

# Albury Wodonga Aboriginal Health Service



Strategic Plan  
2014-2024



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## AWAHS Mission Statement

**“To provide and improve health outcomes for our local Aboriginal community with a range of culturally appropriate, flexible, reliable, professional and viable health and wellbeing services, to strengthen, nurture, enhance and maintain the overall quality of life of our community members.”**

## AWAHS History

AWAHS is a non-profit organisation that was developed and set up to cater for the primary health care needs of Aboriginal and Torres Strait Islander people and their families.

Albury Wodonga is a designated Aboriginal resettlement area. In the late 1960's and early 1970's the government of the day designated Albury Wodonga as an Aboriginal resettlement area, highlighting that Aboriginal families would have greater access to education, health, employment and other essential services.

Over the past 30 odd years the local Aboriginal community of Albury Wodonga which is made up of over 50 different language groups, who lobbied various governments for the establishment of a community owned Aboriginal Health Service.

In 2001 a joint partnership between Mungabareena Aboriginal Corporation, Wandoo Aboriginal Corporation and Woomera Aboriginal Corporation was established. This enabled these organisations to undertake a project to establish what the gaps in Aboriginal health were. The final document produced was the Koori Cross Border Health Plan 2001, which highlighted the fact that an Aboriginal Health Service was needed to address the appalling health statistics for Aboriginal people.

From this report a steering committee was formed and along with the guidance of the Aboriginal Health and Medical Research Council of NSW the Albury Wodonga Aboriginal Health Service was created

The Health Service was incorporated in September 2003 under the New South Wales Incorporations Act after nearly 32 years of lobbying by various Aboriginal community member and community groups. The Health Service commenced full operational service on the 27th June 2005.

In 2007 AWAHS was successful in receiving funding to build a purpose built facility through a joint venture between OATSIH and NSW HEALTH. On Wednesday 26th August 2009 AWAHS officially opened its new building to the public.

*(AWAHS website, August 2014)*



## SWOT ANALYSIS

*(Board and Senior Management Team, AWAHS. July 29, 2014)*

### SUMMARY

Strategic planning forum participants identified a range of strengths, opportunities, weaknesses and threats to the organisation.

Rapid growth over the past few years was identified as both a strength and a weakness – a strength because it reflects increasing service usage and acceptance by the community; a weakness because it creates a strain on resources (physical resources and service provision capacity). Forum participants clearly felt that the organisation functions well in terms of governance, management, structure and operations. They believe that AWAHS has a positive reputation with funding bodies, within the local and regional service sector and within the Aboriginal and wider community.

Reliance on external funding was identified as a key weakness and threat. Funded programs are often limited in the nature and quantity of services delivered, as well as being bound by reporting and other bureaucratic requirements. The need for AWAHS to become more financially independent was identified as a clear strategic objective. However, while government funding is never absolutely secure, AWAHS has a relatively strong financial base and is well positioned to identify and take advantage of other income possibilities.

In terms of future growth and service development key strategic areas were identified as:

- service diversification, including identifying additional ‘markets’ and developing targeted programs
- establishing or reviewing partnerships and service delivery arrangements with other Aboriginal and mainstream service providers
- confirming a clear identity as a centre of ‘expertise’ for and on behalf of the Aboriginal community
- employment, training and professional development opportunities for Aboriginal people.

Current issues that may drive short-medium term service development include

- the need for appropriate drug and alcohol services, particularly rehabilitation services
- a need to focus on preventative and ‘health promotion’ strategies
- a need to achieve positive engagement with the Aboriginal and wider communities.

Emerging issues that may drive future service development included:

- aged care services and access to appropriate aged care facilities
- social and health issues affecting males, young people and families
- government funding priorities and models (e.g. regionalisation, National Disability Insurance Scheme).



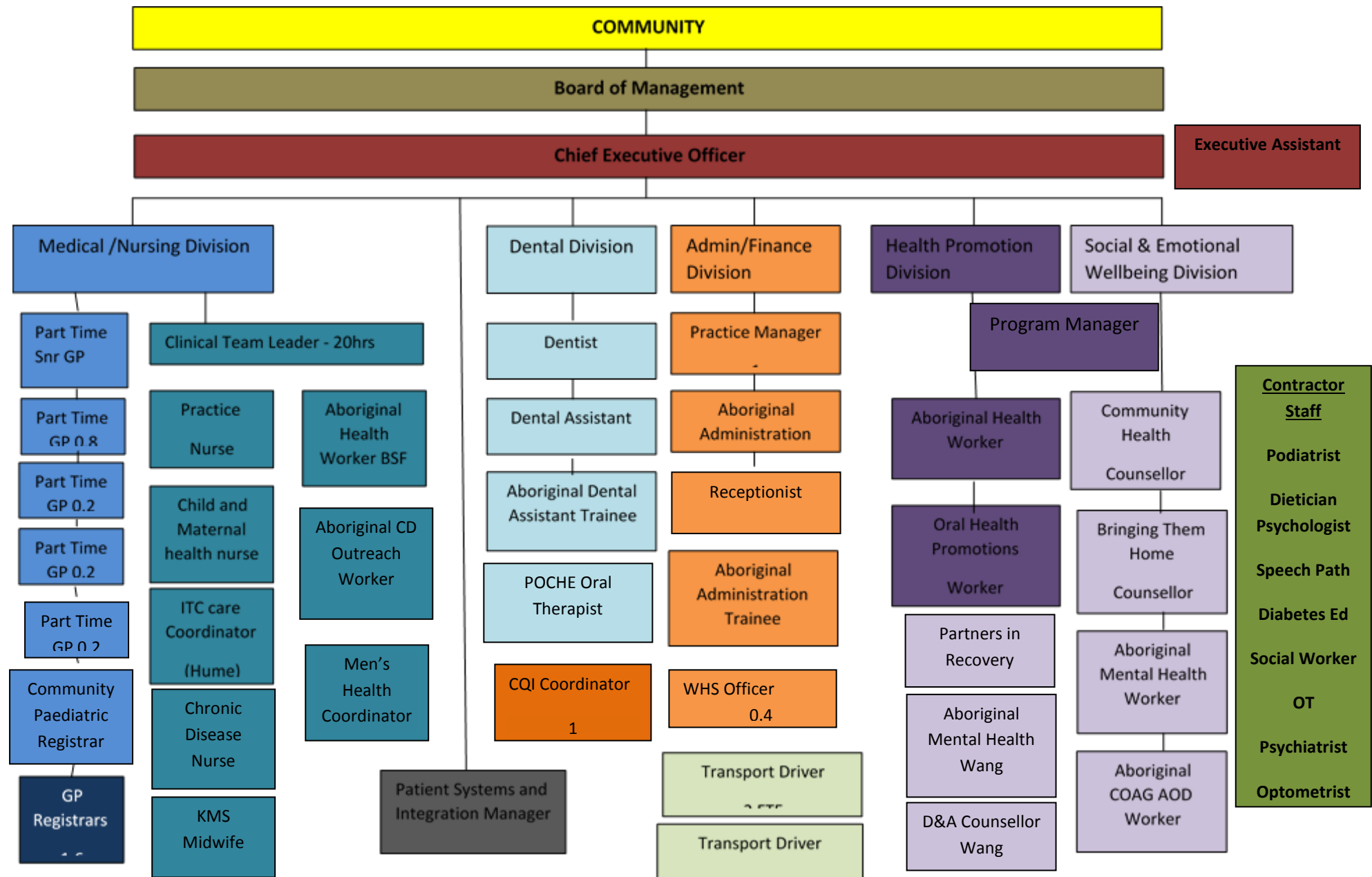
## CURRENT PROGRAM/STAFFING

July 2014

Social & Emotional Wellbeing	Admin/Management	Clinical	Visiting Services (Allied Health)
<ul style="list-style-type: none"> <li>- Drug &amp; Alcohol (counsellor, support worker)</li> <li>- Mental Health worker</li> <li>- Oral health worker</li> <li>- Sexual health worker</li> <li>- BTH</li> <li>- AHW</li> <li>- D&amp;A Counsellor (Wang)</li> <li>- Mental Health Worker (Wang).</li> </ul>	<ul style="list-style-type: none"> <li>- CEO + PA</li> <li>- Reception/Supervisor</li> <li>- Admin/reception</li> <li>- Transport</li> <li>- Work Health &amp; Safety</li> <li>- Patient Systems and Integration Manager</li> <li>- CQI Coordinator</li> </ul>	<ul style="list-style-type: none"> <li>- GP (2.2 EFT) + Registrar</li> <li>- Maternal &amp; Child Health (Nurse, support worker, paediatrician)</li> <li>- Practice Nurse (Acute health, Chronic Disease)</li> <li>- Chronic Disease support worker</li> <li>- Aboriginal Health Worker</li> <li>- Dentist + dental nurse</li> </ul>	<ul style="list-style-type: none"> <li>- Podiatrist</li> <li>- Paediatrician</li> <li>- Dietitian</li> <li>- Diabetes Educator</li> <li>- Speech Pathologist }</li> <li>- Occupational Therapist }</li> <li>- Psychologist }</li> <li>-</li> </ul> <p>Other</p> <ul style="list-style-type: none"> <li>- Financial Counsellor</li> <li>- Legal Aid</li> <li>- Cultural Mentor</li> </ul>
<p>Total Staffing: approx. 46 EFT</p> <p>Annual budget: approx. \$5 million</p>			



## Albury Wodonga Aboriginal Health Service – Strategic Plan 2014-2024





## STRATEGIC OBJECTIVES 2014-2024

<b>1</b>	<b>AWAHS is recognised as a provider of comprehensive, effective and quality health services to the Aboriginal &amp; Torres Strait Islander community.</b>
<b>2</b>	<b>AWAHS is recognised as being representative of and responsive to the Aboriginal &amp; Torres Strait Islander community and demonstrates leadership in promoting Aboriginal culture.</b>
<b>3</b>	<b>Service delivery and development is targeted to ensure that males, females, young people and families have improved knowledge and understanding of health issues and have the opportunity to take preventive/health enhancing action.</b>
<b>4</b>	<b>Elders/older community members and their carers are able to enjoy a satisfying quality of life.</b>
<b>5</b>	<b>Improved outcomes for clients dealing with issues related to abuse of alcohol/other drugs.</b>
<b>6</b>	<b>Young people have opportunities to engage in decision-making, leadership development and employment.</b>
<b>7</b>	<b>Case management processes support Aboriginal &amp; Torres Strait Islander clients to access appropriate services.</b>





## STRATEGIC PLAN 2014-2024



**Strategic Objective 1:**

**AWAHS is recognised as a provider of comprehensive, effective and quality health services to the Aboriginal & Torres Strait Islander community.**

**Rationale:** Historically, AWAHS was established specifically in order to respond to a community-expressed need for culturally appropriate and accessible services. Since its establishment AWAHS has developed into a sophisticated and growing organisation, providing a range of funded health and community programs. Community sentiment continues to support the existence and further development of a dedicated, Aboriginal community focused service.

Goal	Activity	Measure	Timeframe
1.1 AWAHS service development and delivery is based on evidence arising from structured and regular monitoring of community needs	a) Undertake annual needs analysis, including community surveys b) Initiate community engagement strategies that will inform ongoing service development c) Complete regular service usage data analysis	<ul style="list-style-type: none"> <li>Annual community surveys completed and analysed</li> <li>Community engagement strategy developed, including communications plan, community events calendar, consultation guidelines, feedback review considered at service and Board levels</li> <li>Client/patient data collected and reviewed at service and Board levels (e.g. PenCat data)</li> </ul>	
1.2 AWAHS provides primary and allied health services in accordance with funding agreements and expressed need	a) Existing medical, health promotion, dental and SEWB programs continue b) Existing allied health services/visiting services continue c) Funding agreements, MoUs and service agreements enacted to provide additional services as opportunities arise	<ul style="list-style-type: none"> <li>Services and program reports include accurate client data</li> <li>Services and programs reviewed in context of strategic and business plans</li> <li>Service delivery and reporting requirements included in compliance register and reviewed at service and Board levels</li> </ul>	
1.3 AWAHS program funding applications are based on relevance to goals outlined in the current strategic plan	a) Prioritise and prepare funding submissions in accordance with articulated strategic goals	<ul style="list-style-type: none"> <li>Funding applications/submissions reference specific strategic goals</li> </ul>	



## Albury Wodonga Aboriginal Health Service – Strategic Plan 2014-2024

Goal	Activity	Measure	Timeframe
1.4 AWAHS remains financially viable and financial systems satisfy the requirements of funding bodies, the Board and fiduciary responsibilities.	<ul style="list-style-type: none"> <li>a) Continuous review of income streams and monitoring of potential new funding sources undertaken by the CEO</li> <li>b) Compliance register records acquittals and other financial reporting requirements</li> <li>c) Board members undertake training in reading financial reports</li> <li>d) Regular reporting to the Board/Management Team meetings</li> <li>e) Presentations at community meetings provide accurate and transparent reports on AWAHS financial status</li> <li>f) Published audited finance reports included in Annual Report</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly acquittals and annual audit demonstrate positive financial status</li> <li>• Regular financial reports to the Board provide accurate and current information regarding profit &amp; loss statements, balance, income &amp; expenditure, variances</li> <li>• Records show all Directors have completed financial training</li> <li>• CEO and managers work to accurate budgets</li> <li>• Annual audited financial report available to members and included in Annual Report</li> </ul>	



**Strategic Objective 2:**

**AWAHS is recognised as being representative of and responsive to the Aboriginal community and demonstrates leadership in promoting Aboriginal & Torres Strait Islander culture.**

**Rationale:** As a community-controlled organisation AWAHS is bound by its rules to ensure that the organisation is governed by an elected Board comprised of Aboriginal community-based members. Through its participation in the service delivery system, involvement in whole-of-community activities and as one of only a few Aboriginal-specific organisations in the area, AWAHS has a responsibility to promote and support Aboriginal issues.

Goal	Activity	Measure	Timeframe
2.1 AWAHS provides an environment that recognises and celebrates Aboriginal history, culture and identity	<ul style="list-style-type: none"> <li>a) Ensure facilities are inviting and promote Aboriginal &amp; Torres Strait Islander culture.</li> <li>b) Initiate and participate in events that promote Aboriginal &amp; Torres Strait Islander history, culture and identity (e.g. NAIDOC, etc)</li> <li>c) Include promotion of Aboriginal &amp; Torres Strait Islander history, culture and identity in Communications Strategy (e.g. website, newsletters, etc)</li> <li>d) Provide and promote cultural training for all AWAHS staff and to 'partner' organisations</li> <li>e) Provide and promote cultural audit at AWAHS and 'partner' organisations</li> </ul>	<ul style="list-style-type: none"> <li>i. Staff and community surveys demonstrate satisfaction with the physical environment</li> <li>ii. Cultural events organised or attended by AWAHS personnel</li> <li>iii. Communications strategy objectives and review</li> <li>iv. Participation of non-Aboriginal staff in cultural awareness training.</li> <li>v. Partner organisations implement cultural awareness training and/or cultural audit</li> </ul>	



## Albury Wodonga Aboriginal Health Service – Strategic Plan 2014-2024

Goal	Activity	Measure	Timeframe
2.2 The Aboriginal and wider community understand the purpose and function of the Aboriginal Health Service	<ul style="list-style-type: none"> <li>a) AWAHS Communication Strategy designed to promote awareness and understanding of the service</li> <li>b) AWAHS Board and key personnel provide input to local and regional consultation regarding Aboriginal health issues</li> <li>c) Mainstream representatives are invited to attend AWAHS community-focused events</li> </ul>	<ul style="list-style-type: none"> <li>i. Communication strategy in place</li> <li>ii. Participation in local and regional consultative forums</li> <li>iii. Attendance by mainstream representatives at AWAHS events</li> </ul>	
2.3 AWAHS increases employment opportunities for Aboriginal & Torres Strait Islander people	<ul style="list-style-type: none"> <li>a) Implement effective HR systems that recognise the specific needs and qualities of the existing and potential workforce, including: <ul style="list-style-type: none"> <li>– Merit-based recruitment and retention strategies</li> <li>– Supervision and mentoring activities</li> <li>– Performance management systems</li> </ul> </li> <li>b) AWAHS provides traineeships and supports other training activities to increase professional skills of Aboriginal people</li> <li>c) Liaise with schools, TAFE, Universities and employment services to increase engagement with Aboriginal people</li> <li>d) Establish links with key employers in the Albury-Wodonga area to establish support structures to improve retention of Aboriginal &amp; Torres Strait Islander employees in the workplace</li> </ul>	<ul style="list-style-type: none"> <li>i. The number of Aboriginal &amp; Torres Strait Islander staff in professional, clinical, administrative and support roles</li> <li>ii. HR policies and procedures implemented and reviewed</li> <li>iii. Engagement with education providers, employment services and employers regarding Aboriginal &amp; Torres Strait Islander training and employment</li> </ul>	
2.4 AWAHS Board of Directors has a clear policy position regarding Aboriginal identification and confirmation of Aboriginality	<ul style="list-style-type: none"> <li>a) Board determines policy position</li> <li>b) Clear procedures are established regarding staff training, community awareness of identification procedures and confirmation of Aboriginality processes</li> </ul>	<ul style="list-style-type: none"> <li>i. Policies and procedures in place regarding recording Aboriginality (identification) and confirmation of Aboriginality.</li> </ul>	



**Strategic Objective 3:**

**Service delivery and development is targeted to ensure that males, females, young people and families have improved knowledge and understanding of health issues and have the opportunity to take preventive/health enhancing action.**

**Rationale:** It is recognised that not all people within the Aboriginal community seek to access the service and that AWAHS does not provide programs or services targeting some groups within the community. Particular groups have varying issues that require targeted responses. In particular males and young people are typically less represented in service usage data.

Goal	Activity	Measure	Timeframe
3.1 AWAHS is positioned to respond to identified needs of targeted groups, including males, females, young people and families	<ul style="list-style-type: none"> <li>a) Programs are designed and delivered through a consultative, evidence-based approach</li> <li>b) Funding sources are identified to implement targeted programs</li> </ul>	<ul style="list-style-type: none"> <li>i. Current data and consultation results inform funding submissions and program plans</li> </ul>	
3.2 AWAHS is positioned to respond to identified needs of community members with disabilities	<ul style="list-style-type: none"> <li>a) Ensure that people with high support needs are effectively linked to other AWAHS programs (i.e. Health and Family Services)</li> <li>b) Monitor the impact of funding for HACC services and the National Disability Insurance Scheme on service provision for Aboriginal people with support needs.</li> </ul>	<ul style="list-style-type: none"> <li>i. Younger people and their carers participate in programs</li> <li>ii. Participant and carer satisfaction surveys completed and analysed</li> <li>iii. Policies and procedures in place to implement NDIS</li> </ul>	
3.3 Health is regarded as a component of cultural pride	<ul style="list-style-type: none"> <li>a) Targeted health promotion activities are designed to engage the Aboriginal &amp; Torres Strait Islander community in a framework that addresses history, culture and identity</li> <li>b) AWAHS Communication Strategy includes health promotion messages within a cultural context</li> </ul>	<ul style="list-style-type: none"> <li>i. Health promotion activities planned, conducted and reviewed/evaluated within a context of Aboriginal &amp; Torres Strait Islander cultural relevance</li> </ul>	



**Strategic Objective 4:**

**Elders/older community members and their carers are able to enjoy a satisfying quality of life.**

**Rationale:** Changing demographics and an ageing population are presenting new issues for the community. For a range of social and political reasons, aged care services need further development to ensure that older Aboriginal people and their carers have access to appropriate support services.

Goal	Activity	Measure	Timeframe
4.1 Culturally appropriate respite care is available when required	<ul style="list-style-type: none"><li>a) Complete needs analysis for respite care requirements as a basis for further planning</li><li>b) Investigate partnership opportunities with respite care providers</li><li>c) Ensure appropriately trained Aboriginal &amp; Torres Strait Islander carers are available</li></ul>	<ul style="list-style-type: none"><li>i. Needs analysis completed</li><li>ii. Provision of culturally appropriate respite care</li></ul>	
4.2 Support services are in place to minimise isolation and increase socialization for Elders/older people	<ul style="list-style-type: none"><li>a) Identify opportunities to ensure provision of a range of aged care programs including:<ul style="list-style-type: none"><li>– HACC</li><li>– CAPS</li><li>– PAG</li></ul></li><li>b) Identify funding opportunities to enable care coordination (e.g. monitor roll out of NDIS)</li></ul>	<ul style="list-style-type: none"><li>i. Programs provided</li><li>ii. Participation rates monitored and satisfaction surveys completed</li></ul>	



**Strategic Objective 5:**

**Improved outcomes for clients dealing with issues related to abuse of alcohol/other drugs.**

**Rationale:** Drug and alcohol related issues are creating increasing burdens within the community and are regarded as a growing priority. Of particular concern is the lack of detox programs and support services to individuals and their families to provide assistance in rehabilitation that can contribute to better health outcomes and lower engagement in justice programs.

Goal	Activity	Measure	Timeframe
5.1 Clients have access to relevant and culturally appropriate detox services	<ul style="list-style-type: none"><li>a) AWAHS takes a leadership role in regional partnerships (reference group) to drive development of appropriate services</li><li>b) AWAHS drives review of Reference Group strategic plan to inform further service development</li><li>c) Service models reviewed to identify appropriate options</li></ul>	<ul style="list-style-type: none"><li>i. Regional plans support development of culturally appropriate detox services</li></ul>	





**Strategic Objective 6:**

**Young people have opportunities to engage in decision-making, leadership development and employment.**

**Rationale:** Young people have limited educational and developmental opportunities in a regional area. AWAHS has the potential to be a central focus for providing work-related support and activities as well as increasing participation by young people in both health-related and leadership programs.

Goal	Activity	Measure	Timeframe
6.1 Improved engagement of young people in AWAHS governance and programs	<ul style="list-style-type: none"><li>a) Board establishes a 'Youth Council' or sub-committee</li><li>b) AWAHS ensures links with schools through<ul style="list-style-type: none"><li>- Involvement in career advisory activities</li><li>- Work experience and other work exposure opportunities (e.g. 'shadowing')</li><li>- Traineeships/cadetships</li></ul></li><li>c) Promotion and provision of accredited courses (e.g. Certificate 2, 3, 4 courses)</li><li>d) Provision/coordination of youth-inclusive events</li></ul>	<ul style="list-style-type: none"><li>i. Youth Council established</li><li>ii. Engagement with education providers, employment services and employers regarding Aboriginal &amp; Torres Strait Islander training and employment</li><li>iii. Youth-focused activities conducted and evaluated</li></ul>	



**Strategic Objective 7:**

**Case management processes support Aboriginal & Torres Strait Islander clients to access appropriate services.**

***Rationale:** Many AWAHS clients have complex health and social needs and have difficulty accessing services without assistance. There is an expressed need for increased engagement of case managers/case workers and, potentially, new opportunities to be considered through the National Disability Insurance Scheme.*

Goal	Activity	Measure	Timeframe
7.1 Chronic and complex needs clients have support to navigate the service system	<ul style="list-style-type: none"><li>a) Case coordination models are established to maximise involvement of service provision teams within AWAHS</li><li>b) Identify opportunities to employ case managers/case workers</li><li>c) Monitor opportunities arising from implementation of the National Disability Insurance Scheme (NDIS)</li></ul>	<ul style="list-style-type: none"><li>i. Number and nature of case coordination services</li></ul>	

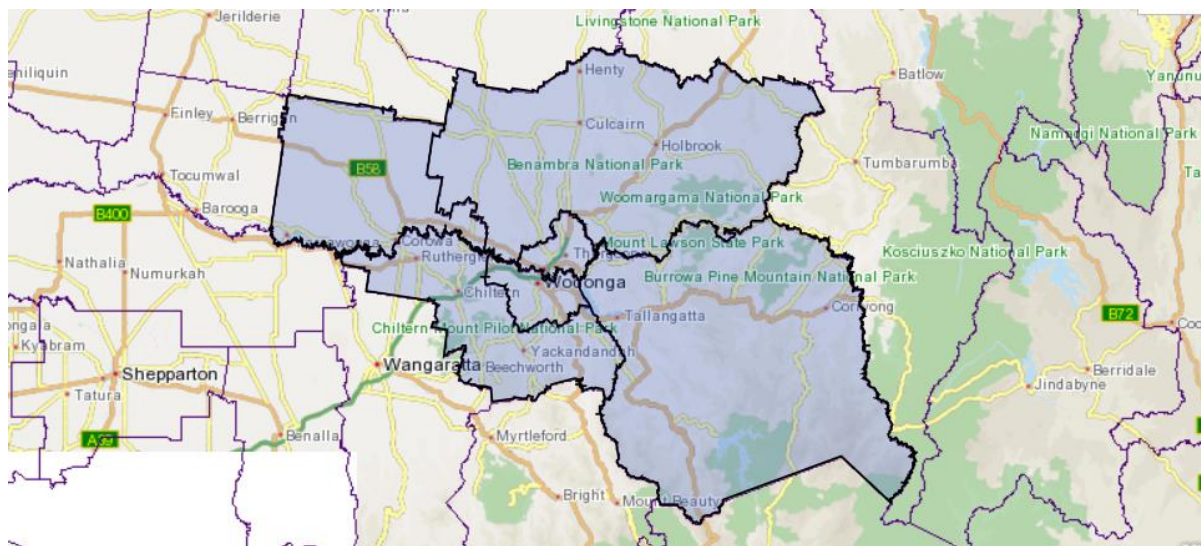


## DEMOGRAPHICS AND POPULATION HEALTH DATA



## Albany Wodonga

The following community profile draws upon a range of data sources and looks at data across a range of geographic areas. Albany Wodonga Aboriginal Health Service's (AWAHs) catchment area spans across six (6) Local Government Areas (LGAs). These include: Albany(C), Wodonga (RC), Corowa Shire (A), Greater Hume Shire (A), Indigo (S) and Towong (S) (maps shown below).



**Map 1: AWAH's catchment area**

In the absence of regional data, some state level of health data has been used.

The Aboriginal and Torres Strait Islander population in Albany-Wodonga is growing. In 2011, there were approximately 2,385 Aboriginal and Torres Strait Islander people living in AWAH's catchment area, up 29% from 1,850 in 2006. Within AWAH's catchment area, the Local Government Areas (LGAs) of the City of Albany and the Rural City of Wodonga have the largest Aboriginal populations (as shown in Table 1a).

**Table 1a. Number of Aboriginal and Torres Strait Islander People by Local Government Area (Source: ABS 2011 Census)**

Local Government Area	No.
Albany(C)	1,108
Wodonga (RC)	706
Corowa Shire (A)	143
Greater Hume Shire (A)	202
Indigo (S)	142
Towong (S)	84
Total AWAHs catchment	2,385

### Age profile

The Aboriginal population in AWAHs catchment area is significantly younger than the non-Aboriginal population. In 2011, the median age of Aboriginal and Torres Strait Islander people living in AWAHs catchment area was 18 years compared to 39 years for non-Aboriginal people.



**Table 1b. Age and sex profile of Aboriginal and Torres Strait Islander Population in AWAH's Catchment Area (Source: ABS 2011 Census)**

Age (years):	Males	Females	Persons
0-4 years	185	183	368
5-9 years	154	159	313
10-14 years	163	151	314
15-19 years	139	126	265
20-24 years	94	111	205
25-29 years	63	73	136
30-34 years	46	81	127
35-39 years	49	61	110
40-44 years	56	70	126
45-49 years	53	55	108
50-54 years	41	47	88
55-59 years	37	41	78
60-64 years	32	32	64
65 years and over	36	45	81
All ages	1,148	1,235	2,383

There is some significant variation in the age structure of the Aboriginal population within the six LGAs that make up AWAH's catchment area. Greater Hume Shire has the youngest Aboriginal population of the six LGAs and the Shire of Towong has the oldest (as shown below in Table 1c).

**Table 1c. Median age by Aboriginal status and Local Government Area (Source: ABS 2011 Census)**

	Aboriginal population	Non-Aboriginal population
Local Government Area	Median age	Median age
Albury(C)	19	38
Wodonga (RC)	18	35
Corowa Shire (A)	17	47
Greater Hume Shire (A)	14	43
Indigo (S)	19	45
Towong (S)	30	48
Total AWAHs catchment	18	39

### Income

In general, Aboriginal and Torres Strait Islander people earn less than non-Aboriginal people living within AWAH's catchment (as shown in Table 2 below). However, in the Greater Hume Shire, the total median weekly household income for Aboriginal households is higher than for non-Aboriginal households (\$1,018 per week compared to \$943 per week). There was quite significant variation in incomes received by households across AWAH's catchment area. Aboriginal households in the Shire of Towong had the lowest median weekly household income within AWAH's catchment (\$579 per week) whereas Aboriginal household in the Shires of Indigo and Greater Hume had the highest (\$1,018 per week).



**Table 2. Total Median Weekly Household Income by Aboriginal status and Local Government Area**  
(Source: ABS 2011 Census)

Local Government Area	Aboriginal households		Non-Aboriginal households	
	Median weekly household income	No. of household	Median weekly household income	No. of household
Albury(C)	\$739	503	\$1,034	18,113
Wodonga (RC)	\$808	310	\$1,081	12,912
Corowa Shire (A)	\$587	73	\$877	4,337
Greater Hume Shire (A)	\$1,018	91	\$1,064	3,521
Indigo (S)	\$1,018	68	\$1,064	5,544
Towong (S)	\$579	39	\$857	2,285

### Overcrowding and housing

Aboriginal and Torres Strait Islander people were more likely to be living in over-crowded houses than non-Aboriginal people living within AWAH's catchment area. In 2011, approximately one in eight (13%) Aboriginal household required one or more extra bedrooms to avoid overcrowding, compared with 1% of non-Aboriginal households (as shown in Table 3 below).

**Table 3. Proportion of homes that require one or more bedrooms by Aboriginal status and Local Government Area** (Source: 2011 Census)

Local Government Area	Aboriginal household	Non-Aboriginal household
	%	%
Albury(C)	7	2
Wodonga (RC)	8	2
Corowa Shire (A)	6	1
Greater Hume Shire (A)	9	2
Indigo (S)	8	2
Towong (S)	13	1

### Disability and caring

The Census indicator 'Need for Assistance' measures the number of people with a profound or severe disability. People with a profound or severe disability are defined as those people needing help or assistance in one or more of the three core activity areas of self-care, mobility and communication, because of a disability, long term health condition (lasting six months or more) or old age.

In 2011, the rate of disability was higher for Aboriginal people living in AWAH's catchment area than for non-Aboriginal people across all age groups except for children aged 0-4 years (as shown in Table 4a below). One in eleven Aboriginal children aged 5-9 years and one in eleven Aboriginal adults age 35-39 years and 55-59 years living in AWAHs catchment had a profound or severe disability. Rates of disability were also high in Aboriginal adults aged 45-49 years where one in 10 required assistance with their profound or severe disability and around one in seven Aboriginal adults aged 50-54 years and 60-64 years. The rate disability was highest for Aboriginal adults aged 65 years and over where almost one in four (24%) required assistance.



**Table 4a. Need for Assistance by Aboriginal status in AWAH's catchment area (Source: 2011 ABS Census)**

Age	Has need for assistance					
	Aboriginal population		Non-Aboriginal population		Aboriginal status not stated	Total
	no.	%	no.	%	no.	no.
0-4 years	4	1%	94	1%	0	98
5-9 years	28	9%	228	3%	3	259
10-14 years	12	4%	234	3%	11	257
15-19 years	10	4%	179	2%	3	192
20-24 years	12	6%	120	2%	4	136
25-29 years	7	5%	127	2%	0	134
30-34 years	8	6%	108	2%	4	120
35-39 years	10	9%	151	2%	0	161
40-44 years	7	6%	193	2%	3	203
45-49 years	11	10%	254	3%	0	265
50-54 years	13	15%	264	3%	7	284
55-59 years	7	9%	347	4%	10	364
60-64 years	9	14%	459	6%	7	475
65 years and over	20	24%	3,178	17%	115	3,313
All ages	158	7%	5,936	5%	167	6,261

The Census measures the number of people who provided unpaid assistance to a person with a disability. The indicator 'Provided Unpaid Assistance' records people who in the two weeks prior to Census Night spent time providing unpaid care, help or assistance to family members or others because of a disability, a long term illness or problems related to old age. This includes people who are in receipt of a Carer Allowance or Carer Payment. It does not include work done through a voluntary organisation or group.

In 2011, one in seven Aboriginal people aged 15 years and over living in AWAH's catchment area cared for people with a disability. Amongst Aboriginal adults aged 35-64 years, around one in five (21%) provide unpaid care for people with a disability.

**Table 5. Provided Unpaid Assistance to a Person with a Disability, Aboriginal and Torres Strait Islander Population in AWAH's Catchment Area (Source: 2011 ABS Census)**

Age	Provided unpaid assistance		No unpaid assistance provided	Unpaid assistance not stated	Total
	no.	%	no.	no.	no.
15-19 years	17	6%	222	25	264
20-24 years	17	8%	173	14	204
25-34 years	35	13%	210	23	268
35-44 years	46	19%	168	22	236
45-54 years	42	21%	137	21	200
55-64 years	32	22%	100	15	147
65 years and over	8	10%	50	22	80
Total	197	14%	1,060	142	1,399



### Level of disadvantage

The Index of Relative Socio-economic Disadvantage (IRSD) is a general socio-economic index produced by the Australian Bureau of Statistics that summarises a range of information about the economic and social conditions of people and households within an area. A low score indicates a relative level of disadvantage compared to other areas.

The six Local Government Areas that make up AWAH's catchment area range from having a relatively medium level of disadvantage to a relatively low level of disadvantage when compared to all other LGAs in Australia. However, within a Local Government Area there are areas of relative disadvantage. For example, within the LGAs of Albury and Wodonga almost half (47%) of all Statistical Area Level 1 had a relatively high or very high level of disadvantage (as shown in Table 5 below)<sup>1</sup>. In the Shire of Corowa almost three-quarters (73%) of all Statistical Area Level 1 had a relatively high or very high level of disadvantage. For all six LGAs there are significant pockets of high or very high levels of disadvantage.

**Table 6. Relative Level of Socio-economic Disadvantage by Local Government Area (Source: ABS 2011 Census)**

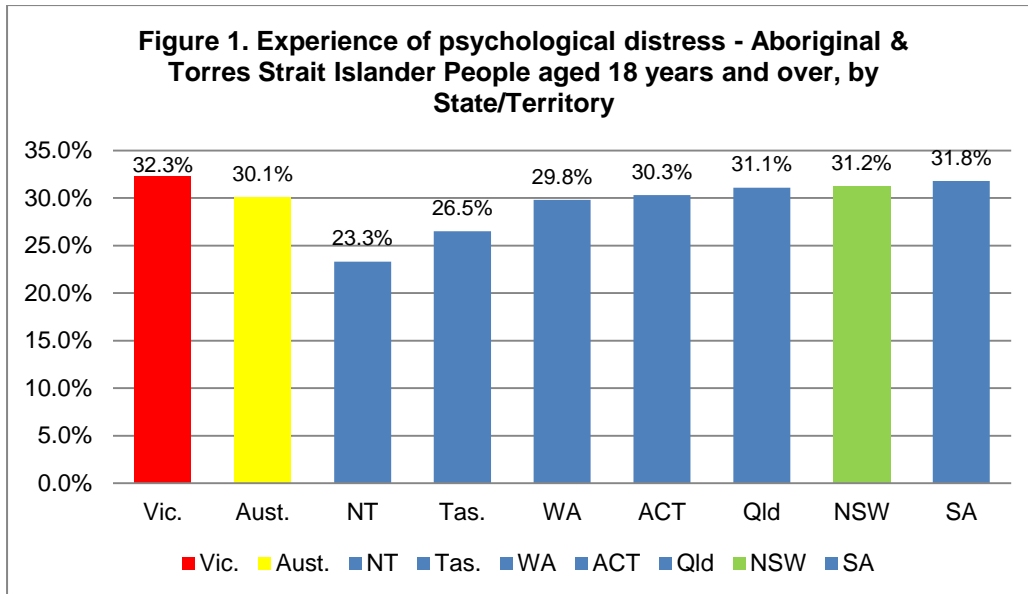
Local Government Area	IRSD Score	Level of disadvantage	Proportion of LGA that has a high or very high level of disadvantage
Albury(C)	979	Medium	47%
Wodonga (RC)	975	Medium	47%
Corowa Shire (A)	968	Medium	73%
Greater Hume Shire (A)	989	Low	38%
Indigo (S)	1,010	Low	32%
Towong (S)	996	Low	40%

### Social and emotional wellbeing

In 2012-13, Victorian Aboriginal and Torres Strait Islander people aged 18 years and over were more likely than Aboriginal people living elsewhere in Australia to have experienced high or very high levels of psychological distress. Almost 1 in 3 (32%) Aboriginal Victorians had experienced high or very high levels of psychological distress. The rate was slightly lower in New South Wales where approximately 31% had experienced high or very high levels of psychological distress. A high score indicates that the person may be experiencing feelings of anxiety or depression on a regular basis, whereas a low score indicates that the person is experiencing these feelings less frequently or not at all.

<sup>1</sup> Based on an analysis of the proportion of Statistical Area Level 1 within the electoral division that had SEIFA IRSD scores in the lowest four deciles.



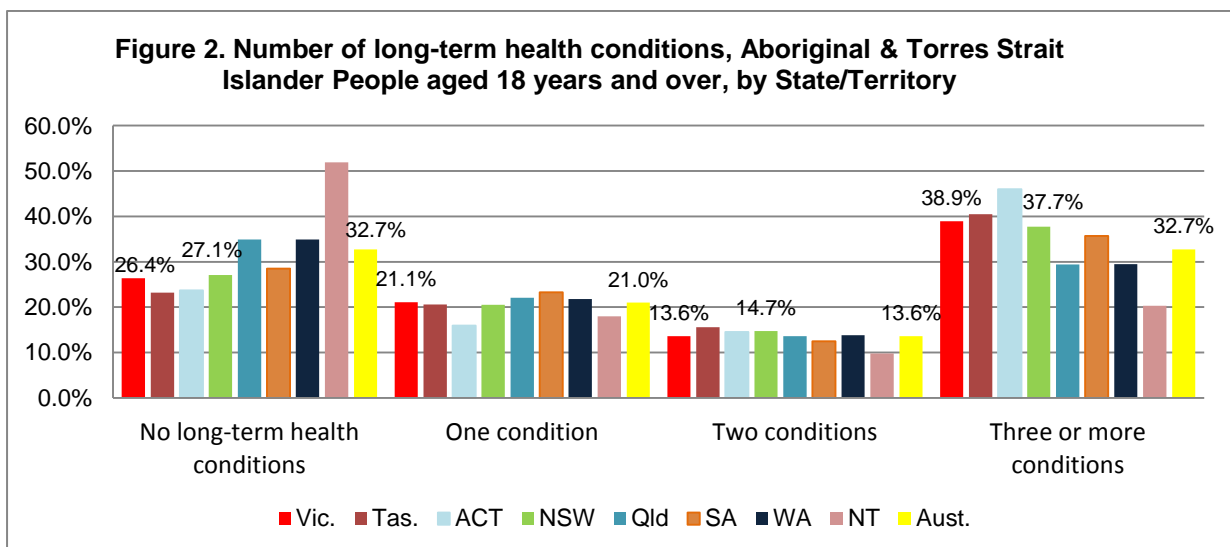


In 2008, 13% of Aboriginal and Torres Strait Islander people living in Victoria had been removed from their natural families. Almost half (47%), of Victoria's Aboriginal and Torres Strait Islander population had a relative removed from their family. In New South Wales approximately 8% of Aboriginal and Torres Strait Islander people had been removed from their natural families and just over a third (36%) had a relative removed from their family.

#### Health characteristics

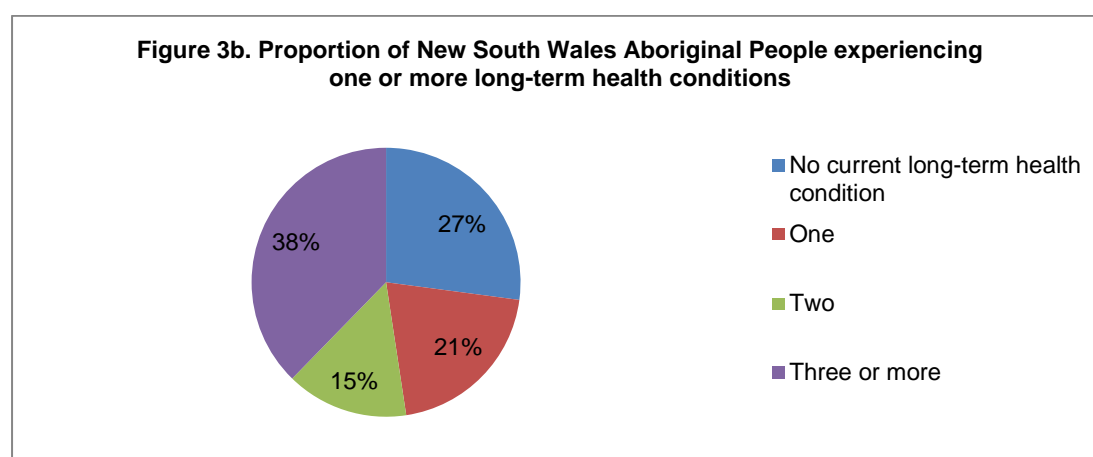
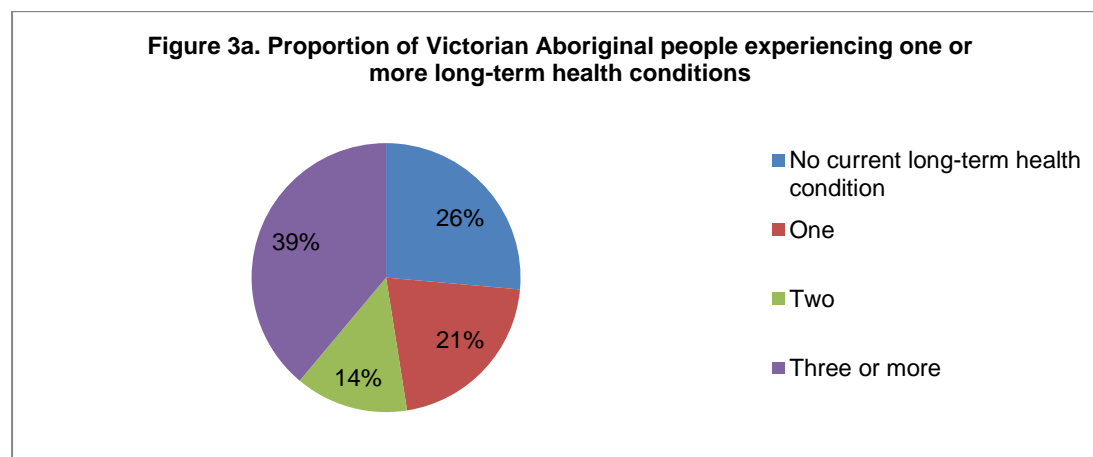
According to the 2012-13 National Aboriginal and Torres Strait Islander Health Survey 27% of Victoria and New South Wales' Aboriginal populations rated their personal health status as fair or poor.

Aboriginal and Torres Strait Islander people living in Victoria, New South Wales, Tasmania and the ACT were more likely than Aboriginal people living elsewhere in Australia to have a long-term health condition. In 2012-13, 26% of Aboriginal Victorians and 27% of New South Wales Aboriginal population had no current long-term health conditions, in comparison, across Australia, almost 1 in 3 (33%) of Aboriginal and Torres Strait Islander people did not have a long-term health condition (as shown in Figure 2).





In 2012-13, 74% of Victoria’s Aboriginal population and 73% of New South Wales Aboriginal population had one or more long-term health conditions. Approximately 39% of Aboriginal and Torres Strait Islander people living in Victoria and 38% of Aboriginal and Torres Strait Islander people living in New South Wales have three or more long-term health conditions (as shown in Figure 3a and 3b).



Victoria and New South Wales’ Aboriginal and Torres Strait Islander populations experience a range of long-term health conditions. Table 7 illustrates the prevalence of selected long-term health conditions within Victoria and New South Wales’ Aboriginal communities.



**Table 7. Selected long-term health conditions experienced by Victoria and New South Wales' Aboriginal and Torres Strait Islander Populations (Source: 2012-13 National Aboriginal and Torres Strait Islander Health Survey)**

	Vic	NSW
Selected current long-term conditions <sup>1</sup>	%	%
Arthritis <sup>2</sup>	13	11
Asthma	22	23
Back pain/problem, disc disorder <sup>3</sup>	12	10
Diabetes/high sugar levels <sup>4</sup>	7	8
Ear/hearing problems <sup>5</sup>	14	13
Eye/sight problems <sup>6</sup>	38	36
Heart and circulatory problems/diseases <sup>7</sup>	10	13

<sup>1</sup> Persons who have a current medical condition which has lasted, or is expected to last, for 6 months or more.

<sup>2</sup> Includes rheumatoid arthritis; osteoarthritis; and other arthritis and type of arthritis unknown.

<sup>3</sup> Includes disc disorders and back pain/problems not elsewhere classified.

<sup>4</sup> Includes Type 1 and Type 2 diabetes, and type unknown. Includes persons who reported they had diabetes but that it was not current at the time of interview

<sup>5</sup> Includes complete deafness; partial deafness and hearing loss not elsewhere classified; diseases of the middle ear and mastoid processes; diseases of the inner ear; and other diseases of the ear.

<sup>6</sup> Includes complete deafness; partial deafness and hearing loss not elsewhere classified; diseases of the middle ear and mastoid processes; diseases of the inner ear; and other diseases of the ear.

<sup>7</sup> Includes cataract; glaucoma; disorders of the choroid and retina; disorders of the ocular muscles, binocular movement, accommodation and refraction; visual disturbances and blindness; and other diseases of the eye and adnexa.

According to the Australian Institute of Health and Welfare (AIHW) *Aboriginal and Torres Strait Islander Health Performance Framework 2012*, key areas of concern for health outcomes of Aboriginal Victorians include:

- low birthweight, which is more than twice as common among babies of Aboriginal mothers as among babies of non-Aboriginal mothers;
- incidence of treated end-stage renal disease is currently 4 times the rate for non-Aboriginal people;
- high rates of hospitalisations due to injury (particularly assault, intentional self-harm and transport accidents);
- barriers to accessing appropriate health care, such as cultural competency continue to remain a problem;
- lower access to procedures in hospitals; and
- breast cancer screening rates for Indigenous women aged 50–64 are much lower than for other women of this age (28% compared with 53% in 2008–09). (AIHW 2013:xi)

With regard to the Aboriginal population living in New South Wales, the AIHW identified the following areas of concern:

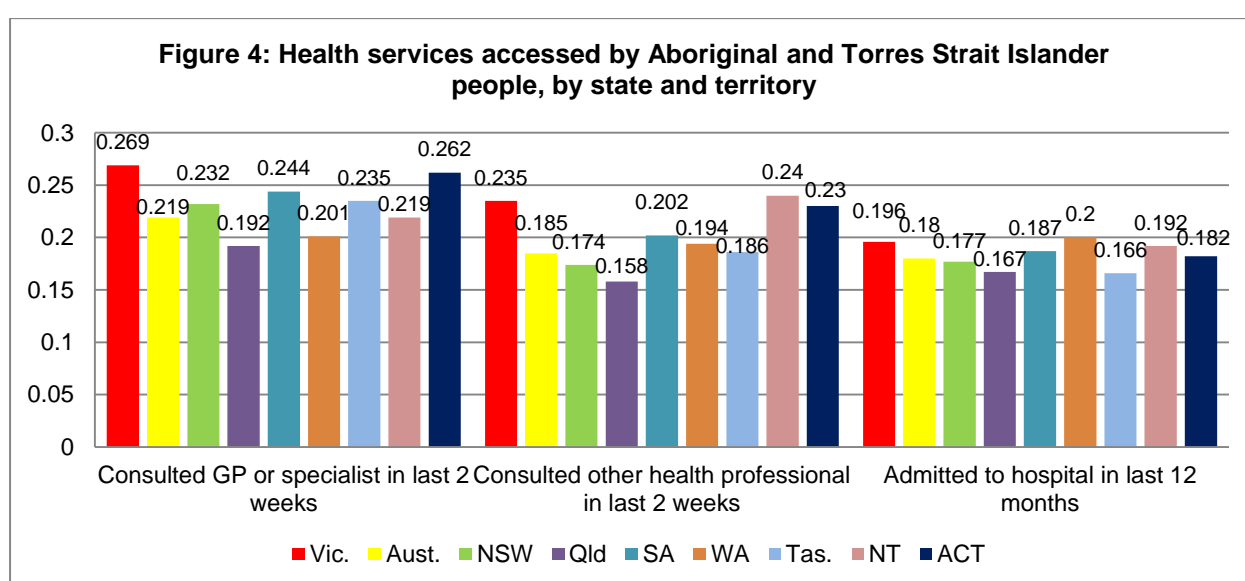
- high rates of smoking during pregnancy (51%);
- lower rates of access to antenatal care in the first trimester of pregnancy;
- mortality rates for chronic diseases are much higher for Aboriginal people (almost 4 times the rate of non-Aboriginal people for diabetes and almost twice the rate for circulatory diseases);
- a 286% increase in Aboriginal people commencing end stage renal disease therapy since 1991 (currently 3 times the rate for non-Aboriginal people);
- high rates of hospitalisations and deaths due to injury (particularly assault, suicide and transport accidents);



- barriers to accessing appropriate health care, such as cultural competency, continue to remain a problem;
- lower access to procedures in hospitals; and
- there is a large unmet need for dental care for Aboriginal children. (AIHW 2013:xi)

### Health services accessed

In 2012-13, more than one in four (27%) Aboriginal Victorians and just over one in five (23%) Aboriginal people living in New South Wales have consulted with a GP or specialist in the two weeks prior to the survey (as shown in Figure 4 below). Just under one in four (24%) Victorian Aboriginal people and 17% of Aboriginal people living in New South Wales consulted with other health professionals during the reference period. One in four (20%) of Victorian Aboriginals and 18% of Aboriginal people living in New South Wales had been admitted to hospital in the 12 months prior to the survey.



### Hospitalisation

Chronic diseases (for example, circulatory disease, cancer, diabetes, respiratory disease, kidney disease) were the cause of a large proportion of hospitalisations of Aboriginal people in Victoria between 2008–09 and 2009–10. Aboriginal and Torres Strait Islander people were hospitalised at 8 times the rate of non-Aboriginal Victorians from diabetes and almost twice the rate from respiratory diseases.

From July 2008 to June 2010 in Victoria, the most common principal diagnosis for hospitalisations among Aboriginal and Torres Strait Islander people was diseases of the digestive system (37.5 per 1,000), followed by symptoms, signs and abnormal clinical and laboratory findings (33 per 1,000). In New South Wales, the most common principal diagnosis for hospitalisations among Aboriginal people excluding health conditions involving dialysis, was injury and poisoning (36.3 per 1,000), and diseases of the respiratory system (35.9 per 1,000).

The greatest difference in hospitalisation rates between Aboriginal and Torres Strait Islander people and non-Aboriginal people in Victoria were for diseases of the respiratory system (rate difference 22.8 per 1,000 population) and mental and behavioural disorders (rate difference 18.9 per 1,000 population). The majority of hospitalisations for Aboriginal and Torres Strait Islander people in Victoria due to mental health-related conditions were for mood disorders (29%) and mental and behavioural disorders due to



psychoactive substance use (26%). Aboriginal and Torres Strait Islander people in Victoria were hospitalised at 1.3 and 2.6 times the rate of non-Aboriginal people for these conditions, respectively.

The greatest differences in hospitalisation rates between Aboriginal and non-Aboriginal people in New South Wales were for diseases of the respiratory system (rate difference 19.9 per 1,000 population) and mental and behavioural disorders (rate difference 17.1 per 1,000 population).

The majority of hospitalisations for Aboriginal and Torres Strait Islander people in New South Wales due to mental health-related conditions were for mental and behavioural disorders due to psychoactive substance use (36%) and schizophrenia, schizotypal and delusional disorders (21%). Aboriginal and Torres Strait Islander people in New South Wales were hospitalised at around 4 times the rate of non-Aboriginal people for these conditions, respectively.

### Cause of death

From 2006 to 2010 in New South Wales, the most common cause of death among Aboriginal people was circulatory diseases (30%), followed by neoplasms (cancer) (22%). These were also the most common causes of death among non-Aboriginal people in New South Wales. Cause of death data is not available for Victoria.

### Child and maternal health

In 2008 in Victoria, about 80% of Aboriginal and Torres Strait Islander infants aged 0–3 years had ever been breastfed. Approximately 14% of Aboriginal and Torres Strait Islander infants aged 0–3 in Victoria were currently being breastfed. The median age at which Victorian Aboriginal and Torres Strait Islander children stopped being completely breastfed was 17 weeks. Among Aboriginal and Torres Strait Islander infants aged 0–3 years in Victoria, 45% were first regularly given solid food when they were between 3 and 6 months old, and 30% when they were between 6 and 9 months old.

In 2008 in New South Wales and the Australian Capital Territory combined, about 69% of Aboriginal infants aged 0–3 years had ever been breastfed and 13% of Aboriginal infants aged 0–3 years in New South Wales and the Australian Capital Territory combined were currently being breastfed. Among Aboriginal infants aged 0–3 years in New South Wales, 45% were first regularly given solid food when they were between 3 and 6 months old, and 29% when they were between 6 and 9 months old.

In 2009 in Victoria, 44% of Aboriginal and Torres Strait Islander mothers smoked during pregnancy. Although this was lower than the proportion of Aboriginal and Torres Strait Islander mothers who smoked nationally (52%), Aboriginal and Torres Strait Islander mothers were more than 3 times as likely as non-Aboriginal mothers to smoke during pregnancy in Victoria.

In New South Wales in 2009, around half (51%) of Aboriginal and Torres Strait Islander mothers smoked during pregnancy. Aboriginal and Torres Strait Islander mothers in New South Wales were over 4 times as likely as non-Aboriginal mothers to smoke during pregnancy.

### Lifestyle risk factors

In 2012-13, the majority (66%) of Victoria's Aboriginal population and New South Wales Aboriginal population (67%) was overweight or obese. Around, 41% of Aboriginal and Torres Strait Islander people living in Victoria and New South Wales smoked daily.



In terms of alcohol consumption, in 2012-13, 19% of Aboriginal people living in Victoria and 18% of Aboriginal people living in New South Wales exceeded the 2009 NHMRC lifetime risk guidelines. More than half of the Victorian Aboriginal population and the Aboriginal population living in New South Wales exceeded the 2009 NHMRC single occasion risk guidelines for alcohol consumption (59% and 55% respectively).

According to the 2013 NHMRC guidelines, in 2012-13 almost two-thirds (62%) of Victoria's Aboriginal population and 58% of Aboriginal people living in New South Wales were consuming an inadequate amount of fruit on a daily basis. Almost all (95%), Aboriginal and Torres Strait Islander people living in Victoria and New South Wales were consuming an inadequate amount of vegetables on a daily basis.

#### Drug and other substances

In Victoria, in 2008, 34% of Aboriginal males and 22% of Aboriginal females aged 18 and over had used illicit substances in the last 12 months (as shown in Table 8a below). Marijuana/hashish/cannabis resin was the most commonly reported type of substance used by Aboriginal and Torres Strait Islander adults in Victoria.

**Table 8a. Substance use, Aboriginal and Torres Strait Islander Victorians aged 18 and over, by sex**  
(Source: 2008 NATSISS)

Type of substance used	Males	Females	Persons
	%	%	%
Marijuana, hashish or cannabis resin	26	14	20
Amphetamines or speed	9	6	7
Ecstasy or designer drugs	9	4	6
LSD or synthetic hallucinogens	3	1	2
Pain killers or analgesics for non-medical purposes	10	6	8
Naturally occurring hallucinogens	2	1	1
Cocaine	3	1	2
Other analgesics	1	1	1
Volatile solvents	3	0	2
Tranquillisers or sleeping pills for non-medical purposes	6	3	5
Kava	2	1	1
Total used substance in last 12 months	34	22	28

In New South Wales, in 2008, 32% of Aboriginal males and 20% of Aboriginal females aged 18 and over had used illicit substances in the last 12 months (as shown in Table 8a below).

Marijuana/hashish/cannabis resin was the most commonly reported type of substance used by Aboriginal and Torres Strait Islander adults in New South Wales.



**Table 8b. Substance use, Aboriginal and Torres Strait Islander people living in New South Wales aged 18 and over, by sex (Source: 2008 NATSISS)**

Type of substance used	Males	Females	Persons
	%	%	%
Marijuana, hashish or cannabis resin	26	12	19
Amphetamines or speed	9	4	6
Ecstasy or designer drugs	5	2	3
LSD or synthetic hallucinogens	1	0	1
Pain killers or analgesics for non-medical purposes	4	5	4
Naturally occurring hallucinogens	1	-	1
Cocaine	1	1	1
Other analgesics	0	0	0
Volatile solvents	-	0	0
Tranquillisers or sleeping pills for non-medical purposes	1	2	2
Kava	2	1	2
Total used substance in last 12 months	32	20	25



## THE GOANNA SURVEY July 2014

**Sexual Health and relationships in young Aboriginal and Torres Strait Islander people:** Results from the first national study assessing knowledge, risk practices and health service use in relation to sexually transmitted infections and blood borne viruses. *James Ward, Joanne Bryant, Handan Wand, Marian Pitts, Anthony Smith, Dea Delaney-Thiele, Heather Worth, John Kaldor*

### Alcohol

Alcohol consumption was common among the study population with 78% reported drinking alcohol in the last year. Drinking alcohol once weekly or more often was reported by 36% of participants overall; 41% of males and 33% of females. Prevalence of alcohol consumption increased with age (70%, 84% and 85% among <20, 20-24 years and 25 years or older respectively).

Among those who reported drinking alcohol 54% of males and 41% of females reported drinking 7 or more alcoholic drinks (risky drinking levels) on days when consuming alcohol. By age 50% of participants in the age group 20-24 years reported risky drinking levels compared to 44% of participants aged less than 20 and older than 25 years of age.

### Tobacco use

Overall, 38% of the study population reported smoking at least one cigarette a day; cigarette smoking was slightly more common among females compared to males (40% versus 37%). Reports of smoking cigarettes increased with age (31%, 43% and 47% among participants aged <20, 20-24 and >25 years respectively). Participants from regional and remote areas were relatively more likely to be a smoker compared to those participants from urban areas (44% and 39% versus 35% respectively)

### Illicit drug use

Overall, 35% of participants reported they had used at least one illicit drug (marijuana, meth/amphetamine or ecstasy) in the past year comprising 39% of males and 32% of females. By age, any illicit drug used in the last year increased with age from 29% of participants aged less 20 years to 39% and 40% of people aged 20-24 and 25-29 years.

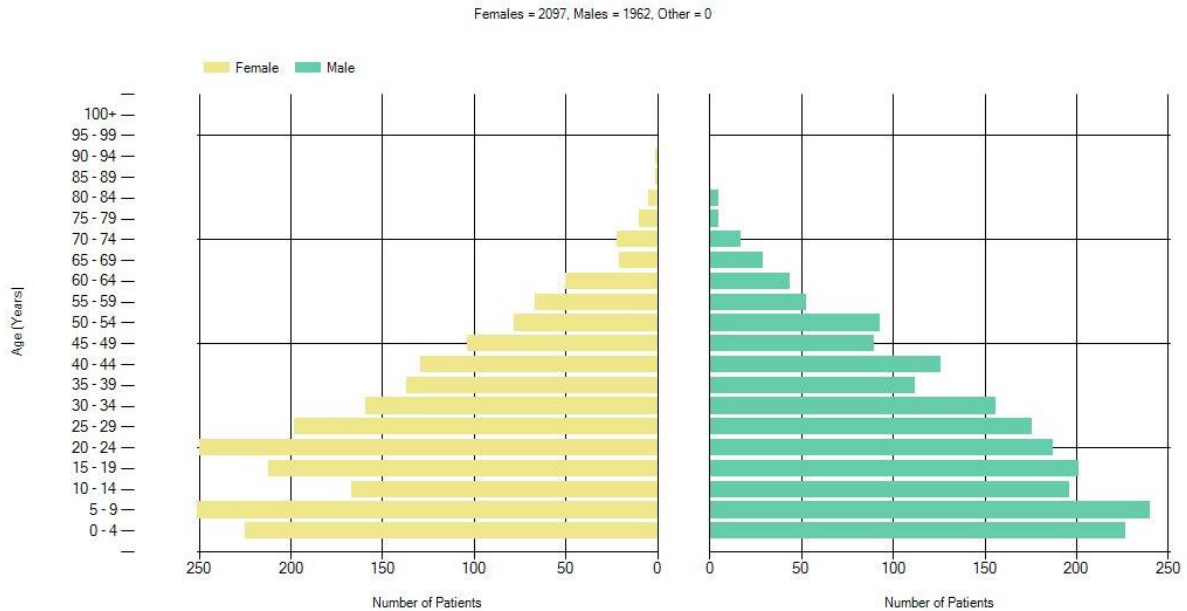
A higher proportion of male participants reported using illicit drugs in the last year compared to the females (39% versus 32%). Of illicit drugs used, marijuana was the most common drug 30% overall- 33% of males and 29% of females. Meth/amphetamine use was reported as used by 9% of participants overall and 12% of males and 8% of females. Ecstasy use was reported by 11% participants overall and 14% of males and 8% of females.





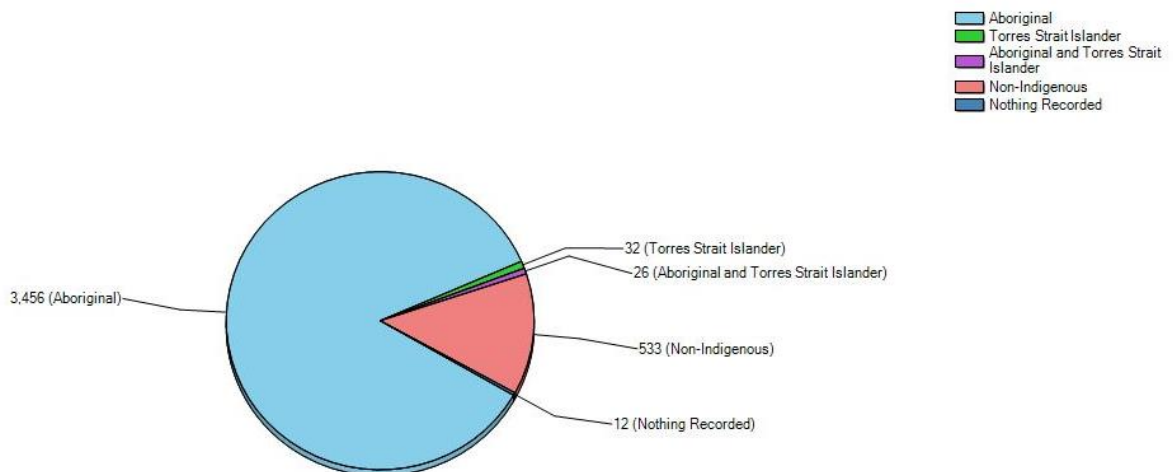
## AWAHS Client Data

Table 1: Age & Gender\*



51.7% of clients attending AWAHS in the past year were female and 48.3% male. The largest proportion of clients was children aged 0-14. Young women (aged 15-29) make up the next largest grouping.

Table 2: Ethnicity\*

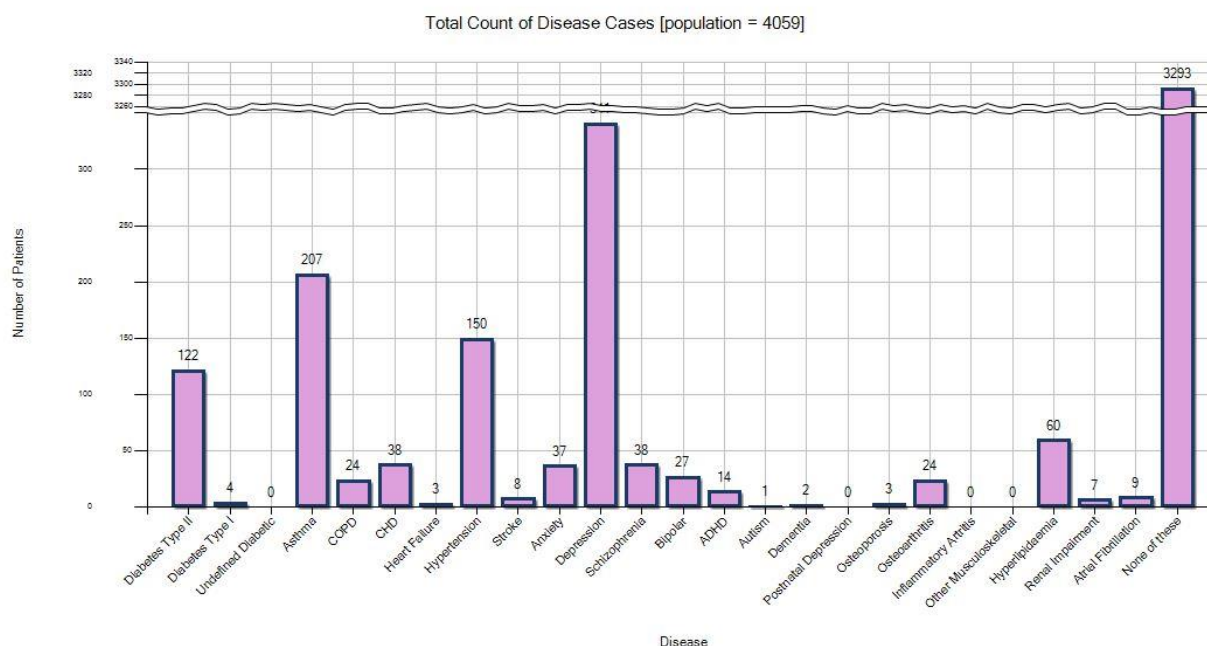


85% of clients attending AWAHS in the past year identified as Aboriginal and another 1.5% identified as Aboriginal and/or Torres Strait Islander. 13% of clients identified as non-Indigenous and 0.3% were not recorded.



\* N = 4059

Table 3: Presenting conditions



1.	Depression	344	
2.	Asthma	207	
3.	Hypertension	150	
4.	Diabetes Type II	122	
5.	Hyperlipidaemia	60	
6.	Chronic Heart Disease (CHD)	38	
7.	Schizophrenia	38	
8.	Anxiety	37	
9.	Bipolar	27	
10.	Osteoarthritis	24	

Mental health issues make up a high proportion of patient medical conditions, with depression being the most frequent presenting condition (8.5%), along with anxiety and schizophrenia (1.0%) and bipolar disorder (0.7%).

Asthma is the second highest presenting condition (5.1%). Type II diabetes, hypertension (high blood pressure) and hyperlipidaemia (high cholesterol) account for a relatively high proportion of presenting conditions.

Source: AWAHS - ClassicCAT data extraction



## Appendix 1 - SWOT ANALYSIS

Strategic Planning Forum SWOT Exercise: AWAHS Board and Senior Management team. July 29, 2014

<b>STRENGTH</b> <ul style="list-style-type: none"> <li>- Growth</li> <li>- Range of services provided</li> <li>- Land, facilities, environment</li> <li>- Funding</li> <li>- Financial integrity</li> <li>- Reputation with funders and other organisations</li> <li>- Relationships within the Aboriginal community and organisations</li> <li>- Community focus and participation</li> <li>- Board and governance procedures</li> <li>- Maternal &amp; Child Health services, linked with obstetrics</li> <li>- IT capacity</li> <li>- Training availability, scholarships</li> <li>- Leadership to community and within service sector</li> <li>- Client transport service, outreach</li> <li>- Bulk billing medical practice</li> </ul>	<b>WEAKNESS</b> <ul style="list-style-type: none"> <li>- Growth</li> <li>- Funding</li> <li>- Staff training</li> <li>- Community awareness of services</li> <li>- Communication</li> <li>- Missing 'markets' (eg youth, men)</li> <li>- Regular policy review</li> <li>- Regular organisational review (structure)</li> <li>- Clarity of roles and responsibilities within the service (including Scope of Practice definitions)</li> <li>- Service schedule (hours of operation, rosters, etc)</li> <li>- Board staff relationships/understanding</li> <li>- Volunteer board</li> </ul>
<b>OPPORTUNITY</b> <ul style="list-style-type: none"> <li>- Ownership of land</li> <li>- Cultural focus/hub</li> <li>- Funding</li> <li>- Training, scholarships, student placement/recruiting</li> <li>- Diversification of services (social model of health – cradle to grave)</li> <li>- Cross border service provision, linkages and partnerships, funding opportunities</li> <li>- Young people</li> <li>- Partnerships</li> <li>- after hours services?</li> <li>- MoUs, service agreements with other orgs</li> <li>- Co-location</li> <li>- Referral pathways</li> <li>- Men's and Youth services</li> <li>- Non-Indigenous clients as a source of Medicare income</li> <li>- Research opportunities (university partnerships)</li> <li>- Preventative programs</li> <li>- NDIS?</li> </ul>	<b>THREAT</b> <ul style="list-style-type: none"> <li>- Funding</li> <li>- IT</li> <li>- Government policy directions</li> <li>- Program insecurity (including GP services)</li> <li>- Sustainability</li> <li>- Community perceptions of the organisation</li> <li>- Competition from other (non-Aboriginal) providers</li> <li>- Loss of key staff</li> </ul>