality was a priority. Fundamentally, the Strategic Plan is focusing the Government's efforts on improving the quality of life and wellbeing of the community. As stated in the Plan:

> "One of the key social determinants of health is socioeconomic status and the level of disparity between the rich and the poor. We will strive to reduce the widening gap in our living standards."[1]

In 2004 the Department of Health commissioned the University of Adelaide's Public Health Information and Development Unit to produce the report *Inequality in South Australia, Key Determinants of Wellbeing, Volume 1: The Evidence*.[2] This highlighted the extent and significance of some of the inequalities in South Australia, particularly those associated with the social and economic determinants of health.

The production of *Volume 1: The Evidence* was part of the Department of Health's response to the South Australian Government's identifying inequality as a State priority. Providing the evidence on inequalities is a first step in taking action.

This current volume, *Working Towards a Fairer Society: Community case studies*, is a companion document to Volume 1, and presents case studies of programs and projects from across the human service sector which are targeted towards groups in the community who are facing disadvantage or inequality. These case studies provide examples which may assist in developing strategies and programs for groups facing similar disadvantage.

The case studies were collected from a series of workshops about Volume 1. The workshops were held across metropolitan and regional South Australia, with attendees from both government and non-government sectors. Approximately 140 examples of programs that addressed inequality were submitted. A selection committee made up of representatives from across government helped select the final 40 case studies. The case studies in no way reflect all of the programs in South Australia that address inequality, rather are designed to be a snapshot of what is happening across the State.

Inequalities in South Australia

While there is no intention to repeat the evidence provided in Volume 1, it may be useful to summarise some of the key factors in the inequalities landscape in South Australia.

Overall the health and wellbeing of Australians, as in other Western developed countries, has improved markedly over the last century. Across Australia, there has been a 20 year increase in life expectancy between 1901 and 1998, with a sharp reduction in infectious diseases. The last 40 years, since the 1960s, have seen falling death rates from heart disease and stroke; and since the early 1990s, there has been a decrease in deaths from some cancers.[2]

This good news story, however, is not the same for everyone in the population. There are significant disparities in health and wellbeing between specific groups in the population. Indigenous people and those who are socioeconomically disadvantaged suffer significant health inequalities.

On numerous social indicators the Indigenous population experience significant disadvantage.[3] In education, Indigenous children have lower school retention rates, lower completion rates of vocational education and training, and lower participation rates in higher education. Aboriginal people have significantly lower income levels, lower labour force participation and higher unemployment levels. They are less likely to own their own home, and have a disproportionate contact with the criminal justice system. On health differentials, Aboriginal people die younger. They have a death rate three times that of the general population, have higher infant mortality, and significantly higher prevalence of chronic diseases such as diabetes, hypertension and a range of communicable diseases.[3] The situation facing the Indigenous population in South Australia clearly shows significant inequities and it requires urgent redress.

While not as extreme as in the Indigenous population, there are indicators of wellbeing which clearly show that the geographic areas which are most disadvantaged experience greater inequalities. In the geographic areas of most disadvantage there are lower rates of secondary school participation, higher rates of unemployment, higher rates of crime, higher levels of losses through gambling, higher rates of self reported ill health, lower life expectancy, higher rates of smoking during pregnancy, higher proportion of low birthweight babies, higher rates of overweight and obesity, more likelihood of homelessness and less likelihood of an adequate diet.[3]

This very quick snapshot clearly shows that there are significant inequalities in South Australia which require action. The case studies presented in this volume provide examples of some actions already taken, and of projects targeted towards those suffering disadvantage.

What do we mean when we talk about inequalities?

While it is useful to have these case studies as examples of possible interventions which can provide us with inspiration when considering the way forward in tackling inequalities, what is also required to inform our strategic planning about tackling inequalities is a conceptual understanding of the social determinants of health, and how they operate to bring about health inequalities.

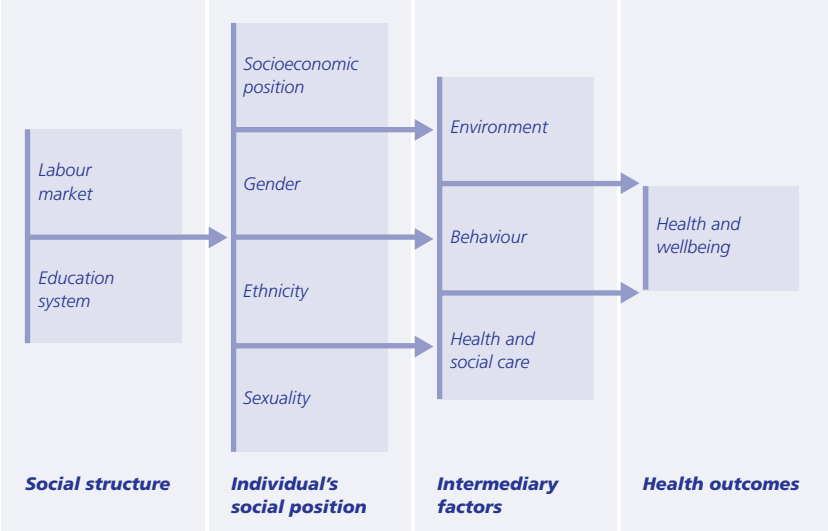
For instance, is there a difference between inequality and inequity? What do we mean by the determinants of health inequality? It is important to understand that while there is a gap in health between the rich and poor, there is also a gradient between the different sectors in society, as well as absolute health disadvantage. These are not simply abstract theoretical concepts. A deeper understanding will enable more appropriate responses, and responses which are capable of making the differences we are hoping to achieve.

Firstly, the difference between health inequality and health inequity. When we talk of health inequality we are signifying differences, variations and disparities in health achievements between populations, groups or individuals. It is a measure of difference. If, however, this health inequality is avoidable, is unfair or stems from some form of injustice, it is inequitable. Health inequities are those differences in health that people experience which are unjust and unfair.[4]

Health inequities are the result of unequal opportunity and unequal access to "social goods" such as housing, education, and health care, and they represent a degree of exclusion of people from full and equal social participation.[3] This is what we mean when we talk about the social determinants of health.

> "In today's debate, the determinants of health include all the major non-genetic and non-biological influences on health. The term therefore covers individual risk factors, such as smoking and what are called the 'wider determinants'. [5]

Figure 1: How key determinants connect up



Source: Graham, H, Kelly MP. Health inequalities: concepts, frameworks and policy. Briefing Paper, Health Development Agency, NHS, London.

These wider determinants include social, cultural and environmental factors. The link between individual risk factors and the wider determinants, as well as an individual's social position, are illustrated in Figure 1. An individual's social position - for example their socioeconomic status - mediates both their access to education and job opportunities, and also their exposure to risks and their access to health care, all of which impact on health and wellbeing.[5] Social inequalities lead to health inequalities which, if unfair or unjust, can be said to be health inequities. As Amartya Sen puts it:

> "Health equity cannot be concerned only with health, seen in isolation. Rather, it must come to grips with the larger issue of fairness and justice in social arrangements, including economic allocations… Health equity is most certainly not just about the distribution of health…[6]

Broadly speaking then, when we are talking about health inequity it encompasses social inequalities and health inequalities.

A further concept that needs to be understood in the health inequities discussion is that of difference between absolute health disadvantage, the health gap and the health gradient. In tackling health inequalities and inequities, we can aim to improve the health of the poorest groups, that is aiming to reduce disadvantage; we can aim to reduce the difference between poorer and better off groups, that is tackling the gap between social groups; or we can opt to lift the levels of health across the socioeconomic hierarchy closer to those at the top, that is tackling the health gradient.[5] While these are of course all related, there are important differences in these approaches which will have different outcomes.

Reduce disadvantage

Strategies to improve the health of the most disadvantaged, while important, do have limitations. It is of course the first stage in narrowing the health gap, which in turn contributes to reducing the health gradient,[5] but on its own it will not reduce health inequities.

Let's take an example from the case studies in this volume, the Mental Health Magistrate Court Diversion Program. This is a targeted program aimed at a particularly disadvantaged subgroup of an already disadvantaged group – people with a mental illness involved in the criminal justice system. The program facilitates a range of service options, with the aim of helping participants to address perceived links between their offending and their impaired intellectual or mental functioning. In this way, responses to the client from both the criminal justice system and the health and disability systems can be effectively improved.

The program has positive results for those individuals involved in the program, but of itself it will not fundamentally change the health inequities this group face. This is in no way a judgement on the worth of the program, as this type of program is very necessary and worthwhile. It is simply that individual targeted programs are about minimising harm, not about changing casual factors and addressing fundamental health inequity.

Decrease the health gap

The health gap refers to the gap between the best and worst off in society. Narrowing the health gap is about improving the health of the poorest groups, and doing it at a rate that outstrips the improvements in the health of the overall population, that is "raising the health of the poorest, fastest."[5]

An example of this is a public housing policy which provides housing on a needs basis to those on low incomes, but is not directly targeted to the most disadvantaged, e.g. welfare recipients. It has been demonstrated that the provision of public housing has the capacity to contain what would be potentially higher levels of poverty through lower housing costs.[7]

Lower the gradient

At each stage along the health continuum, the health of any group is better than the group below, and worse than the group above. Health improves at each step up the socioeconomic ladder. This is the health gradient. Reducing the health gradient:

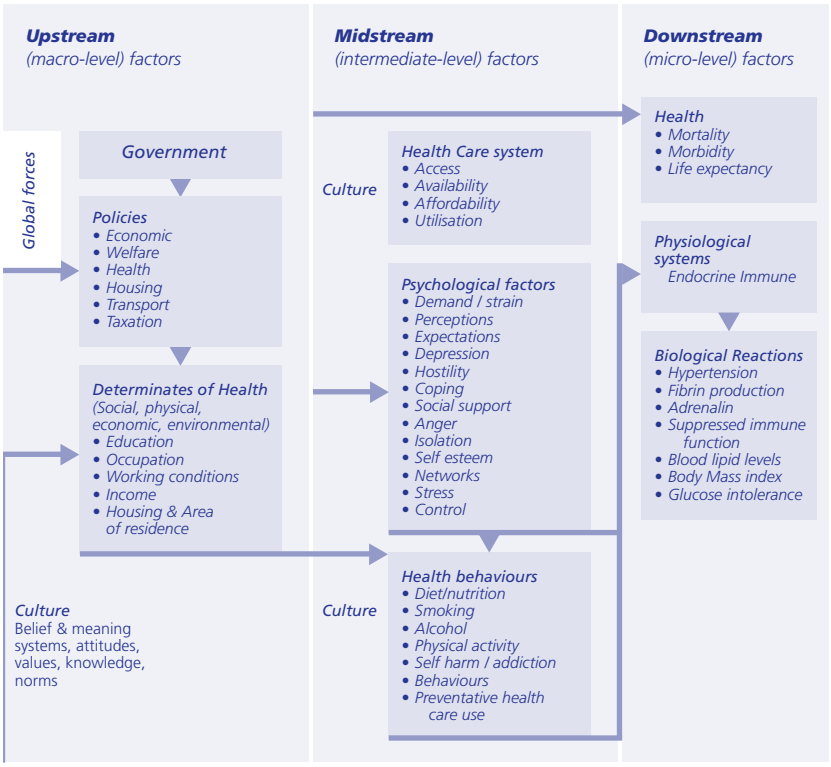
> "…is associated with (i) improvements in health (or a positive change in its underlying social determinants) for all socioeconomic groups up to the highest, and (ii) a rate of improvement which increases at each step down the socioeconomic ladder. … a differential rate of improvement is required: greatest for the poorest groups, with the rate of gain progressively decreasing for higher socioeconomic groups."[5]

Policies and programs which reduce the gradient are those which are population-based approaches. An example could be the policy to add fluoride to the water supply. This reduces dental caries across the population, but as caries have a socioeconomic gradient, with low SES groups having higher rates and less ability to afford dental treatment, it has the potential to positively impact more on low SES groups. This is a whole population-based approach which advantages the whole population but advantages the poorest the most, thus reducing the gradient.

Other examples include progressive taxation policies and a universal health care system such as Medicare. Policies and programs which reduce the gradient, that is make the greatest improvement to the health of the least well off, will also narrow the health gap and reduce disadvantage. Population strategies are the most likely to lower the gradient and improve the health and wellbeing of the whole population, including low SES groups. It must be acknowledged that higher SES groups have more resources and capacity to take advantage of some types of population-based strategies, and therefore careful consideration of the impact of these strategies on low SES groups need to be undertaken prior to their implementation.

The decision about whether we deal with disadvantage, tackle the health gap or deal with the health gradient have an impact on what strategies we choose. Conversely, the strategies we choose may have unintended consequences in each of these directions.

Figure 2: A framework of socioeconomic determinants of health



Source: Turrell, G. Oldenburg, B. McGuffog, I. Dent, R: *Socioeconomic determinants of health: Towards a national research program and a policy and intervention agenda*. Queensland University of Technology, School of Public Health, Ausinfo, 1999 Canberra.

Where should we intervene? Upstream, downstream, midstream – different approaches, different strategies, different outcomes

A framework which is useful in understanding socioeconomic and health determinants and in considering intervention points for tackling health inequities is that developed by Turrell and Kavanagh.[2] This framework orders the health determinants as an upstream (macro), midstream (intermediate) or downstream (micro) influence, and classifies interventions accordingly.

Upstream factors are the most fundamental determinants of health inequity, and include housing, education, income, employment, occupation, working conditions and neighbourhoods; the social, economic, physical and environmental context in which we live. Changes in these factors are likely to make the greatest difference to population-based inequalities but are the most difficult for us to achieve. Interventions at this level impact upon health disadvantage, the health gap and the health gradient.

Strategies which aim towards upstream include changing economic and social policies, policies which impact on income, social security, education, reducing income inequality through progressive taxation, housing, and labour market polices directed towards those at greatest risk of unemployment. It includes community capacity building and urban renewal strategies, investment in urban infrastructure, food safety and food security policies and programs.

Midstream factors are the psycho-social factors and health behaviours of individuals which impact on their health, but which are the product of their social, physical, economic, cultural and environmental context. This includes our physical and psycho-social makeup, social supports and attachments, health protective behaviours and health damaging behaviours. Interventions at this level are likely to benefit those individuals and subgroups who are the target, but are not likely to make a detectable difference to population-wide differentials. They may impact on health disadvantage but may possibly increase the gap and the health gradient.

Midstream interventions are those which we are very familiar with – those which aim to change health damaging psychological factors and behaviours and encourage health promoting behaviours and increase accessibility to health services. Programs which focus on smoking, alcohol misuse, nutrition, physical activity, self-esteem, social isolation programs which are limited in making a difference to health differentials at the population level, but programs which nevertheless can impact on an individual's health and wellbeing status through behavioural change and improving access. To maximise the effectiveness of health promotion approaches to make changes in health inequalities, these strategies need to be implemented in partnership with disadvantaged groups, tailored to their specific needs.[2]

Downstream or micro factors are those with which much of the health care system is concerned. It is about dealing with illness and disease. It is of course important to recognise that these illnesses and diseases:

> "…are brought about by psycho-social processes and health behaviours, and that these in turn are a consequence of exposure to adverse social, physical, economic and environmental circumstances: this latter group of upstream factors is where the 'problem' of socioeconomic health inequalities originates."[2]

How do we know if our projects are designed to reduce inequalities and inequities?

If we are to tackle the issue of inequalities, we need to be rigorous in our approach. We need to take into account when planning and implementing programs and projects the effects they may have on reducing inequality and consider that they could in fact unintentionally further exacerbate inequalities. This could occur if programs or projects do not adequately consider the underlying determinants or implement strategies more readily adopted by high SES groups.

There are a number of ways to assess programs, policies and strategies regarding their effects on inequalities and inequities. These include Health Impact Assessments (HIA) and Equity Focused Health Impact Assessments (EFHIA).

What is equity-focused HIA?

This section of the introduction relies heavily on the research and EFHIA Framework developed by the Australian Collaboration for Health Equity Impact Assessment.

It is widely recognised that policies, programs and projects within the health and other public and private sectors can have significant and often unintended negative impacts on health and wellbeing.

HIA is a way of assessing and addressing these impacts at the planning and development stage. Equity is one of the core values of HIA but is not explicitly built into the HIA methodology.

However, EFHIA uses health impact assessment methodology to produce a structured way of determining the equity impacts. It looks for potential differential and distributional impacts of a policy or practice on the health of the population as well as on specific groups within that population and it assesses whether the differential impacts are inequitable. For example, an equity-focus relates to assessing whether identified differences in health such as higher Aboriginal infant mortality rates are the result of factors that are avoidable and unfair i.e. they are potentially inequitable.[8]

Application of the EFHIA framework will allow decision-makers to determine the unanticipated and systemic health inequities that may exist in policies and practice. The framework has been developed for people who are in a position to review an existing or potential policy or practice and can contribute to, or effect change.[8]

EFHIA seeks to:

- Put concern for equity and the reduction of inequalities in health on the planning and policy agendas where it currently is not considered
- Provide a flexible, yet structured approach to routinely and consistently identifying and determining the possible impacts of policies and practices on different population groups, and
- Provide a means for adding evidence about inequalities and the consequences of inequity into decision-making processes at all levels of government.[8]

The principal function of EFHIA is to assess a specific proposal (be it a policy or practice) at an appropriate stage in its development, when there is still an opportunity to modify it, to ascertain:

- How the proposal will (or does) impact differentially on groups within the population
- What the nature of those impacts might be (or are)
- Whether the differential impacts will be (or are) inequitable
- In the light of the findings, what, if any, recommendations or changes should be made to it so that inequities are reduced and positive impacts are enhanced

Ideally, EFHIA is undertaken prospectively so that changes can be made before the proposal is finalised and implemented – hopefully reducing the potential for inequalities in health status to arise or worsen.

Despite the potential for confusion with evaluation, EFHIA can also be used retrospectively where it is being used *as a way of looking backwards in order to move forwards*. As we are not yet in the position to consider all policies prospectively, it is critical that retrospective EFHIA be applied as a way of understanding the ways in which policies have had an impact so that alternatives can be considered.

There is a range of other equity-focused tools which are similar to EFHIA but are used at different stages of the program/policy development process.

- An **Equity Lens** refers to 'a metaphorical pair of glasses that ensures people ask 'who will benefit?'. An Equity Lens is a tool which would be applied throughout the development cycle to ensure that the proposal was developed, implemented and evaluated taking due account of equity. [9]
- An **Equity Audit** is used to identify the differential needs of targeted population groups usually in local areas and to set priorities. It would be conducted during the needs assessment and planning stages.[10]

As all of these activities are time and resource intensive, the differential role of each and the added value they provide within the policy and practice planning processes must be clear. EFHIA is no exception.

The principles underpinning HIA and EFHIA

There is general agreement that the four basic values underpinning the use of HIA in the decision-making process are:

- **Democracy:** emphasising the right of people to participate in a transparent process for the formulation, implementation and evaluation of policies that affect their life, both directly and through the elected political decision makers

- **Equity:** emphasising that HIA is not only interested in the aggregate impact of the assessed policy on the health of a population, but also on the distribution of the impact within the population, in terms of gender, age, ethnic background and socioeconomic status
- **Sustainable development:** emphasising that both short-term and long-term as well as more and less direct impacts are taken into consideration, and
- **Ethical use of evidence:** emphasising that the use of quantitative and qualitative evidence has to be rigorous, and based on different scientific disciplines and methodologies to get as comprehensive assessment as possible of the expected impacts.[11]

Additional to these, EFHIA is based on following broad principles which are important to considerations of equity:

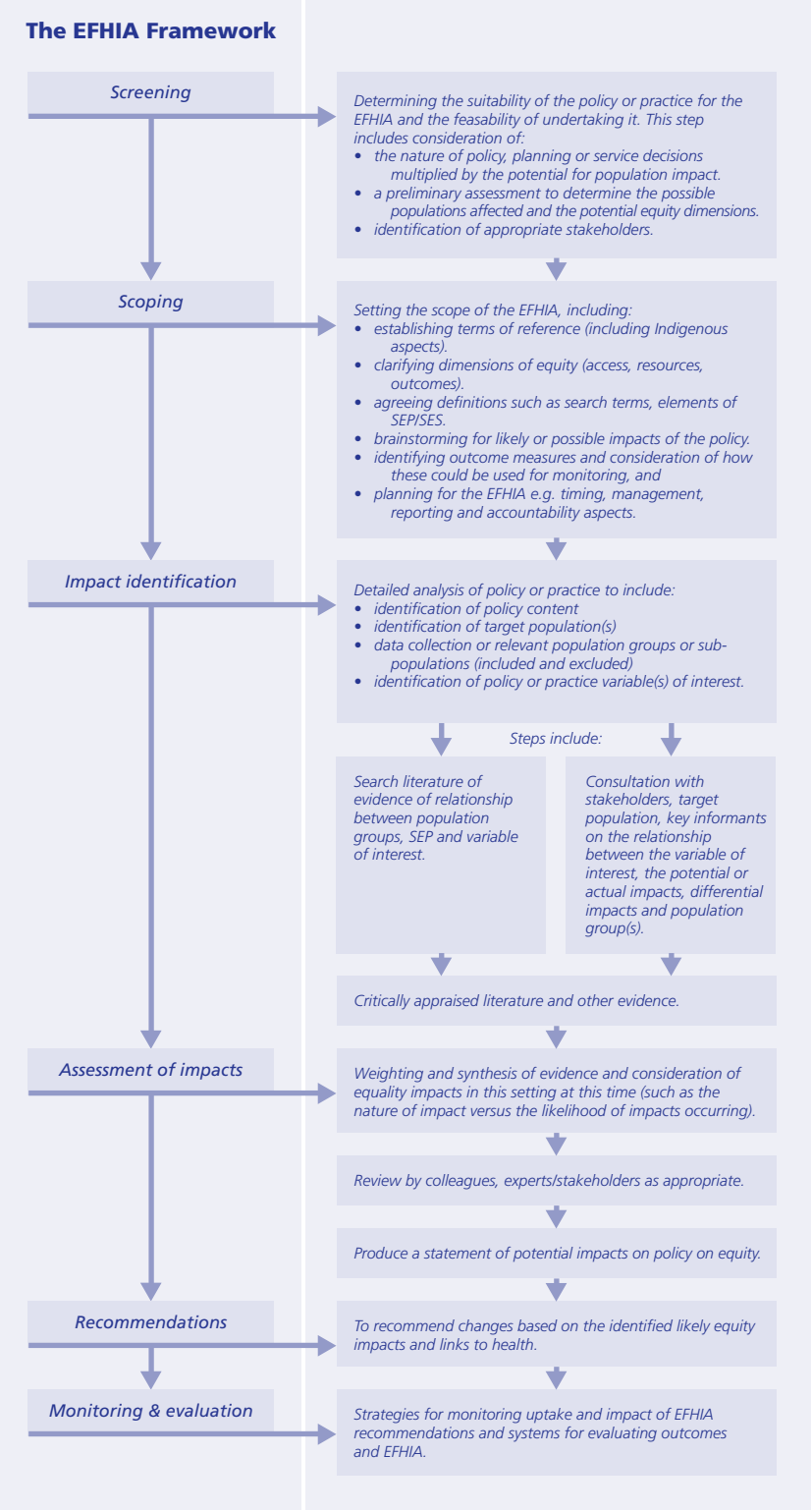
- Health and illness are produced by social, environmental, political, economic, as well as biological conditions, and inequalities arise from the unequal distribution of the determinants of health
- All policies, programs and projects should seek to be socially just and equitable in their aims and outcomes
- Many health inequalities and inequities are largely avoidable
- Decision-makers should be accountable to the communities they serve, and actions are required to include public participation in the process, and
- Individual experiences serve as valid representations of lived experiences and should be considered as a form of evidence, thus taken into account by decision-makers.[12]

Components of the EFHIA Framework

The following diagram shows the steps and components of the EFHIA framework.

EFHIA follows the six generally accepted steps of HIA.

To undertake an EFHIA one needs to: screen, scope, identify impacts and assess these making judgments based on equity considerations, develop recommendations and evaluate and actively apply an equity focus at each step.



For more detailed information on how to apply the Equity Framework refer to:

Mahoney M, Simpson S, Harris E, Aldrich R, Stewart Williams J. *Equity Focused Health Impact Assessment Framework*. The Australasian Collaboration for Health Equity Impact Assessment (ACHEIA); 2004.

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Chapter 2: The Case Studies

The process for collecting the case studies

The process for collecting the case studies for inclusion in this volume was a consultative and collaborative one. Following the publication of *Volume 1: The Evidence*, a series of workshops was held across the State to present the evidence on inequalities in South Australia and also to look for examples of good practice for tackling inequalities. The purpose of this is twofold. Firstly, to provide information to the human services sector about the inequalities in their region to which they could direct their attention, and secondly, to begin to collect evidence of programs, that is the case studies, which may assist in their efforts. Approximately 140 case study examples were submitted and through a selection process the final 40 case studies were chosen as examples of programs that addressed inequality.

This process was overseen by the Inequalities Reference Group, the membership of which was drawn from across the human services sector. The Reference Group assisted in the workshops, sourced examples of good practice case studies from their sector and provided advice on the development of the criteria for the inclusion of case studies in this volume.

The case studies were collected over a number of months from late 2004 to mid 2005. In some cases the programs are now completed, or they may have evolved, developed, expanded or perhaps contracted. This is the nature of programs. The case studies as presented here should be seen as a snap-shot in time. Up to date information can be gained from the contact person nominated at the end of each case study.

Caveats on the case studies

A large number of case studies, well over 100 from across the government and non-government human service sector, were submitted for consideration, indicating wide diversity and innovative practice. However, it became clear that while the case studies provided a cross section of the wide variety of very exciting projects, programs and activities, they could not be seen to be providing evidence for best practice to reduce inequalities.

This is in no way to diminish the importance of the work being carried out or is in any way a judgement on the worth of the projects. The issues are that:

- In most cases the programs had not been designed and developed with the aim of reducing inequalities
- In many cases the programs were still underway and had yet to be evaluated, and
- Those which had been evaluated had not been evaluated from the perspective of reducing inequalities, as reducing inequalites was not their aim.

It should be noted that this situation is not unique to South Australia. There is a dearth of evidence internationally on the way forward in tackling health inequalities. In the words of one researcher:

> "Recent international reports have indicated that the evidence base for the outcomes of attempts to reduce health inequalities is quantitatively small and qualitatively weak."[1]

So, as a start in the right direction, all of the case studies which are presented here are dealing with some form of inequality or targeted towards a group facing disadvantage, although they are not necessarily specifically designed or evaluated with this in mind.

Thus, the case studies should not be seen as evidence-based best practice for tackling inequalities, but rather as examples of the wide ranging variety of activities which can provide practitioners working in the human services sector with new ideas and inspiration in planning activities to deal with inequalities.

Utilising the data on inequalities presented in *Volume 1: The Evidence* and taking account of the examples of innovative practice presented in this volume, can improve our understanding of inequalities and help build our capacity to effectively address them.

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Chapter 3: The Categories

Inequalities affecting Aboriginal people: An introduction

Aboriginal people comprise over 25,000 of the 1.5 million South Australian population. They suffer poorer health and wellbeing than any other population group.[1, 2] Major causes of death and illness among Aboriginal people include cancer, ischaemic heart disease, respiratory disease, and cerebrovascular disease. Obesity, lack of exercise, poor diet, and smoking are major causes of preventable illness.[2, 3] Indigenous South Australians suffer much more from chronic diseases, injuries and substance misuse than non-Aboriginal people.[3, 4]

Death rates of Aboriginal people in South Australia are three times higher than the general population.[1, 2] The estimated life expectancy of Aboriginal people is around 17 years less than the non-Aboriginal population.[4] This change from previously reported life expectancies is a statistical anomaly rather than the result of an improvement in health outcomes.***

The infant mortality rate is 18.0 per 1,000 live births while that of the non-Aboriginal population is 4.2 per 1,000 live births.[5] The proportion of low birth weight Aboriginal babies is 18%. This level is the highest in Australia. The percentage of low birth weight non-Aboriginal babies (<2500g) is 7%. The rate of teenage pregnancy for Aboriginal women in South Australia in 2002 was 22.1% and rising, compared to 5.5% for non-Aboriginal women.[1] The health of Aboriginal children is significantly poorer than that of non-Indigenous South Australians.[1, 2]

The social and economic disadvantage that Aboriginal communities and individual families experience impacts significantly on themselves and their children. Key social and economic indicators, including household and individual income, employment, housing and home ownership, education, victims of crime rates and contact with the justice system, demonstrate more severe disadvantage among Aboriginal people than for non-Aboriginal people.[1, 6]

Inequalities that Aboriginal people experience in South Australia are a result of complex and cumulative historical events including dispossession, colonisation, genocide, lost and stolen generations of families.[1] The impact of trauma and loss from cultural dislocation and disruption from European invasion is intergenerational.[7, 13]

Racism and prejudice have also exacerbated the plight of Indigenous Australians that has marginalised Aboriginal people from social and community life, with significant detrimental effects on health.[8] Furthermore, racism, lack of acceptance and loss of identity contribute to low self-esteem, particularly for young Aboriginal people.[9]

Today there are higher incidences of mental ill health, including suicide and overnight hospitalisation for psychotic episodes and substance misuse than other Australians.[14] The Aboriginal concept of health is holistic, mental and physical health are strongly interrelated to cultural and spiritual health.[15] The over representation of Aboriginal and Torres Strait Islander people in the custodial setting is indirectly attributable to the breakdown of family and community structures and the resultant anger, frustration, crime, violence and self harm.[16]

Early childhood experiences, which often include infectious diseases, are an important contributor to adult health profiles.[3] Deprivation, stress and neglect impact on cognitive function[4], growth and development, the ability to learn, physical and mental health, resilience in later life, also have intergenerational effects. Lower school attendance rates of Aboriginal children has long-term impacts including high unemployment for the Aboriginal youth and adult population and the resultant difficulty in housing ownership.[1, 2] In addition, economic and social disadvantage contributes to Aboriginal people's high representation in the criminal justice system.[1]

Addressing health and social disadvantage experienced by Aboriginal people requires a coordinated and culturally appropriate approach to service planning and delivery. Planning should be based on meaningful consultation and involvement of the local Aboriginal community so that targeted programs that address community-identified health needs can be developed. Experience suggests that for a program to be successful in an Aboriginal community it should be driven by community members. The Iga Warta Principles, established at the Virra Wimila (Kidney meeting) in South Australia in May 1999, require projects to enhance the traditional guiding function of Aboriginal communities and families over Aboriginal people. The principles established in the Aboriginal Workforce National Strategic Framework 2002 include community control of primary health care services. Programs developed in collaboration with and delivered by Aboriginal workers are more likely to

*** "It has resulted from refinements to the methodology rather than a substantive improvement in life expectancy for Indigenous people (SCRGSP, 2005, p. 3.3). It illustrates in a stark way the practical difficulty of monitoring Indigenous disadvantage when even the most basic data are bedevilled with problems. Many of these have their origin in the inability to accurately identify Indigenous people. Changes in identification over time can undermine the ability to draw firm conclusions from apparent trends, notwithstanding progress in adjusting historic data." Gary Baks, Chairman of the Productivity Commission, "Indigenous disadvantage: are we making progress?" an address to the Committee for Economic Development in Australia (CEDA), 21 September 2005.

be effective and impact positively on the community being served.[#10,11,12]

The efforts of many dedicated workers in undertaking apparently successful projects to begin to redress these issues have unfortunately not been subject to consistent or extensive documentation and evaluation. This publication contributes to extending the literature. It hoped that resources such as the South Australian Aboriginal Health Partnership's regional resource package, 'Aboriginal Health - Everybody's Business' will translate into effective, well-documented and thoroughly evaluated programs that result in real reductions in health and social inequities.

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Aboriginal Day Activity Program

Aboriginal

A REGIONAL initiative
Riverland

Culturally appropriate day care activities include the involvement of Aboriginal Elders in planning and ownership of the program.

Introduction

Older Aboriginal people living in the Riverland were not accessing mainstream day care activities, as they perceived these services to be inappropriate to their needs. The lack of access to services by this group contributed to their social isolation, and was likely to be affecting their overall health.

Evidence shows that for a program to be successful in an Aboriginal community, community members should drive it.[1, 2, 3] The involvement of Aboriginal Elders in the planning not only ensures that the program is culturally appropriate, but also provides them with the sense of ownership and contributes to the sustainability of the program.

A program of regular activities and outings for older Aboriginal people, based on their input and assisted by Aboriginal staff, has been established in the Riverland region of South Australia.

Aims and objectives

The objectives of the Aboriginal Day Activity program are to provide a holistic approach that is culturally appropriate, as well as:

- Promote good health and wellbeing.
- Develop supportive networks.
- Improve nutrition.
- Teach budgeting and diabetic meal preparation.
- Provide a vehicle for social interaction and activities.

Project

The program targets older Aboriginal people who reside in the Riverland region and who are eligible for Aboriginal Home and Community Care (HACC).

The people involved in this initiative include the Riverland Regional Health Services Day Activity Coordinator, Aboriginal HACC workers, the Community Services Coordinator and local Aboriginal Elders.

As an initial step, the planners developed a questionnaire that was distributed to existing Aboriginal HACC clients and older Aboriginal people, asking if they would like to attend an Aboriginal Day Activity Program. Aboriginal HACC workers supported their community to answer questions and helped the older Aboriginal people complete the questionnaire.

A planning day was then held to develop a program, utilising the positive feedback from the questionnaire. The program was set up to include regular outings and existing day activity facilities were used for in-centre activities. Transport was provided for all participants.

Project outcomes

The program has not yet been formally evaluated, however, most indicators show that it is achieving its objectives. For example, the number of participants and outings is growing; outings were being held once a month when the program started, however they are now held at least twice a month. The regular outings work well, particularly fishing and going out for lunch. The women also enjoy craft activities that are non-traditional to them, such as 'mod podge' (coupage/bricolage) and teddy bear making.

It has been an achievement to conduct a successful and ongoing Aboriginal Day Activity Program. It was recognised that employing Aboriginal staff is important in implementing a program such as this. The staff help make clients feel comfortable and maintain the culturally appropriate quality of the program.

Initially it was thought that clients could contribute a small amount of money towards their meals, however this was not the case. A planned interstate shopping trip was not successful, also for financial reasons.

Recurrent HACC funding and acceptance of the program by Aboriginal clients will sustain the Aboriginal Day Activity Program. Social outings and overnight trips are already planned for the future and the number of participants is increasing.

This program has a lot of potential and can easily be adapted and implemented in other regions with similar Indigenous populations and under similar conditions.

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Healthy Ways Project

Aboriginal

A REGIONAL initiative
Rural and remote South Australia

Educational support is offered to women and families to improve pregnancy, birthing and child health and development.

Introduction

The Healthy Ways Project has been developed in response to the serious child and maternal health issues facing Indigenous communities. It is a partnership initiative between the Department of Health and the Department of Education and Children's Services.

This joint approach has engendered community-initiated responses that enhance the confidence of mothers in child rearing, as well as focussing their education on nutrition and tobacco use. The approach took its starting point from aid agencies in the developing world. The project focuses on the education of young women as a key strategy to achieve sustainable health and wellbeing benefits for families and communities.

Indigenous people face significant inequalities in birth outcomes, as indicated by the following data:

- In 2002 infant mortality in the Aboriginal population was 18.0 per 1,000 births compared to 4.2 per 1,000 births for non-Aboriginal infants.
- In 2002 the percentage of Aboriginal babies with low birth weight (<2500 grams) was 18% compared to 7% in the non-Aboriginal population.
- In 2002 22.1% of Aboriginal women giving birth were still in their teens compared to 5.5% of non-Aboriginal mothers.
- In 2002 41% of Aboriginal women giving birth had inadequate antenatal care, compared to 6.4% of non-Aboriginal mothers.
- 50% of Aboriginal women were still smoking in the second half of their pregnancy as compared to 19% in the rest of the population.

Factors such as low birthweight, teenage mothering, inadequate antenatal care and smoking in pregnancy contribute to poorer birth outcomes for the infant, and can have effects on their health throughout life.

Aims and objectives

The Healthy Ways Project was designed to tackle these inequalities. The aims are to:

- Increase Indigenous women's understanding of how to be healthy during pregnancy so as to have a healthy baby, born at a healthy weight.
- Increase Indigenous women's confidence in themselves and in their ability to support the learning of their infants and young children.
- Identify, implement and support learning opportunities for Indigenous women, particularly young women.
- Identify the training needs of young Indigenous women to develop and sustain careers.

Project

The Healthy Ways Project targets young Indigenous women and their babies. The project has been established in seven areas across the state. The areas were selected due to the poor health status of women, high smoking rates and low infant birthweights.

The four key elements of the project are:

- *Mums to be:* understanding pregnancy, looking after yourself, and infant health.
- *Growing little kids up:* increasing women's confidence in supporting the growth and development of their infants and children.
- *Kids and young mums learning:* provision of safe space and private time for kids and mums learning together.
- *School building bridges:* peer education and support in and out of school around Healthy Ways objectives.

The Healthy Ways Project is predicated on established community development theory and principles. Community development is a process that leads to individuals and communities having the confidence to determine their own directions and futures. This project also attempts to address some of the social determinants of smoking and poor nutrition, which includes fostering social interaction and providing safe and supportive environments. All Healthy Ways funded community programs are set up in response to community-identified priorities and are driven by senior Indigenous women within the community. It is recognised that community development is not a quick process that can deliver outcomes within short time frames.

In line with the community development philosophy, each participating community established, or identified membership of, an Aboriginal Women's Leadership Group to play the key role in facilitating their community's participation in Healthy Ways activities. With the support of the Healthy Ways team, the women developed action plans, and this has led to each community developing a unique program to meet their specific needs. Some of the activities include:

Coober Pedy

- *Young Mum's Group:* focuses on art and craft activities and cooking to encourage mothers to learn healthy recipes in a smoke-free environment.
- *Traineeship positions:* two trainees have been employed under the Child, Family and Home Support program. They aid in the development of a 'Homemaker Team' that will visit people in their homes and provide support for improving their living conditions.
- *Healthy Living Workshops:* seek to educate community members about how their bodies function in relation to disease, how to recognise the signs and symptoms of illness, and knowing what can be done for its prevention.
- *Tobacco cessation:* this initiative was conducted to help people reduce smoking, however it had little success.

Oodnadatta

- *Quitskills Training Session:* Quit SA staff conducted a Quitskills day workshop in Oodnadatta (funded through Quit SA). This workshop was well received and demonstrated the potential for more Quitskills training and support in Healthy Ways communities in the future.
- *Advocacy work to access further funding:* funding has been successfully sought for other activities including:
  - Community Benefits SA funding for the renovation of the 'Women's Shed'.
  - Commonwealth Department of Family and Children's Services funding to continue the crèche service at the school.
  - Department of Health funding for two Government Youth Traineeships, and funding the Oodnadatta Aboriginal mental health worker for a further year.

Marree

- *Pika Wiya Health Promotion Program:* health programs delivered to the Marree Aboriginal School and the whole community, that focus on nutrition and tobacco.
- *Training and Employment Action Plan:* developed for the Marree Community. Training includes:
  - An Aboriginal Health Worker position in Marree.
  - Two Enrolled Nursing Cadetships.
  - First Aid training through 'Futures Connect' in 2005.
  - Nutrition training through the Children Youth and Women's Health Service.
  - Aboriginal Apprenticeship Scheme.

Whyalla

- *Indigenous Antenatal Program:* for teenage mothers, some still in school.
- *Traineeship Positions:* two trainee Aboriginal Antenatal Workers have been employed (training has included pregnancy, caring for babies and young children, nutrition and pregnancy).
- *New Baby Package:* resources and supplies for new mums, including a breastfeeding guide.
- *Indigenous Antenatal Program Information Sessions:* a collaborative information program involving a range of services.
- *Postnatal Support Program:* the Anangu Bibi Regional Birthing Program and Healthy Ways have similar objectives and the two have been incorporated into an integrated model to provide continuing support for mothers post-delivery.

Yalata

- *Women's Group:* meets on a weekly basis and is currently developing the first draft of their action plan.
- *Store Health Promotion* – this includes:
  - 'Healthy Food Choices' poster competition for children.
  - Displays in the store of traditional bush tucker foods and easy to prepare healthy recipes, labelling healthy food choices in both Pitjantjatjara and English.
  - Developing a Stores Policy.
- *School Uniform Program:* following the community's decision to have school uniforms, Healthy Ways assisted with the purchase and laundering of uniforms in conjunction with a showering program. Attendance at school has increased by approximately 20, and involvement in the laundry program gains credit towards two South Australian Certificate of Education units.
- *Healing Workshop:* a healing, self-esteem and self-empowerment camp for women.

Anangu Pitjantjatjara Yankunytjatjara (APY) Lands

- *Supporting the 'Early Intervention, Child and Family Support Program':* on the APY Lands, the four communities, Pukatja, Amata, Kalka and Watarru are all currently focusing on the development of the 'Early Intervention, Child and Family Support Program'.
- *Meetings held in all four communities:* in each community the women identified priority issues for the Family Support Workers to address. The priorities focused on home pride (clean, hygienic homes), nutrition and baby/childcare, and a safe meeting place where mothers, young women and children can spend time. The curriculum and appropriate support structures are still being developed for TAFE education and training, with units included on tobacco and nutrition issues. Progress is slow and has been hampered by the lack of infrastructure 'on the ground'.

Oak Valley

- The Healthy Ways Project in Oak Valley is building on school-based activities around hygiene, nutrition and healthy eating, and encouraging drinking water.

Project Outcomes

Formal evaluation of the project has not yet been completed, however, as indicated in the project description, there have been many successes along the way.

A project of this scale and complexity faces enormous challenges. There have been issues in understanding the community development foundation of the project and the time required for this model. The communities are remote and very disadvantaged; some have small, highly mobile populations, and in some there are language barriers. There are issues of community politics, the precedence taken by ceremonial business, and the number and impact of deaths in the communities. Despite all of this, it is clear that the project has had significant impact in bringing these communities together around the important issue of child and maternal health, and that this impacts across the whole of the community.

Negotiations are taking place with several agencies in the hope that some or all of the Healthy Ways community-based initiatives can be continued in an ongoing way. The Indigenous Coordinating Centres are in an ideal position to build on Healthy Ways achievements through Community Responsibility Agreements. Similarly, the Commonwealth Department of Health and Ageing is interested in expanding on the work undertaken by the Healthy Ways team in the communities of Oodnadatta and Marree. There is great potential for Regional Partnership Agreements, which link a number of Government agencies and communities.

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Improving Aboriginal and Torres Strait Islander Birthing Outcomes

Aboriginal

A STATEWIDE initiative
across South Australia

Development of a framework to improve Aboriginal and Torres Strait Islander birthing services across South Australia.

Introduction

There are consistent patterns of poorer birthing outcomes for Aboriginal and Torres Strait Islander women in South Australia, as identified by data collected and collated by the Department of Health's Pregnancy Outcomes Unit.[1,2] This data illustrates that Aboriginal and Torres Strait Islander women in South Australia continue to have children at a younger age than non-Aboriginal and Torres Strait Islander women, and also have less access to appropriate antenatal care. The perinatal mortality rate for births to Aboriginal and Torres Strait Islander women in South Australia is two to three times the rate for births to non-Aboriginal and Torres Strait Islander mothers, and the infant mortality rate[a] is three to four times that of babies of non-Aboriginal and Torres Strait Islander mothers (due to the small number of Aboriginal and Torres Strait Islander births, the rate fluctuates from year to year).

The National Aboriginal Health Strategy has been highlighting this problem for many years. In 1996, the National Health and Medical Research Council released a report, *Options for Effective Care in Childbirth*,[3] which also highlighted the need for more culturally appropriate practices to support improved birthing outcomes for Aboriginal and Torres Strait Islander women.

It was recognised that significant gains for health and wellbeing could be achieved in the short and long-term in South Australia by focusing in a strategic way on improving birthing outcomes for Aboriginal and Torres Strait Islander women. The Department of Health undertook developmental work to achieve this through the 'Improving Aboriginal and Torres Strait Islander Birthing Outcomes' project.

Aims and objectives

The main objectives of the project are to:

- Improve birthing outcomes for Aboriginal and Torres Strait Islander women.
- Establish a 'Strategic Statewide Services Planning Framework' to guide the development and delivery of pregnancy and birthing services for Aboriginal and Torres Strait Islander women and their infants.

Project

The 'Improving Aboriginal and Torres Strait Islander Birthing Outcomes' project has developed *"Our Culture, Our Babies, Our Future": Framework for Action for Improving Aboriginal and Torres Strait Islander Birthing Outcomes*. The main aspects of this framework are to take a statewide approach to reorienting birthing services to improve birthing outcomes, reduce perinatal mortality and improve birthweights.

The framework was developed in consultation with Aboriginal women, Aboriginal health services and health workers, and mainstream health services and providers. The project was overseen by a reference group and in partnership with the Aboriginal Health Council.

Project outcomes

The model outlined in the Framework is currently being piloted in the Northern and Far Western Region through the 'Anangu Bibi' Regional Family Birthing Program. It should be transferable to other communities, though local community consultation may result in some minor adjustments to the model.

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a Perinatal mortality includes stillbirths and neonatal deaths (death of a liveborn infant within 28 days of birth). Infant mortality refers to death of a liveborn infant within the first year of life.

Metropolitan Domiciliary Care - Aboriginal Service Development Framework

Aboriginal

A REGIONAL initiative
Metropolitan Adelaide

An Aboriginal Service Development Framework has been developed by Metropolitan Domiciliary Care to increase access to their services for Aboriginal people.

Introduction

Due to the greater disadvantage experienced by Aboriginal people compared with the rest of the population in Australia, and following feedback from internal and external consultations, Metropolitan Domiciliary Care (MDC) has developed an Aboriginal Service Development Framework. The framework aims to increase access to MDC services for Aboriginal people. It commits MDC to defining Aboriginal services for the agency, increasing resources toward Aboriginal services, improving organisational cultural competency, recruiting Aboriginal staff to provide services for the Aboriginal community, and supporting and retaining Aboriginal employees.

The framework has been developed to address inequalities in health and wellbeing for Aboriginal people, particularly socioeconomic disadvantage, chronic ill health, mortality rates and psychosocial problems. It provides a planned organisational approach to Aboriginal service delivery, policy, recruitment and retention. Several key government documents have guided MDC in the development of the plan, including the Cultural Respect Framework.[1]

Aims and objectives

In addressing inequities in health and wellbeing for Aboriginal people, MDC is seeking to achieve the following vision:

"….[to] ensure that Aboriginal and Torres Strait Islander people enjoy a healthy life equal to that of the general population that is enriched with a strong living culture, dignity and justice."[2]

The objectives of the project are to:

- Develop, implement and evaluate a flexible, timely and responsive Aboriginal service delivery model.
- Incorporate the Cultural Respect Framework into service delivery, policy, organisational practices and procedures.
- Develop and implement Aboriginal recruitment and retention programs.

Project

The framework targets Aboriginal people, 18 years and over, who are eligible for MDC services.

The following groups were involved in the initiative to develop the framework:

- MDC Aboriginal Reference Group – membership included representatives from the Council of Aboriginal Elders SA, Ageing and Community Care, Aboriginal Home Care and the Aboriginal Health Council.
- Aboriginal and Torres Strait Islander (ATSI) Working Group – membership included representatives from each of the MDC sites.
- Consultative Group – MDC consulted with approximately 25 Aboriginal people and/or Aboriginal specific organisations (including presentations to and discussions with the Council of Aboriginal Elders SA) in the development of the framework.
- MDC Board and Executive.

Early in the project, an Aboriginal team structure was identified and implemented. Guidelines were developed to outline cultural considerations or principles to be followed during assessment and service delivery, and existing staff received specific training in culturally safe communication skills. A set of formal work instructions and a priority system for acceptance of Aboriginal clients was developed.

MDC explored the possibility of working in partnership with community health organisations, and to develop other partnership agreements. For example, a Memorandum of Understanding (MOU) was undertaken with Options Coordination and Aboriginal Home Care. This clarifies the role of MDC in providing services to the Aboriginal community, and outlines service protocols between the partner agencies. This MOU is a comprehensive response to client/family needs and is being implemented between the three partner agencies, with a package of care being developed for Aboriginal clients. Access to services will be improved for older people and people with disabilities in the community.

The principles of the agency partnership are to:

- Improve access and remove barriers to service.
- Prevent people falling through the gaps.
- Reduce inequality in service delivery.
- Consolidate services to avoid duplication.
- Improve clarity with regard to agency boundaries and eligibility criteria.
- Increase the quality of services.
- Discuss each client/family situation between the agencies and take a best fit approach with appropriate client consent.
- Develop a Reconciliation Statement for MDC.
- Map existing community resources and Aboriginal specific programs.

With regard to the project's second main objective (incorporation of the Cultural Respect Framework into service delivery, policy, organisational practices and procedures) MDC's strategies were to:

- Develop a system of Aboriginal data collection for service planning.
- Invite Aboriginal representation on the MDC Consumer Advisory Committee to ensure Aboriginal perspectives are incorporated into service development and decision making.
- Incorporate a variety of consumer feedback strategies in the evaluation of services and programs.
- Ensure that consumer participation strategies and research that involves Aboriginal people follows culturally respectful guidelines.
- Review key operational policies and operational procedures to ensure they are culturally respectful.
- Develop a Respect for Indigenous Australians Policy which outlines procedures and work instructions for culturally respectful practices.
- Identify consultation processes and perform joint consultation days with Options Coordination to improve community awareness of the aged care and disability service.
- Develop promotional materials to increase understanding and awareness of MDC services.
- Incorporate acceptable behaviours towards Aboriginal staff into the MDC Anti-Bullying and Anti-Harassment Policy.
- Encourage staff participation in NAIDOC and Reconciliation Week activities.
- Require all staff to demonstrate cultural awareness and sensitivity during the performance management process (linked with Job and Person Specifications).
- Develop an intranet site for Aboriginal services, providing information on cross-cultural practice, Aboriginal identity and culture, and including key documents relating to Aboriginal health.
- Provide mandatory cultural competency training for MDC staff including team leaders and managers.

To meet the project's third objective (to develop and implement Aboriginal recruitment and retention programs) MDC's strategies were to:

- Ensure that Job and Person Specifications are written in clear language and reflect the importance of applicants' previous experience in working with the Aboriginal community.
- Employ a representative number of Aboriginal staff (commensurate with numbers of Aboriginal clients) to provide services for Aboriginal clients, families and communities. This includes an identified Aboriginal leadership position.
- Develop a Cultural Leave Policy that recognises cultural obligations such as attendance at funerals and community days.
- Provide coordinated gatherings for MDC Aboriginal staff so that debriefings and networking can occur in a culturally safe context and to reduce cultural isolation.
- Explore opportunities with Aboriginal staff to develop their skills through mentoring, coaching and training programs.
- Provide career planning advice, assistance with development of applications, interview workshops and support for Aboriginal staff.
- Recruit two identified Aboriginal Service Coordinator positions that provide clinical and service coordination functions to MDC.

These strategies were selected on the basis of consultation, feedback from consumers, key government documents, contemporary methods of practice, advice from the MDC Aboriginal Reference Group, advice from the Department of Families and Communities and the Department of Health, and feedback from the Aboriginal Disability Forum held in 2003.

Project outcomes

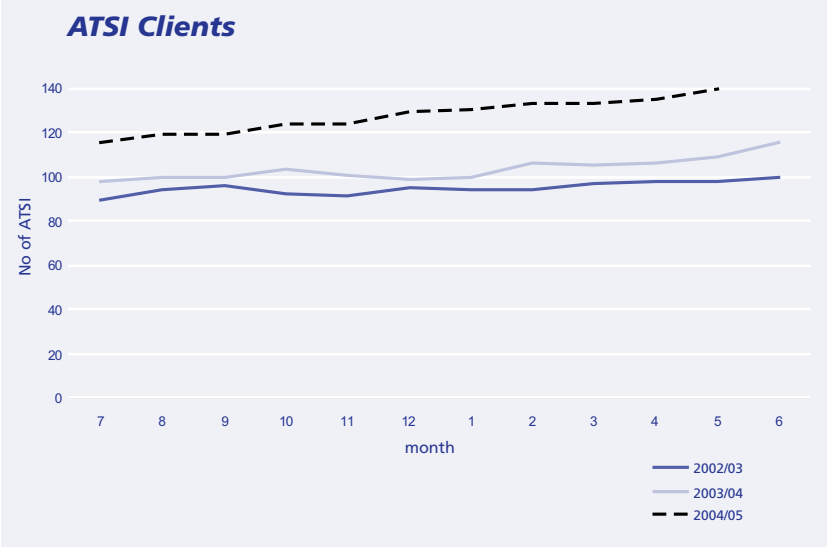
The following parts of the project have been evaluated:

Cultural competency training:
MDC has received Home and Community Care (HACC) funding to initiate training from the end of 2006. Specific achievements will include the development of four Aboriginal and Torres Strait Islander Working Groups (learning circles) within MDC who will develop a reconciliation statement, an Aboriginal specific brochure, an Aboriginal specific intranet site, and a cultural considerations document. These groups will network with local Aboriginal community groups and organisations.

Access to services:
One of the major key performance indicators for the success of the framework has been the number of active MDC Aboriginal and Torres Strait Islanders clients. This has increased significantly during the development and implementation of the framework, rising 40% in the 2004/2005 financial year.

MDC will ensure sustainability of this framework within the organisation by allocating ongoing funding for Aboriginal Services within MDC. Several permanent Aboriginal services positions have been established within the organisation, including a senior position, and the MDC Board and Executive have committed to further development and implementation of the framework, as identified in the MDC Strategic Plan.

This initiative is easily transferable to other sectors, as the process has been guided by key government documents regarding Aboriginal health and wellbeing. In addition, the project methodology used, including the consultation methods can be easily replicated across sectors.



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Anangu Bibi - Regional Family Birthing Program

Aboriginal

A REGIONAL initiative
Port Augusta and Whyalla

Midwives and Aboriginal Maternal & Infant Care workers are employed in two hospitals to collaborate in caring for mothers during their antenatal, birth, labour and postnatal periods.

Introduction

Antenatal programs delivered by the hospitals in Port Augusta and Whyalla have tended to be clinically focussed, with support for pregnancy and birthing being provided by community midwives. Clinical antenatal services are not always well attended, particularly by Aboriginal and teenage women. The hospitals were not always recognised as delivering a culturally appropriate service, and the actual needs of clients were not always met.

Many families in the Port Augusta and Whyalla areas are from poor socioeconomic backgrounds, with smoking being identified by community midwives as prevalent among Aboriginal and teenage women within the region. Consultation with local families and Aboriginal health services provided advice to the hospitals about changes in the way antenatal education and support could be delivered to these high risk groups, recognising that services must be culturally appropriate in promoting healthy pregnancies and good birthing outcomes.

The Department of Health 'Improving Indigenous Birthing Outcomes' project has developed a model for the delivery of birthing services to the Indigenous community. This model has provided the foundation for an intensive birthing support program developed in the Northern and Far Western Region. The program not only aims to improve birthing outcomes for 40 high risk pregnant women in Port Augusta and Whyalla, but more significantly, to deliver a program that is culturally appropriate and relevant to this target group.

Aims and objectives

The aim of the 'Anangu Bibi' Regional Family Birthing Program is to improve pregnancy and birthing outcomes for Aboriginal, young and socially disadvantaged women in Whyalla and Port Augusta. The key performance indicators of the program are:

- Antenatal attendance
- Smoking patterns
- Breastfeeding uptake
- Birth weights
- Patient satisfaction
- Cultural satisfaction
- Health worker satisfaction.

Feedback from some women indicates that they have seen the hospital as a place for the sick, or a place to die. This program aims to erode such a perception, and to deliver a service to women that is relevant to their needs.

Ultimately, the aim of the program is to increase participation in antenatal visits, and to increase the target group's awareness of healthy pregnancy, particularly in relation to smoking, nutrition and alcohol. A further key objective is to increase referral and collaboration between relevant support agencies for this group of women.

Improving birth weights is clearly an important key performance indicator, but program staff recognise that this is a complex issue that is influenced by much broader socioeconomic factors, including housing, unemployment and social alienation, which also need to be addressed.

A longer-term aim of the program is to develop evidence of successful interventions that support at-risk women during their antenatal, birth and early postnatal periods.

Project

The 'Anangu Bibi' Regional Family Birthing Program targets socially disadvantaged Aboriginal and teenage mothers living in the rural towns of Whyalla and Port Augusta. The project employs Aboriginal Maternal and Infant Care (AMIC) workers and midwives in the hospital setting to work together with the Pika Wiya Health Service, the Aboriginal community controlled health service and the newly set up Nunyara Aboriginal Health and Wellbeing Centre at Whyalla. Based on the principles of primary health care and continuity of care relevant to a community midwifery service, the program operates on a relationship model to care for mothers during their antenatal, birth, labour and postnatal periods. Twenty women are supported at each site per year, and the pilot program has initially been funded for two years.

The program has dedicated part of its budget towards upskilling the AMIC staff, not only to provide links between often hard-to-access socially isolated women, but also to identify the individual needs and circumstances of the program participants, such as drug and alcohol support, family violence and nutrition. The program facilitates a reciprocal skills exchange, as the AMIC workers receive day-to-day support, training and clinical skills from the midwives, whilst the midwives receive support and education on cultural issues and practices from the AMIC workers when working with Aboriginal families.

The following organisations are involved in the initiative:

- Department of Health
- Northern and Far Western Regional Health Service
- Pika Wiya Health Service, Port Augusta
- Nunyara Aboriginal Health and Well Being Centre, Whyalla
- Whyalla Hospital and Health Services
- Port Augusta and Regional Health Services
- Edward John Eyre High School's Young Mums Program
- Children, Youth and Women's Health Service, through
- Child and Youth Health (CYH).

The program staff also work closely with obstetricians, paediatricians, General Practitioners (GPs) and other relevant support services.

A Regional Aboriginal Women's Advocacy Group has been established to offer appropriate cultural expertise and direction to the program. The group is comprised of Aboriginal women from a wide range of cultural groups and Aboriginal organisations within the Port Augusta and Whyalla communities. The AMIC workers are also members of the group, sharing information and cultural mentorship among themselves and with the midwives and program staff. The Advocacy Group is an integral link in successfully gaining respect and acceptance of the program within the community. The group is represented by highly respected women in both communities, and their support and input is greatly valued by all involved in the program.

A Regional Management Group oversees the overall running and coordination of the program to ensure its sustainability, to monitor the program's progress and to address any issues that arise.

The program is situated in two regional hospitals, 80 kms apart, and has developed slightly differently within each of the two targeted communities:

- In Port Augusta, AMIC workers and midwife staff provide care during the antenatal period, are on call to attend the birth, and then provide up to eight weeks postnatal care. The program focuses solely on high-risk Aboriginal pregnant women.
- The program in Whyalla aims to support ten Aboriginal women and ten teenage women (per year) and employs one part-time midwife and one part-time AMIC worker who provide support during the antenatal and postnatal periods, however direct support to the mother during delivery is not provided.

Project outcomes

The program outcomes so far are positive. Clinical pathways and selection criteria have been established in partnership with the Division of GPs and local obstetricians. Communication between key stakeholders is excellent and the guiding advice and support from the Aboriginal Advocacy Women's Group has ensured the acceptance of the program within the Aboriginal community.

The Spencer Gulf Rural Health School and the Flinders and Far North Division of General Practitioners were appointed to evaluate the program in 2005. There has already been a marked improvement in collaboration and information sharing between the hospitals and CYH, particularly around improving the 'handover' from the program to the Family Home Visiting Program. Case conferencing and forward planning is now regularly conducted between the birthing program and CYH staff.

Strategies such as the employment of AMIC workers and the establishment of the Aboriginal Women's Advocacy Group have gone a long way towards improving the images of both hospitals.

This initiative can certainly be utilised by other communities and in similar areas. The program is transferable, provided the local communities have been well informed and possess a clear understanding of the objectives and the collaborative nature of the program's implementation.

Since this study was developed the aforementioned evaluation has taken place and has demonstrated excellent outcomes.

There are plans for the program to be rolled-out across the State.

More information is available on request.

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Early years: An introduction

Child health and wellbeing is influenced by a range of social, biological and environmental factors. How a child develops depends on the care and support they experience in their family, neighbourhood and community environments.

In particular, it is well recognised that good nutrition and nurturing during the early years of a child's life, supports optimal brain and physical development. These play a critical role in shaping children's health, wellbeing and coping skills throughout their entire lives. Evidence indicates that children who do not receive appropriate nutrition, stimulation and care in the earliest months and years of life, including in utero, have poorer health outcomes. These negative experiences have long lasting effects that can be difficult to overcome later in life.[1]

Poorer outcomes are not evenly distributed across the population. South Australian data shows that there are groups of young children who experience increasing socioeconomic disadvantage that is likely to have a highly adverse effect on their health and wellbeing. Links exist between socioeconomic disadvantage and a range of indicators, including adverse perinatal outcomes, higher rates of infant deaths, low birth weight, overweight and obesity, and documented evidence of child abuse and neglect. These indicators of disadvantage are further exacerbated for the Indigenous population.[2]

Giving children a good start in life means both supporting all parents and young children, and reducing the social inequalities that lead to poorer health outcomes. We can do this by:

- Working to improve the comprehensiveness, quality, timeliness, accessibility and cultural appropriateness of preventative and clinical programs and services that support children's development. For example, antenatal and postnatal care, encouraging breastfeeding, good nutrition, literacy and positive relationships.
- Working to improve environments of stimulation, support and nurturance in ways that support healthy child development. For example, addressing issues of poverty, unemployment, poor housing and homelessness, inadequate access to green spaces, public transport and quality child care.[3]

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Books from Birth

Early Years

A LOCAL initiative
Southern metropolitan Adelaide

Parents are encouraged to read to their babies using a wide range of strategies to promote long-term language and literacy development.

Introduction

Language delay has consistently been one of the top ten reasons for attendance at Noarlunga Community Health Services. Early language difficulties correlate strongly with poor literacy development that can lead to poor educational and social outcomes. These include lower school retention and participation rates, higher unemployment rates, social disadvantage due to poverty, poor social skills and low self-esteem, ultimately leading to inequities in health outcomes.

The project 'Books From Birth' (formerly 'Babies Like Books Too!') arose through interagency collaboration in Adelaide's southern suburbs. Reading aloud to babies from birth is seen as a tool for promoting positive parent/child attachment and other significant benefits such as language and early literacy development, listening, attention, concentration and problem solving skills.

Aims and objectives

The project's objectives are to:

- Increase parents' and caregivers' awareness of the benefits of reading and communicating with babies from birth
- Increase the likelihood of parents and caregivers reading aloud to their babies from birth and, thereby, maximising the benefits
- Form and sustain partnerships with organisations and individuals who can assist in promoting the message to the target populations.

Project

The target group for this project is parents and carers of babies and young children in the outer southern metropolitan region of Adelaide, particularly those families whose children may be at risk of early language and literacy difficulties.

The network of partners involved in the project includes:

- Southern Adelaide Health Service and Noarlunga Health Services (NHS) – speech pathologists and primary health care nurses
- Children, Youth and Women's Health Service
- Onkaparinga Council – libraries and neighbourhood centres
- Coolock House - a residential support service for young mothers at risk of homelessness
- The 'Pathways for Families' program, which is funded by a Commonwealth grant through the Stronger Families and Communities Strategy.

The project is managed by an interagency task group, with membership representative of all the key project partners and led by an NHS speech pathologist. Tasks and roles are determined by the task group and delegated accordingly.

There is strong research to show that strategies such as book giveaways and home and community-based parenting support are successful in encouraging reading to babies, particularly for families from low socioeconomic groups.[1] A number of interrelated strategies have been implemented throughout the community to achieve the program's educational objectives. These strategies are a reflection from the World Health Organisation's Ottawa Charter for Health Promotion.[2]

- *Promoting the Project* - via pamphlets, magnets, website links and articles. Two website links have been created – one on the Child and Youth Health (CYH) web site and one on the Onkaparinga Families website. Over 1,000 magnets and pamphlets have been distributed (e.g. at community events/displays) and this is an ongoing activity.
- *Developing Personal Skills* - through input to antenatal and postnatal parent groups, and storytelling and bookmaking workshops. Over 30 new parent groups have become involved so far, reaching approximately 200 parents. Ten bookmaking workshops have been held in community venues, and more are planned. Three 'Storytime for Babies' sessions have been held, with more planned due to community demand and in order to link with the Government's 'Little Big Book Club' initiative.
- *Creating Supportive Environments* - by training and utilising CYH home visiting volunteers to promote and model the message. Input to training sessions for volunteer home visitors is provided as requested. A major initiative has been setting up accessible Community Book Banks (stocked with donated pre-loved children's books for families to take home and keep) at a number of local health centres and neighbourhood houses. Five community book banks have been established and more are planned. In addition to the book banks, hundreds of new or pre-loved books are also given out directly to families.
- *Reorienting Services* - such as library services, by developing baby book packs and developing and running 'Storytime for Babies' sessions.
- *Strengthening Community Action* - by holding book drives for the book banks and for book give-aways.

- *Building and Influencing Public Policy* - by maximising media coverage and linking strategically with key political lobbyists (e.g. Mem Fox) to influence political and public discourse.

Project outcomes

Impact evaluation strategies have included telephone interviews and questionnaires to participants. Other than these, formal impact evaluation of the project has not taken place. This is currently being addressed, however, positive responses to the project are evidenced by a number of outcomes highlighted in the evaluations so far.

A six-month telephone follow-up was made to families involved in the initial book give-away project, where parents registering their newborn babies at their local CYH clinic were given a free book and pamphlet. This revealed that 50% of families were already reading or planning to read to their babies, and 48% were influenced by the promotion to do so. Pre and post-questionnaires were given to parents attending the 'Storytime for Baby' sessions. These indicated an increased likelihood that these parents would borrow books for their babies.

An impact evaluation of the work with mothers at Coolock House is currently being developed. It will involve comparing pre and post-group ratings of book sharing behaviours among the mothers and their children.

Acknowledged successes of the project include the establishment of the interagency task group and the development of key partnerships, particularly with agencies and workers in ongoing relationships with the target population. Trust was identified as a key issue to maximise the success of the project.

The book banks, the popular 'Storytime for Babies' sessions and the book give-aways to new parents have been particularly successful strategies. Longer-term effectiveness has been achieved by integrating the literacy message into local antenatal and postnatal parenting programs and volunteer training programs. Trust has been established with young mums at Coolock House through providers consistently attending weekly playgroups and gradually incorporating the message by designing relevant playgroup activities. An attempt to involve local florists to include books in baby baskets was less successful. No particular reason has been determined for this.

Long-term outcomes are difficult to evaluate within the scope of this project, however could involve regular measurement of emergent literacy skills of children in participating families over a five-year span, and an analysis of referral rates and trends over time.

There is a strong emphasis on ensuring the sustainability of the project and its strategies. For example, the book banks have been set up in partnership with the host agencies, with a view to becoming self-sustaining. In time, the host agencies will generate their own book drives to maintain stocks, and will assign volunteers or workers to oversee maintenance. The 'Storytime for Babies' sessions have been developed and trialled by the task group's speech pathologists in consultation with local libraries. Library staff will eventually take on the responsibility for integrating this initiative into their regular community services program, meaning the libraries will eventually run and promote the project. Similarly, the speech pathologists are currently offering input to establish antenatal and postnatal programs, with the view to this becoming integrated into the course content.

The project is highly transferable given its focus on developing strong local partnerships with key agencies and community groups.

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Learning Together

Early Years

A REGIONAL initiative
Metropolitan and country South Australia

Educators support parents to learn about their children's early learning, thereby reinforcing the literacy and learning skills of the parents.

Introduction

The 'Learning Together' program, announced in August 2002 by the Department of Education and Children's Services, aims to improve early literacy learning for children from birth to age three in the context of their families.

The importance of the early years in setting the foundation for children's learning is now widely acknowledged. It is a critical period when learning and development can be maximised. If this early advantage is missed, learning and development can be slower, more difficult and, in the end, more expensive, not just in economic terms but also in social terms. Three Learning Together programs have been established in the metropolitan area and two in the country.

Aims and objectives

The focus of this project is to assist families to support their children's early literacy learning and development. One of the intentions of the project is to connect with parents who may themselves have disengaged early from school, through their interest in their children's learning, and support their re-connection with learning. Learning Together aims to address areas of social, economic and educational inequality.

The program is underpinned by an understanding that interagency collaboration and coordination of family programs help strengthen communities and promote positive relationships between families and early childhood services and schools.

Project

Funding of $2.78 million over three years was allocated to establish Learning Together programs in five areas of identified socioeconomic disadvantage across the state.

The programs are located at:

- Enfield Primary School
- Para West Adult Re-entry Campus in Davoren Park
- Fraser Park Child Parent Centre to Year 7 School in Murray Bridge
- Carlton Aboriginal School in Port Augusta
- Christie Downs and O'Sullivan Beach Schools and Preschools.

Parents are supported to build social networks with other parents in their neighbourhoods, connect with local schools and children's services, and provide a range of early literacy learning experiences for their children.

The project was initiated based on contemporary research that indicates the critical importance of the very early years (birth to age three) in setting the foundations for lifelong learning, and that successful interventions incorporate both early childhood development and parent learning and support. [1, 2]

All Learning Together programs feature the dimensions of:

- *Adult learning and support*
- *Adult/child engagement*
- *Child involvement in learning.*

Each program plans specific activities or initiatives for each of these dimensions. Interactions between parents and their children (*adult/child engagement*) are a major focus of the facilitated playgroups. Learning Together Coordinators support interactions by working with families on a one-to-one basis, modelling, providing a focus for interactions and providing a framework for parents to observe and interact with their children.

The dimension of *adult learning and support* means that specific adult learning/education activities are organised for parents based on their interests. These range from First Aid Certificate Courses, to 'Learning Disposition' or 'Living Literacies' study groups, enrolment in the South Australian Certificate of Education (SACE) studies or support to enrol in other adult education courses.

Each Learning Together program provides an environment and experiences to optimise young children's *involvement in learning* through play. Learning Together Coordinators work alongside parents to plan for and support children's learning. Some programs provide books and resources for families to borrow, to support play and learning at home.

Each program is led by a Learning Together Coordinator (i.e. an Early Childhood Educator) who has responsibility for their community based Learning Together program and for promoting the project across the district. Funding has also been provided to employ support staff with local community connections.

The project values of *Voice, Diversity, Relationships* and *Learning* highlight a commitment to working with families in ways that acknowledge the hopes, aspirations and unique knowledge they have of their children and their central role in supporting their children's learning and development. The principles of *Community Consultation and Development, Interagency Collaboration, Partnerships with Families, Quality Driven* and *Evaluation for Change* describe the intention to work in ways that promote community involvement and interagency collaboration in the development of each Learning Together program.

Each program has developed a range of unique Learning Together activities for their families and communities. Activities have a focus on children's early literacy learning and include facilitated playgroups, parents using digital technology to make books for and about their children, take-home literacy packs, home visits, family outings and parent study groups. All of the Learning Together programs have the involvement of professionals from a range of other agencies including Child and Youth Health and community health organisations.

Any family with children (from birth to age three) in the local community can enrol in their local Learning Together program. Families may be referred to the program by professionals from other agencies, although many hear about the program from friends or neighbours or through their local preschool or school.

Project outcomes

As of June 2005, 383 families had enrolled in Learning Together programs across the state. Of these families 20% identify as Aboriginal, 37% are sole parents and 73% are receiving a pension or benefit. Eighty per cent of parents enrolled in Learning Together did not complete Year 12 at school.

One of the intentions of the project is to engage with parents about their children's early learning and to support them to make connections with their own learning. This is happening in a number of ways. A group of Aboriginal parents at the Carlton Aboriginal School enrolled in and completed a First Aid Certificate, and eight young mothers at Enfield Primary School completed their SACE studies in 2004, based on their work about their children's learning. Parents at Christie Downs and O'Sullivans Beach schools have joined 'Learning Disposition' and 'Living Literacies' study groups, and families at Para West Adult Re-entry School have enrolled in a range of courses offered at the campus. In 2005, 11 parents at Enfield and 15 parents at Christie Downs have enrolled in SACE studies.

A contract for research on the project has been signed with the Children and Education Research Centre at the University of Newcastle. Learning Together Coordinators have gathered a range of data about family confidence and children's literacy experiences. The first analysis of this data indicates that parents feel confident about which toys and books to select to give their children a good start in literacy but less comfortable about their knowledge of computers and literacy related vocabulary. A second data collection period was completed in May 2005. This included video data of children interacting with books and will provide valuable information about children's literacy understandings and skills.

Changes in terms of wellbeing indicators such as education and training, and social support, are likely to be longer-term. There are, however, indications that isolated parents are building connections with others and are regularly attending Learning Together activities with their children. They are also making connections with a range of other agencies and services, e.g. community health organisations and libraries.

Learning Together received additional funding in the 2005/2006 State Government budget. This will support the continuity of the current programs for an additional four years. In the longer term, learning from the Learning Together program will inform Departmental policy and program development. The processes used in each of the Learning Together programs to connect, engage and build relationships with families, for example, could be duplicated in other services or settings. The processes of educators supporting parents in learning about children's literacy, parents learning through interaction with their own children, parents and educators working together to make resources for children, and parents joining study sessions with other parents can also be duplicated in other settings.

Relationships between early years educators and parents in the programs are the key to the program's success. They are built on a respectful partnership approach where parents' personal knowledge of their child and educators' professional knowledge is valued and shared.

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Mothercarers

Early Years

A REGIONAL initiative
Playford, Elizabeth and surrounding suburbs

Unemployed women are trained and employed to provide supported home-based care to new mothers and their families.

Introduction

New parents in the northern suburbs of Adelaide face high levels of unemployment, poverty, smoking and drug use, low birthweight infants, single parent families, teenage pregnancy, ineffective family networks or parenting role models, child abuse and neglect, domestic violence, gambling, and lack of transport. This project deals specifically with the inequalities of unemployment and lack of social support for young mothers.

Aims and objectives

The Mothercarer Service aims to provide supported home-based care to new mothers and their families in Playford, Elizabeth and surrounding suburbs.

The aim of the program is to not only improve the health and wellbeing of new parents and their infants, but also to ensure the welfare and safety of the Mothercarers. In order to reach that aim, the main objectives have been to:

- Create jobs and provide training and improved life skills for young women in the area (and to others in their social networks).
- Provide a positive experience of community care for new parents and refer them to appropriate community services for ongoing support.
- Provide improved postnatal support and reduce isolation for the young and those with poor social networks.
- Improve parenting skills and support breastfeeding.
- Give effective support to those suffering from depression and anxiety.

It was also hoped that the opportunity for a paraprofessional Mothercarer to relate to women in their own homes for an extended period of time would provide more effective health promotion opportunities than are possible in the busy, alien hospital environment.

Project

The project is targeted at mothers who choose to go home early from hospital, ideally within 24 to 48 hours of normal birthing, or 72 hours after a Caesarean birth. They are supported at home as they recover from childbirth, adjust to their new baby and learn to care for it. This support is provided through daily visits from a Home-Visiting Midwife, and a Mothercarer stays with them for five hours per day for six days.

This program also provides employment opportunities, as young unemployed women from the area are eligible to be trained and then employed as Mothercarers. So far, two groups of about 20 students have been trained, two years apart, in a six-month Certificate 3 course in Community Services/Children's Services through the University of South Australia (UniSA). The course includes sessions about a range of areas including midwifery, childcare, interpersonal skills, intervention skills, family structure, anti-discriminatory practice, household management, domestic violence and teenage pregnancy.

Home-based postnatal care is evidence-based practice and has been successfully operating in Europe and parts of the United States for many years. It was hoped that this model of care would achieve improved outcomes for families in the northern community. The Head of Obstetrics at the Lyell McEwin Health Service (LMHS) has had experience with this model of care in Holland, where levels of postnatal depression are known to have always been much lower than those in Australia.

The Mothercarer Service began as a collaborative venture between the LMHS, the Department of Health (DH), UniSA, the Playford Partnership and the Foundation for Young Australians (FYA). The Steering Committee also had representatives from Children, Youth and Women's Health Service, Children, Youth and Family Services, Anglicare South Australia, Smithfield Plains High School (VET program), Muna Paendi, Nunkuwarrin Yunti, the Department of Education and Children's Services (DECS) and a youth representative.

The management of the LMHS first organised focus groups to determine whether the young women in the area would use such a service or would work as a Mothercarer. Midwives were surveyed for their opinion, a business plan was compiled, and negotiations began with FYA and DH to establish their involvement. Funding was secured from the FYA, the DH and the LMHS. LMHS then set up a steering committee, negotiated with UniSA about the content of the course, employed a Coordinator, negotiated appropriate awards and classification, applied for a dispensation to allow only young women to be offered positions, and advertised the Service.

Project outcomes

An external evaluation of the program was commissioned by the FYA and undertaken through the Department of Sociology at Flinders University. Key findings were that the program:

- Enhanced the trainees' life skills and self-esteem
- Eased the transition of being home and reduced the anxiety of postnatal women
- Has the potential to reduce the incidence of postnatal depression (although further research needs to be done in this area).

The model of care was said to offer an important new framework within which women in contemporary Australian society can make a positive transition to life with a new baby. It also has the potential to make a significant impact on the health and wellbeing of mothers and babies, and undoubtedly warrants implementation in other geographic areas.

On discharge from hospital, 90% of women chose to have daily visits from a Home Visiting Midwife, however only 30% accepted the Mothercarer Service. There has been a small increase in breastfeeding rates since the program's initiation.

Of the fist 20 trained Mothercarers, seven women have gained permanent positions with the program.

Funding is the key issue to the sustainability of the program. With the already short-length of stays postnatally in public hospitals for many women, there is little potential for further reducing the length of hospital stay, thereby cutting costs in this way.

The Service can be easily adapted to other areas. However, time should be allowed for women to accept the new model of care, especially if they have an expectation that hospital-based care is superior.

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Outback Childcare - Remote and Isolated Children's Exercise

Early Years

A REGIONAL initiative
Outback South Australia

Childcare for families living in remote areas.

Introduction

Until recently there were no childcare services of any type in outback South Australia (SA) to support isolated families. A particularly vulnerable group in this situation were women who were suffering post-natal depression. It is sometimes difficult to convince women that they are entitled to childcare (and should use it) as they are used to managing and making do by themselves. There is also a perception (especially among men and sometimes older women) that the previous generations managed without the help of childcare, so why should today's women need any assistance.

Childcare, at least for respite and for emergency situations, is of significant help to families. It is now available to parents who are busy trying to meet the variety of commitments involved in living and working in remote areas of SA.

Aims and objectives

The aim of this project is to provide quality childcare that is innovative and flexible in its approach and responds to the special needs of outback families in rural and remote SA.

In planning the program the objectives were to:

- Identify the childcare needs of outback families in SA
- Establish a flexible childcare service suitable to the needs of outback families in SA
- Meet work-related childcare needs of parents living in remote areas of SA who don't have access to existing childcare services
- Provide each family with periods of childcare (up to six weeks in any calendar year)
- Assist families in crisis and to provide respite care.

Project

The target group includes all outback families in rural and remote areas of SA with children aged from 0-12 years. Outback families are identified as those whose normal place of residence is within the cattle and sheep pastoral areas of SA, (as designated on the 'Pastoral Areas of South Australia' map printed by the Department of Environment and Natural Resources) and/or who reside outside the district council areas of SA, that is, 'Out of Districts', and/or islands and lighthouses.

Outback Childcare, a project within Remote & Isolated Children's Exercise Inc. (RICE) is funded by the Commonwealth Department of Family and Community Services (FACS), and is licensed and supported by the Department of Education and Children's Services (DECS). The RICE Management Committee works with the Adelaide office staff of FACS and with District and State office staff of DECS.

Through the program, care is provided by approved carers for children aged 0-12 years in the homes of families who live on isolated stations and communities. Each family may access up to six weeks of childcare support in any calendar year, and in exceptional circumstances, extra care may be offered. Carers travel to properties by public transport or in the service's vehicle and live with the family for the duration of each placement, which is usually organised in two-week blocks.

Outback Childcare also provides crèche care, which enables families to attend training, meetings and activity days to correspond with race meetings and other community events.

The program was conceived and implemented using the following strategies:

- The RICE Management Committee and staff discussed the perceived needs of families with FACS.
- RICE conducted a childcare survey of remote and isolated families in SA and reported the results to FACS.
- With a special grant from FACS, RICE employed a Project Officer to look further at the needs to investigate options and to make recommendations. Her report, Caring for our Kids, was the catalyst which led to funding being sought for the project.
- The RICE Management Committee successfully applied to FACS for funding to trial a mobile childcare service.
- The RICE Manager and a Project Officer from FACS worked closely together to set up the services, drawing from a model on the policies and procedures of the Remote Family Care Service in Western Queensland.

The project was set up within this framework to address evidence-based needs. It was developed on the strength of community consultation and departmental advice, being shaped by the restrictions of the South Australian Children's Services Act and regulations. The successful example of a remote childcare program in Western Queensland provided further motivation to trial the same idea in SA.

Project outcomes

Successful outcomes of the project include providing a flexible in-home childcare program to meet the needs of families living and working in outback SA where childcare facilities are not available, and to provide crèches for meetings, training and development days and activity days at community events.

Specific outcomes have been:

- The ability to arrange for a carer to be available when a mother came home with her second baby. She had suffered severe postnatal depression after her first baby and was displaying all the symptoms of the condition with her second pregnancy. Having a carer for the first few weeks made a huge difference for this mother. The whole program has been worthwhile just for this.
- Respite for busy mothers with toddlers who are extremely active and difficult to manage.
- Isolated toddlers learning to relate to adults other than their families.
- Mothers having undisturbed time to undertake study by distance education.
- Safety of children at activity days (e.g. Field Days, Gymkhanas etc) while their parents are involved in the organisation of the day and/or competing.
- The ability of both parents to attend meetings and training and development days while knowing that their children are being safely cared for.
- Respite for parents and safety for children during particularly busy times on stations, such as shearing, mustering and crutching when both parents are heavily involved with work. The farm safety aspect of childcare is particularly important.

There are periods of low demand during the year which can make managing the service difficult. Full-time carers are employed so that they are available at all times, but there must be a balance that allows for the slower periods. All carers have appropriate induction, so recruiting extra carers to meet spasmodic demand can be difficult and costly, especially if a request for care is made at short notice.

The project was evaluated in a report dated December 2001 with the following recommendations:

- That the program continue to be funded to provide home-based care, crèche and activity day childcare to the pastoral areas of SA, as specified in a renewed service agreement negotiated with FACS in June 2002
- That FACS and RICE explore appropriate levels of sliding scale fees that are linked to Childcare Benefit Eligibility requirements, which will assist to raise additional income for outback childcare services without adversely affecting the level of service available to families
- Increase homecare family entitlements from four to six weeks of care per year
- Reduce home-based childcare from 40 to 35 hours per week, spread over six days
- That the availability of crèche care continues to be marketed to organisations holding events and meetings within the region
- That information about the program's role as a childcare service to assist families in crisis and non-crisis situations continues to be regularly provided to agencies and new workers across the region.

The 2001 review recommended a continuation of funding from FACS. The only threat to the service would be if the need for or usage of the service was to significantly reduce. Statistics of usage are supplied to the FACS on a quarterly basis to justify continued government funding.

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Education: An introduction

Higher levels of education are associated with higher levels of employment and earning for individuals, as well as a range of other positive personal outcomes such as better health and a lower likelihood of incarceration or social exclusion.[1]

Participation in schooling and/or training is a major protective factor across a range of risk factors, including substance misuse and homelessness.[2] Evidence shows that health improves with increasing levels of education achievement.[3, 4] Higher levels of education can contribute to social capital, including greater equity, inclusiveness and political stability. Education can also contribute to economic growth through its effect on labour productivity and technological innovation and adaptation.

Recent research identifying the personal and social costs and benefits associated with higher levels of education also recognise that some groups of young people face particular difficulties.[5] The research focus on those most at-risk has led to an interest by government at all levels in post-compulsory education, particularly for young people.[1]

Case studies in this section focus on several groups of learners facing specific challenges in engaging and remaining engaged in learning. The term learner is a broad one that includes children and students – from birth to adults re-entering education[6] – and thus is especially pertinent to these case studies. Adult learners from disadvantaged groups require support to build a strong foundation from which to pursue pathways to tertiary studies. In rural and remote locations learners face additional challenges when higher education requires relocation away from family and community support networks – another key determinant of health and wellbeing.[2]

Evidence suggests that physical, social and emotional welfare and development are integral rather than incidental to learning.[6] A learner will find it difficult to engage with learning programs if they are distracted by significant physical, social and emotional issues. At a policy level, research about improving student retention across Australia highlights 12 policy drivers to achieve improved outcomes for all learners. Examples of these include community-school relations, learner support services, quality alternative pathways, return to study programs and program evaluation. The researchers conclude "the focus of policy efforts should be on creating the conditions for effective learning and personal growth …"[7]

The following case studies illustrate the ways in which innovative programs are engaging and re-engaging learners, and building a sound foundation for the current and next generation of learners. This is important because "the wellbeing and success of our young people is vital to the present and future of South Australia. We can create pathways for this future through ongoing education"[1]

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The Young Mums Program

Education

A LOCAL initiative
Whyalla

Pregnant and parenting teenagers are supported to continue their education in a positive and caring community environment.

Introduction

Whyalla has one of the highest teenage pregnancy rates in South Australia. Typically these pregnant teenagers leave school and rarely complete their South Australian Certificate of Education (SACE). They often don't access health programs such as antenatal and postnatal care. Nor do they actively engage in community recreational activities.

These young women can find it difficult to secure future stable employment opportunities, and this impacts on their ability to provide for their family. In some cases, negative effects on the health and wellbeing of these young women and their families sees them trapped in poverty. Some enter a cycle of abuse, crime and violence.

The children of these young mothers are similarly underrepresented in health and wellbeing programs. This could include doctors' appointments, check-ups through the child health clinics, immunisation, or participation in recreational activities such as Kindergym and playgroups.

The Young Mums Program was developed to encourage the continuing self-development of these teenagers by incorporating flexible school attendance arrangements and gradually changing community attitudes. Relevant student-focused content, methodologies that engage the students, as well as a strong pastoral care focus offer the young mothers a positive environment for the growth and wellbeing of themselves and their children.

Aims and objectives

The long-term goals of the Young Mums Program are:

- Pregnant and parenting teenagers (and their children) remain engaged in their education to the completion of Year 12 or its equivalent.
- The future employment options and higher education aspirations of pregnant and parenting teenagers are identified, supported and secured.
- Health and wellbeing issues are identified early, addressed and risks are subsequently decreased for both pregnant and parenting teenagers and their children.
- Pregnant and parenting teenagers and their children participate in a range of community and recreational activities.
- Community perceptions of pregnant and parenting teenagers are improved, with higher levels of advocacy in health, education, recreational and community programs and services.
- There is a decrease in the number of unwanted teenage pregnancies due to a range of programs operating in local schools that educate students in the realities of teenage parenting.

Project

A teacher working and living in Whyalla for five years initiated the Young Mums Program. The teacher worked together with local health professionals and with pregnant and parenting teenagers and their families to improve their ongoing access to education and services, and to help them plan for a positive future. Initially, 50 local pregnant and parenting teenagers were surveyed about their needs and wants, and staff talked with district and local level education and health professionals about how it would be possible to structure a program to address these issues.

A pilot program was designed with a small grant from the Office of Youth. In liaison with Child & Youth Health, Whyalla Hospital and Community Health Services, the teacher first established a six-month program in 2003. Seventeen pregnant and parenting students and their children were picked up from their homes each morning. They attended and participated in a range of activities at the Edward John Eyre High School. The teacher liaised with the Senior Secondary Assessment Board of South Australia (SSABSA) to design Individual Assessment Plans, allowing each student to engage in community activities which would form part of a SACE subject. Each student also received support to organise housing, childcare, Centrelink and medical support.

The Coordinator's previous experience working with disengaged students suggested that an effective strategy to try and engage them in learning was to involve them in the planning process. The students helped design the daily structure of the program, such as starting and finishing times, and participated in developing the content of the curriculum by identifying the knowledge and skills they wanted to develop. They also provided valuable insights into the barriers that stop them from participating in services, allowing agencies to address the structures and processes that

inhibit this within their individual organisations.

Early in 2004, the Edward John Eyre High School attracted substantial funding from the Department of Premier and Cabinet's Social Inclusion School Retention Action Plan to operate and staff a full-time Young Mums program for a further period of three years. Many organisations were invited to attend the first planning meeting and key organisations continue to participate in Steering Group meetings held each school term. The community organisations that were represented and that now provide ongoing support include: Child and Youth Health, Whyalla Hospital and Community Health Services, Whyalla City Council, South Australian Housing Trust, Spencer TAFE, Centrelink, Department of Education and Children's Services (DECS), University of South Australia Whyalla Campus, Mission SA, Shine SA, Centacare, Whyalla Police, Port Augusta Secondary School and representatives from other local schools in Whyalla.

The Edward John Eyre High School's Young Mums Program coordinates and advocates for the wide range of needs experienced by pregnant and parenting teenagers. They are encouraged and supported to enrol at school to complete their SACE, and the students may also have TAFE modules incorporated into their school curriculum. Most importantly, the Young Mums Program provides a meeting place where pregnant and parenting teenagers can make friends with other pregnant and parenting teenagers.

There are many aspects of the program, and individuals participate in those that best meet their needs. Each student has a Care Management File in which information is documented about each student's educational achievements, their future parenting goals, education and employment, and the identification of whatever services they may need support to access. Assistance is provided to help them make positive connections with services including childcare, antenatal classes, postnatal care, Child and Youth Health programs, Centrelink and the South Australian Housing Trust.

Transport is arranged to help the students attend school. Assistance is given to organise childcare (including transport) and a large classroom space has been resourced and fitted out appropriately to support the young women who attend school with their children.

The culture of the school community is continually being shaped towards becoming more accepting of difference in both structured and unstructured ways. Training and development has been provided to staff. Student achievements, including births, and outstanding attendance or academic achievements, are formally recognised and publicised.

Project outcomes

The program has not yet been formally evaluated, however quarterly reports are submitted to the funding body through DECS. At a school level, quantitative data is collected on the number of pregnant and parenting students enrolled in the school, their attendance, the number of SACE subjects they are enrolled in, satisfactory achievements obtained, and partnerships with community organisations formed by each individual. Qualitative data is also recorded in the form of anecdotal evidence about the changes in individual students' self-esteem, self-worth and confidence, and the associated effects of this on their participation and achievements.

Attendance, participation and retention rates have improved for this group of students. Another positive outcome is that stereotypes within the school community have been challenged, and greater levels of acceptance are becoming apparent.

Within DECS, managers, policy makers and finance administrators are developing a greater awareness of the complex needs of parenting and pregnant students. The system is currently in the process of identifying the real costs of keeping this program running beyond its three year grant, and how best to assist other schools to implement this or similar programs for their pregnant and parenting teenage students.

At a systemic level, partnerships have developed between agencies so that the young women and their families receive collaborative support. Agency personnel have become more aware of the issues facing parenting and pregnant teenagers, and have implemented different strategies to be more inclusive.

The whole community approach towards collaboratively working together to improve the educational, recreational and health outcomes of pregnant and parenting teenagers and their families has been key to the success of this program. A network of support has been established, and the people involved communicate with each other regularly, allowing a unified approach to develop. Processes and structures are now assured within and between the agencies that support pregnant and parenting teenagers. The program has also received local media support.

Communication within DECS and with SSABSA has been important. Flexible learning programs now enable documentation of Assessment Plans and Community Contracts to be used in recognising community learning experiences and allowing the achievements of individual students to be counted towards accredited SACE subjects.

Childcare is an ongoing issue for the young women in the program. Long-term, stable childcare cannot be secured for every participant, hence many students bring their children to school with them. This does require extra planning and resources, however, attempts to establish an onsite crèche have not yet been successful. Although initially disappointing, this has simply motivated those involved in the program to be more creative in trying to locate other funding sources.

The commitment and energy of the Program Coordinator, and the positive results being achieved by the students have been contagious and have spread to other people within the school community over the last three years. This has resulted in community ownership of the program and indeed, a change of culture in which pregnant and parenting students are not only expected to continue to stay at school but are extensively supported and encouraged to do so within a friendly, safe and caring environment.

DECS is now involved in discussions with the school to calculate the costs of operating the program and to develop strategies to support future pregnant and parenting students beyond the three years of School Retention Action Plan funding.

The entire program is extremely transferable, and could be adapted to suit individual sites. The structures and procedures of the Whyalla program have been documented, and could be followed as a whole or adapted to suit the local needs of other communities. Care Management Files and other administrative paperwork, such as Memorandums of Understandings could be used as templates for adaptation to other situations. Curriculum documents and sample assignments have been, and will continue to be, shared at both the department and individual school level. Partnership structures between the school and local agencies could similarly be reproduced within other communities.

The community of Whyalla now has an expectation that the school will provide the program and that pregnant and parenting teenagers will participate within it. This support, along with the processes and structures that have been developed within the school, will see it continue to operate while pregnant and parenting teenagers continue to exist.

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Doing Something, Going Somewhere - An Alternative Learning Program

Education

A LOCAL initiative
Whyalla

Marginalised youth gain literacy, numeracy and life skills in the process of re-engaging with mainstream society.

Introduction

'Doing Something, Going Somewhere' is an alternative learning program based at Youth Organisation United Through Health (YOUTH) operating as the Plaza Youth Centre in Whyalla. The students targeted by the project are representative of the most marginalised group in our society. Lack of connection with education perpetuates their marginalisation and so this project's attempt to reconnect these young people with education is a vital part of re-building their connection with mainstream society.

Aims and objectives

The purpose of the program is to support up to ten students, aged between 12 and 16, in returning to education and other activities within the mainstream of society. Its aim is to re-engage students in the learning process ('Doing Something') and then to support them to be 'Going Somewhere'. That 'somewhere' could be back to mainstream education, employment or other vocational courses through places such as TAFE.

The key objectives of the project include the following:

- Each student's attendance and participation will improve.
- Each student's literacy and numeracy will improve.
- Each student will further develop communication skills, positive social skills and life skills (e.g. anger management, health and hygiene, personal grooming, drug misuse minimisation, nutrition and cooking, and menu planning skills).
- The lifestyle of each student will be more healthy through their engagement in sporting and recreational activities (both formal and informal).
- Each student's engagement in the community, with both government and non-government agencies will improve. Students will keep appointments and build their confidence in approaching agencies for help.
- Each student's involvement in the Juvenile Justice system will decrease.
- Each student will have a planned transition from the program back to mainstream education, TAFE or employment.

Project

The project operates weekly from Monday to Thursday between 9am and 1pm at the Plaza Youth Centre, and at other locations such as Stuart High School for Music and the local recreation centre (for gym activities). The students are collected from home at the beginning of the day and taken home at the end of the day's program. The Plaza Youth Centre owns a vehicle that is used for this purpose.

Up to ten students aged between 12 and 16 can be enrolled in the program for up to 12 months (or longer in exceptional circumstances).

All students have been:

- Enrolled in Department of Education and Children's Services' (DECS) Whyalla Schools
- Referred to the Northern Country District's Attendance Counsellor
- Chronic non-attenders at school prior to their entry to the program, not attending school for at least 50% of the time in at least the previous school term.

Most students are likely to be:

- Aboriginal
- Male (though the program does include females)
- Currently young offenders and involved in the Juvenile Justice system
- Involved (or previously involved) in substance abuse and other anti-social behaviour.

The following government agencies have been involved in the project to date:

- Innovative Community Action Networks (ICANs)
- DECS - District Office and schools
- SA Police and Blue Light Volunteers
- Children, Youth and Family Services – Whyalla Office
- Nunyara Aboriginal Wellbeing Centre
- Sport and recreation agencies
- Plaza Youth Centre
- Bungala Aboriginal Corporation Community Development Employment project workers
- Aboriginal Health Division, Department of Health
- A Community Health Dietician
- Drug and Alcohol Services of South Australia

The following non-government agencies are, or have been, involved in the project:

- Mission Australia in Whyalla - Job Placement, Employment and Training
- Road Safety Centre Volunteers
- Proco Music
- Graham Hyman - a motivational speaker
- Baker's Delight
- Westlands Centre Management
- Whyalla Youth Workers' Network
- Anglicare.

Staff at the Plaza Youth Centre run the program, which is designed to be responsive to the needs of the students enrolled at the time. This means that no two terms of the program are the same. Parents must agree to their children attending the program, and schools are involved in overseeing the group and placement of students. The Steering Group meets three times each school term.

The sites used by the program are generally away from a school setting, though schools have contributed financially to the program and literacy and numeracy skills development is given priority. Substantial funding has also been provided through the School Retention Action Plan, ICAN and Community Benefit SA. Attention to the basic needs of transport, shelter, food and health is also built into the project.

Young people attend the program four days a week from 9am to 1pm. This time begins with a bus run in the morning to get the young people together at the site. They can then have breakfast, which they prepare themselves, and this is supplied through the program. Lunch is also supplied between 12.30pm and 1pm.

To keep the students motivated, the staff focus on asking what the students would like to do and establishing their interests. They take a caring interest in the lives of participants, and particularly in any problems within their family life.

This makes the young people feel cared for and a valued part of the program. Sometimes they do become unmotivated, however, the staff can usually establish a reason for this behaviour and assist through case management. The students also tend to motivate each other. They learn by doing things they enjoy, and this is supported by a style of teaching that allows them to easily absorb new information. Naturally there are one or two students who, for example, dislike maths, but they know that if they stop attending because of this they will miss out on the many things they do enjoy. They also sign a contract that explains the program is based on participation and all the young people appear to respect this.

The staff continue to work hard to build up a substantial network of organisations in the community who have subsequently become involved in the program. This broadens the development of the young people and, as a result, they become aware of the many services on offer to them within the community, while building up the confidence to access them. Similarly, in some areas, relationships have been very poor between the students and different community organisations, however, the program staff continue to work to improve communication.

One example is in the local shopping centre, where many of the young people congregate and get into trouble. The relationship with the shopping centre management was therefore quite poor. However, the students have been educated to understand why this behaviour is unacceptable. At the same time, many discussions were held with the centre's management, resulting in the management organising donations to the program, such as unsold pizza from Baker's Delight. In turn, the youths have written, thanking them for this, and now the management have been able to put names to faces. As a result the program clientele now have a very good relationship with the local shopping centre.

Project outcomes

The success of a trial conducted in Term Two of 2004 is currently being built on. The project was evaluated in late 2005. Interviews with students and their families, both before and after their involvement, have suggested that the strategies of the program are appropriate to the young people involved. Successes include increasing the attendance of almost all of the participating young people. Some students have returned to school part-time or full-time, and some have moved on to other programs such as TAFE literacy. Some have made moves to control their substance intake. Most have increased their social skills, and most are engaging with literacy and numeracy in ways that they would have rarely done before.

Appropriate funding, the skill of youth workers and their enthusiasm for the project are key to its sustainability. Commitment from stakeholders and the attitude of the young people involved in the program are also vital to its success. The initiative is extremely transferable to other communities.

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Flinders University Rural Clinical School

Education

A REGIONAL initiative
Renmark and Mount Gambier

Flinders University offers places to medical and nursing students at its regional campuses, where the rural clinical schools meet a growing need for rural health practitioners.

Introduction

Inequalities in health and education opportunities underpin a complex web of issues that create significant socioeconomic problems for rural communities. Access to higher education is frequently a cause of social dislocation. Every year, bright young people move to cities to undertake their tertiary studies. They and their families often struggle emotionally and financially with the costs of living away from home. Many years of planning and saving are essential to meet the escalating costs of tertiary education, accommodation, living expenses and transport.

These young people suffer enormous pressure. Often they experience a culture shock and isolation from their friends and family. The associated expectation to do exceptionally well can often lead to depression. A large proportion of students from rural communities drop out of their university studies. The Isolated Children and Parents Association found that three out of four rural students do not finish their degrees.[1]

Rural Clinical Schools are a national initiative designed to address the critical shortage of health professionals, particularly doctors and registered nurses, in rural and remote areas.[2] Established in 2001, the rural campuses of the Flinders University based in Renmark and Mount Gambier, enable people to study medicine and nursing in a rural setting, thereby providing study opportunities that can reduce the burden of dislocation for students. Undertaking tertiary study within a rural community benefits both students and the wider community. For example, the students' studies have a focus on local community health issues.

Aims and objectives

The primary objective of the program is to increase South Australia's rural health workforce. The secondary aim is to build capacity in rural communities.

Project

A substantial amount of international research has been conducted regarding the shortage of health practitioners in rural areas. State and Federal Governments have acknowledged the need to develop strategic programs to build the rural health workforce capacity throughout Australia. The development of extensive local partnerships was a fundamental ingredient for the program's success.

The establishment of the Flinders University Rural Clinical School is a result of extensive partnerships with groups representing the health interests of the community, health practitioners, professional organisations and all levels of government. Through active participation, the community perceives that the program has the capacity to improve the clinical workforce and therefore lessen health inequality for people living in rural areas. When a program is resource intensive, the community must be engaged to support the program by contributing to it directly and by using political influence to attract ongoing university and government commitment.

The medical education program was initially pilot-tested for 12 months and then evaluated. The regional health services were committed to the concept and these partnerships provided major support and infrastructure so that the Clinical School could be co-located with health services. Extensive political and professional lobbying was needed to gain support and to secure funding. Relationships with the regional health services and local practitioners were actively fostered. The Rural Clinical School recruits local people and imports only the necessary expertise. Locally based General Practitioners (GPs) and specialists have become university faculty members, and many are now undertaking postgraduate studies that are also based at a rural campus.

Capital funding was secured to expand general practices so that students would have the necessary facilities to work within these clinics. Data are collected about all aspects of the program so that there is evidence to demonstrate the need for expansion of services in the future. Research is conducted to publish achievements and evaluate success.

The rural campus employs around 30 staff. The infrastructure consists of lecture theatres, a Simulation Learning Centre, information technology and videoconferencing facilities. These facilities are used for a wide variety of education programs in addition to the medical and nursing courses. These courses include Indigenous and multicultural health education, clinical education (such as antenatal courses) and tele-health (such as mental health consultations). The facilities are also utilised by a range of community organisations and groups.

Project outcomes

The Rural Clinical School's policy is to recruit locally to build capacity. Several highly skilled managers and academics have been attracted to live and work at rural campuses. The main target group are potential students interested in becoming rural doctors and nurses, however, this project offers enormous advantages to the broader community.

Research has been conducted from the inception of this program, and has resulted in the development of a model for providing tertiary education. The model suggests that education must be embedded within the wider context of the community. The model is called symbiotic clinical education.[3] It means that learning occurs not only as a result of the relationship between educators and students but also requires close collaboration between universities, health services, government and the community.

The Flinders University's mainstream medical curriculum offers a parallel rural community curriculum. This gives students who have a genuine interest in becoming a rural practitioner the opportunity to spend the entire third year of their four-year program learning in the context of rural practice. Academically, these rural medical graduates are performing as well and if not better than those studying exclusively in the city.

The nursing program is taught entirely at the Riverland campus in association with local rural health services. Experienced local nurses are employed as lecturers, and several lecturers also visit from the city, ensuring a steady stream of knowledge sharing between the city and rural campuses. Nursing enrolments have now increased to 30 first-year, 18 second-year and 17 third-year students, ranging from school leavers to 58 years of age. The Rural Clinical School offers opportunities to those who would have found it impossible to move or commute to study in the city. Around 50% are married with children, some are single mothers, and others have a disability. Many have said that they would never have had the opportunity to study at university were it not for the rural nursing program. The first group of 10 nurses graduated in 2004. All are now employed on graduate nurse programs, eight in the Riverland and two interstate.

The Rural Clinical School's program was evaluated as a part of a national evaluation of Commonwealth funded rural clinical schools.[4] It found that the implementation of the School's program was progressing efficiently, with "widespread acceptance and commitment of local health services". The initiative offers an opportunity to increase the number of medical students who want to practice in a rural location. However, it is still appropriate for national policy and programs to address medical workforce shortage issues.

Significant achievements were acknowledged, including the establishment of community advisory boards to facilitate local community involvement. Key stakeholders were positive about the potential to increase the number of rural medical practitioners through this initiative, and substantial development of capital infrastructure, telecommunications and rural curriculum were recognised.

Other research has shown that local nurses and school leavers would not have been able to undertake or continue their education if the Clinical School did not offer Bachelor of Nursing (pre-registration). Commitment to quality and the community-based model of education and support provided to the medical students has enabled them to consistently rank in the top 10% of students in the state.

With ongoing Commonwealth funding under the Regional Health Strategy (the initiative is currently funded until June 2008) the project is sustainable. The medical program is consistently receiving applications to be included in the sub-quota for the Parallel Rural Community Curriculum (PRCC) program. A sub-quota of up to four places is available annually for students who have lived in non-metropolitan areas in Australia for five or more years since beginning primary school, and are able to demonstrate a commitment to a career in rural practice. Students selected in this sub-quota enter a rural stream that will provide innovative rural experiences throughout each year of their study. The PRCC students are located in the Riverland rural community for all of their third year. During the year PRCC students have the privilege of learning under the guidance and mentorship of experienced GPs, allowing the local community to become their living and learning environment.

Local GPs are enthusiastic about the initiative, consistently providing unpaid tuition to the students as well as undertaking further education to enhance their teaching skills (several have enrolled in the Graduate Program in Clinical Education). This initiative has received considerable international interest and accolades and continues to be at the forefront of rural medical education. The nursing program was initially allocated 20 first-year places, but after the first year this increased to 30 first-year places. This program continues to attract school leavers and mature age students from within the local Riverland area as well as from interstate.

The Aboriginal Primary Health Care Certificate is currently being taught from the Clinical School and indicates an increased interest from local Indigenous students. The Clinical School also offers a 'Clinical Simulation Laboratory' that provides 'hands on' training for a variety of community members including GPs, specialists, nurses, medical and nursing students, SA Ambulance paramedics and other emergency service providers. The pride and ownership that the community has for the Clinical School has a large bearing on its continued and projected success.

The Flinders University Rural Clinical School initiative has recently been awarded funding with two other partners to establish a Northern Territory Rural Clinical School.

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Preparation Program for Adult Learners

Education

A STATE initiative
University of South Australia

Students 'learn how to learn' at tertiary level in two tailored programs that lead towards Bachelor level study.

Introduction

Since its initial intake in 1995 the Diploma in University Studies (called UniSA Foundation Studies from 2006), a foundation program offered at the University of South Australia (UniSA), has provided access for 'equity characteristic' students. These are students who may be non-English speaking, from rural or isolated locations, Aboriginal or Torres Strait Islander, disabled, or from low socioeconomic backgrounds. The parallel Preparation Program for Adult Learners (PAL) offers opportunities to students enrolled at adult re-entry campuses. By explicitly teaching how students learn and what is expected of them at tertiary level, the programs open up new pathways towards Bachelor level study.

Aims and objectives

Among other socially conscious directives, the University of South Australia's Act 1990 enjoins the University to provide tertiary education 'to meet the needs of groups within the community that the University considers have suffered disadvantages in education'.

Project

Two foundation programs are now in place at UniSA, each with a different focus and target group, though both address inequalities in access to higher education for some students.

A one year full-time (or part-time equivalent) program, the Diploma in University Studies provides the foundation for successful further study by building on students' existing skills and outlining the demands of university study. The course focuses on organisation, information literacy and information technology, communication and team skills, while introducing students to a variety of academic disciplines.

In 2002 the Diploma's 'sister' program, the UniSA Preparation Program for Adult Learners (UniSA-PAL) was initiated. UniSA-PAL is a collaborative intersectoral initiative between UniSA and the Department of Education and Children's Services (DECS) which 'mirrors' the Diploma in University Studies, and extends the 'second chance' strategy to students enrolled at adult re-entry campuses throughout Adelaide's metropolitan area. It is focussed on supporting the educational needs of adults in their surrounding communities.

The UniSA-PAL initiative commenced with a group of students at Para West Adult Campus in 2002, and in 2003 Hamilton Adult Campus, Marden Senior College and Thebarton Senior College joined the initiative. In 2004 a Year 13 trial of the program was conducted at Fremont-Elizabeth City High School. In 2005 there was an initiative to boost Indigenous participation in the program especially in the northern metropolitan areas. This was based at Para West Adult Campus. In addition, external delivery (focusing particularly on rural and isolated students and those who may be incarcerated) was initiated through the Open Access College. In 2005 there were approximately 100 students enrolled in this program across five adult campuses.

The following tables show the range of student equity characteristics in the two programs from 2002 to 2004.

Project outcomes

The Diploma of University Studies has a proven history of making an educational difference for its students who, upon completion of the program progress to study at Bachelor level, in a variety of programs including business, education, applied science, arts, health sciences and social work.

Since 1995, many students have benefited from their study in the Diploma in University Studies, and the majority have progressed to further study. The table below shows the pathways followed by graduates of 2003 and 2004. More popular courses of study are highlighted in bold.

Table 1: Equity Characteristics of all UniSA-PAL Cohorts [1, 2]

	UniSA All 2002	MDUS 2002	UnisSA-PAL 2002	UniSA All 2003	MDUS 2003	UniSA-PAL 2003	UniSA All 2004	MDUN 2004	UniSA-PAL 2004
Low SES	23.6%	34.6%	#86.6%	23.5%	33.9%	#16%	23.5%	40.8%	***65%
Disability	2.4%	7.7%	13%	4.4%	10.2%	13%	5.1%	7.1%	5%
N.E.S.B.	2.6%	0	*0% **8.7%	3.2%	1.7%	*0 **9.6%	2.9%	0	*0 **13%
Rural	14.1%	19.2%	0	13%	5.1%	0	13.6%	9.2%	2%
Isolated	1.2%	3.8%	0	1.3%	0	0	0.9%	3.1%	0
Indigenous	1.4%	3.8%	0	1.4%	0	0	1.5%	17.3%	3.6%

* National equity indicator definition
** Speaks a language other than English at home
*** Receives an income tested Government payment or holds a Health Care Card
# based on postcode methodology which does not accurately reflect a low SES

MDUS/MDUN: Diploma of University Studies
N.E.S.B.: Non-English speaking background
SES: Socioeconomic status

Table 2: UniSA courses enrolled in by 2003 and 2004 Diploma of University Studies graduates

Program	Number of students
Bachelor of Applied Science (Biodiversity, Environmental and Park Management)	1
Bachelor of Applied Science (Human Movement)	1
Bachelor of Applied Science (Recreation Planning and Management)	1
Bachelor of Architecture	1
Bachelor of Arts (Aboriginal Policy and Management/ Aboriginal Studies/Australian Studies	**3**
Bachelor of Arts (International Studies)	1
Bachelor of Arts	1
Bachelor of Business	1
Bachelor of Commerce	2
Bachelor of Construction Management and Economics	1
Bachelor of Early Childhood Education	1
Bachelor of Education (Junior Primary and Primary)	**5**
Bachelor of Education (Primary and Middle)	1
Bachelor of Industrial Design	1
Bachelor of Management (Human Resource Management)	2
Bachelor of Management (Marketing)	1
Bachelor of Medical Radiation (Diagnostic Radiography)	2
Bachelor of Nursing	1
Bachelor of Psychology	**5**
Bachelor of Social Science	1
Bachelor of Social Science (Human Services)	1
Bachelor of Social Work	6
Bachelor of Tourism and Hospitality Management	1
Bachelor of Visual Communication	1
Business Double Degree (Aboriginal Policy Management, Administrative Management)	1

Similarly, since 2002, 66 students have completed the PAL program and the table below shows their pathways to further study.

Both the Diploma of University Studies and the UniSA-PAL program are important initiatives by UniSA to provide tertiary education opportunities to members of the community who have been traditionally underrepresented in universities. The continued success of these programs ensures improved access to a wide range of undergraduate programs for those who otherwise may not have considered university study as a possibility.

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Table 3: UniSA courses enrolled in by UniSA-PAL graduates since 2002

Program	Number of students
Bachelor of Adult and Vocational Education	2
Bachelor of Applied Finance	2
Bachelor of Applied Science (Biodiversity, Environmental and Park Management	1
Bachelor of Applied Science (Food Science and Nutrition)	1
Bachelor of Applied Science (Occupational Therapy)	**3**
Bachelor of Arts (International Studies)	1
Bachelor of Arts (Journalism), Bachelor of Arts (International Studies)	1
Bachelor of Arts (MBAR)	**7**
Bachelor of Business (Administrative Management)	2
Bachelor of Commerce	1
Bachelor of Commerce, Bachelor of Business (Commercial Law)	1
Bachelor of Education (Junior Primary and Primary)	**8**
Bachelor of Early Childhood Education	1
Bachelor of Education (Primary and Middle)	2
Bachelor of Management (Marketing), Bachelor of Arts (International Studies)	**3**
Bachelor of Management, Bachelor of Arts (International Studies)	1
Bachelor of Medical Radiation	**3**
Bachelor of Nursing	**6**
Bachelor of Midwifery	**3**
Bachelor of Psychology	**8**
Master of Psychology (Specialisation)	**3**
Bachelor of Social Work	**4**
Bachelor of Urban and Regional Planning	2

1 Ramsay E. A New Pathway for Adult Learners: evaluation of a school-university access pilot report, University of South Australia, Department of Education, Science and Technology, Canberra (ACT): Commonwealth Government; 2004.

2 Planning and Assurance Services, University of South Australia, Equity Statistics Trend report, University of South Australia, Department of Education, Science and Technology, Canberra (ACT): Commonwealth Government; 2004.

Employment: An introduction

Work plays a fundamental role in our society. It provides income opportunities for social support, a structure to daily life, and a means of participating in society. People often define themselves or are defined by the work that they do. People who have access to safe, secure and satisfying work are more likely to have adequate financial resources, increased opportunities, and better health and wellbeing than people who are either under or unemployed.[1, 2]

Given the critical role that employment plays in our society, it is not surprising that people who find themselves unemployed or working in stressful and hazardous environments face major risks to their health and wellbeing. Unemployment has a significant negative impact on both physical and mental health. The risk of morbidity and mortality is higher for both unemployed men and women, who suffer higher levels of depression, coronary heart disease, injuries and suicide.[1] Unemployment leads to poorer health outcomes through social exclusion and stigma, poverty and lack of access to adequate income, changes to health related behaviours and through disrupting future employment and career opportunities.[1]

Unemployment rates are associated with lower levels of education, and are higher among unskilled or semi-skilled workers, single parents and people living in disadvantaged geographical areas. For example, in 2003 the unemployment rate in the most disadvantaged areas of Adelaide was 10.6 % compared with 3.9% in the most advantaged areas of Adelaide.[2] Lack of skills and access to an adequate education may be a barrier to obtaining employment and compound earlier disadvantage.

It can be seen that the opportunity to access safe, secure and meaningful work is not distributed evenly across the South Australian population. Some population groups have increased chances to obtain employment. It is essential that programs are established to support children from disadvantaged backgrounds to gain meaningful education and to provide unemployed people with the confidence and opportunity to get back into the workforce. The case studies in this section and in the previous education section outline a number of programs that show promise.

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The Big Issue

Employment

A STATEWIDE initiative
South Australia

Vendors of a street magazine gain social inclusion through self-employment with the support of its publishers.

Introduction

The Big Issue in South Australia (SA) is part of a national project that is affiliated with similar projects internationally. The Big Issue is a national not-for-profit organisation which publishes and distributes a street paper of the same name, supporting local vendors of the magazine with the opportunity of self-employment.

Aims and objectives

The project aims to help people on a low income who are socially excluded or at-risk of social exclusion and have obstacles to securing mainstream employment. It is designed to address social isolation, homelessness, low income, welfare dependency, unemployment and the limited choices available to people who cannot access mainstream employment. It hopes to address cultural marginalisation by helping people to earn an independent income and take steps towards making positive changes in their lives.

Project

The Big Issue supports disadvantaged people in selling the street paper and effectively being in charge of their own micro business. Vendors buy the magazine for $2 from The Big Issue office and sell it on the streets for $4. The vendors keep the money they earn from the magazine sales. Vendors are given every assistance to get themselves started. They may be men and women who are homeless, long-term unemployed, physically or intellectually disabled, or at-risk of becoming socially excluded. Ongoing support and training is provided to assist vendors to claim the social, economic and personal benefits that this kind of work can provide.

In 2002, two committed individuals offered their support to The Big Issue Australia to assist in bringing the project to Adelaide. They networked and garnered support from city agencies. They were able to secure funding from local and State government and established a vendor support hub. Local government and businesses supported the establishment of regular pitches (vendor work locations) and people signed up as vendors. Visitors and residents supported the project by purchasing the magazine and chatting with the vendors. In 2003 the project spread to metropolitan council areas. In 2004 a vendor began work in Whyalla.

The core work of the project is to support people in selling The Big Issue magazine.

The support that is offered is as diverse as the journeys vendors have made in their lives. The target population, which is homeless and physically and intellectually disabled persons, are recruited to distribute The Big Issue magazine. Part of the recruitment entails talking with those who are interested and letting them know that participation is optional. Referrals from existing vendors have also provided a major source of new vendors.

The organisation sets out to maintain relationships and routines while simultaneously creating an environment where vendors are in charge of their actions. These strategies have been successful in other Australian cities as well as internationally. Everybody has a part to play in the chosen strategy.

Project outcomes

The project has not yet been formally evaluated. Over the last four years, over 300 people have taken the magazine to the street, by hand and on foot (or wheelchair), and they have used the opportunities this project provides to improve their lives. Vendors have sold over 110,000 magazines since 2002, earning themselves over $200,000. Of those who have remained vendors for more than a year, 100% have experienced primary homelessness at some time in their lives. They all now have secure accommodation, some have gone on to other work, some to study, and many have developed wider interests. Anecdotally, vendors across the board have gained confidence and developed relationships with people from all walks of life.

The Big Issue in SA is now four years old and continues to grow, along with similar projects nationally. Steadily more vendors sell more magazines in more locations. The organisation is currently around 75% self-funded (by magazine sales and advertising in the magazine) and hopes to be completely self-funded in the medium term.

Clearly this initiative can be used in a range of communities. Current plans are for a greater reach into suburban and regional centres.

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The Work Bank

Employment

A LOCAL initiative
Northern metropolitan Adelaide

People looking for 'fragmented work' and those who need such work done are assisted to find each other through a comprehensive system of networking, promotion and support.

Introduction

Individuals who are unemployed or underemployed face serious disadvantage. This can be compounded by other social issues which together trap people into a cycle of poverty. People who are unemployed often do have skills that are highly valuable, but are not aware of their marketability. Many people also find it difficult to break out of unemployment as they lack a recent employment history and work often needs to be structured around their other responsibilities. We know that many small businesses need to have certain types of work done, but they can't afford to employ people on an ongoing basis, nor can they afford typical consulting rates. The Work Bank helps to address this by promoting suitably skilled and supported workers to undertake such work.

The Work Bank is a support and promotional system for workers who are looking for 'fragmented work' and for employers with fragmented work opportunities. Fragmented work means a few hours here and there or short-term contracts. The Work Bank operates by putting the worker 'in the centre of the circle'. Most systems are about fitting people to the job, whereas the Work Bank is about fitting jobs to people.

Aims and objectives

The project aims to:

- Assist workers in developing and marketing their skills
- Promote workers through the www.workbank.com.au website, with each worker having a dedicated profile page from which to promote themselves
- Provide systems and processes that will help the Work Bank members successfully manage paperwork, work processes and access to resources.

Project

The project was designed to assist disadvantaged job seekers, parents returning to work, mature age job seekers, and people on benefits such as the Single Parents Pension, Disability Support Pension or Age Pension who wish to supplement their income. The Work Bank can be used in two ways - either to build a business or to gain paid work experience to build a résumé that will be taken seriously by employers.

Workers within the Work Bank are essentially self-employed, as either sole traders or as Odco® Independent Contractors (a system whereby the Work Bank provides the added support of managing the income tax and insurance deductions for workers). Odco® Contracts are administered as a joint venture between the Work Bank and a licensed Odco® contracting company. In this way, the Work Bank helps people to undertake small amounts of work that would otherwise be impossible (outside the cash economy) given the constraints of the current taxation system.

Those involved in the initiative as a community project include:

- Playford Proud Network (initiated the project)
- Anglicare SA (leadership and home for the project)
- SA Works (funding and project support)
- Northern Adelaide Business Enterprise Centre (NABEC) / (Board member plus resource for both the Work Bank and workers)
- Office of the North (support and network contacts)
- City of Playford (support and network contacts)
- Salisbury Council (support and network contacts)
- South Australian Housing Trust (help with initial design of the project)
- TAFE SA (Board member and Joint project to provide training for the Work Bank members)
- Commonwealth Department of Employment and Workplace Relations and Job Network Members (partnership)
- Centrelink (Board member and active support)
- Local business (Board membership)
- Mission Australia (partner and networking)

The Work Bank began by networking with local businesses and organisations and establishing direct involvement with the local community. With this approach, the project was significantly changed from its original design that was to assist people to become handy-persons and gardeners. The project has now grown into a system that promotes all kinds of workers at three different skill levels – learner, journeyperson and master. The aim is that employers will know exactly the level of skills of the person they are contracting, and workers will have a pathway to increased income, either through permanent employment, or by acquiring more highly paid skills.

To automate the process of looking for a worker, the website (www.workbank.com.au) was designed and built. The website has been live since June 2005. Prospective employers use search criteria to locate suitable worker profiles. They then contact the worker direct to discuss the work opportunity.

This approach led the project away from labour hire (public liability insurance was prohibitive) and towards a joint venture with Tusford Contracting Services to provide a means whereby the Work Bank could assist workers, if required, to take out income tax and insurance. All workers are self-employed, therefore they are not covered by Work Cover. Odco® contractors pay into a group insurance scheme, while workers who opt for full self-employment can access insurance discounts offered to Business Enterprise Centre members. The Work Bank has had to be aware of taxation and insurance requirements, and the effect that working may have on Centrelink benefits and Job Network obligations. It is important to ensure that all workers understand this information.

To assist members most appropriately, the Work Bank uses a tailored approach, depending on each worker's needs. Some require a great deal of assistance while others become very self-directed, simply using the Work Bank as a catalyst to get them on their way. Support includes coaching, helping workers obtain an ABN, providing access to information about record keeping and business processes, and training through TAFE SA, the Australian Taxation Office and the NABEC. Where the Work Bank members are struggling with issues such as paying bills, the partnership with Anglicare SA has been invaluable, as a range of assistance is available.

The Work Bank developed a system of supported contracts that were designed to provide a short-term 'paid work experience' opportunity for workers who already have some technical skills (perhaps learned through Work for the Dole or volunteering) and now need to build employability skills.

These strategies are aimed at building a sustainable project that meets community, business and legislative requirements. The Work Bank is operating within the reality of the current world of work and helping people do the same. The security of long-term permanent employment is no longer the norm for many people. By providing support and promotion for workers, the Work Bank offers a foundation they can each build upon to create their own security.

Project outcomes

When this case study was compiled, the project had been running for nine months in what was effectively its pilot phase. It has now been running for over two years and has attracted recurrent funding due to the perceived value to the community and outcomes achieved by members. Above all, the provision of one-on-one support for members has been highly valued. This can be labour intensive but seems to be the best way to achieve sustainable results. Similarly, consultation and ongoing involvement with the community has been very positive, and linking with government departments has worked well for all concerned. The original plan included a substantial amount of group work and group coaching but, as one-on-one support is proving most effective at this stage, the idea has not yet been pursued.

The Work Bank website useful in providing an easy way for employers to connect with workers. Supported contracts have recently been replaced with a partnership with West Works, an Anglicare enterprise that offers 'real work experience' and opportunities for contracting.

There have been advantages in being flexible and tenacious, and though some road blocks have looked insurmountable, there is almost always a way to deal with issues. Finally, the value of partnerships cannot be overlooked – without these the Work Bank would not exist.

Some examples of outcomes for Work Bank members include: a single mother doing part-time domestic cleaning who now has a small commercial cleaning business with three sub-contractors; a man on DSP who lost his part-time job when the company failed, then went on to win the contracts himself as a self employed gardener; a 40+ ex-Work Cover man who was trying to move from process work to administration, but discovered that he could employ his considerable customer service skills as a driver. What we know is that motivation is the key. For those who are committed to building a future, Work Bank provides a high level of support.

The Work Bank is receiving a great deal of interest from other communities, and from Centrelink and Job Network members. Indications are that the project will also receive ongoing funding for at least another year beyond the current funding date.

The Work Bank is transferable to other contexts and communities. All partners have a national presence, the website has been designed with the capacity to grow, and systems and processes can be utilised throughout the country. In the short-term it may be wise to expand to adjoining geographical areas, however, there is no reason not to replicate the Work Bank eventually into other communities.

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Food security and health[1]: An introduction

Eating adequate amounts of nutritious food throughout life, from in utero into old age, is essential for good health. Good food supports healthy growth and development, and protects from both acute and chronic diseases (e.g. heart disease, type 2 diabetes).

Ensuring that disadvantaged groups are 'food secure' (see box below) is an important component in addressing the health inequalities they experience compared with more advantaged groups. Improving nutrition for vulnerable groups is a priority of the national nutrition agenda[2], and is part of South Australia's nutrition action plan, *Eat Well South Australia*.

Food security refers to the ability of individuals, households and communities to acquire appropriate and nutritious food on a regular and reliable basis, and using socially acceptable means. Food security is determined by the food supply in the community, and whether people have adequate resources and skills to acquire and use (access) that food.

Food insecurity can refer to the following: not having sufficient food; experiencing hunger by running out of food and not having enough money to afford more; eating a poor quality diet as a result of limited food options; anxiety about acquiring food; or having to rely on food relief.

Definitions from NSW Centre for Public Health Nutrition

Factors affecting food security are complex, related to both the supply of food in the community and peoples access to it. Supply indicators include the location of food outlets, foods available from those food outlets, its price, quality and variety as well as promotion at point of sale. Factors affecting access include financial resources, distance from and transport to shops, food knowledge, skills and preferences, storage, preparation and cooking facilities, time and social support.

These supply and access factors are in turn determined by other factors in the food and nutrition system (e.g. food production and processing, and urban planning) as well as socioeconomic factors (e.g. employment, education, housing and social inclusion).

It is suggested that to reduce food insecurity, policy and program interventions are needed at many points to improve the availability of healthy food and people s ability to acquire and use this food. The case studies in this section provide South Australian examples of programs that begin to address some of these intervention points.

References

1 This introduction draws heavily on the following publication: New South Wales (NSW) Centre for Public Health Nutrition and NSW Health. Food security options paper: a planning framework and menu of options for policy and practice interventions. NSW: NSW Health; 2003. Available from: http://www.cphn.biochem.usyd.edu.au/resources/foodsecurity.pdf

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Eat Well Outback SA

Food

A REGIONAL initiative
Rural and remote South Australia

Food supply and accessibility has improved in rural and remote South Australia through community collaboration and education.

Introduction

In 1999 a study titled *Eat Well SA: Food Supply in Rural SA* investigated the cost, quality and variety of food supply in shops in rural and remote parts of South Australia (SA). The study found that people living outside of Adelaide and large rural centres generally paid more for food and had fewer fresh food choices. This was particularly evident in the smallest towns, the most remote locations, the most socioeconomically disadvantaged areas and places where there were no large shops. In addition, people in some remote areas needed to shop on or near the day of delivery in order to obtain good quality produce.

The project undertook a wide range of strategies to address issues of supply, access and food quality in rural and remote SA. It was based upon the concept of developing community capacity within community groups, schools, stores and health services. The project was funded for three years in 2001-2004 by a Federal Department of Health and Ageing grant as part of the National Child Nutrition Program.

Aims and objectives

The aim of Eat Well Outback SA (EWOSA) was to improve food supply and access in rural and remote SA. The project had five specific objectives, namely to:

- Increase community awareness and involvement in improving access to healthy food
- Advocate for the development of policies that address community-identified issues concerning the lack of consumption of a healthy diet
- Collaborate with stakeholders to facilitate improvement of country freight logistics
- Facilitate the delivery of training to retailers in the region, and the adoption of effective stores policies, through the development and provision of a good services guide manual
- Facilitate the delivery of education programs encouraging a healthy diet.

Project

The project targeted people living in remote communities in the northern and far-western region of the State, particularly stores, Aboriginal communities and schools in these areas.

The project partners included the Northern and Far Western Regional Health Service and the Women's & Children's Hospital, with support from the Spencer Gulf Rural Health School. In addition, the following stakeholders were involved in planning and steering the project:

- Department of Health (DH)
- Department of Education and Children's Services
- Pika Wiya Health Service
- Transport Planning Agency, Transport SA
- Spencer Institute of TAFE
- Australian Competition and Consumer Commission
- State Retailers Association of SA
- Whyalla City Council
- Whyalla Community Health, Whyalla Hospital and Health Service
- Remote and Isolated Children's Exercise
- Coober Pedy Area School
- Ceduna Area School.

The first step was to establish a Project Advisory Group consisting of relevant stakeholders. An experienced Project Officer was employed to liaise with existing community groups and to provide information to the community through a series of targeted presentations. The Project Officer was able to identify and recruit stakeholders from within the Indigenous community, and to establish partnerships with schools, retailers and health workers. Input was also sought for the development of food safety training programs for outback communities. The Project Officer promoted the project through conferences, publications and the media.

Transport SA's Transport Planning Agency was approached to discuss the implementation of recommendations from the Country Freight Improvement Study and other freight transport activities. Relevant retailer freight data was offered to the Transport Planning Agency for this purpose.

The Project Officer also liaised with professional bodies who could identify training needs and help in the development of a manual to support outback stores. Contact was made with IGA retailers for further input. A list of appropriate resources was then developed, compiled and adapted for inclusion in the Healthy Outback Stores. Ongoing contact was established with store stakeholders through the provision of the Healthy Outback Stores manual. The manual was sent to 19 retailers engaged in EWOSA, and they were also given information about local community initiatives so that linkages could be formed at a local level.

Schools and communities were invited to identify needs or gaps in existing education programs that could be addressed by the project. Specific food needs were also identified through liaison with regional dietitians, the Pika Wiya Aboriginal Health Service, the DH, local health workers and local retailers. Partnerships were formed to collate and provide the materials and resources to schools, in order to meet these needs. In addition, an existing program called 'Creating a Stir' was adapted and extended in order to meet the needs of the outback communities. Representatives from ten rural schools were engaged in the project, and each school subsequently received an EWOSA Nutrition & Education Resource Kit.

These strategies were based on a health promotion model of:

- Building supportive environments
- Using multiple strategies to address a complex issue
- Working collaboratively with organisations and community groups
- Building capacity in communities through schools
- Involving a wide range of sectors to address social and economic determinants of health.

Project outcomes

Qualitative evaluation of the project was conducted by the Spencer Gulf Rural Health School in 2004. This identified some important outcomes, including demonstrable improvement in stakeholder knowledge and awareness of nutrition/food issues in the rural and remote areas involved. There was an increasing sense of community ownership of the aims of the project, and useful collaborative partnerships emerged between service providers, agencies and the community. Similarly, progress is being made in the supply and availability of healthy foods in rural areas through the involvement of transport personnel.

The adoption of primary health care working practices has successfully been encouraged among regional dieticians. Consultation and engagement with rural and Indigenous communities has also meant that people living in the rural communities have gained knowledge, awareness and skills to make healthy food choices. A suitable range of targeted educational resources is now available to them.

It was widely asserted amongst the stakeholders that the project constituted a practical attempt to facilitate an integrated intersectoral and inclusive response to a multi-faceted and profound health and equity issue. All of the agencies involved were viewed as essential components in identifying and successfully addressing the problems of improving healthy food supply and access in rural and remote SA.

Limited mechanisms are in place to support the project's sustainability (notably with regard to the compiled resources, their development and wider dissemination). Ongoing activities include continuing relationships and coordinating mechanisms among the project partners. However, the need for similar ongoing activity in this area, and for someone with the skills of the Project Officer to be conducting this work, was widely asserted and strongly argued in the evaluation.

The project has laid the groundwork for achieving strategic intersectoral and primary health care activities to improve food access and supply in rural areas. Furthermore, the concept and implementation should be transferable to similar communities. It was widely agreed that this work should be further developed by an organisation with a regional focus, however, in order to be successful, the collaboration of a range of supporting statewide organisations would also be crucial.

This case study is largely based on information written by the EWOBSA Project Officer, Chrissie Hallett, in the EWOBSA Final Report, and Paul Aylward, in the EWOBSA Evaluation Report. Many people were involved in funding, supporting, evaluating and staffing the project, which was largely managed by Linda Crutchett, Whyalla Hospital and Health Service.

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'Food 'n' Fun' and 'Adults Only'

Food

A LOCAL initiative
Northern metropolitan Adelaide

A kids' food and activities club, and an associated group for adults, are located in a community shopping centre near the primary school. Together they link into the network of local services, providing a strong and well-supported environment for integrated family, personal and social growth.

Introduction

The Peachey Belt corridor north of Adelaide has been identified as having the worst income support to income tax ratio in any area of metropolitan Australia[1]. It also has the highest unemployment level in metropolitan Adelaide and very low average income levels. The area has numerous other indicators of high need, with high and increasing levels of sole parents, high public housing levels and low school retention rates[2]. In addition, the Playford region, where the Peachey Belt is located, has more than double the reported rates of child abuse and neglect than the Adelaide Statistical Division, as well as double the reported rate of domestic violence[3], and extreme levels of transiency within and through the area exist.

The need for a breakfast service for primary school age children was initially identified five years ago through an analysis of community needs in the Peachey Belt, conducted by Anglicare SA's Family Centre North. Seed funding was made available for an initial period, enabling the employment of staff to pilot the project. The program, however, developed a focus that was far broader than breakfast, becoming a prevention and early intervention service that developed a broad range of relationship, practical and leadership skills with children and their parents. The Department for Family and Community Services then provided longer term funding. Involvement grew slowly in the initial years, and dramatic increases in attendance have been occurring over the past four years. The project has always used an action research approach, enabling positive program changes over the years, such as the creation of the literacy program and the leadership program.

An important development arising from the 'Food 'n' Fun' program is the associated Adults Only project which is described in full in the adjoining panel.

Aims and objectives

Based on the region's statistical profile, the Food 'n' Fun project was established in the Peachey Belt in order to address local indicators of inequality such as:

- Lack of safe spaces for children and families
- Low literacy and numeracy levels
- High rates of drug and alcohol use
- High rates of community and family violence
- High rates of family breakdown
- High rates of disengagement with schools
- Difficulties with parenting
- Inadequate formal and informal support networks for both children and parents
- Lack of leadership opportunities and leadership development programs.

The Food 'n' Fun project was intended to provide a safe and respectful space where children and their parents would be encouraged to develop social skills, life experience skills, literacy and numeracy. The aim was to promote children's resilience, enhance teamwork between children and parents, enable both children and adults to demonstrate leadership skills, and support the children and their parents in their familial relationships. At the same time, the environment and activities would connect children with other children and parents with other parents to foster constructive peer relationships. A further outcome would be the positive relationships built up between children, their parents and a variety of service providers.

Project

Food 'n' Fun, along with its associated project, Adults Only, operates from the Annexe, a site comprising two adjoining shops in the Fields Community Shopping Centre, next to the Davoren Park Primary School. The project has been successfully working with young children in Davoren Park for the past six years.

The main target group for this project is children attending the Davoren Park Primary School and their siblings. The families and peer networks of these children make up the secondary target group. The involvement of parents and children has been critical to the development of both projects prior to their inception.

One hundred and fifty children from more than 80 families are currently engaged with the project (more than half the children attend the local primary school). An average of 41 children participate in breakfast each day, approximately 28 in after-school activities, and a further 25 children drop in briefly after school each day. Attendance is evenly split between boys and girls, and 18% of the children who attend the project identify as Indigenous (approximately 2% of the local population identify as Indigenous).

Food 'n' Fun offers children the following activities:

- Breakfast and before-school activities three mornings a week during school terms
- After-school activities and snacks three afternoons a week during school terms
- School holiday activities for children and their parents
- A literacy programme for children, promoting a love of reading, literacy and creative story telling
- A leadership programme for children operated in conjunction with Child and Adolescent Mental Health Services and the local primary school
- Access to advice, information and support during these activities and also at other times during the week.

The reference group for Food 'n' Fun involves children, parents, Davoren Park Primary School, Playford Community Health Centre, Playford Council, the Commonwealth Department of Family and Community Services and Anglicare SA.

Children participate in the reference group for two years. In the first year they are mentored by their more experienced peers as well as by staff. In the second year they become full representatives and mentor the next representatives. This process enables children, in a safe and supportive environment, to learn the skills involved in self-advocacy, clear communication, assertiveness, representing the views of others – in other words, leadership. As a result of this process, children are very vocal in the reference group about the needs and wishes of children who participate in the project. They also have the opportunity to model these skills and foster them in their peers.

Parents who are involved in the Food 'n' Fun reference group usually participate for a longer period than children do. Some parents have been involved for five years. Their involvement with the reference group typically lasts for the duration of their children's participation in the project. New parents are regularly encouraged by staff to participate in the reference group, either as members, or by discussing their wishes and ideas with parents who are already involved in the reference group. In the initial stages of involvement in the reference group, staff play a mentoring role with parents and as parents' confidence and skills grow, parent participants mentor their peers.

Most families who are involved in the project also have children aged 0 to 4 years and many have four or more children aged from 0 to 14, creating links with other services (e.g. Adults Only), ensuring that a response to the whole family is possible.

The strategies adopted in this program are consistent with the organisation's experience in service delivery, anecdotal evidence, community feedback and research findings about community capacity building, resilience, community development and early intervention.

The staff create environments and activities that allow for minimum structure and maximum flexibility, so that the diverse and changing needs of each child and parent can be met. Children and their parents are therefore provided with a wide range of options and choices. We have found that this emphasis on flexibility and choice is crucial to both child and parent resilience, as well as their capacity to become self-directed in their skills development.

The Davoren Park Primary School is strongly supportive of the program, and the City of Playford has consistently encouraged and promoted both Food 'n' Fun and Adults Only. The Playford Community Health Centre also plays a key role through its participation on the reference group and by providing nutrition advice. Priority access to the health centre's individual and group services is assured for children and families involved in the project.

Project outcomes

Food 'n' Fun was externally evaluated in 2001 with qualitative findings. Amongst other positive comments, the children liked:

"…the fact that the Club is fun…. the staff….being able to be with friends….the fact that it was OK with their parents to be there….it doesn't cost anything so they can come….food is good….gives their parents a break….being able to drop in."

Internal evaluations and child satisfaction surveys have found children reported the following:

- Their problem solving skills are getting better.
- They have friends they like doing things with.
- They are good at dealing with their angry feelings and helping their friends when they have angry feelings.
- Their family spends time doing fun things together.
- They get on better with their parents and siblings than they used to.
- They are doing better at school than they used to.
- They know an adult who isn't in their family that they can trust.
- They can tell staff what they want to do at Kids' Club and know they will be listened to.
- They feel safe at Kids' Club.

Teachers from the local school reported positive improvements in children's behaviour, concentration and teamwork. Parents reported that their relationships with other parents in the area have increased, they have developed greater informal support networks and they meet regularly on the site outside the times the formal project activities occur. During these interactions with each other and with staff, they share parenting difficulties and successes, as well as strategies for resolving problems. Staff involved in the project are frequently asked for advice and information about resources and strategies to manage struggles that parents are experiencing with children. The approach used with families has meant that over time families who first approached staff with crises now have the confidence and skills to either manage the situation themselves, or identify the risk factors and then prevent the crisis from occurring.

This initiative is highly transferable, and in 2005 began in Smithfield Plains, in a similar setting and in partnership with the local school. Initial results from this new service are very encouraging.

The project is currently funded by the Department of Families and Community Services 'Stronger Families and Communities Strategy' until 2008. Its ongoing success is dependent on this funding for staffing, activities, food and rent.

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Adults Only

Introduction

Soon after 'Food 'n' Fun' was established it became clear that parents were keen to meet, plan, share stories and develop skills. They would gather on the site, talk with each other and with staff about their successes and their struggles. 'Adults Only' grew from this interest. Parents are actively involved in establishing the plan for each term's activities, evaluating the success of the group and making changes regarding how the group operates.

Adults Only assists parents in their parenting role without being a 'parenting' group. The primary target group is parents with primary school aged children living in the Peachey Belt, and its secondary target group is parents from the same area with children aged 0 to 4.

Aims and objectives

A large proportion of parents who have been and are involved with the project are under 25 years. The majority of the remainder are under 35 years. Most parents have never had paid work and the majority have not completed secondary education. The area is characterised by very high and entrenched unemployment, therefore one of the primary aims has been to provide opportunities and pathways for parents to build their confidence and their skills, to develop dreams for their future, and to set and achieve goals.

Despite the fact that education on appropriate methods of child rearing underpins numerous programs and groups, traditional parenting courses have failed to engage many parents who live in the northern area. We believe this failure stems from a number of factors, including:

- A fear of children being removed by statutory authorities
- A use of traditional 'parenting' jargon which alienates many parents
- A belief that parenting is not something one can teach
- A fear of admitting that one is not a 'good' parent
- Difficulties accessing services.

Adults Only aims to support parents in their parenting role, working with parents' strengths and providing information, education and resources in a safe environment in order to expand participants' existing skills and develop new ones.

Project

For the past four years, during the school term, parents of children involved in Food 'n' Fun have met weekly at the Annexe community venue. The group is open to new members and works with parents to identify their strengths and skills, and to resolve parenting issues in a safe and non-threatening environment. Parents are actively involved in planning, budgeting and evaluating the project's success.

Adults Only grew from an action research model, with staff noticing that parents congregated at the site after dropping their children at school, wanting to have a cuppa and a chat with each other and with staff about their children, their families, and their hopes and dreams. Staff invited parents who regularly dropped in to go out for coffee and cake. During that morning tea, a discussion was started by staff about interest in starting a group that met regularly and focussed on the needs and interests of parents. This discussion resulted in the formation of Adults Only.

Adults Only operates as its own reference group, with parents actively participating in managing, planning, budgeting and evaluating the group on a regular basis. As well as the weekly group, there have been three Saturday overnight retreats for women without their partners and children. In order to reinforce the women's absence from their families, support was given to the partners and other carers of children while the women were away. These retreats have been times of significant personal growth and development for the women, with group members supporting and challenging each other to 'dream big'!

Project outcomes

Adults Only has not been externally evaluated, however internal evaluation has revealed:

- Aspiration and confidence-building among parents disconnected from employment and training has been high, with numerous parents now considering employment a realistic goal, not an unattainable dream
- New opportunities and support for project participants to become volunteers and then employees
- New work experience placements for students.

Through links with partner organisations (such as Para West Adult Campus and TAFE) parents have been able to visit and meet teachers, and have become confident to leave their children in childcare. They are now more likely to access secondary and post-secondary education earlier than they would otherwise have been able to do.

A number of parents have become involved with further education since becoming involved in the project, several others are involved in Work For The Dole initiatives, and others have successfully obtained employment.

These outcomes are highly significant given that the parents involved in the project are often dealing with the impact of past or current abuse and violence, multiple young children, low literacy and numeracy skills, unstable/inadequate housing and low incomes that are not keeping pace with increasing costs.

Healthy Food Choice in Family Day Care

Food

A STATEWIDE initiative
South Australia

Family Day Care providers promote healthy food choices to children in their care and their families.

Introduction

Family Day Care is a universal child care service. Many children attending Family Day Care are from families experiencing disadvantage, including families on low incomes, families where unemployment is generational, rural families, Indigenous families and refugee and recently-arrived families. These families and children benefit from the increased attention paid to nutrition and appropriate food choices, particularly for children in the birth-to-five age range. The close relationship between the family and the care provider, and the home environment in which the care takes place, allows for greater support of families who experience disadvantage.

Aims and objectives

The Healthy Food Choice project was targeted towards Family Day Care providers, and aimed to increase their capacity and confidence to promote healthy food choices to children in their care and their families.

The aims and objectives of the project were to:

- Strengthen organisational commitment for nutrition promotion through the development of a Healthy Food Choice policy, and supporting strategies, using a consultative method
- Increase the capacity of care providers to promote healthy food practices, through the development of nutrition training and resources that promote acceptance and preference for healthy food and healthy eating practices
- Increase care providers' confidence to promote healthy food choices to parents through enhancing their skills and legitimising their health promotion role.

Project

The Healthy Food Choice in Family Day Care (FDC) project came about from a separate project undertaken by the Department of Public Health at Flinders University and Noarlunga Health Services in 1999. That project explored nutrition-related issues and the practices of FDC providers in the outer southern metropolitan area of Adelaide. It found that care providers had good knowledge about nutrition and were concerned about the amount and type of food provided by parents, as well as the management of food-related behaviour issues. One in five care providers believed that parents did not want to listen to suggestions about healthy food choices for their children.

This project emerged from a collaboration between members of the health, education and child care sectors, including Noarlunga Health Services, Flinders University, and Family Day Care in South Australia. It was funded for three years in early 2001 by the Commonwealth Department of Health and Ageing, through the National Child Nutrition Program. All of the 1400 care providers in SA were involved, as well as around 90 field staff, FDC management, many families, and nutrition staff from Noarlunga Health Services and Flinders University.

Project Officers with sound nutrition knowledge and qualifications worked with the FDC community to explore nutrition related issues, concerns and successful strategies through focus groups, questionnaires, surveys and meetings. Extensive qualitative consultation processes were employed with FDC workers, parents and health professionals. Various quantitative methods were also used to identify the issues, needs and capacity of FDC in relation to the aims of the project. Gathering data also enabled the development of a grassroots, community-oriented food and nutrition policy. It facilitated ownership and enthusiasm for the project, and created an avenue to successfully evaluate the project outcomes.

These strategies were employed to ensure staff and care providers felt a sense of ownership over the policy and that the policy would meet their needs. The first 18 months of the project involved extensive consultation with FDC management, field workers and care providers to determine the most appropriate content for the policy and the most appropriate process for its implementation. Focus groups enabled the project team to obtain themes and specific suggestions. Pre-project surveys provided baseline information on attitudes and behaviour related to food and nutrition. Post-project surveys aimed to assess the reach and impact of the project and implementation of the policy.

The resulting food and nutrition policy was implemented and supported with a range of relevant training materials and forums. Resource materials were developed specifically to meet the expressed needs of FDC workers and families.

Project outcomes

All performance indicators set in the early phases of the project were met. Evaluation of the project identified that it was considered overwhelmingly successful by care providers, fieldworkers and FDC families. Post-project outcomes include:

- A strong organisational commitment for nutrition promotion within the FDC management and organisation structure, demonstrated by the acceptance and wide implementation of the new 'Healthy Food Choice in Family Day Care' policy
- Improved training and resources, enabling care providers to more easily promote healthy eating practices and healthy food choices
- Strongly supported nutrition promotion activities in the care provider's home, backed up by committed FDC workers
- More confident care providers, able to encourage healthy eating preferences in the children in their care
- An increased capacity of the entire FDC organisation to work in partnership with families to promote healthy food choices.

Ensuring the sustainability of the new FDC food policy was a significant consideration from the outset of the project, and has been achieved through embedding the Healthy Food Choice in Family Day Care policy into FDC practice at an organisational level. This has also led to its inclusion in pre-service training, national standards, approval and accreditation processes, and through the increased level of intersectoral support, it has been developed and strengthened to enable ongoing implementation.

Implementation of the new Healthy Food Choice in Family Day Care policy has led to both care providers and staff playing an important role in supporting well-nourished and healthy children.

The project was very successful and has resulted in best practice policy development. Collaboration between members of the partnership has ensured that skills and knowledge have been shared. Knowledge of the FDC program and home-based childcare has been offered by the FDC staff, nutrition and food-related expertise by Noarlunga Health Services, and knowledge of sound research practice and nutrition has come from Flinders University.

The strategies and framework of Healthy Food Choice in Family Day Care could be used by others, however, the availability of a grant to fund this project was the key to its success. The consultation, development and analysis of questionnaires and project management would have been impossible without considerable funding.

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Playford Food Alliance

Food

A LOCAL initiative
Northern metropolitan Adelaide

Local agencies and services work together to alleviate food insecurity in the Peachey Belt community.

Introduction

Food security is a basic human need. It is well known that people's ability to reach their potential is limited if they are hungry. Food security is influenced by many social determinants of health, such as food choices, access to food, storage of food, poverty and other social, emotional and health-related factors. The Playford Food Alliance project sees food security as a substantial issue for many local residents in the northern suburbs of Adelaide.

The health system alone cannot address all the factors that influence food supply and access. There is a need to look at the 'bigger picture' social and economic determinants that affect food access, such as employment, income, education, housing, area of residence and social inclusion.

Organisations often work in isolation on different aspects of the same problem without sharing information or coordinating their activities. The Playford Food Alliance brings a collaborative approach to services concerning food and nutrition across a broad range of sectors.

Aims and objectives

The Playford Food Alliance is a three-year project aimed at increasing food security for the residents of Playford, particularly in the Peachey Belt area, and encouraging families to make nutritious food choices. The project aims to promote cooperative working relationships across sectors, coordinate food and nutrition services in the local area, develop support/training and networking opportunities for workers and community members, and increase local awareness of the multiple factors involved in food security.

The overall project is structured as a series of phases. The first of these received funding to:

- Develop a shared understanding among key stakeholders of food security and the broader issues involved
- Facilitate worker and community participation in the planning and provision of services to build social capital and address food security issues in the Peachey Belt

The strategies of the initial phase were to:

- Research, map and document existing local services that relate to food, food provision, nutrition education and food security, to establish the extent of the services offered
- Organise and facilitate a local forum and food expo, including an interactive workshop with service providers, as an initial means to raise awareness of food security among key stakeholders, and to identify issues around the provision of and access to, food in the Peachey Belt
- Establish two consultative groups for the project: an agency/funding group and a community advisory group
- Conduct a literature search on tools and methods for community planning processes, community participation and consultation, and present results to the community advisory group for input
- Facilitate a community mapping exercise by conducting focus groups and local forums, linking with existing groups, and feeding information gained in early groups into the later ones in an action research cycle
- Develop a Local Area Action Plan with information gained from the forum/expo and community mapping exercise.

Project

The Playford Food Alliance targets the general community in the Peachey Belt corridor, which includes the suburbs of Davoren Park and Smithfield Plains within the City of Playford. The area has pockets of disadvantage and the Peachey Belt, in particular, is one of the areas of highest disadvantage in Australia, based on the Socioeconomic Indicators for Areas (SEIFA) Index and Australian Bureau of Statistics figures.

The project is based at the Central Northern Primary Health Care Service N/NE, Playford Community Health Centre. Funding to implement the initial phase was received from the South Australian Department of Health.

An active and committed project management group supports the project, with representation from a range of sectors and agencies, including health, community services, local government, non-government, education, business and horticulture. The project is also guided by input from community members who are actively involved in the project strategies and activities.

In April 2004, the Playford Food Alliance project hosted a highly successful forum and community food expo, attended by community members, local workers from across sectors, managers, policy and decision-makers. The event was successful in raising awareness of food security and exploring potential strategies to address it at a local level.

From the forum/expo discussions and subsequent feedback, five key areas were identified for action to address food security, including:

- Building local knowledge and skills
- Developing initiatives to improve access to fresh foods
- Exploring food security issues relevant to diverse groups
- Promoting local services and industry
- Building community ownership and involvement.

As a result of strong community feedback, the project management group saw the need for some tangible outcomes from the forum/expo discussions, to help ensure ongoing community involvement and trust, and to harness the overwhelming energy that had been generated by the event. It was this climate that saw a slight shift in the project towards the actual development and implementation of two community development programs:

- Community Foodies (building local knowledge and skills)
- Peachey Food Market (developing initiatives to improve access to fresh food).

Community Foodies:
The Community Foodies project, first developed by Noarlunga Health Services in southern Adelaide, was identified as a community development initiative that would work well in the north. Foodies is seen as a logical way of expanding food-related services in the local community, by training local people to work with other local people. It is a peer education project which aims to increase knowledge, skills and capacity associated with nutrition, food choice and food preparation. Towards this goal, a Memorandum of Understanding has been developed between Playford Food Alliance and the Northern Metropolitan Community Health Services (Playford Community Health), Para West Adult Campus, City of Playford, and TAFE (Elizabeth Campus).

The Community Foodies project is also outlined in this publication

Peachey Food Market:
Community feedback from the food forum/expo identified a perceived lack of access to an adequate range of low-cost healthy food in the Playford area. This led to the development and implementation of the Peachey Food Market. The market was trialled in November 2004 and has continued due to overwhelming support from the local council and the community.

To sustain the momentum of this project, the project management group is continuing to meet on a regular basis to support the linked provision of services to address food security in the area. The City of Playford is providing financial support of $10,000 annually to the Playford Community Fund and $50,000 annually to support the operations of two food cooperatives. It also operates an aged care day facility, providing lunches and other services. Rotary and local schools provide breakfast programs to children in the area. Anglicare SA provides services such as a community garden, low-cost prepared food and cooking skills programs, and Northern Area Youth and Community Services operates a community garden.

Project outcomes

The project was evaluated in mid-2005.

A major outcome for the project to date is a substantial increase in community, agency, business and government awareness. Specifically:

- Food security, its influences and impacts, is more broadly understood.
- There is increased awareness of local food growers' issues.
- Increased industry/business and agency sector networking has occurred, with valuable relationships developing.
- Local community nutritionists have increased links with local agencies to support further understanding of nutrition.
- Information is being shared more readily between community members, organisations and agencies.
- Two exciting community development initiatives are being implemented: the Community Foodies program and the Peachey Food Market.
- A community food directory for the Peachey Belt has been developed.

The community mapping exercise has not yet been completed. However, a number of opportunities have enabled community involvement, engagement and consultation, including the forum/expo held in April 2004, the community advisory group, and community membership on planning committees for Community Foodies and the Peachey Food Market.

The food security chain is made up of multiple community links, so the project has focused on communicating and collaborating with people from multiple industries and backgrounds. Ensuring that the project was not driven by a single agency has been a key factor in its success. Food security is not simply the responsibility of nutritionists and the health sector. The promotion of nutritious food, safe food and access to affordable food is a core role of all services and sectors. Food security has become a recognised issue within local agencies in the Peachey Belt/Playford area, and has been incorporated into the workload, strategic planning and service provision of a number of agencies.

The Central Northern Primary Health Care Service N/NE has made an unprecedented decision to continue supporting the work of the project after the formal funding period, by agreeing to redefine the substantive nutritionist position of the Project Officer to incorporate a community development/food security focus. This is a substantial outcome for the project and reflects the organisation's shift in focus towards initiatives that address broader social health issues through community development. It is also in line with the Generational Health Review findings.

The aim of this initial phase of the Playford Food Alliance project was to:

> *"… research, develop and document a model that identifies strategies to achieve coordination between key stakeholders across sectors that will contribute to improved food security for residents in the Peachey Belt area of the City of Playford".*

Documentation of the project as a model will eventually be made available to other communities who may want to adapt it for their needs in the area of food security.

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Community Foodies

Food

A STATEWIDE initiative
Across South Australia

Community peer educators working to foster community knowledge and skills about food and nutrition.

Introduction

The 'Community Foodies' project was initiated by dietitians/nutritionists at Noarlunga Health Services (NHS) in 2001 in response to an interest expressed by community members to learn more about nutrition. A number of nutrition programs such as 'Cheap Easy Meals' and 'Food and the GST' conducted at NHS led to the original Community Foodies project. Based on an evaluation of this program, it seemed that appropriate strategies could be developed and extended as a statewide initiative.

'Community Foodies' is now progressing as a statewide peer education project with a strong focus on community development. It aims to increase the access of people on low incomes to nutrition information and skills, by training and supporting local community members in many aspects of food and nutrition. The term 'Community Foodies' refers to community members who take an interest in improving health and wellbeing and are trained to run programs in their local community.

Aims and objectives

The project primarily aims to address poor community access to nutrition information and skills, especially for people on low incomes. However, through partnerships and peer education, the project also addresses many other inequalities present within communities, including access to education, employment and a range of health and community services. It hopes to improve personal empowerment, confidence and community networks through meaningful community participation.

The objectives of the project are to:

- Increase the access of people on low incomes to nutrition information and skills, using the Community Foodies peer education program
- Engage South Australian dietitians/nutritionists and relevant stakeholders in the use of peer education strategies
- Increase the confidence of participating dietitians/nutritionists to demonstrate the key skills necessary for delivering Community Foodies programs in their regions
- Increase the capacity of the NHS Community Foodies program to serve as a peer education model for the state.

Project

In 2003, Community Foodies was provided with two years funding by the Department of Health to extend the NHS project across the state and to strengthen its successful peer education model. The project has recently received an additional four years funding to run until 2010. The project is now called the 'Community Foodies Peer Education Nutrition' project. The Department of Health agreed to fund this project, as it contributes to the implementation of its public health nutrition action plan, Eat Well South Australia. In this way, Community Foodies has become part of a statewide approach to improving food and nutrition for disadvantaged groups.

The philosophy of this project is centred on the principles of peer education, community participation and community development. Peer education is based on the notion that community members, especially those in hard-to-reach groups, learn better from fellow members of a similar age, background and socioeconomic status. Peer educators become connectors between health care providers and the community. Community participation is also a way in which community members become empowered in decision-making processes in a meaningful and constructive way.

The target group for the program is people on low incomes within a given community. Community Foodies are predominately volunteers who invest their time in a number of nutrition-related programs. As part of the project, community members who are interested in food and nutrition commit to a six-week training program covering basic nutrition, presentation and group skills. Following the training, the community members become 'active' Foodies. At this stage Community Foodies are 'buddied' with health or agency workers, to promote healthy eating in their community.

Agencies already involved in the project are diverse, and include health services, councils, schools (high schools and adult re-entry schools), the SA Housing Trust, TAFE SA, Uniting Care Wesley, and other non-government agencies, community houses, low-income support workers and Flinders University. Community people are involved at many different levels, for example as peer educators, on state and local steering committees, and as consumer representatives for healthy eating within their communities.

One of the first tasks for the project organisers was to conduct a literature review of peer education strategies. Using the NHS Community Foodies as a model they went on to develop and deliver presentations to SA dietitians/nutritionists on peer education strategies for nutrition intervention. Other relevant organisations were drawn into discussion, and the potential to engage them in supporting the Community Foodies model was established. Interested dietitians/nutritionists were then recruited to participate in the training and to implement the peer education strategy.

A Project Officer provides training, resource packages and support to the participating dietitians/nutritionists, using the NHS Community Foodies model. The Project Officer encourages and monitors progress in the implementation of Community Foodies at each of the sites, and develops appropriate measures to ensure that local dietitians/nutritionists can demonstrate the key skills needed to deliver the Community Foodies peer education program.

Project outcomes

This project has achieved all of its original objectives with measurable outcomes in a number of areas of the project. Regular reports and presentations on activities have been delivered to all stakeholders, and a full report is available on request.

To date, 15 dietitians/nutritionists have been recruited and trained in the Community Foodies program. Eleven of these have implemented the program in their region, or are about to do so, and in this way they are helping to build the capacity of the primary health care workforce as well as the non-health care workforce. As of June 2006, the project had also trained two health promotion offices and two community development workers to support the implementation and sustainability of the project.

In participating health services there has been a gradual reorientation towards community development and primary health care. This is evident by the workloads of the dietitians/nutritionists moving from direct clinic-client contact towards the delivery of a service based on community development principles.

Collaborative interagency partnerships have been developed with organisations such as the SA Housing Trust, Department of Education & Children's Services, SA Council of Social Services and local councils. Potential pathways to further education have been established for Foodies by exploring the recognition of their training by TAFE SA and within the South Australian education curriculum.

So far, 90 community members have been trained to work as Foodies, now promoting and improving nutrition across SA, as evidenced by a demonstrable increase in nutrition knowledge and participant skills in Foodie-led programs. Significantly, the program has been able to reach community groups that do not usually access health services (e.g. five Aboriginal women are currently Community Foodies). When local community members are empowered to become Foodies, they tend to empower other community members in turn. This in itself is an indicator of the valuable social capital to be gained through a project such as this.

To sustain the project, continued collaboration is required at both a state and local level, as the establishment of partnerships between a variety of agencies has been the key to the success of the Community Foodies project. While the statewide project trains dietitians/nutritionists to implement the program in their local area, the program can only be sustained if supported by multiple agencies in each locality, and greater community/Community Foodie control of the programs is clearly desirable. It is also essential that the regional health services support the statewide project and that they embrace a reorientation of nutrition services to incorporate community-focused primary prevention programs.

Clearly the project can be transferred to other communities, as evidenced by its statewide implementation. In order to be fully effective, the dietitian/nutritionists who become newly involved must be trained and supported either by the State Project Officer, or by other health services or agencies who have experience with the project elsewhere.

This project currently runs until June 2010 and will continue to develop, implement and evaluate the Community Foodies program across the state, and to provide peer educator support where required.

Key aspects of successful local implementation of Foodies includes long-term commitment, development and maintenance of key partnerships, adequate staff and a multidisciplinary approach.

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Health and inequality: An introduction

Individual and population health is influenced by a range of social and environmental factors including employment, housing, education, income, access to social support networks and social services.[1, 2] These factors, "the social determinants of health", are either protective or damaging to health. They are the underlying causes of illness, injury and disease, and make it easier or harder for us to be healthy.[1, 2, 3]

Access to the determinants, or "social goods" is not evenly distributed among the South Australian population, and this difference in access leads to differences in health outcomes.[2, 4] Those with greater access tend to live longer and experience less ill health when compared to those with less access.[4] This difference in morbidity and mortality creates health inequalities within, and between, different population groups.[1, 2, 3, 4]

Genetics and individual biology also play a part in health outcomes, but for most of us it is only one factor and often not the most powerful. Health behaviours do contribute to health outcomes, but these behaviours are strongly influenced by social position and exposure to the social determinants of health.[4] For example, the prevalence of smoking, lack of physical activity and poor eating patterns amongst disadvantaged population groups can be explained by their lack of access to adequate resources like safe affordable housing, meaningful employment, supportive social relationships, education and access to appropriate social and health services.[4]

As the vast majority of the social determinants of health lie outside the influence of the health system, it has been argued that it is not well placed to reduce health inequalities. As can be seen from the following case studies, there are a number of strategies that can be put into place to reduce the adverse consequences of disadvantage and inequality. These case studies provide some promising examples of what the health system can do to begin to tackle health inequality.

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Outreach Clean Needle Program

Health

A LOCAL initiative
Inner city of Adelaide

Clean needle programs, equipment and education are offered to target groups at high-risk through collaboration between agencies.

Introduction

Injecting drug use is often associated with a range of harmful physical and mental health conditions. These may be caused by both the practice of injecting drugs and also factors of socioeconomic disadvantage, as injecting drug users are more likely to be financially and socially disadvantaged.

Within the injecting drug user community, a higher rate of Hepatitis C virus transmission exists amongst Indigenous, homeless and sex worker injecting drug users, and there is increasing incidence and prevalence of infection amongst young injecting drug users. This project seeks to address the inequities that exist for these target groups in gaining access to clean needle programs, by increasing their access to sterile injecting equipment as well as safer injecting information and education.

Aims and objectives

The aim of the program is to reduce the transmission of blood-borne viruses and to improve the health of injecting drug users who reside in, or access, the inner city of Adelaide.

The objectives are to:

- Increase the after-hours availability of, and access to, free sterile injecting equipment in the inner city
- Increase access to the Clean Needle Program for injecting drug users in the highest-risk profile groups (Indigenous, homeless, young and/or sex workers) within the inner city
- Increase access to safer injecting and disposal information for injecting drug users who reside in, or access, the city
- Increase referral to drug treatment and other health and social services for injecting drug users who reside in, or access, the city
- Improve access to primary health care services for injecting drug users in the highest risk profile groups in the city
- Increase the knowledge of inner city agency staff about the benefits of clean needle programs and injecting drug use related issues.

Project

The Outreach Clean Needle Program (CNP) is a blood-borne virus prevention project that targets marginalised groups of injecting drug users, namely those who are homeless, Indigenous, young and/or sex workers. The CNP distributes sterile injecting and sharps disposal equipment, provides information and education on safer injecting and disposal, and offers referrals to other health and social services.

Three main initiatives constitute the project:

- 'Nu hit Outreach' (run by Nunkuwarrin Yunti): this service provides outreach CNP services throughout the city to homeless injecting drug users, with a specific focus on those who are Indigenous
- 'South Australian Voice for Intravenous Education (SAVIVE) Youth Peer Educator': this initiative targets young injecting drug users in the city and provides CNP services through a peer education model at Second Story Youth Service
- 'South Australian Sex Industry Network (SIN) Sex Worker Peer Educators': this initiative targets street-based sex worker injecting drug users at various inner metropolitan locations. SIN Peer Educators provide CNP services, as well as providing safe sex equipment and education

During the development of the project, both local and interstate consultations were conducted. Interstate consultations were held with agencies that run Outreach CNP services in other cities, and local consultations were conducted with inner city agencies that provide services to the target groups in Adelaide.

The project proceeded as follows:

- Funding was provided to Nunkuwarrin Yunti to employ an additional full-time Nu hit worker to join No Pulgi, a comprehensive primary health care outreach for homeless Aboriginal and non-Aboriginal people in the city
- A SAVIVE CNP Peer Educator was placed at the Second Story Youth Service in Adelaide
- SIN Peer Educators were established to provide CNP services to street-based sex workers in inner metropolitan Adelaide
- A mobile CNP was trialled to provide CNP Peer Education services through use of a vehicle in the inner city and western suburbs
- Workshops were provided for inner city agency staff on issues surrounding injecting drug use, blood-borne virus prevention and the CNP.

The Outreach CNP has received funding from the South Australian Department of Health, as a collaborative effort with Drug & Alcohol Services SA (DASSA), Nunkuwarrin Yunti; the AIDS Council of SA, SAVIVE and SIN.

Several CNP service delivery models have been developed within the project to accommodate the different needs of injecting drug users. An extensive review of the literature on outreach CNP models was conducted to inform the development of the project, including a number of studies that have examined the characteristics of injecting drug users according to the type of needle and syringe program they access.[1, 2, 3, 4]

The research has yielded two major and complementary findings:

- Different CNP service delivery models reach, and are accessed by, different sub-populations of injecting drug users.
- Outreach services are predominantly accessed by the most disadvantaged groups of injecting drug users, and those with the highest risk profile, including the Indigenous, homeless, young and/or sex workers.

The program specifically targets marginalised groups of injecting drug users, to increase their access to sterile injecting equipment, and offer information on the prevention of blood-borne virus transmission to these particularly at-risk groups.

These strategies were based on evidence from local and international studies, as well as advice received from organisations running similar programs interstate, and advice from local agencies who work with the target groups. There is strong evidence to support the effectiveness of needle and syringe programs in preventing the spread of blood-borne viruses, including Hepatitis C virus (HCV).[5, 6, 7] The Commonwealth Department of Health and Ageing's (2002) Return on Investment Report,[6] examining the effectiveness of needle and syringe programs in Australia between 1991 and 2000, found that they prevented 25,000 cases of HIV and 21,000 cases of HCV, and saved between $2.2 and $7.7 billion. Needle and syringe programs are also advocated in both the National and State HIV Strategy and the National Hepatitis C Strategy as essential in the prevention of HIV and HCV.

Project outcomes

A process evaluation has been conducted. These preliminary findings suggest that the services are successfully targeting the identified marginalised population groups and appear to be working well.

- Statistics collected from Nunkuwarrin Yunti show much higher rates of Aboriginal people accessing their Outreach CNP (37%) as opposed to their fixed-site CNP (18%).
- There have been high numbers of referrals from the Nu hit CNP to No Pulgi primary health care service.
- Following the implementation of a youth Peer Educator at the Second Story Youth Service CNP, the service has seen a rise in both the number of clients generally and in particular, the number of young clients (i.e. under 25 years of age) accessing the service. The average number of clients per month has increased from 40 to 64 and the number of young people increased from 35.4% to 50.4% of all clients.
- The SIN Outreach CNP is proving to be an effective way of engaging sex workers in brief interventions regarding safer injecting and safe sex practices.

There has also been good attendance at the workshops conducted for inner city agencies and positive feedback has been received from those agencies.

The project was initially funded as a pilot for the 2004/2005 financial year. The project is continuing and further information can be accessed using the contact details above.

This model of outreach services to marginalised communities is transferable to a range of other settings and communities.

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Don't Bet On It!

Health

A LOCAL initiative
Noarlunga

Middle-school students receive interactive and engaging education on the dangers of problem gambling.

Introduction

The prevalence of problem gambling in the South Australian community is influenced by a range of determinants, including the health and social characteristics of vulnerable populations. Research indicates that gambling-related harm impacts disproportionately on lower socioeconomic groups and communities. The impact of gambling losses on low-income individuals, families and communities is greater, due to their relative lack of disposable income. This results in a loss of basic necessities such as food, rent, utilities, clothing, healthcare and education.

Targeted community education programs which are designed in partnership with these communities are an important investment in building healthier communities that are more resilient to gambling-related harm. Research into losses from electronic gaming machines closely follows patterns of disadvantage. That is, the poorest sections of Adelaide's population are among those losing the most money in this way.[1]

The schools involved in this project are located in an area of disadvantage where inequalities exist, as characterised by unemployment and a high student drop-out rate. A comprehensive literature review revealed that the rate of problem gambling among adolescents is alarmingly high, and that gambling behaviours can develop as early as eight years of age.

It is believed that boredom contributes to, and exacerbates, the uptake of problem gambling, adding to the probability that problem gambling stems from instances of low literacy and unemployment. Furthermore, studies have shown that problem gambling among young people can have serious consequences, including disruption to education, loss of friendships, familial discord, and an increased likelihood of risk-taking behaviours such as drug use and criminal behaviour in order to finance gambling.[2, 3, 4, 5, 6]

Aims and objectives

Don't Bet On It! is an early intervention program that aims to prevent problem gambling behaviours from developing among young people and address the associated inequalities in the process.

The objectives of the program are to:

- Deliver information about gambling to children in Year 6 to Year 9 who attend schools within the Noarlunga Health Services (NHS) catchment area
- Increase students' knowledge about the risks and impacts of gambling
- Provide the Department of Education and Children's Services (DECS) with a sustainable education package
- Provide the wider community with a health promotion tool that can be used within a range of settings and populations.

Project

This initiative was instigated by the Clinical Psychology Department of the Noarlunga Health Service (NHS). It was funded by grants provided by the Gamblers' Rehabilitation Fund, a joint initiative of the Australian Hotels Association (SA), Clubs SA and the Government of South Australia.

A literature review was completed in the early stages of the project. Few resources were found that would be suitable for young people in addressing the issues of problem gambling. Any resources that were available (nationally and internationally) were obtained for reference in planning this program.

The final Don't Bet On It! program design was based on research relating to problem gambling, and informed by current knowledge of childhood development and pedagogy. This innovative resource was designed to educate students in the middle school years (Year 6 to Year 9) about the risks of participating in gambling. As the resources are available to take home, their parents are also indirectly targeted.

The resource was developed in consultation with clinical psychologists and teachers from three local schools (primary and secondary). A pilot study evaluating the effectiveness of the resource material was completed with schools located in the NHS catchment area. Feedback from students was also obtained in the early stages of the development of the resource materials.

The classroom resource addresses key themes about problem gambling. It was designed to be interactive and engaging, and allows students to critically reflect on the issues raised. The final design incorporates a large floor mat game that engages students in the topic of problem gambling and introduces the key themes. A series of follow-up lesson plans allow students to explore these themes and to think about gambling within a wider social perspective.

All aspects of the resource have subsequently been linked to the South Australian Curriculum Standards and Accountability Framework.

Project outcomes

The program was evaluated through a pilot study using a range of indicators including student attitude to gambling (pre and post comparison) and student and teacher feedback.

Over 200 students participated in the pilot project. Prior to and at the completion of the pilot, students were asked to complete a questionnaire that measured their attitudes to gambling. Over half of the students completed the questionnaire and, of these, the majority recorded post-intervention scores that demonstrated an increased awareness that gambling was unprofitable. This represents a statistically significant result.

Students indicated that they had enjoyed participating in the activities that form these resources, and that they felt they had learned more about the effects of gambling. Many of the students were able to articulate their increased understanding.

Teacher feedback indicated that the material had been easy to use and their students had enjoyed participating in the activities. They said the material was relevant to their students and the students had gained an understanding of the material presented to them.

Collaboration with teachers was invaluable in the design of these materials. The availability of funds to pay for teacher relief time to allow teachers to work on the project assisted in its successful development.

The 'Don't Bet On It!' resource has been used in the curriculum of the DECS Responsible Gambling Education in Schools Strategy. The program is now being further developed, and a large scale evaluation is currently underway.

The resource is suitable for use throughout schools in South Australia.

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HOPE: Helping Ourselves though Peer Education

Health

A REGIONAL initiative
Northern and Far Western Region of South Australia

Young people gain information and life skills through community-based programs on mental health promotion.

Introduction

Major mental health disorders, particularly depression and psychoses, often have their first onset in adolescence and early adulthood. The teenage years are notable for increases in self-deprecation, boredom and depression. Early to middle adolescence (15 to 17 years) is a peak time for developing depression, particularly for young women, and it is known that young people are especially at risk in rural areas.

The Helping Ourselves through Peer Education (HOPE) program recognises that young people living in the Northern and Far Western Region (NFWR), like young people in many rural and remote settings, face social, economic and geographical circumstances that may pose risks to their mental health. The program gives young people information and skills that help them respond positively to their circumstances, as well as recognising and enhancing the factors that protect good mental health status among young people. In utilising a population health approach that involves communities and increases their capacity to respond positively to young people, the HOPE program offers an innovative and effective model of mental health promotion.

Aims and objectives

HOPE utilises the principles of peer education and support in order to:

- Enable young people to gain access to current and appropriate information about issues affecting their mental health
- Support young people in developing life skills and resilience, allowing them to respond positively to life circumstances, including adverse ones.

In particular, HOPE works towards achieving the following objectives:

- Providing young people with strategies to promote good mental health for themselves and their peers
- Strengthening young people's capacity to develop and maintain strategies to positively manage and respond to life circumstances
- Reducing the adverse impact of difficult or adverse life consequences
- Enhancing relationships between young people and the communities in which they live.

Project

Taking a population health perspective, HOPE was designed in 2000 in response to an identified need to promote mental health among young people in the Northern and Far Western Health Service Region (NFWHSR). The project targets young people aged between 10 and 25, and programs have been successfully run in eight communities in the NFWHSR.

Collaborative involvement in the project has brought together the following groups, schools and organisations associated with young people in the region:

- NFWRHS, Northern and Far Western Regional Mental Health Service
- Andamooka Progress Association, Youth Group
- Coober Pedy Area School, Children, Youth and Family Services (CYFS), Child and Youth Health, Community Health Services
- Hawker Hospital, Youth Group, Area School, Progress Association
- Leigh Creek Area School, Community Health Service, Flinders and Outback Regional Health Service
- Marree Area School
- Port Augusta Ranges Youth Service, Drug and Alcohol Services SA (DASSA), Secondary Schools
- Quorn Hospital, Area School
- Roxby Downs Health Services, Area School, Council
- Whyalla Community Health Service, Police, Whyalla Plaza Youth Service, Whyalla Stuart Primary School, Nunyarra Health Centre, Whyalla Ranges Youth Service, DASSA services.

Through the use of peer education as a youth participation strategy, the project fosters leadership skills and builds the emotional resilience of participants as well as the regional capacity for working with the young people. In Phase I of the project, 32 young people designed their own self-development program, participated in resource folder collation and heard a variety of guest speakers. Following the initial success of this phase, facilitators were trained in the delivery of the program in other rural and remote areas within the region (Phase II).

The program consists of 12 two-hour sessions, held weekly. Participants may choose from the following topics:

- An information session
- Peer education/getting to know you
- Communication
- Anger management
- Stress management
- Self-confidence/preventing health problems
- Suicide.

The program allows flexibility, so that particular groups can choose topics that are relevant to them. Two of the sites, for instance, had a session on suicide because it was a topic relevant to their communities.

In addition to being given information by the facilitator (or guest speaker), the sessions involve a range of activities designed to illustrate the key features of the topic being dealt with, as well as making the program fun. The program was designed for people between the ages of 15 to 25, to date however, all participants have been teenagers. The groups have varied in size, depending on location. Some groups had six to eight participants, others had up to 15 involved, and there was a fairly even gender distribution in all the groups.

Each participant receives a participant's manual containing information on every topic in the program. It also contains web and email addresses and telephone numbers, so that young people can seek further information or advice. Participants in the NFWR received a small honorarium for participating in each session and signed a contract stipulating their rights and responsibilities during the program. The payment and the contract were instigated to encourage young people to take the HOPE program seriously, and to make them aware that the program takes young people and their participation seriously.

In each NFWR setting, or site, the program was run by a facilitator. The facilitator was a community member who was either invited or volunteered to run the program. They were given a facilitator's manual providing extensive information on each topic in the program. The manual also contained advice on how to run the sessions and how to deal with any conflict in the group, as well as providing follow-up information and resources for the facilitators, and contact details of guest speakers for particular topics. In addition, the facilitators were contacted regularly by the HOPE Project Coordinator to see if there were any problems and to allow facilitators to de-brief and air any concerns they had. Facilitators also had regular teleconferences with one another as a means of clarifying issues and providing peer support.

The process for recruiting and selecting participants varies in each of the sites. In one setting, the school implemented HOPE as part of its health education curriculum and it was therefore compulsory for all students in the final three years of secondary school. In another instance, all the participants in the program were volunteers, recruited primarily after an information session with the youth group. A third study site was a regional city and, following information sessions delivered at the local secondary schools, 50 young people applied for a place in the program. Participants were then selected on the basis of their responses in a written questionnaire. In another site, some recruits were invited to attend by adults who felt they would benefit from the program, while others volunteered after attending information sessions.

Project outcomes

The HOPE Project has been evaluated by the Spencer Gulf Rural Health School in relation to the two original aims of the project. Their findings were as follows.

Aim 1: Enable young people to gain access to current and appropriate information about issues affecting their mental health.

HOPE provides accessible and appropriate information to young people on topics that have a direct bearing on their mental health status. Australian research has found that topics such as tobacco, alcohol and drug use, sexual risk-taking behaviour, crime and anti-social behaviour, depression and suicide should be addressed in physical and mental health promotion programs directed toward young people.[1] Young people themselves generally identify the following as areas of concern, where they need information:

- Drugs and alcohol
- Bullying
- Street safety
- Diet and body image
- Sexual health
- Stress and depression.[2]

Adolescents in rural areas give particular priority to depression, suicide and pregnancy as topics of interest.[2]

HOPE provides young people with information nationally recognised as important for reducing risk factors and enhancing protective factors pertinent to mental health. The young people who have participated in the program said that the information was relevant and useful to them, and they positively endorsed the way it was delivered within the program. In addition, facilitators, community drivers and parents have commented that the young people who completed HOPE had benefited from the content of the program.

Aim 2: Support young people in developing life skills and resilience, allowing them to respond positively to life circumstances, including adverse ones.

In relation to the second objective, the program provides young people with life skills and with strategies to develop and exhibit resilience in the face of life circumstances. It is difficult to document specific indicators that young people have developed resilience, though facilitators and community drivers do say that they have seen positive changes among young people who have undertaken the HOPE project.

It can be conclusively demonstrated that HOPE is underpinned by principles of best practice, that it incorporates a high degree of theoretical justification and coherence and that it is efficient and effective for its target audience. The HOPE program sits within the overall framework for mental health promotion within Australia, set out in the National Action Plan for Promotion Prevention and Early Intervention for Mental Health[3]. The Action Plan lists a range of outcomes that good mental health promotion programs for 12 to 17 year olds should demonstrate. These are:

- Environments and infrastructure that support family and social functioning
- Family friendly workplace policies and practices
- Acceptance and valuing of social and cultural diversity
- School environments that enhance mental health and mental health literacy
- Opportunities for personal development and exploration.[3]

With the exception of promoting family friendly policies and practices, which is beyond the scope of HOPE, the program has made a substantial contribution to each of these outcome measures in the communities in which it has been implemented.

Rural communities are, very often, culturally and socially homogenous and not accepting of difference. HOPE has allowed young people who are different in the context of their communities to feel more comfortable with their own identities and aspirations, while encouraging others to respect peers who have different values and goals from their own. The close involvement of the school in almost every community where HOPE has been run has led to a greater awareness of the mental health needs of young people and has promoted more harmonious social environments within schools.

The HOPE project is transferable to other communities and settings, having been conducted in a range of areas across the NFWR. The program has since been utilised in most country health regions of South Australia and with other youth initiatives across the state.

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Housing: An introduction

Affordable, secure and culturally appropriate housing provides the basis for social integration. Without adequate and appropriate accommodation and support services, there is a danger that vulnerable groups within the community will be left homeless or be at risk of homelessness.

A person's physical health can also be affected by the condition, construction and even the location of housing. There has been considerable research documenting the poor housing status of Indigenous households in recent years.[1] Such research reflects contrasts with the housing status of the general population, however, much less attention has been given to ways of overcoming the barriers preventing Indigenous households from obtaining and maintaining good quality housing.

There are several other social groups for whom housing is a major factor influencing their health and quality of life, especially the ability to participate in society. These groups include people with high level and complex needs, for whom appropriate types of housing, internal design features and psychosocial support are essential; households on low incomes, for whom housing costs including power and water are central concerns, and those with mental illness, for whom both support and independence are important.

The following case studies focus on innovative, effective ways to address the housing needs of these groups through:

- Partnership approaches between different levels of government and community-based organisations, to deliver education and support programs that reduce the financial and other hardships experienced by households on low incomes
- Agencies working together to develop integrated, individualised and seamless service responses that promote independent living skills and increased motivation, confidence and self-esteem
- Working in partnership with those who are affected by health and social issues in order to contribute to the acceptance, and relevance of specific programs
- Ensuring the supply of good quality low-income housing where there are shortages of suitable or culturally appropriate housing.

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Catherine House Mental Health Program

Housing

A REGIONAL initiative
Metropolitan and rural South Australia

Accomodation and integrated support services are offered to homeless women with a mental illness or psychiatric disability.

Introduction

The Catherine House Mental Health Program is one of twelve supported accommodation initiatives being implemented across metropolitan and rural South Australia. The program offers intensive residential and psycho/social rehabilitation, based upon individual levels of need, to women experiencing mental illness and/or psychiatric disability who are homeless and/or exiting Glenside Hospital.

Aims and objectives

The program aims to deliver an innovative model of integrated support services to women with complex needs, including psychiatric disability, to enable them to live independently in the community or in another nominated form of accommodation, and to experience improved quality of life.

The objectives of the Catherine House Mental Health Program include:

- Integrated delivery of housing, independent living support and clinical service provision
- Collaboration between services working within a formal partnership arrangement
- Participant centred individual planning to enhance outcomes in consultation with service providers
- Attainment of wellness in all domains of life through strengths-based assessment and planning, with a focus on individual capacity
- A developmental (rehabilitation) model of support delivery
- Provision of flexible, individually tailored support services provided by a community managed organisation
- Provision of appropriate housing where current housing arrangements are inappropriate, inadequate or unsustainable.

Project

The Catherine House Mental Health Program was developed in response to the evaluation of the supported housing demonstration projects within South Australia, and through knowledge gained from successful national and international programs.

The program targets women who have a psychiatric disability and those who are homeless or at risk of homelessness. Many of these women have a history of childhood abuse, domestic violence, drug and alcohol use, family breakdown, unemployment, health issues and lack independent living skills, motivation, confidence and self-esteem.

Women live in the Catherine House Mental Health accommodation for between 6 and 12 months, and during this time they develop the skills and confidence necessary to sustain independent community living. The program then provides ongoing home-based outreach services to assist them with the establishment and maintenance of suitable accommodation and provides linkages into a diverse range of community supports and activities.

The initiative operates through a formal partnership involving a Memorandum of Understanding between the appropriate organisations. This involves the provision of clinical and daily living support services that are linked to community-based housing and provide an integrated proactive response to the underlying factors that contribute to homelessness. Recognising the crucial links between stable housing tenure, flexible support and quality of life, the partnership was formed between public housing and community housing agencies, a non-government support provider (Catherine House) and state mental health services. The program is funded through the Department of Health and was developed in collaboration with the following agencies:

- Department for Families and Communities - High Needs Housing Unit
- South Australian Housing Trust
- Multi Agency Community Housing Association
- Royal Adelaide Hospital - Glenside Campus
- Catherine House Inc.
- Royal Adelaide Hospital.

Project outcomes

The Department of Health conducted an interim evaluation, and the Interim Report on the Catherine House Mental Health Program was published in May 2004. A final evaluation is currently being completed. The report's findings were as follows:

Program implementation:
The task of setting up a program within the context of partnership is time consuming and requires a high level of communication and negotiation. Expectations within the partnership need to be realistic. For example, there was an expectation that women would be fast-tracked into suitable housing when it was deemed ready for them to leave the program. However, there are difficulties with this as the housing providers often have significant shortages of suitable accommodation.

Project management:
Active involvement of all partners in developing the project, and the ability to bring contentious issues to the table, has been effective in supporting the partnership.

Communication:
Ensuring effective communication between all partners in the project is both difficult and critical to effective service provision.

Roles and responsibilities:
Clear delineation of roles and responsibilities for each of the agency partners is imperative to avoid confusion and uncertainty.

Impact of the program:
Initial findings suggest that the program is having a positive effect for some of the women involved. They have experienced significant improvement in housing stability, having moved on to live independently in the community. They have also developed a range of skills (from budgeting to social skills), and improved their confidence and self-esteem.

Support and training for workers:
The intensive nature of support and, at times, slow client progress, along with the dilemmas and challenges associated with the model and the new program, has placed considerable demands on support workers. Adequate training, support and supervision are therefore critical in maintaining a high quality program.

The partnership model is transferable across all community services. Sustainable funding is required for a housing strategy that would ensure access to appropriate accommodation for the project's future clients. This would necessarily include a continuing partnership across government and non-government sectors, and the ongoing commitment of partner agencies towards the best possible outcomes for this client group.

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Energy Efficiency Program for Low-Income Households

Housing

A STATEWIDE initiative
South Australia

To help counteract rising energy costs, The Department of Transport, Energy and Infrastructure's Energy Division and selected welfare agencies offer energy audits, advice and free equipment to households on low incomes.

Introduction

Increases in fuel costs impact disproportionately on households on low incomes, whose tenants are not usually able to install energy saving devices such as roof insulation and efficient space heating. The Energy Efficiency Program for Low-Income Households is a South Australian Government initiative designed to address rising energy costs by reducing the financial hardship experienced by households on low incomes in paying their energy bills.

Aims and objectives

The objectives of the program are to:

- Reduce the financial hardship experienced by households on low incomes as a result of energy costs
- Reduce energy use and gain associated environmental benefits
- Improve comfort levels in households on low incomes
- Develop employment opportunities in energy efficiency services such as home energy auditing and retrofitting.

The overall target of the program, which began in January 2004, is to provide free home energy audits and retrofit kits to 10,000 households on low incomes in South Australia.

Project

The program involves the provision of energy efficiency services to households on low incomes in collaboration with six community based welfare organisations. Services include free home energy audits, the provision of energy saving retrofit kits, a fridge buy-back scheme and an interest-free loan scheme.

Free home energy audits can be valuable to households on low incomes. Each audit takes around 60 to 90 minutes and is carried out in the home by a trained Home Energy Advisor. The aim of the audit is to identify opportunities to save energy, and usually includes looking at the hot water system, fridge, heating and cooling appliances, shading, insulation, lights and other appliances. The auditors can look at people's bills, show them how to read their meter, and can measure the standby and running costs of electrical appliances.

As part of the audit, households are also offered a free energy saving retrofit kit consisting of two compact fluorescent lamps, a water-saving showerhead and draught-excluder (colloquially known as a door snake). The auditor can install the showerhead and lamps during the audit so that the householder can start saving on their bills immediately. Installation of the items is estimated to save around $62 per year on energy bills.

Through the fridge buy-back scheme, households in metropolitan Adelaide, the Hills and the Barossa can be offered a $125 payment to retire an old inefficient fridge. There is also a statewide interest free loan scheme whereby eligible households can access loans of up to $1,000 to purchase a new energy efficient fridge, washing machine, microwave, curtains, blinds or insulation.

The Department of Transport, Energy and Infrastructure's (DTEI) Energy Division (formerly Energy SA) is the State Government agency that coordinates the Energy Efficiency program, in partnership with:

- Anglicare - Fieldforce is sub-contracted by Anglicare to deliver audits and retrofits
- Lutheran Community Care
- Salvation Army
- UnitingCare Wesley Adelaide
- UnitingCare Wesley Bowden
- UnitingCare Wesley Port Pirie.

In addition, Child, Youth and Family Services undertake financial counselling assessments as part of the Interest Free Loan Scheme. Primary Industry and Resources SA's Rural Finance area administers the Interest Free Loan fund, and Denron is contracted by Energy Division to collect the fridges.

Households on low incomes are targeted for these services, and a Health Care Card or Pension Card is used as a basic measure of eligibility. Service providers can also use their discretion in deciding eligibility, for example, they may offer the service to clients who have had an Emergency Electricity Payment in the last 12 months or those who have a payment arrangement with an energy retailer. A client who is threatened with disconnection, or seeking emergency welfare assistance or financial counselling, and anyone who is going without essentials in order to pay energy bills may be offered the service. Others may be eligible to access services on the discretion of the providers.

The welfare groups chosen as service providers have strong connections with their communities. People often regard such groups as being highly credible and trustworthy, and for this reason they can be far more effective in motivating household energy action than the simple provision of information from impersonal sources.

This program delivery model is based on the community approach taken in Energy Division's Energy Friends program. Another benefit is that the program complements other programs and services delivered by Energy Division. For example, if one of the service providers or the householders they are helping need further energy advice, they can contact the Government's Energy Advisory Service or visit the Government's Energy website.

Project outcomes

The program has been operating well and services are being delivered effectively through the six contracted service providers. The partnership between State Government and the community-based welfare organisations has worked well, and after a few initial minor issues everything has gone to plan.

Energy Division meets with the program managers from each service provider on a monthly basis to discuss progress and resolve any issues. Energy Division also meets with project facilitators from each service provider every six weeks to discuss information, network, share information and resolve issues. Good working relationships have been developed between Energy Division and the service providers.

The program was formally evaluated in late 2005. At the end of September 2005, 9,869 audits had been completed. Of these, approximately 550 households participated in the fridge buy-back scheme, with a total of 700 fridges collected (each household is able to retire up to 3 fridges).

At the end of September 2005, 148 interest free loans had been approved. Eighty per cent of these were for energy efficient fridges, 10% for energy efficient washing machines, and 10% were for curtains or external blinds. Nearly all households accepted two compact fluorescent light-globes. Around 50% accepted the showerhead (which is not always compatible with their hot water service or existing shower fitting), and around 80% to 90% accepted the door snake.

An independent evaluation of the project is available on request.

Ongoing education is required to sustain the changes that have been achieved to date. Although the program does not include provision for education on an ongoing basis, a follow-up call is made to each household between three and six months after the audit to see how the household is going with the energy saving items they were given and the recommendations that were made. The follow-up call is a good chance to further motivate people to implement recommendations if they have not already done so. The program evaluation will also provide a chance for making further contact with households (e.g. through a phone survey).

The program is extremely transferable. The main requirement is collaboration between community services and an energy check service.

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Supported Residential Facilities Sustainment Program

Housing

A STATEWIDE initiative
South Australia

Assessment and individualised services for people with complex needs who live in supported residential facilities.

Introduction

The Supported Residential Facilities (SRF) Sustainment Program is a strategic response to the needs of vulnerable people living in 'pension-only' licensed Supported Residential Facilities, where a resident's only form of income and asset is a government pension or allowance.

The SRF Sustainment Program is one of a range of supported accommodation options which has been developed and implemented in South Australia to comprehensively respond to vulnerable citizens with high and complex needs.

Aims and objectives

The SRF Sustainment Program is based on the principles of recovery and psychosocial rehabilitation.

The program's aims and objectives include:

- Building inclusion, capacity and sustainability through collaborative partnerships between services in the delivery of whole-of-life responses to individual needs
- Delivery of integrated clinical, non-clinical and other support services provided within a holistic framework
- Flexibility and responsiveness of care services to changing needs
- Recognition of people's strengths, ensuring enhancement of skills and capacity
- Developing the non-government sector in the provision of non-clinical whole-of-life psychosocial support.

Project

The target population for the program comprises approximately 950 residents of the 35 'pension only' SRFs in regional and metropolitan South Australia. The target group is extremely diverse, disadvantaged and marginalised, with many people having high and complex care requirements, functional impairments and unmet social and healthcare needs.

A significant report[1] was completed in 2003, examining the SRF sector, the residents, their housing and support needs. This report was commissioned by the former Department of Human Services in order to inform key policy and planning agendas with regard to housing, care and support needs of vulnerable adults with complex and chronic needs.

The report revealed that the 'pension only' SRF sector was not meeting the substantial needs of its very vulnerable population group, which had largely remained 'hidden' in the community with people unable to access appropriate supports and services. It also failed to meet a range of disability standards, principles and expectations in relation to privacy, dignity, safety, consumer choice, decision-making and rehabilitation.

The report[1] highlights that people living in SRFs:

- Experience a range of disabilities, predominantly resulting from mental illness
- Include a high proportion of aged people, including frail aged
- Have minimal community integration and little access to psychosocial rehabilitation and disability support
- Have limited capacity to negotiate alternative, appropriate and affordable accommodation and support options
- Have a compromised quality of life
- Experience a high level of poverty, discrimination and stigma.

Without adequate and appropriate alternative accommodation and support options being available in the community, there was concern that SRF residents would be left homeless or be at risk of homelessness. An urgent response to this situation was considered necessary by the South Australian Government. The Department for Families and Communities (DFC) therefore implemented service agreements with the majority of the agencies who provide services to SRF clients.

An assessment team was formed to assess all SRF residents in South Australia. This team currently consists of one coordinator and four assessors with a range of skills encompassing the ageing, disability, mental health, housing and advocacy sectors. With input from relevant stakeholders and the University of Adelaide, the team has developed an assessment tool for use within the SRF sector. Assessments commenced using a process which prioritises people who:

- Are in danger of losing their accommodation
- Are involved in a pending SRF closure
- Present with high and complex needs.

The SRF Assessment Team determines the support and service requirements of all 'pension only' SRF residents. Those people who are assessed as having particularly high and complex needs are eligible for additional support and services equating to approximately three hours per week. This support includes:

- Disability support services run by not-for-profit, non-government organisations on a regional basis. These services provide whole-of-life non-clinical support that includes enhancing people's living skills in areas such as personal care, household management, community engagement, personal development and practical assistance
- Allied health services such as podiatry, physiotherapy, nursing/medication management, nutrition and dietician services, counselling and primary care services are provided through community health services.

This support is in addition to other mainstream agency support including:

- Support services for older people with mental health and age-related issues delivered by Mental Health Services for Older People
- Clinical Interface Workers (Mental Health/Disability) are employed on a statewide/regional basis to manage interface issues that may arise between the clinical/specialist sector, the non-government sector and the SRF sector
- All SRF residents are eligible to receive one-off free optical and dental services.

Most significantly, the SRF Program is underpinned by a three-tiered regional collaborative partnership model, based on the innovative model of partnership developed and implemented in South Australia as part of the Supported Accommodation Demonstration Projects. Many positive outcomes have resulted from this model.

Project outcomes

Each of the service providers contracted to DFC via the SRF Sustainment Program are required to submit financial and qualitative outcome reports on a regular basis.

Although the project has not been in operation for a significant period of time, anecdotal evidence indicates an improvement of health and quality of life for residents, along with re-engagement and return to interest in community life, as a result of increased social contact and reduced isolation and loneliness.

The SRF Sustainment Program is approved by the South Australian Government for an initial five-year funding period, due to end in 2008. Program evaluation and review will be conducted prior to the end of this funding cycle to determine future program direction.

The SRF Sustainment Program would be transferable to other population groups experiencing high degrees of disadvantage. The regional partnership model provides a formal structure through which all relevant stakeholders are brought together to develop an integrated and seamless service response.

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Wodlitinattoai Program

Housing

A LOCAL initiative
Salisbury

Indigenous families are offered holistic support to find and retain suitable accommodation.

Introduction

Safe, affordable and culturally appropriate housing is not readily available for Indigenous families. The Wodlitinattoai program addresses the limited accommodation options for Aboriginal people.

Wodlitinattoai, one of eight such projects throughout Australia, is an early intervention program that identifies families who are at risk of losing their accommodation because of their inability to pay rent. This may be for a variety of reasons including drug and alcohol problems, or overcrowding by family members through kinship responsibilities.

The program works holistically with Indigenous families and can involve rebuilding bridges with other services while acknowledging the historical past hurts which continue to effect the survival of Indigenous families in today's society. Wodlitinattoai supports families in areas such as family counselling, advocacy/support, budgeting skills, building stronger connections to services, provision of an outreach service and provision of one-to-one support with families. In South Australia, Salisbury was chosen as a suitable location for the Indigenous-specific program.

Aims and objectives

The objectives of the program are to:

- Identify Indigenous families who are at risk of homelessness
- Support families who are experiencing difficulties in maintaining their accommodation.

Project

The Wodlitinattoai program targets Indigenous families who are at risk of losing their accommodation. The criteria for selecting entry to the program are:

- A family must consist of two or more people regardless of blood, adoption or cultural identification.
- The client must be Aboriginal or Torres Strait Islander.
- Clients must be housed, but experiencing difficulty in maintaining accommodation as a result of financial, personal, family or relationship issues.

The Commonwealth Department of Family and Community Services, in partnership with Centrelink, invited tenders from agencies to provide programs within the community in each Australian state. In South Australia Centacare was the successful agency. A working party/advisory committee was devised consisting of the Aboriginal Housing Authority, Centacare, South Australian Housing Trust, Child, Youth and Family Services, Salisbury Council, Kumungka and Muna Paiendi Health Service.

The program covers the Salisbury and Elizabeth areas (Para Hills West to Andrews Farm).

Once a partnership was established between the participating groups, an Advisory Committee was formed to develop the program. An action research model was used to help the program identify effective strategies for preventing homelessness.

Research has shown that involving people and working in partnership with those who are affected by health issues contributes to the acceptance, relevance and sustainability of a program. Community consultation and evidence-based literature led to the choice of the strategies adopted for this project. The Department of Family and Community Services consulted with the Aboriginal community to identify the strategies and guidelines needed to work effectively in this community.

Project outcomes

The program was evaluated by RPR Consultancy. The evaluation showed that early intervention has been successful in preventing homelessness among Indigenous families in the Salisbury area. For example:

- Housing situations have significantly improved by 71% for families who remained with the program for a support period of no less than 12 months.
- At the end of the support period families stated that their own personal stress levels had decreased and that they were feeling happier in general.
- School attendance by children improved quite significantly.
- There were increased numbers of adult participation in training and employment.

The original pilot is now a fully funded program until June 2008. Centacare has benefited from the program by becoming more aware of and responsive to cultural difference and change. Centacare has recognised that Wodlitinattoai works holistically and has given the program expert advice on becoming a successful and efficient tool for the Indigenous community.

For the initiative to be sustainable, ongoing funding, community participation and direct input from Indigenous elders and young people is required, as the program is constantly evolving to meet the needs of the Indigenous community.

This model can be adopted by other communities with similar population and socioeconomic characteristics, provided that it is adapted to local realities. Involving the local Indigenous community is of crucial importance in shaping a program that will deliver culturally acceptable and effective services.

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Justice: An introduction

A number of factors associated with inequality can contribute to crime, which are often referred to as risk and protective factors. The presence of a higher proportion of risk factors experienced by an individual can contribute to their involvement in criminal activity.

Inequality in social and economic status can cause stress in the family environment, which can increase social isolation and have a disruptive effect on good parenting. Children and young people are particularly vulnerable to negative influences during their early development. Poor parenting and supervision, family violence, single parent families, child abuse and neglect, drug use by parents, and parents suffering from psychiatric disorders are all considered as critical risk factors that can impact on the development of a child. Availability and affordability of housing often concentrates people who experience lower social and economic wellbeing in specific areas. This concentration is also considered to contribute to an environment that can have a negative impact on parenting and encourage contact. It can also encourage interaction with people who are involved in crime, leading to a higher probability of involvement in criminal activity.

Some groups are particularly vulnerable to inequalities in social and economic wellbeing. Indigenous people are overrepresented in our criminal justice system, and there is an increasing number of people with a mental impairment coming into contact with the criminal justice system. In areas of disadvantage, residents are more likely to be a victim of crime or to witness crime in their local community. Fear of crime can impact on a person's wellbeing to the point that they are unable to interact and function effectively in society. This can be debilitating for individuals who are particularly vulnerable to fear of crime, such as the very young and the aged. These vulnerable groups need to be taken into account when developing responses to inequalities through services and programs.

A balance of strategies is required to address inequality and lessen the impact that inequality has on criminal activity. Strategies that have shown positive results aim to address economic inequality, increase education attainment, enhance the development of young people particularly in the early years, build community wellbeing and social capital, and deal effectively with offending behaviour.

There are many examples across the State that demonstrate the efforts of the criminal justice system to respond to these inequalities. A selection of successful programs are outlined in this publication. These programs deal with:

- Supporting people who have been victims of crime to ensure that they are not further traumatised when they report criminal activity or give evidence in court
- Reintegration of offenders by providing skills to address their offending behaviour. Some of these include skills that build self-esteem, to obtain housing, manage money, to gain employment, and effective parenting skills
- Provision of culturally appropriate services to Aboriginal people who have offended
- Providing offenders with a mental impairment, and drug users, with managed and structured access to treatment as part of their contact with the criminal justice system.

Magistrates Court Diversion Program

Justice

A STATEWIDE initiative
Across South Australia

Clients of the criminal justice system with a mental illness or impairment are offered comprehensive support and treatment in conjunction with their court cases.

Introduction

We know from research[1] that those with a mental illness are overrepresented within the criminal justice system. Until recently, it has not been possible to provide the necessary range of health and other appropriate services to assist individuals who otherwise would be left to continue through the criminal justice system with unresolved mental health or impairment problems. The Magistrates Court Diversion Program (MCDP) offers the opportunity for eligible individuals to voluntarily address their mental health and disability needs, and any related offending behaviour while legal proceedings are adjourned. The program facilitates a range of service options, with the aim of helping participants to address any perceived links between their offending and their impaired intellectual or mental functioning. In this way, responses to the client from both the criminal justice system, and the health and disability systems, can be improved.

Aims and objectives

The major aims of the project are to achieve:

- Access to early assessment and intervention
- Facilitation of the treatment and support of clients
- Reduction in offending behaviour.

Key objectives include the provision of:

- Specialised court-based personnel with an in-depth knowledge of court processes, mental impairment, service providers and treatment regimes, who can advise on the management of people with an impairment
- Simplified and streamlined processes for dealing with people with a mental impairment who come before the court
- Improved interface between health and justice responses
- Collection of data for establishing trends and projections
- Incentives and opportunities for support services to proactively respond to issues impacting on their clients involved in the justice system
- A greater understanding among service providers and the general public of the needs of people with a mental illness or disability who have committed an offence, and the issues impacting on the behaviour leading to that offence.

Project

The program operates in the Adelaide Magistrates Court, four suburban courts and three regional courts. It is designed to meet the needs of those individuals appearing in the Magistrates Court of South Australia who have committed certain minor and summary offences and have impaired intellectual or mental functioning. This could result from mental illness, intellectual disability, personality disorder, acquired brain injury or a neurological disorder, including dementia. On average, 75% of the individuals who appear before the MCDP court suffer from a major mental illness.

Those involved in the initiative include:

- Justice Department, South Australian Police, Legal Services Commission, Department of Correctional Services
- Department of Health, Public Advocate, Mental Health and Forensic Mental Health services
- Non-government organisations including those representing victims, service providers and Indigenous organisations.

The program provides an independent assessment by psychologists which highlights the primary diagnosis and treatment, and supports recommendations and other needs of the client relating to their situation. This information is then reported to the court. Participation in the program addresses both the mental impairment of the client, their offending patterns of behaviour, and the possible interaction between the two.

Liaison staff advocate for the client to ensure that their treatment, support and other issues are addressed. The court monitors the progress of the defendant in a supportive and encouraging way. The high level of available expertise enables the court to fully embrace the notion of therapeutic jurisprudence, in which encouragement and positive incentives are offered to the client.

The specific strategies of this program were chosen at a time when a similar program was commencing in the United States. However, it is not clear what influence one program has had on the other. The development of the MCDP has been dynamic and unique in Australia, responding to local needs and trends and fitting within the existing legal framework.

Project outcomes

The program has resulted in higher levels of compliance from participants, which benefits service providers in obtaining longer-lasting and effective changes. Courts also have more information available to aid sentencing, and 38% of individuals have had their matters withdrawn following their successful completion of the MCDP.

The MCDP has been the subject of an ongoing evaluation by the South Australian Office of Crime Statistics and Research. Reports are available on their website, www.oscar.sa.gov.au, in the form of a program evaluation and an outcome study focusing on recidivism.

Despite low survey numbers, the post-program study shows that "a high proportion of participants were not apprehended for offending in the 12 months following program completion".[2] The number of incidents charged against those who had offended was also considerably lower than before the commencement of the program.

This program has been very successful, with many positive outcomes for client participants, the courts and service providers. There continues to be a high participation rate, with a referral rate from the court, legal practitioners and service providers that consistently averages 30 per month. These referrals should continue to grow and develop. There is a high level of support from the steering committee and key stakeholders. The future aim is for the program to become mainstream and part of the court's core business, however, further funding would be necessary to cover additional regional courts.

A major contributor to the program's success relates to its ability to access appropriate services for the client group. Of particular concern is the identified need of those individuals coming before the court in regional South Australia, where service provision may be non-existent.

It is felt that this initiative could well be used in other communities with similar areas of need. The concept is transferable to a range of situations where there is a link between offending and impaired intellectual or mental functioning.

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1 Jones GP, Coombes K. The prevalence of intellectual deficit among the Western Australian prison population, Western Australia: Department of Corrective Services; 1990.

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Aboriginal Courts in South Australia

Justice

A REGIONAL initiative
Regional centres in South Australia

Culturally sensitive Aboriginal Court days encourage higher levels of attendance and more appropriate support for Aboriginal defendants.

Introduction

The establishment of Aboriginal Courts has been a result of changes in legislation for the collection of fines. Aboriginal Justice Officers are now employed by the Courts consistent with the recommendations of the Royal Commission into Aboriginal Deaths in Custody. The recommendations called for increased recruitment and training of Aboriginal people by court authorities and the need for court authorities to improve their services to Aboriginal communities.

The Courts Administration Authority (CAA) has made an effort to increase the level of Aboriginal access to, and compliance with, non-custodial sentencing options and, in doing so, attempting to address the needs of Aboriginal people when dealing with the Criminal Justice System.

Aims and objectives

The Aboriginal Court (Nunga Court) has been designed as an alternative legal process that recognises the integral role of family and community in the lives of Aboriginal people. It creates a venue that is less intimidating for offenders and their families. The overall objective of the Nunga Court is to treat Aboriginal people in a more culturally sensitive way.

Project

From his work with Aboriginal communities on the Lands and in the metropolitan area, a supervising Magistrate observed that Aboriginal people were less likely than non-Aboriginal people to attend court. He saw that this resulted in warrants of arrest being ordered, which often led to a cycle of arrest and imprisonment.

The Magistrate drew on experience he had from dealing with a range of Aboriginal cultures and from consultation with the Aboriginal community. In liaison with Aboriginal Legal Rights, the SA Police and the Aboriginal community, he established the first Aboriginal Court at Port Adelaide. It was soon evident that with the support of Aboriginal Justice Officers, Aboriginal Sheriff Officers and other Aboriginal groups, defendants were more likely to attend court and have their matters finalised. The first Nunga Court commenced at Port Adelaide Magistrates Court in March 1999, followed by Murray Bridge in March 2001 and Port Augusta in July 2001.

The program targets Aboriginal persons who come into the criminal justice system, but the only cases heard in this courtroom are guilty pleas for which the defendant faces the possibility of imprisonment.

In a Nunga Court the Magistrate does not sit high on the bench, rather, at the bar table nearer the defendant. Aboriginal advisors (respected Aboriginal persons or elders) sit next to the Magistrate, and they all sit facing the defendant. The defendant sits with his or her counsel on one side and family or support person on the other. Other family members can also be present in the courtroom.

After the prosecution and counsel have had their say, the magistrate will ask the defendant if he or she would like to talk. The family can also express their views and talk about any further information that is relevant to the case but not yet known to the court. The Magistrate will advise the defendant of services or groups that are available to help him or her, and Aboriginal advisors or community members can also have their say. After carefully listening to the views of everyone present, the Magistrate is the only person responsible for decision-making in sentencing the defendant.

In developing this program, several meetings and community consultations were undertaken to encourage dialogue between the CAA, the Aboriginal community, other Government agencies and key community agencies, with the goal of improving court services to the Aboriginal community. These consultations resulted in a commitment by the CAA to establish a regular Aboriginal Court Day (Nunga Court) and this was originally based at Port Adelaide.

The Aboriginal Court Day is also supported by Aboriginal Justice Officers (AJOs) who are based in metropolitan and Port Augusta courts. The AJOs undertake a strong community education role in regard to the Court and its relationship with the Aboriginal community. This includes assisting with the recruitment of Aboriginal advisors (elders) to attend and sit with the Magistrate on Court Days. They also work with the Fines Payment Unit to ensure that Aboriginal people are given the opportunity to meet their legal obligations, particularly in relation to the payment of fines. The AJOs support the Magistrate and the community in running an Aboriginal Court Day at Port Augusta, Murray Bridge and Ceduna, as often as business dictates.

In a further attempt to assist Aboriginal clients, the Sheriff has employed Aboriginal Sheriff's Officers, who are usually available to support the Aboriginal Court when it sits. Together with elders, the AJOs also provide information to the Magistrate that may be relevant to individual cases regarding programs provided by agencies for the Indigenous community.

The CAA has introduced a number of initiatives to improve the responsiveness of the Courts system for Aboriginal people and to make it more culturally appropriate. Apart from the Aboriginal Court days and support from AJOs described above, there is also a move towards video conferencing, a youth court and other specialist courts.

Project outcomes

Reports from the Aboriginal community suggest that, because Indigenous defendants are now able to speak directly to the Magistrate, they feel they have a voice in court and are being listened to. Comments have been received that say the Court is less alienating and more culturally relevant to Aboriginal people, and levels of attendance by Aboriginal defendants on these Court days have remained considerably higher than for other Court sittings.

Processing of Aboriginal Court outcomes by the Registry is given priority, enabling custody and other matters to be dealt with quickly. The AJOs have become an integral part of the Aboriginal Court resulting in a positive link being established between the Court system and the Aboriginal community.

South Australia's CAA is committed to extending the Aboriginal Court Day model to other areas where Aboriginal people are strongly represented in the courts.

This initiative has already been adopted in similar culturally relevant forms in Queensland, New South Wales and Victoria.

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Karinga Women's Release and Diversion Hostel

Justice

A REGIONAL initiative
Metropolitan Adelaide

Supported accomodation is offered to Indigenous women who are in contact with the justice system.

Introduction

Aboriginal women involved with the justice system need stable, transitional accommodation that supports them while they seek longer term or permanent accommodation. The Karinga Women's Release and Diversion Hostel is unique in Australia, providing culturally appropriate, safe, stable, transitional and supported accommodation for eligible Indigenous women. Prior to the Karinga Hostel, only limited accommodation options were available to Indigenous women post-release in South Australia.

Aims and objectives

The project's five objectives are to:

- Provide Aboriginal women with an accommodation option for early release and diversion from the courts and prison system
- Provide culturally appropriate, safe, stable, transitional accommodation for eligible Aboriginal women involved with the criminal justice system, who are case managed or supported by the Department for Correctional Services (DCS), Offenders Aid and Rehabilitation Services (OARS) or Aboriginal Prisoner and Offender Support Services (APOSS), with priority given to women on parole, bond supervision, home detention and bail
- Provide supported accommodation that focuses on basic life skills and self-empowerment
- Reduce the risk of re-offending and use of licit and illicit drugs amongst the client group
- Support residents' reintegration with their family and the community.

Project

The Karinga Women's Release and Diversion Hostel has been operating since July 2004 as a partnership between DCS and Aboriginal Hostels Ltd. (AHL), with funding provided by the Social Inclusion Unit in the Department of Premier and Cabinet. These two organisations have signed a formal agreement. Other major parties include the SA Police, OARS, APOSS, Centrelink and the Aboriginal Housing Association. An Advisory Group of key stakeholders meets monthly to address ongoing issues arising from Karinga Hostel's operations. A new position of Aboriginal Hostel Liaison Officer (AHLO) has been created to support Karinga's operations.

Karinga Hostel can accommodate 11 residents, including five home detention clients, and it is run by a live-in female Indigenous Manager. Residents are either supervised by DCS, or supported by APOSS or OARS. The women are provided with three meals a day and they must observe a curfew. They may also access support from external agencies, who provide a range of culturally appropriate life skills programs to the hostel. This can help the residents to reconnect with their family and community, reduce their use of licit and illicit drugs, and reduce their risk of re-offending.

The provision of culturally appropriate services remains a key principle in how things are done at Karinga. Prospective residents are clearly advised of their rights and obligations on entering Karinga, and the key stakeholders are encouraged to contribute input at monthly meetings. Flexibility is important in the project as well, as a rapid response is needed when problems arise. Also important are the particular circumstances prevailing in metropolitan Adelaide where the greatest pool of potential clientele is to be found.

Project outcomes

The project is currently undergoing formal evaluation. The project cannot function without a cooperative working relationship between stakeholders and a good relationship with the SA Police and Karinga's neighbours. Due to Karinga's relationship with Centrelink, the agency has been very responsive in processing forms that would otherwise take much longer to complete.

There are some ongoing issues that arise directly from the women's situations. For example, they frequently object to the board money they have to pay, as often they could live cheaper elsewhere. Privacy is a constant issue, as residents do not like sharing rooms. Residents on home detention have been challenging to deal with as they suffer from boredom. The women need to be motivated to do things that are beneficial to their own needs, and the programs offered must respond accordingly. Transportation of clients takes time and requires patience. For example, if women are dismissed from court late in the day and no-one is there to pick them up, they have the opportunity to abscond.

Good policies and procedures need to be put in place and action taken to make sure these are carried out. In relation to this, stakeholders need to cooperate and respect each other's position. In the initial stages there was not sufficient tolerance with policies and procedures, however, this has since been addressed.

The Karinga Women's Release and Diversion Hostel needs to be widely publicised within the appropriate channels to gain referrals. The future of the project will depend on Indigenous clients choosing to use the opportunities available at Karinga. The concept is transferable to other communities. If other centres want to use the same concept, the DCS can assist them to develop the project in their area.

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Witness Assistance Service

Justice

A STATEWIDE initiative
Across South Australia

Information and support for witnesses and victims of crime.

Introduction

People who are victims of crime and members of the public who witness a crime are often unfamiliar with the Criminal Justice System. Crime victims and witnesses often have limited knowledge and understanding about their rights, the realities of giving evidence in court, or how to deal with legal processes. At the same time they are trying to cope with the impact of the crime on their lives and, as a consequence, they may feel overwhelmed and anxious about what happens during the court process.

The Witness Assistance Service (WAS) was set up to provide written and verbal information to increase the knowledge and understanding of victims and witnesses where the Office of the Director of Public Prosecutions (DPP) is involved in prosecuting a case. Its purpose is also to provide emotional and practical support to crime victims and witnesses throughout their experience with the Criminal Justice System.

Aims and objectives

The WAS aims to minimise the inequalities experienced by victims and witnesses, many of whom come from marginalised groups in the community, such as children, people with intellectual disabilities or mental illness, women, the elderly, Indigenous, and Culturally and Linguistically Diverse groups. The program aims to ensure that victims of crime and prosecution witnesses have access to information and support services, and that they are informed of their rights when involved with the Criminal Justice System in cases prosecuted by the DPP.

Project

The DPP is an independent Statutory Authority. Its main function is to prosecute serious criminal cases in South Australia (SA). The WAS is part of the Office of the DPP and commenced operation in 1995 with the employment of a Social Worker who provided an information and support service to victims of crime and prosecution witnesses. The WAS team has grown considerably over the past ten years and today the team comprises ten full-time equivalent experienced Social Workers employed as Witness Assistance Officers (WAOs). Three and a half of these positions are funded specifically to work with child victims or witnesses.

Target groups are:

- Victims of crime (children and adults) and their family members involved in cases being prosecuted by the DPP in SA
- Witnesses of a crime who are likely to be required to give evidence for the prosecution in serious criminal cases in SA.

The WAOs provide services to crime victims and witnesses at no financial cost. The services they offer include:

- Verbal and written information about legal processes, court procedures and vulnerable witness provisions to assist witnesses giving evidence in court
- A comprehensive social work assessment and referral to appropriate services in the community
- Liaison between witnesses, DPP legal staff, external agencies and police
- Court preparation and familiarisation tours prior to the witness giving evidence
- Assistance and support during meetings with DPP legal staff
- Assistance with the preparation of victim impact statements, which assist the Judge to understand the impact of the crime on the victim when sentencing the offender
- Attendance at court to support victims or witnesses and their family members when they are required to give evidence or when they attend to observe proceedings
- Crisis counselling and debriefing, before, during and after giving evidence in court
- Arranging for court companions via Victim Support Service Inc.

In addition, the WAOs regularly provide education sessions and presentations to external stakeholder agencies (such as SA Police, TAFE SA, universities and community health agencies) to raise awareness about issues relevant to victims and witnesses, and how the service can support them. They have also designed and produced printed material to assist with people's understanding of these processes.

Referrals to WAS are initiated by the DPP legal staff or external agencies such as SA Police and victims' services. Liaison with other victim support organisations enables WAOs to discuss common issues and develop strategies to improve services to crime victims and witnesses. Contact with interstate WAS units is also helpful for discussing common issues and ensuring best practice.

Involved in the initiative in SA are:

- Office of the DPP personnel
- Attorney-General's Department (Victims of Crime Coordinator)
- SA Police - patrol officers, detectives, Major Crash Unit, Major Crime Task Force, Sex Crimes Investigation Branch, Victim Contact Officers
- Victim Support Service Inc.
- Yarrow Place Rape and Sexual Assault Service
- Respond SA - Adult Childhood Sexual Abuse Service
- Community Health Services, Child Youth and Family Services, Child Protection Services

Project outcomes

The demand for Witness Assistance Services has dramatically increased, with numbers of victims and witnesses referred for an information and support service increasing from 497 in 2000-2001 to approximately 900 in 2004-2005.

A review of the WAS was conducted, with a special focus on children, and a report was prepared for the Attorney General's Department, Justice Strategy Unit and the Office of the DPP. The outcome of this review concluded that the greatest strength of the WAS was its high level of credibility. According to the review, all evidence from consultation and profiling supports the conclusion that quality services are provided to victims, witnesses and family members.

The existence of the Victims of Crime Act 2001 (enacted in November 2003), which outlines the principles governing the treatment of victims in the Criminal Justice System, has contributed to the longevity of the program. It has a strong emphasis on the need to provide victims of crime with information upon request about the progress of a case throughout the system, and this clearly supports the existence of the WAS program. The Prosecution Policy Guidelines of the DPP also reinforce the need to have regard for the rights of victims. The DPP would not be able to properly meet its obligations to victims without the assistance of WAS.

Similar programs exist in New South Wales, Northern Territory and Victorian Offices of the DPP and employ strategies comparable to those available in SA. Equivalent services also exist externally to the DPP's office in Western Australia, Tasmania and Queensland.

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Social support: An introduction

Everyone has a right to participate in the wider community and share the social and health benefits of doing so. As yet there is no one theory to adequately explain the link between social relationships and health, but the link itself is clear from long standing and extensive research around the world. Social inequalities in health can be compounded by social exclusion, because social relationships have a great impact on health education and health behaviour, and also on emotional and social wellbeing.

The term 'social exclusion' refers to a broad range of factors and processes that accentuate material and social deprivation and thereby affect the ability of individuals to participate in the regular activities of everyday life.[1] These factors can include being on a low income, language barriers, and experiencing disabilities such as a hearing impairment and health problems that affect mobility. A range of factors such as these can result in people having resource-poor social networks.

Various means of support have been developed to encourage social participation among those who face exclusion. Social support can act as a protective mechanism against stress, provide practical assistance, and help people develop social networks and friendships. In terms of policy, the interdisciplinary nature of social exclusion emphasises the importance of developing new approaches to government service delivery that deliver more innovative and holistic policy solutions than in the past.

The case studies highlight these types of approaches where:

- Different agencies work together, to make the best use of new developments in technology that assist people with hearing impairments to more fully participate in the community
- Programs are developed in partnership with people on low incomes to improve their financial skills and empower them to make informed financial decisions
- The barriers to community participation are identified using community development approaches that employ workers from local communities.

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'Hi' Deafness Friendly Program

Social Support

A STATEWIDE initiative
South Australia

Improved access to services for hearing impaired people.

Introduction

People with a hearing impairment find it difficult to access services and therefore often feel socially isolated. This is a major issue within our community, as it has been estimated that over 150,000 of South Australians have a degree of hearing loss sufficient to impact upon their daily lives. People with a hearing loss or impairment tend to avoid places where communication will be an issue, for example, banks and shops. Communication difficulties tend to isolate the hearing impaired and prevent them from fully participating in the community.

Aims and objectives

The aim of the 'Hi' Deafness Friendly Program is to establish systems that can be used by businesses and service providers to improve access for hearing impaired people. The program aims to improve access and reduce the social isolation of people with a hearing impairment in South Australia. This is achieved through the following:

- Advocating for increased accessibility to services by people with a hearing impairment
- Raising awareness of the communication needs of people with a hearing impairment
- Encouraging and assisting organisations to use available technology and become more accommodating of people with a hearing impairment - that is, to become 'deafness friendly'
- Providing hearing impaired people with information that will allow them to use services that are hearing impairment friendly.

Project

In setting up the program, consultation was carried out with Disability Services, WorkCover and Workplace Services, the Australian Red Cross and a number of State Government departments and local councils. Mitcham, Burnside and Salisbury councils, in particular, were consulted as they have a higher proportion of aged people and it is well known that hearing loss is more common in the aged population. Informed by international research, and through consultation with local councils and Red Cross, it became obvious that new strategies were needed to minimise the isolation of people with a hearing impairment.

To address this need, the 'Hi' Deafness Friendly Program developed three related systems. These are:

- **Counter Hearing System**
  The Counter Hearing System consists of a walkman style headphone or telephone handset, an amplifier and microphone and can be used by either hearing aid or hearing impaired non-hearing aid users. This system is used in services where a counter is the point of contact between the service provider and client such as banks, health services and government offices.
- **Personal Hearing System**
  The Personal Hearing System enables the hearing impaired person to go to places such as public meetings, restaurants, theatres and other places that make hearing difficult or impossible. This system is also ideal for communicating with family and friends and can be used by either hearing aid or hearing impaired non-hearing aid users.
- **Public Hearing System**
  The Public Hearing System has been designed for large public venues where the hearing impaired person would find it difficult to hear. For example flight announcements at an airport, church services and arts performances.

In developing these systems, research was conducted into communication products and the available technology worldwide. Presentations were made to business and Government leaders to raise awareness of the problem and the 'Hi' Deafness Friendly Program. A consumer group of hearing impaired people is being established.

The 'Hi' Deafness Friendly Program is run by DeafSA whose role includes advocating for people with a hearing impairment. Through the program, people with a hearing impairment are encouraged to voice their needs in a supportive environment. A significant feature of the program is that it raises awareness of the needs of the hearing impaired. For example, a 'checklist' was drawn up to encourage organisations to assess their hearing-impaired friendliness, and a number of information materials were created.

The program targets organisations used by members of the general public who may have a hearing impairment, including businesses, Government offices, health facilities and shops. Organisations are particularly targeted if they have a requirement to comply with the access provisions of the Commonwealth Disability Discrimination Act.

Project outcomes

The program is being informally evaluated based on the number of organisations that become hearing-impaired friendly. As a result of the program's success, Counter Hearing Systems have been set up in a number of organisations. Moreover, a number of people with a hearing impairment possess Personal Hearing Systems, and a few public facilities are now fitted with Public Hearing Systems.

Numerous organisations have adopted the Counter Hearing System and this initiative also appears destined for use interstate. Those already using the systems include the Department for Families and Communities (Terrace Towers building), Legal Services Commission of South Australia, Medicare, South Australian Housing Trust branches, many Transport SA Customer Service Centres, some local councils, a number of hospitals and the University of South Australia.

The initiative is transferable and has attracted interstate interest. Having a consistent approach across Australia is desirable for the hearing impaired, who can then use the same devices no matter where they travel.

The need to comply with the access provisions of the Commonwealth Disability Discrimination Act will contribute to sustaining the achievement of this initiative. As DeafSA is a charitable organisation, funding from both Commonwealth and State Governments is vital for maintaining the program.

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SACOSS Microfinance Development Project

Social support

A LOCAL initiative
Adelaide western suburbs

Microfinance as an asset-building poverty reduction strategy. Tenants and service agencies work together to promote financial inclusion, knowledge, skills and saving strategies.

Introduction

A group of public housing tenants in the western suburbs of Adelaide have formed a Tenants Committee to work with the SA Housing Trust, local council and Adelaide Central Community Health Services (ACCHS) to develop a range of activities that aim to promote social and economic participation and inclusion.

One of the problems being addressed is financial exclusion. This can be described as the 'inability of individuals, households or groups to access necessary financial services in an appropriate form'. Exclusion can be the result of problems with access, prices, marketing, financial literacy or self-exclusion in response to negative experiences or perceptions.[1]

People living on low incomes are often skilled financial managers, however many also have very limited financial skills. When income is very low, it is difficult to access safe and affordable credit. Many people have never received the skills and knowledge of how to save and build assets. Much of the work that has been done to help people on low incomes to improve their financial skills has focused on budgeting (how to manage from week to week). Little attention has been paid to helping people establish long-term savings and asset goals, regardless of how modest they might be.

Many tenants involved in this project have been in contact with numerous community and welfare services over many years, however, none of the tenants can recall being approached with help to develop skills around financial management. In addition to consumers on low incomes being excluded from mainstream financial services, many community service and welfare providers have not been addressing the building of financial skills, and so in effect may have been perpetuating the problem.

Aims and objectives

The aim of the activity was to identify and implement an appropriate and sustainable financial inclusion program for tenants on low incomes. The project focuses on services developed to help tenants' groups improve their potential for financial inclusion and self-reliance.

In order to combat financial exclusion, a set of tools and strategies have been developed that are broadly known as *microfinance*. The term includes small scale loans, financial literacy training and support, micro-enterprise development and asset building. The aim of the project is to complement savings goals with skills and knowledge to help people make informed financial decisions.

Project

The project involves the participation of the South Australian Council of Social Services (SACOSS), the Holbrooks Tenants Group and ACCHS. It targets individuals and families who live on low incomes.

Initially, a Community Development Worker from ACCHS who works with the Holbrooks Tenants received information regarding savings circles and financial literacy, and subsequently made inquiries regarding how they work. The SACOSS Project Worker then met with two Community Workers and two tenants to discuss the possible setting up and operation of a savings circle. All were interested, and they took the information to the next tenants meeting. The SACOSS Project Worker was then invited to meet the tenants and discuss how a savings group could work. The housing complex provided a supportive environment for the tenants to examine their financial goals.

Based on evidence from interstate,[2] savings groups are known to work best when:

- Members own the activity and there is little bureaucratic interference
- Members are willing to share tasks and make decisions collectively and modestly.

The program was established within a community development framework. Tenants were invited to an information session on how improving financial inclusion could improve their financial and emotional wellbeing, and a set of discussions took place on how to develop an appropriate savings group. This involved tenants establishing savings and financial security goals. Tenants challenged the notion of passivity and helplessness, and promoted self-help, empowerment and mutuality. The issues of trust, incentives and record keeping were all discussed and tasks were allocated. The workers provided support, however tenants undertook most of the administrative roles including establishing an agreed set of group rules.

The key principles which underpin *microfinance*, namely, self-help, reciprocity and solidarity resonated well with the tenants, and they were all keen to help each other reach their savings aspirations. The group commenced in April 2005 and now meets every fortnight. Each member contributes a minimum of $5 per fortnight as part of the group's savings strategy. Although each group member contributes to the pool of funds, separate ledgers are held for each member. In this way, there are elements of both group and individual savings. The Community Development Worker will be trained in a financial management program that will be delivered to the tenants over a six-month period.

Project outcomes

The project has not yet been fully evaluated as it is ongoing. However the worker has approached the activities from an action research perspective, and the following are key learnings to date:

- People on low incomes have savings goals just like many other people, and they can save given the right mix of support and incentives
- The tenants group project provides an overall sense of community, and this in turn has promoted the notion of looking after your neighbour as well as yourself (mutuality) in the context of savings goals
- Active participation in group activities has resulted in social outcomes such as sharing stories of financial issues, discussing how to manage money better, stopping smoking in order to save money, and increasing pride and self-esteem by taking positive steps to improve financial stability.

Notable achievements of the project include the willingness of tenants to improve their financial situation and reach their savings goals, and also the support of the project partners involved. Less positive was a degree of scepticism expressed by some potential group members. The continuing success of this project will rely on ongoing support from the workers as well as established leadership within the group.

Participation has been slow however, and this is consistent with a similar project conducted in Queensland in 2001:

> *" For many groups, it was not the right time, that is:*
>
> - *Relationships may not have been strong enough*
> - *Members were involved in several other projects, or*
> - *There was (sic) just not enough people interested at the same time.*
>
> *This did not mean that a group would never develop...we had contact with groups up to 12 months after initial contact saying that they were interested...again."* [2]

Reported here are preliminary findings from an activity that is still in its early days. Further activities are planned over the next six months to improve the group's sustainability and financial security.

The project has been able to facilitate a set of digital documentaries which, while not specifically focusing on the savings group, has enabled tenants to tell their stories about community and inclusion. These mini-documentaries are available to view online at www.dococom.com

The idea of savings circles has been promoted throughout several networks and organisations as a strategy to combat financial exclusion. A general guideline booklet has been developed by SACOSS, with input from Foresters ANA (a Queensland based microfinance organisation working in the area of savings and asset building), so the initiative is transferable.

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1 Sinclair S. Financial exclusion: an introductory survey. Centre for Research into Socially Inclusive Services, Edinburgh College of Art/ Heriot Watt University; 2001.

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Riverland Multicultural Day Activity Service

Social support

A REGIONAL initiative
Riverland

A socialising opportunity for people from a Culturally and Linguistically Diverse background where a diverse range of cultural and traditional activities are valued.

Introduction

The Riverland agricultural area has a long history of migration of workers and farmers from many parts of the world. This has led to a local culture of rich cultural diversity, but some individuals may experience debilitating social exclusion and isolation, especially those who are old, frail or have a disability.

Although various programs and activities are held in the area, including day activities for people in need of support, those of different cultural backgrounds are often reluctant to go to mainstream events for various reasons. The language barrier is a consistent constraint, but it may also be that the program is not what they are looking for; craft, cards and board games are not necessarily of interest to all. It is likely that they do not know anyone else there, nor can they adequately communicate their needs to the staff, and, importantly, the food is not what they are used to.

The Multicultural Day Activity Program is an initiative for social integration that enables people from a Culturally and Linguistically Diverse (CALD) background to come together and socialise with other people who may be from their own country of origin or from a variety of non-Australian backgrounds. The program is client-owned, and ideas for activities are generated by the participants.

A major focus is food, which is cooked on site by the staff, along with clients who are able to participate. This alone adds to the people-orientation of the program. Bilingual staff are employed to coordinate the program, and there are three bilingual workers in the Day Activity Centre, located in Renmark.

Aims and objectives

The major aim is to achieve a program that meets the cultural needs of a variety of clients from many different countries in one location at the same time. The goal is to eradicate barriers to clients from CALD backgrounds, so that they can access a service that has no language constraints and where staff are employed to understand their culture, their religion and other traditional needs they may have.

Project

The target group comprises persons from a CALD background who also fit into the Home and Community Care (HACC) target, that is, frail aged, young disabled, financially disadvantaged and those who are socially isolated.

HACC funding was received in 2002 to provide the service on a regional basis. The managers and staff at Renmark Community Care discussed the idea with an established group of Greek clients who met on Fridays. Bilingual workers were also involved with the initiative from this time.

At present, an Italian Coordinator works at the Renmark Day Activity Centre with Greek, Turkish and Italian support workers. The program has 195 registered clients from across the region and is run every Friday. The program is based at the Centre and travels to other towns on a regular basis. Most Fridays would see between 50 and 60 clients attending from Greek, Italian, Croatian, Turkish, German, Polish and Russian backgrounds. Volunteers from the Philippines and from Greek and Turkish backgrounds also provide support on these days.

Transport is a regional issue in all areas of health, education and disability, which needed to be addressed as most of the clients are women who do not drive. Community transport is used for clients from Loxton and Barmera, while those from Renmark and Berri are picked up by community buses.

In developing the program, a crucial strategy was to employ people from their own communities who were already known to the clients. The bilingual workers were encouraged to educate all the staff about their cultures, helping them to form a shared understanding of the religious and cultural needs of the clients. Participants were encouraged to speak up and say what they wanted as part of their program, therefore giving them ownership of it.

The program has been developed from ideas suggested by clients. An example of this is a monthly picnic day, where everyone brings along a plate of food to share with the group, which is often in excess of 70 people. On these days, clients may bring along their partner or a friend. The nature of the picnic day also encourages men to attend, with games of bocce and cards and a shared glass of homemade wine often featuring. An important outcome is that the clients can talk to the staff about problems being experienced at home or with their health, and can be referred on to other HACC services such as Home Help or Home Assist.

It is also important for the CALD clients to gain a good understanding of each other's cultures. For example, the Turkish clients do not drink alcohol, but the other CALD groups do. The Turkish group were made aware that the other groups do drink alcohol, and the other groups were asked not to offer it to the Turkish clients, nor to put any on their tables.

Religion is another area that was to be addressed in meeting the needs of such a variety of cultures. Amongst the clients are Muslims who are required to pray after lunch and who do not eat pork. A praying room has been provided at the centre for this group. Greeks may fast on Fridays, and for special occasions, and Catholics may fast for various reasons, so a calendar of special fasting times is on display, and a fasting menu is provided on Fridays for the Greek Orthodox clients as well as the Catholics.

The initiative is funded for one day per week and runs on a very small HACC budget. No component has been costly. For example, the praying room for the Turkish clients is the quiet room for mainstream day activity from Monday to Thursday. On Fridays, praying rugs are brought in and a sign is put up on the door. Meals are cooked as part of the general activities. Bowls of soup or pasta, lots of crusty bread, bowls of tossed salad and fruit and ice-cream are not costly, and clients pay $5 per head for their meal. Most of the bilingual staff have had little or no training, but all have been supported to study for Certificate 3 in Aged Care or Community Services. All of the bilingual workers have now achieved this, and all are now studying for Certificate 3 in Front Line Management, fully funded by South Australian Multicultural and Ethnic Affairs Commission for women from a CALD background.

A large number of people who immigrated to the area in the early 1950s are now reaching their 70s and requiring services. At all times the multicultural community in the Riverland, with its many CALD groups, has provided some excellent sources for consultation.

Project outcomes

Clearly the employment of bilingual workers has been the most effective way to eliminate the barriers of language and cultural awareness. The success of the program is evident in the number of clients it attracts, and most of all the fact that the clients have ownership of the program and happily promote it to others from their community.

At first, the bilingual staff used to go out into the community and meet with key stakeholders, to promote the service with church ministers, ladies auxiliaries and so on. However, the best promotion has been word of mouth, and as clients talk to each other there has been a huge growth in the program. There is now no longer any need for official promotion as the clients already achieve very good publicity for the program.

Participants in the program are surveyed twice a year. They are asked what they would like to see in the program for the year, and a client satisfaction survey is conducted each October. A significant finding in the first survey was that they did not want hospital food, so cooking has since been done at the Centre, which now provides an important focus for the group.

The program is funded by HACC and its future is assured. Eventually there will have to be a waiting list, as the Centre is small and the client numbers keep growing. The program will be adapted as required to meet client needs. This has been the case in the past, and as each new group of clients becomes known, changes are made in the program to accommodate the individuals and their culture.

The initiative is very transferable, very cost effective and would work effectively in most rural and metropolitan areas. Once a community is known, it is easy to find key stakeholders and bilingual workers among them.

There was some doubt that the program would not work due to the vast cultural differences of the clients. However, it has been extraordinarily successful. Many friendships have been formed and, on any given Friday, it is good to see, for example, Greek and Turkish clients having a chat over a coffee. The clients have a shared maxim: 'one face, one race', which seems to encapsulate both the concept and the implementation of their Multicultural Day Activity Centre.

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Towards Community Inclusion - Men's Support Group

Social support

A LOCAL initiative
Northern metropolitan Adelaide

A men's support group that has been instrumental in alleviating social isolation for the elderly.

Introduction

Social isolation has been identified as a significant problem for many older people living in the northern metropolitan region of Adelaide. Recognising the importance of addressing social isolation for older people, Helping Hand Aged Care established community integration services in 1998. These services target older people and especially those at risk of social isolation, living in northern Adelaide, with the aim of increasing their social networks and community participation. In 2001, the 'Towards Community Inclusion' (TCI) Project was introduced, trialling a group-based capacity building model to promote community inclusion for older people.

TCI first identifies barriers to access and then develops appropriate strategies for addressing social isolation. There is scope for both personal and collective visions of community inclusion, which are attained through individual casework (one-to-one interventions), group work (involving barrier-breaking focus groups) and the activities of community organisations, such as information-gathering forums.

Aims and objectives

The program seeks to identify and address social isolation amongst the older population in the northern metropolitan region of Adelaide. In this case, the target group was older men living in the area and identified as either isolated or at risk of isolation.

The objectives of the program are to:

- Heighten community awareness of social isolation issues
- Identify barriers to community participation and utilise a community capacity-building approach to develop strategies for overcoming these
- Develop 'non-service' solutions to meet needs identified by the target group in collaboration with community services and groups
- Develop self-sustaining informal support networks for individuals at risk
- Provide a safe, friendly and welcoming environment for those who are socially isolated or at risk.

Project

TCI began to recognise the common occurrence of social isolation through numerous interactions, particularly with men, and consequently coordinated a focus group with eight self-identified socially isolated men to look at these issues together. The focus group process first identified local barriers to social participation, and then explored strategies to address the identified barriers. Finally they established a consumer working party to advance a particular issue or identified goal. The outcome of this focus group was to set up a men's support group.

The program works through the use of a community development/ capacity-building model that results in outcomes of both informal and formal support. This men's support group has benefited greatly by empowering the older men to be instrumental in their success. Men who originally self-identified as isolated now fill many roles. The action group consists of 12 members. Those who drive help with transport, and the more capable help others with toileting, eating and other activities of daily living, as needed.

The group has grown to more than 60 members that meet every fortnight. The formal stakeholder group meets at the Ex-Military Rehabilitation Centre, who not only offers their site but also help with transport. Numerous agencies (including Resthaven, Anglicare, Royal District Nursing Service, local councils, Options Coordination, local hospitals, mental health services and General Practitioners) are involved in identifying isolated older men and referring them to the group.

The model is based on the concepts of empowerment,[1] mutual aid,[2] and community development,[3-7] utilising an ecosystemic approach that recognises the connectedness of person to environment and the need to work simultaneously with both.[8, 9] Work is premised on a strengths perspective, seeking to identify each individual's dreams and aspirations (both for themselves and for the communities in which they live), along with recognising and building capacities (at the individual, community and systems levels).

Project outcomes

The project was evaluated using a pre and post self-evaluation form and an eco-map recorded community connections before and after the project.

Most participants have reported better moods and greater levels of motivation, positive thinking, confidence, self-esteem and a sense of personal power. There have been significant increases in links with friends, neighbours, services, volunteers, recreation and clubs. Ninety per-cent of the people were able to achieve at least one of their goals and about two-thirds of those involved were successful in reaching all the goals they had set for themselves. Figure 1 illustrates how the support group has influenced one participant's life.

The TCI men's support group has now been running for over three years and continues to grow. The main reason for this is that it is owned by the men themselves and they are the main decision-makers. The group has grown significantly and is now seeking other funding opportunities as a means of offering more activities.

From the beginning, the men have been treated as the experts in this situation, and they have been listened to and worked with. The model's partnership approach is a powerful tool for empowerment. In this situation it has proven successful not only in getting the program started, but also for its sustainability.

This model is easily transferable to other communities and other areas. As with any human service, if people are included in the decision-making (not in a tokenistic way), they develop a sense of ownership of the initiatives.

A worker involved with these men is consistently amazed by their resistance and strength. One man said to him: "We do not want to be pitied, we just want to enjoy ourselves. Just like any one else".

Figure 1: Tim's story

Seventy-five year old Tim was living in his own home following a stroke that left him paralysed on one side of his body. He was determined to remain in his home, but had spent a significant amount of time in hospital and in rehabilitation, and he now found he was housebound. He could no longer drive, his old friends had withdrawn, and the social woodwork group that Tim had been part of had now disbanded. Tim had limited finances and virtually accepted that he would now just stay at home. He was socially isolated.

Tim was introduced at the TCI men's support group and they were informed of his desire to be involved in woodwork. The group was quick to accept Tim and set about helping to facilitate woodwork as part of the activities they offered. The men's support group also coordinated and paid for Tim's transport. As a result, Tim now has more opportunities for social involvement and this has increased his enjoyment of life.

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1 Lee JAB. The Empowerment Approach to Social Work Practice, New York: Columbia University Press; 1994.

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Appendix one

Project Reference Group

Reference Group Membership ^*

Clare Shuttleworth (CHAIR)	Metropolitan Health Division, Department of Health
Allan Quire	Health System Management, Department of Health
Christy Akins	Office of Country Health, Department of Health
Steve Charles	Community Connect, Department for Families and Communities
Gwyn Jolley	South Australian Council of Social Service representative
Lisel O'Dwyer	SA Community Health Research Unit, Flinders University
Chris Mayer	Transport Planning Division, Department for Transport, Energy & Infrastructure
Peter Tisato	Transport Planning Division, Department for Transport, Energy & Infrastructure
Angela Young	Planning SA, Department of Primary Industries and Resources
Sharon Meagher	Aboriginal Affairs and Reconciliation, Department of the Premier and Cabinet
Natalie Harkin	Aboriginal Affairs and Reconciliation, Department of the Premier and Cabinet
Tania Toth	Indigenous Affairs, Department of the Premier and Cabinet
Andre Simmonds	Strategic Development, Attorney General's Department
Ruth Motley	Learning Improvement and Support Services, Department of Education and Children's Services
Christine Sanders	Youth Engagement and Retention, Social Inclusion Team, Department of Education and Children's Services
Helen Tunbridge	Youth Engagement and Retention, Social Inclusion Team, Department of Education and Children's Services
Harry Stewart	Aboriginal Mental Health, Department of Health
Carmel Williams	Health Promotion Branch, Department of Health
Sue Booth	Health Promotion Branch, Department of Health
Agnes Maddock	Health Promotion Branch, Department of Health

*Agency names reflect agencies at the time the project was undertaken.

^Some agencies had more than one representative during the time the project was undertaken.

Appendix two

Terms of reference

The terms of reference for the Inequalities Reference Group were:

1 To establish principles to guide the process for gathering and selecting case studies

2 To determine criteria for the case studies

3 To determine what types of case studies should be included, e.g. local level, Statewide etc

4 To actively promote the call for case studies within agency and across sector

5 To assess case studies against agreed criteria and for inclusion in Volume II

6 To further inform individual reference group members and their networks of the importance of addressing social inequalities to promote health.

Appendix three

Further reading:

1 Keating DP, Hertzman C. Developmental Health and the Wealth of Nations, Social, Biological and Educational Dynamics, New York: Guilford Press; 1999.

2 National Crime Prevention, Pathways to Prevention: Developmental and Early Intervention Approaches to Crime in Australia, National Crime Prevention, Canberra (ACT): Commonwealth Attorney-General's Department; 1999.

3 Carson E, Martin S. Social Disadvantage in South Australia, University of South Australia and South Australia Council of Social Service Inc. (SACOSS), Adelaide: Social Policy Research Group; 2001.

4 Raphael D. Barriers to Addressing the Societal Determinants of Health: Public Health Units and Poverty in Ontario, Canada. Health Promotion International 2003;18(4):397-405.

5 Lynch J, Smith GD. Commentary: Income inequality and health: the end of the story? International Journal of Epidemiology 2002;31(3):549-551.

6 Wilkinson R. Unhealthy Societies. The Afflictions of Inequality. New York: Routledge; 1996.

7 Marmot MG, Wilkinson RG. The Social Determinants of Health. Oxford: Oxford University Press; 1999.

8 Turrell G, Oldenburg B, McGuffong I, Dent R. Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda. Queensland University of Technology, School of Public Health, Ausinfo, Canberra: Department of Health and Aged Care; 1999.

9 National Public Health Partnership, Health Impact Assessment Guidelines September 2001, Canberra: Department of Health and Aged Care; 2001.