Seeking a Way to Bridge the Gap:
A Scoping Study to Identify the Preferred Aged Care Service Model for Older Aboriginal People in Mid North Coast NSW

Report to Department of Health and Ageing
Conducted for and on Behalf of Yarrawarra Aged Care Ltd

August 2008
ACKNOWLEDGEMENTS

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- Southern Cross University Office of Regional Engagement: Ms Jan Strom
- QCare Australia Pty Ltd/Carexcell Pty Ltd: Mr Lyal Allen
- The Enterprise and Training Corporation Limited: Mr Michael Close, General Manager

We also thank the following people for their advice and information

Aboriginal Elders:
- Aunty Bea Ballangarry; Aunty Marie Tarplee; Aunty Fay Haslam

Ms Marilyn Body – Community nurse – Aboriginal-specific; Coffs Harbour Health Campus, North Coast Area Health Service
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Funding for this study was provided by the Commonwealth Department of Health and Ageing
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EXECUTIVE SUMMARY

INTRODUCTION
This Report details the Scoping Study of the health and care needs of older Aboriginal people of the Mid North Coast of NSW, conducted by the Aged Services Learning and Research Centre (ASLaRC) of Southern Cross University (SCU), in collaboration with Yarrawarra Aged Care Ltd (YACL), SCU Office of Regional Engagement, Carexcell and The Enterprise and Training Corporation Limited. The focus of the study was how to deliver culturally appropriate care to older Aboriginal people in the region, and to maximise use of the Moonee Centre for Aboriginal Aged Care.

LITERATURE REVIEW
A literature review was conducted using search terms including: Aboriginal, Indigenous, aged, elder, older people, aged care, health, health care, health services, Australia. Very little literature specifically relating to aged care provision for older Aboriginal people was found, apart from a number of journal articles relating to palliative care of older Aboriginal people (e.g. Maddocks and Rayner, 2003; McGrath et al 2005; McGrath et al 2007). Many of the issues identified in that literature were considered relevant to the provision of care services for older Aboriginal people more generally, including an understanding of the importance of kinship and ‘who has the right to know’ about an older Aboriginal person’s health care needs, as well as Aboriginal views on health and illness, death and dying. Information from consultations held with Aboriginal Elders and the Service Providers who support them were used to exemplify where the accessed literature resonated with local issues and to identify service needs.

STUDY REGION AND EXISTING SERVICE PROVIDERS
The Report defines the study region, noting that the Moonee site is centrally positioned within the Gumbaynggirr Nation (the main Aboriginal group in this region), which makes it well-situated to fill a gap in existing services for older Aboriginal people. A review of some major mainstream aged care services was undertaken, with identification, where possible, of Aboriginal use of those services. This was followed by identification of Aboriginal-specific services. Services discussed include residential aged care facilities (RACFs), respite care and community care, with particular emphasis on Aboriginal-specific community care Packages and day activities and support services and Aboriginal medical Services.
DEFINE THE DEMAND
In the 2006 Census, from a total population of 143,371 in the four Local Government Areas (LGAs) in the study area, 5,961 people (4.2%) identified as Aboriginal, of whom 1,058 (17.75%) were aged 45 or above, i.e. the target population for this study. As there is some evidence to suggest that Census data under-represents the Aboriginal population, it is recommended that this figure be increased by 10% when planning for services.

SUMMARY OF EXISTING RESEARCH RE: SOCIAL AND CULTURAL TRENDS AND SPECIFIC HEALTH AND AGED CARE NEEDS
Significant issues identified in the available literature regarding Aboriginal social and cultural trends and expectations were investigated. These include: key historical factors which still impact on Aboriginal health; the importance of understanding and acknowledging Aboriginal beliefs regarding health, dying, death and burial; fear of relocation associated with health care; the importance of kin and the extended family; cultural and social communication issues; the role that older Aboriginal people play in their communities; and the diversity of Aboriginal culture. Data on Aboriginal illnesses and disease is next considered, followed by insights into emergent themes from research into Aboriginal general health care, aged care, and palliative care, including issues relating to family care and carer burden:

Problems with communication were noted as impeding good care for older Aboriginal people, with a need to build an Aboriginal workforce and support the development of Aboriginal Health Workers. Lack of appropriate transport was also noted as a barrier to good care of older Aboriginal people, reflecting a problem experienced by older people in the wider community.

SUPPLY AND DEMAND MATRIX
Following the above investigations, a matrix showing the inter-relationship between existing programs and the identified demand for Aboriginal Aged Care services and programs was developed. Planning rations and population estimates indicated that the number of Aboriginal-specific community care places should be 132. It was noted that there are currently no Aboriginal-specific residential places in the study area (and apparently not high demand for such places) but there are 68 community care places, primarily Community Aged Care Packages, including a small number of Extended Aged Care at Home Packages.
The major service gap identified by this study was the need for respite, including day respite, overnight respite and short-term emergency respite. Several Service Providers saw the Moonee site as a potential hub for Aboriginal-specific aged care services and an ideal informal environment for education of both older Aboriginal people and workers.

PREFERRED FUTURE SERVICE MODEL

Based on the evidence collected, there is a demonstrated need for an Aged Care Service Centre, operated by an Aboriginal organisation, for older Aboriginal people living in the Gumbaynggirr Nation. The need for an Aboriginal-specific residential respite service for older Gumbaynggirr people is also a clearly identified service gap within the overall project area. The project team recognises the significant challenges that establishing a well-utilised Aboriginal-specific residential respite service presents, including:

- a mature Aboriginal organisation to operate it;
- the achievement of community trust; and
- improved understanding amongst the Aboriginal community about the nature of respite services.

The Moonee site appears to be a satisfactory location for the development of such a Centre for older Aboriginal people within the Gumbaynggirr Nation, being centrally sited within the Nation and having existing infrastructure that can, with modest refurbishment, be made appropriate for this purpose.

The findings from this study support the concept of the evolutionary/staged development of aged care services within the Gumbaynggirr Nation, including social, care and health needs of older Aboriginal people and gradually extending these services over time to encompass residential respite services. This service development would involve ongoing consultation and work with the older Aboriginal people and their families to ensure that services that are developed meet their needs and address their fears.

Innovation: A key feature of the proposed future service model is the establishment of ‘Home Away From Home’ Packages at the Centre, a new Aboriginal-specific aged care service for day respite, crisis respite and step-down respite. It is acknowledged that the cost of such a service will be a major consideration, which will require innovation and flexibility to address. An analysis of the impact of such a service is presented, followed by an
outline/time-line of the proposed future service model and staged planning for the Moonee Centre for older Aboriginal people.

FINANCIAL FEASIBILITY
The financial feasibility of proposed service delivery models based at the Moonee site were examined, including consideration of:

- an appropriate rate of return to YAC (as owner of the land);
- the cost of capital works required to render the property suitable for service delivery; and
- the ongoing financial viability of service provision through both recurrent funding streams and client contributions.

Summary of Financial Feasibility Modeling: The Moonee Centre as proposed brings to a geographically and socially important place a range of small but very much needed services for older Aboriginal people living within the region. The Centre is remote from the major CBD areas, but is positioned in culturally-appropriate country. Each program proposed for the Centre addresses an identified need within the target region. Individually, some programs are self supporting (DADHC & CACP) but other programs such as the planned growth into respite/HAFH programs would appear to be unsustainable without ongoing supplementary funding.

For the Centre to operate within Health and OHS guidelines, significant capital will need to be expended. The restoration of the former DOTARS Sustainable Regions Grant ($470,000) would go a long way toward providing the required capital. Whilst the DADHC, CACP and visiting Allied Health programs could conceivably operate and be self sustaining from the Moonee Centre, their effectiveness will be seriously compromised if these are the only services to be provided through the Centre.

GOVERNANCE, MANAGEMENT AND ACCOUNTABILITY MODEL
Existing and proposed Governance, Management and Accountability Models are presented in the final section of the Report.
SECTION 1. INTRODUCTION

1.1 BACKGROUND

The Moonee Centre for Aboriginal Aged Care began as an initiative of Yarrawarrra Aboriginal Corporation (YAC) in association with Coffs Coast Future of Ageing, and has been in development for approximately six years, in partnership with regional community, education and business organisations. The primary purpose of the project is to deliver culturally appropriate care to older Aboriginal people in the Mid North Coast region of NSW.

In 2004, YAC purchased a former motel site at Moonee, which is to be renovated and refurbished to make it suitable for the delivery of a range of on-site and off-site flexible care services to older Aboriginal people. To further develop and manage this project, Yarrawarrra Aboriginal Aged Care Ltd (YACL) was formed.

In 2005, the Aged Services Learning and Research Centre (ASLaRC) of Southern Cross University, based at the Coffs Harbour Campus, was invited to be part of the Project Team. At the end of 2006, ASLaRC agreed to undertake research to support the project, by conducting a scoping study on the health and care needs of older Aboriginal people in the region, with input from other members of the project team as appropriate (see Project Brief – Appendix 1).

1.2 LITERATURE REVIEW: (NOTE: The term Aboriginal rather than Indigenous has generally been used in this Report, except where citing specific literature. This approach has been taken as ‘Indigenous’ does not have a specific meaning, defined in the Macquarie Dictionary as “originating in and characterising a particular region or country” and considered by some Aboriginal people as diminishing their Aboriginality, and therefore a term to be avoided [NSW Health 2004:11]. The Project Brief, outlining the Partner’s key responsibilities in conducting this Study and forming the basis of the Report’s structure, also used the term Indigenous and this has been changed to Aboriginal throughout the Report.)
The following academic databases were searched for this review:

- Australian Indigenous Health InfoNET
- EBSCO (including Medline, CINAHL plus with full text databases)
- InfoRMIT (including APA-FT, APAIS- Australian Public Affairs, ATSIROM, Australian Health Online, Asia ROM - Social Sciences and Asia Online, AustROM - Social Sciences, Law & Education, Family –Australian Family and Society, Family and Society plus, MAIS, Meditext)
- Proquest 5000 (including Proquest Health and Medical Complete, Health Module, Research Library)
- Pubmed

Search terms used included: Aboriginal, Indigenous, aged, elder, older people, aged care, health, health care, health services, Australia.

Very little literature specifically relating to aged care provision for older Aboriginal people was found. Warburton and Chambers (2007:3) also noted “the absence of a body of conventional academic literature on …the social and cultural roles played by older Indigenous Australians within their communities”. This is not a new problem; in 1996, Crowe lamented “the lack of comprehensive literature concerning Aborigines and how they view ageing, the aged and the needs of the aged” (p11).

Of the journal articles that were identified, a number related to palliative care of older Aboriginal people (e.g. Maddocks and Rayner, 2003; McGrath et al 2005; McGrath et al 2007). While palliative care is not the specific focus of this report, many of the issues identified in that literature are relevant to the provision of care services for older Aboriginal people more generally. These include an understanding of the importance of kinship and ‘who has the right to know’ about an older Aboriginal person’s health care needs, as well as Aboriginal views on health and illness, death and dying.

For the purpose of this Report, ‘older Aboriginal people’ refers to those aged 45 and above; although 50 and above is the age band used by the Commonwealth government in calculating service needs (ABS: AIHW, 2005:222), discussions with Service Providers in the study region at the commencement of the study indicated that 45 and above is a more realistic starting point when considering the health care needs of older Aboriginal people.
(NOTE: The term ‘older Aboriginal people’ is generally used in this Report, rather than ‘Aboriginal Elders’ because in Aboriginal society the attainment of ‘Elder’ status, with its corresponding conception of power, authority and respect, has to be earned and depends not just on age but on a combination of factors which include relationships, gender, status and community contribution [Warburton and Chambers, 2007:3]. ‘Aboriginal Elder’ is used where the person is identified as such in the cited literature, by an interviewee or by an older person’s membership of a specific Elders’ group.)

Warburton and Chambers (2007:3) note that, despite the lived experience of many older Aboriginal people having included loss of human rights, violence, removal and loss of children and attempted eradication of their language and culture, and even contemporary experiences of “short life expectancies, low incomes, and experiences of racism and prejudice”, their very survival in the face of such a struggle demonstrates resilience.

These researchers observed that “a consistent theme in Indigenous comment is the immense time and effort that older Indigenous people invest in their communities” (ibid 4); the roles they undertake range from support for the young and transmission of cultural knowledge to visiting schools, hospitals and prisons and “sitting on boards fighting for political and cultural rights” (ibid).

In order to fulfil these important and significant roles, older Aboriginal people need safe and appropriate support and care as they age, which will not only allow them to live their remaining years as well as possible but will provide a ‘place’ from which they can continue to contribute to their Aboriginal community as mentors and role models. Many Aboriginal people, both male and female, report that it was their grandmothers who played a major role in passing on cultural knowledge and identity (Warburton and Chambers, 2007:5). Early discussions for this project with older Aboriginal women indicated that they would welcome the formation of a grandmothers’ group at the Moonee facility, both as a place of respite for older Aboriginal women and as place from which older Aboriginal women can ‘outreach’ to the young people in their communities.
Aged care for older Aboriginal people must include concepts of death and dying; Maddocks and Raynor (2003:S18) note:

The decision-making processes in Indigenous communities are collective and often protracted. Particular people in the patient’s ‘skin’ group will make decisions with or on behalf of an individual. … A family meeting may involve up to 30 people, some of whom may need to be brought in from a considerable distance. … To achieve an agreed decision within such large groups may take many days.

They stress the importance of “the need to ‘sit down’ with patients and family members, giving enough time and space to hear how needs are expressed and to bring family-based decisions into professional-led care plans” (2003:S19) and, following the death of an Aboriginal person, that “the correct ceremonies should be held, with the correct people present” (ibid).

Maddocks and Rayner (2003:S19) highlight the need for culturally appropriate care for older Australians nearing the end stage of life; they point out that Aboriginal people often experience feelings of suspicion and discomfort if they have to enter a major healthcare institution and they argue that there is a “need for Indigenous ownership, management and staffing of more acceptable healthcare facilities”. They argue that Aboriginal health workers may also assist Aboriginal people to “make the best use of both traditional and modern medicine” (2003: S18) and to have an Aboriginal health worker as part of a palliative care team can ensure that cultural considerations around death and dying are taken into account (ibid).

Additional literature, sourced to address specific topics in this Report, is presented in the appropriate section.
1.3 OVERALL PROJECT BRIEF

1.3.1 Project Team/Collaborative Partners

The following organisations have committed to involvement in the Elders’ Centre project. Individual responsibilities are outlined in the full Project Brief (see Appendix 1).

- YACL: in 2006 Yarrawarra Aboriginal Corporation established a separate entity, Yarrawarra Aged Care Ltd (YACL) to undertake and lead this project, in collaboration with the following partners:
  - The Aged Services Learning and Research Centre, Southern Cross University (ASLaRC, SCU); Professor Colleen Cartwright, Principal Investigator
  - SCU Office of Regional Engagement (ORE): Ms Jan Strom
  - QCare Australia Pty Ltd/Carexcell Pty Ltd: Mr Lyal Allen
  - The Enterprise Training Company Ltd: Mr Michael Close
  - Coffs Coast Future of Ageing: Ms Deborah Kuhn (Supporting YACL)

1.3.2 Report Structure

The Report is presented in accordance with the Project Brief (PB) (for full details of each component, lead partner(s) and required outcomes see Appendix 1): (Numbering is as per the PB)

PB 2: Define the Study Region and Profile Existing Aboriginal Aged Care Service Providers.
PB 3: Define the Demand (including a demographic analysis)
PB 4: Develop a Supply and Demand Matrix
PB 5: Conduct Local Aboriginal Community and Regional Service Provider Consultations
PB 6/7/8: Preferred Future Service Model – including Nature and Scope and Financial Feasibility Model
PB 9: Develop a Governance and Accountability Model
SECTION 2. STUDY REGION AND EXISTING SERVICE PROVIDERS

This Section of the Report deals with Project Brief Item 2: Define the Study Region and Profile Existing Aboriginal Aged Care Service Providers.

PB2.1: Define the Study Region

The area covered by the Moonee Project is part of the Many Rivers Indigenous Coordination Centre region. Mr Tony Perkins, YACL’s principal representative on the Moonee Project, confirmed the boundaries for the project – both in terms of Aboriginal groups to be covered by the proposed service and the funding agreement with the Commonwealth Department of Health and Aged Care.

Mr Perkins advised that the proposed area extends north to Maclean/Yamba and south to where it meets the sea at Valla Beach. From north to south is a distance of over 350kms. Inland the distance varies because of tribal boundaries and at any point it would probably be less than 100kms. At the northern end it extends out to Jackadgery, a town north west of Grafton, and in the central part it goes out past Dorrigo, ending on the east side of Armidale, and at the southern end it ends west of Bowraville. The area includes the Local Government Areas (LGAs) of Bellingen, Coffs Harbour and Nambucca, and most of the Clarence Valley LGA.

PB2.1.1 YACL’s Rationale for Determining the Geographic Boundaries

(NOTE: The following information was provided by Mr Perkins on behalf of YACL).

In 2000, Yarrawarra Aboriginal Corporation (YAC) worked with two well-connected Gumbaynggirr Aboriginal people from the Grafton and Nambucca areas to consult with Aboriginal groups and Aboriginal services operating in the proposed region. YAC already had knowledge of many of these groups and services through its family and tribal links.

The YACL map boundaries (see Appendix 2) were determined based on the same language-speaking group. The map’s boundaries identify the area in the Mid North Coast of NSW where Gumbaynggirr people live. Bordering the Gumbaynggirr Nation is the Dunghutti people in the south and the Bundjalung in the north.
Pursuing a one-Nation approach to meet the identified needs of older Gumbaynggirr people has always been YAC’s goal. However, YAC has also been aware that a plan to meet identified needs (social, health, respite), would also need to reflect the services currently available. YAC has always been aware that there is no Aboriginal-specific, overnight respite or residential care available within the Gumbaynggirr Nation and therefore it was interested in exploring strategies that would provide services to all older Gumbaynggirr people. In the case of Aboriginal-specific social activities and health services, YAC (henceforth YACL) was aware that there was already provision for these in both the northern and southern ends of the defined region, so the focus would therefore be on addressing any unmet needs of older Aboriginal people living in the central part of the Nation (i.e. the area covering north up to Corindi beach area, south to Coffs Harbour and west to include Glenreagh, Lowanna and Ulong, See map, Appendix 2). In summary, YACL identified two mapping areas; firstly, one for respite and residential care that covers the entire defined study region and secondly, when looking at social and health needs, a more limited area within the study region.

YACL believes that because the Moonee site is centrally positioned within the Gumbaynggirr Nation, it is thus well situated for the provision of any future respite services or residential services for older Gumbaynggirr people and for day activities and outreach health services targeting those older Aboriginal people living in the central part of the Nation. Given the proposed level of service provision currently being considered for the Moonee site, and with other Aboriginal services providing services in the northern and southern ends of the Nation, the area should therefore be well-serviced (See also Section 4.3).

**PB 2.1.2 Mapping the Area:** (See Appendix 2 – Map of Project Area).

ASLaRC was given conflicting advice about the propriety of producing a map of the project area. The website of the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS), a Commonwealth statutory authority within the Department of Education, Science and Training (DEST) portfolio, developed The Aboriginal Australia wall map for inclusion in the Encyclopaedia of Aboriginal Australia, which “attempts to represent language, tribal or Nation groups of Australia’s Indigenous peoples” (AIATSIS website, accessed 17/8/07). The website includes a disclaimer which states that “This map indicates only the general location of larger groupings of people, which may include
smaller groups such as clans, dialects or individual languages in a group. The boundaries are not intended to be exact”.

The website states that it is not acceptable to reproduce only a section of the map; however, permission was granted to the NSW Department of Education and Training to reproduce a section of the map showing the area covered by the North Coast Institute of TAFE, which includes the area covered by the Moonee project. This map was provided to ASLaRC by a member of the ASLaRC Advisory Committee, who is a senior manager for the North Coast Institute of TAFE. However, when the map was presented at the first Mapping and Gapping Workshop, (a meeting of Service Providers providing services to Aboriginal people in the proposed area) it was considered not to be appropriate for use for this study. A new map was therefore developed in accordance with input from workshop participants. This amended map was then presented and approved at a second Mapping and Gapping workshop of Service Providers. In addition, a senior (male) Aboriginal Elder took the amended map to a Gumbula Julipi Elders’ group meeting and no concerns were expressed by this group.

PB2.1.3 Aboriginal Nations in the Study Area
The Aboriginal Nations noted on the AIATSIS map were the Gumbaynggirr people and the Yaegl people – also called Gumbaynggirr and Yiegera people in some documents - but other groups in the study area identified by the project team include the Banbia, Ngaku, Gabi, Gumbula and Mudgai peoples.

Advice from some older Aboriginal people is that, although the study area encompasses one Aboriginal Nation, there are a number of Elders groups in the area, relating to geographic locations.

PB2.2: Profile of Existing Aboriginal Aged Care Service Providers.
For this component of the Report, a review of some major mainstream aged care services was first undertaken, with identification, where possible, of Aboriginal use of those services. This was followed by identification of Aboriginal-specific services.

PB2.2.1 Residential Aged Care Facilities /Respite Care in Australia:
As at 30 June 2006, there were 166,291 residential aged care places in Australia, including 1,951 places provided by Multi-Purpose Services and 332 places funded under the
Aboriginal and Torres Strait Islander Aged Care Strategy. The majority (98%) of residents in aged care facilities in Australia were permanent residents (151,737); of the 95% of permanent residents for whom data relating to Indigenous status were recorded, 872 (about 0.6%) identified as Indigenous. Overall, women comprised 72% of the residential aged care population; however, only 57% of Indigenous permanent residents were female.

There were a total of 2,931 mainstream residential aged care services, Australia wide, at 30 June 2006; there were 94 Multi-Purpose Services and 22 services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy. Not all of these services provided Care Packages or residential places (AIHW, 2007a). The AIHW report notes that, because of the flexible nature of the services provided by Multi-Purpose Services and services receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy, only limited data are available on these services. (ibid).

The report stated that provision ratio of residential aged care places was lower in outer regional and remote areas. While “[u]sage rates are higher for Indigenous people than for non-Indigenous people in every age group” (AIHW, 2007a:1), the actual number of Aboriginal people receiving these services is very small. Data from June 2004 indicated that Indigenous people in mainstream residential services represented only 0.6% of all permanent residents and 0.7% of all people in respite care (ABS: AIHW, 2005). Indigenous people who are admitted to residential care are likely to be younger than non-Indigenous people (29% aged less than 65 compared with fewer than 4% for non-Indigenous, with some Indigenous people in residential care being as young as 45 (ABS:AIHW, 2005). Although usage rates for the Indigenous population rise with age, as for the non-Indigenous population, they are significantly higher at younger ages than for the non-Indigenous population, and are generally higher than the corresponding rates for non-Indigenous people in all age groups. These rates at 30 June 2006 were 17.4 per 1,000 Indigenous persons aged 65–69 years (cf 5.9 for non-Indigenous), 27.8 per 1,000 aged 70–74 years (cf 13.1 for non-Indigenous), and 105.2 per 1,000 aged 75 years and over (cf 101.0 for non-Indigenous) (AIHW 2007a).

**Aboriginal-Specific Residential Care/Residential Respite (Project Area):** There are no Aboriginal-specific residential or respite facilities in the project area. The closest such facility is Booroongen Djugun, located at Kempsey, approximately 112 kms to the south of
Coffs Harbour, which is funded for 60 residential aged care places, both permanent and respite but this service does not provide day care. There are also 10 high care residential places for older Aboriginal people (from a total of 30 places) at the Baptist Community Service’s Maranoa Village Assisted Living Centre at Alstonville, near Lismore, some 250 kms north of Coffs Harbour. Also, Canowindra Tweed Byron Aged and Disabled Aboriginal Corporation is funded for 14 flexible places\(^1\), which include the provision of residential respite.

**Non Aboriginal-Specific Residential Care/ Residential Respite (Project Area):** In July 2007, 23 mainstream RACFs in the project area were contacted and asked if their facility had any older Aboriginal people in residence (see Appendix 3). Only two facilities said that they currently did – one had a male resident who had been at the facility for 5 years and a female resident who was there for 4 weeks respite; the other had a female resident who has lived at the facility for 18 months and a male who was there for 4 weeks respite. A third facility reported that they had had a ‘long-term’ Aboriginal female resident who died in December 2006. Respondents at several facilities chose not to answer the question – perhaps out of concern for resident privacy/confidentiality.

Respondents from the 23 facilities were also asked if the facility had any guidelines or specific policies regarding caring for older Aboriginal people and if they thought that the facility was suitable to care for older Aboriginal people. Only 1 facility had a specific policy; 11 others reported that they had basic cultural awareness programs in place and, again, several facilities chose not to answer the questions.

**PB2.2.2 Community Care**

Community Care in Australia is provided mainly under HACC\(^2\) Programs through both government and non-government organisations, including church-and-charitable service

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\(^1\) Funded under the Commonwealth’s National flexible Aboriginal Aged Care program

\(^2\) The [Home and Community Care (HACC) program](#) is a joint Commonwealth, State and Territory government initiative. In NSW, the Department of Ageing and Disability and Home Care is responsible for the program’s administration. Through a range of different service agencies (local government, voluntary organisations, religious and charitable organisations and commercial organisations) particular types of assistance are provided such as: personal care and domestic assistance, nursing care, social support, allied health care, respite care, centre-based day care, meals and other food services, home modifications and maintenance, transport, formal linen services, counseling/support, information and advocacy, assessment, case planning/review and coordination.
providers. It includes Community Care Places\(^3\), Community Care Options, Home Care and a range of other services. Mainstream services provided through the HACC program are also accessed by Indigenous people and in 2003-2004 this amounted to approximately 2.4% of all services provided across Australia, with the client profile again showing that Indigenous people access these services at younger ages than non-Indigenous people (ABS: AIHW, 2005:226).

**Aboriginal-Specific Community Care:** At 30 June 2006 there were 94 Multi-purpose Services and 22 other Services across Australia receiving flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy; while not all of these provide Aged Care Packages, 308 Packages were provided to Indigenous clients by Multi-purpose Services and 248 by services receiving flexible funding (AIHW 2007b:4); in comparison, as at June 2004, 243 Packages were being provided under the Aboriginal and Torres Strait Islander Aged Care Strategy. (ABS: AIHW, 2005:224). In addition, approximately 4% of people receiving mainstream CACPs identified as being of Aboriginal or Torres Strait Islander origin. (ibid) As with residential care, Indigenous recipients are likely to be younger than non-Indigenous recipients,

\[\text{reflecting their poorer health status and consequent need for care services at younger ages … with 5\% aged under 50 years and only 44\% aged 70 years and over (compared with less than 1\% and 90\% respectively for other Australian care recipients (AIH 2007b: viii).}\]

A primary purpose of such Packages is to assist older people to remain in their own homes as long as possible. Older people assessed by an Aged Care Assessment Team (ACAT) as requiring services to enable them to remain in the community become eligible to receive a range of health and personal care and support services delivered to their place of residence.

\(^3\) Community Care Places refers to the Commonwealth Department of Health and Ageing’s community care packages and includes: Community Aged Care Packages (CACPs), Extended Aged Care at Home packages (EACH) and Extended Aged Care at Home Dementia packages (EACH Dementia).

- CACP - Program provide for a coordinated Package of care to recipients with complex needs who are eligible for low level residential care. Approval must be given by an Aged Care Assessment Team (ACAT) before a coordinated Package of care of up to 6 hrs a week can be provided. Services provided are similar to those available under HACC with the exception of nursing care and allied health care. The services are usually coordinated through a care manager/coordinator.
- EACH/ EACH Dementia – these programs provide for a coordinated Package of care to older people with multiple and complex support needs and for those with additional needs associated with their dementia (EACH Dementia). The care recipients are generally those who would be eligible for high level residential aged care. Requires ACAT approval. Services under an EACH and EACH Dementia Packages include those available to CACP care recipients plus nursing care and allied health care.
In the project area, the major allocation of CACPs and EACH (and more recently EACH Dementia) Packages for older Aboriginal people are managed by the Nambucca Valley Community Services Council (which currently has 35 CACPs, 10 EACH and 10 EACH Dementia Packages). Information provided by the DOHA on the 6 May 2008 identified the following Packages for North Coast NSW (Table 1).

Table 1: Aboriginal-Specific Community Aged Care Packages, Mid North Coast NSW, as at 6/05/08

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>TOWN</th>
<th>REGION</th>
<th>SERVICE TYPE</th>
<th>NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coffs Harbour Nursing Service Pty Ltd</td>
<td>COFFS HARBOUR</td>
<td>Mid North Coast</td>
<td>EACH</td>
<td>3</td>
</tr>
<tr>
<td>Nambucca Valley Community Services Council Inc</td>
<td>MACKSVILLE</td>
<td>Mid North Coast</td>
<td>CACP</td>
<td>35</td>
</tr>
<tr>
<td>Nambucca Valley Community Services Council Inc</td>
<td>MACKSVILLE</td>
<td>Mid North Coast</td>
<td>EACH</td>
<td>10</td>
</tr>
<tr>
<td>Nambucca Valley Community Services Council Inc</td>
<td>MACKSVILLE</td>
<td>Mid North Coast</td>
<td>EACH Dementia</td>
<td>10</td>
</tr>
<tr>
<td>Carexcell Pty Ltd</td>
<td>COFFS HARBOUR</td>
<td>Mid North Coast</td>
<td>CACP</td>
<td>10</td>
</tr>
<tr>
<td>Sub total</td>
<td></td>
<td></td>
<td></td>
<td>68</td>
</tr>
<tr>
<td>Biripi Community Aged Care Packages</td>
<td>PURFLEET</td>
<td>Mid North Coast</td>
<td>CACP</td>
<td>24</td>
</tr>
<tr>
<td>Booroongen Djugun Aboriginal Corporation</td>
<td>Green Hills (Kempsey)</td>
<td>Mid North Coast</td>
<td>CACP</td>
<td>35</td>
</tr>
<tr>
<td>Community Private Homecare Pty Ltd</td>
<td>FORSTER</td>
<td>Mid North Coast</td>
<td>CACP</td>
<td>3</td>
</tr>
<tr>
<td>Sub total</td>
<td></td>
<td></td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>TOTAL MID NORTH COAST</td>
<td></td>
<td></td>
<td></td>
<td>130</td>
</tr>
</tbody>
</table>

(NOTE: Only the first 3 Service Providers are in the project area; the next 3 are in the Mid North Coast but outside the project area.)

**Aboriginal-Specific Day Respite:** Also funded in the Mid North Coast under the Department of Health and Ageing’s National Respite for Carers Program (NRCP) are two Aboriginal-specific day respite services, one of which, the Ngambaga Bindarry Girwaa Community Service in Macksville, is within the project area. The other service, Biripi Aboriginal Medical Centre, is outside the project area in Taree South.

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4 Came on line 05/05/08.
5 In September 2007, DOHA announced a provisional allocation of 10 new CACPs Packages to Carexcell, under its ‘Innovative/Flexible care delivery and respite services’ category. Carexcell has also been provided a one-off capital funding grant to assist it with establishing the service. Carexcell is committed to working closely with, and mentoring, YACL staff to enable them to become an ‘approved provider’ in their own right and to assume responsibility for the operation of the service.
HACC-funded Aboriginal services in Bellingen, Coffs Harbour and Nambucca (see also appendices) include the following (Table 2):

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Support*</td>
<td>Abcare Australia - Aboriginal Social Support Program, Coffs Harbour</td>
</tr>
<tr>
<td>Social Support*</td>
<td>Yarrawarra Aboriginal Aged Care Ltd</td>
</tr>
<tr>
<td>Social Support*</td>
<td>Ngambaga Bindarry Girwaa Community Service, Macksville</td>
</tr>
<tr>
<td>Aboriginal Transport</td>
<td>Coffs Harbour, Nambucca and Bellingen Community Transport</td>
</tr>
<tr>
<td>Aboriginal Community Options</td>
<td>Booroongen Djugun Aboriginal Corporation; Regional Service (based in Kempsey)</td>
</tr>
<tr>
<td>Aboriginal HACC Development</td>
<td>Booroongen Djugun Aboriginal Corporation; Regional Service (based in Kempsey)</td>
</tr>
<tr>
<td>Home Care Services</td>
<td>State-wide, through DADHC</td>
</tr>
</tbody>
</table>

*Social Support funding can be used flexibly, to meet identified needs in the particular area.

PB2.2.3  Aboriginal Medical Services (AMS): (Appendix 4)

The region is comparatively well-serviced by AMS, with an AMS in Coffs Harbour (Galambila), another at Grafton (Bulgarr Ngaru) and health outposts of the Kempsey-based Durri AMS at Bowraville and Nambucca Heads. (Services provided by Durri are therefore also outlined in Appendix 4). While Galambila AMS is also currently auspiced by Durri AMS it is in the process of becoming a stand-alone service.

The AMS services relevant to older people include General Practitioners, specialist medical practitioners, community nurses and a wide range of allied health staff, as well as specific programs such as diabetes, renal and cardiology clinics and other chronic disease programs. Some AMS provide wellness or health promotion programs, including (at Galambila) a fruit and vegetable co-op. and a ‘spring into shape’ program, although these are not specifically aimed at older people.

Staff numbers at the AMS’s range from 8 full-time staff plus visiting medical, nursing and allied health specialists at the smaller services to over 50 full-time staff plus additional visiting medical, nursing and allied health specialists, at Durri AMS.
Funding for the AMS is provided primarily by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in NSW Health, with a small amount of funding for some services being provided by Department of Community Services (DOCS).

PB2.2.4 Aboriginal Health Services (Appendix 5):
In addition to the Aboriginal-specific AMS, the Mid North Coast Area Health Service also provides/funds Aboriginal Health Services in the project area at Grafton Community Health – Aboriginal Health and Maclean Community Health – Aboriginal Health. Services provided to older Aboriginal people from these Community Health Centres ranges from health promotion and education programmes to referral services to vascular and cardiac clinics (see Appendix 5 for a list of services provided).

PB2.2.5 Support Services for Older Aboriginal People (Appendix 6):
In addition to the AMS, there are also a number of Aboriginal organisations which provide support services for older people in the project area. These services include home visiting services, transport services, personal care and domestic help as well as social support and recreational outings.

While the organisations outlined above provide a limited number of services to older Aboriginal people, they do not provide the diverse range of activities and services envisaged by YACL for the Moonee Centre, nor do they do so in the preferred, holistic ‘community’ context of this project.

(NOTE: it is not within the scope of this study to document all mainstream services accessed by older Aboriginal people, nor the extent to which Aboriginal people make use of those services).

PB 2.3: List Key Contacts, Number of Personnel Engaged in Service Delivery and any Specific Expertise Developed by the Service.
Key services have been identified and listed at PB 2.2 (above). Other relevant organisations, which provide services to older Aboriginal people and attended the project’s Mapping and Gapping Workshops, included:
• Aged Care - Coffs Harbour Health Campus, North Coast Area Health Service
• Coffs Harbour, Bellingen and Nambucca Community Transport
• ACAT - Coffs Harbour Health Campus, North Coast Area Health Service
• Aboriginal Health - Coffs Harbour Health Campus, North Coast Area Health Service
• Department of Health and Ageing

Other organisations that provide services to older Aboriginal people and were invited, but unable to attend the Mapping and Gapping Workshops, were sent Minutes of the Workshops and invited to comment. These include:

• Coffs Harbour Community Village
• Abcare Australia - Aboriginal Social Support Program - Coffs Harbour
• DADHC’s Home Care Services of NSW - Aboriginal Home Care - Coffs Harbour and Grafton
• Waratah Respite Centre - Coffs Harbour
• Community Programs Incorporated - Grafton
• Ngambaga Bindarry Girwaa Community Service - Macksville
• Nambucca Valley Community Services Council - Macksville

(NOTE: Although a database has been developed with individual contacts made to date, this data will not be included in the Report as it was not possible to obtain the express consent of the individuals involved. Also, our understanding is that, in the organisations listed above, there are frequent staff or role changes, which would make such information unstable. Contact details for some of the above organisations can be found in Appendices 4 - 6.)
SECTION 3: DEFINE THE DEMAND

This Section of the Report deals with Project Brief Item 3: Define the Demand

PB3.1 Summary Demographic Analysis, Including Population and Age Cohort Trends and Projections - (Key Outcomes: Understanding of Regional Aboriginal Demography)

PB3.1.1 Total Population

The total population of the four Local Government Areas (LGAs) in the study area (i.e. Bellingen, Coffs Harbour, Clarence Valley and Nambucca) in the 2006 Census was 143,371; of these, 5,961 people (4.2%) identified as Aboriginal (which is twice the overall NSW percentage of 2.1%).

PB3.1.2 Aboriginal Population

This region of Mid North Coast NSW is part of the Many Rivers Indigenous Coordination Centre region, which has the third largest Aboriginal and Torres Strait Islander population in Australia. The Many Rivers Regional Council Strategic Plan 2005-2010 notes that since 1996 the population has increased by around 30% and is one of the fastest growing Aboriginal populations in Australia. Table 3 presents the number and percentage of the older Aboriginal population for Local Government Areas in the study area, taken from the 2006 Census Data (with summary comparison for 2001).

Table 3: Number and Percentage of Older Aboriginal People in the Project Area LGAs 2006, with 2001 Comparison

<table>
<thead>
<tr>
<th>LGA</th>
<th>2006</th>
<th>Total 45+</th>
<th>Total Indigenous All Age Groups 0+</th>
<th>Total 45 as % of all Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellingen</td>
<td>40</td>
<td>20</td>
<td>14</td>
<td>74</td>
</tr>
<tr>
<td>Clarence Valley*</td>
<td>189</td>
<td>116</td>
<td>85</td>
<td>390</td>
</tr>
<tr>
<td>Coffs Harbour</td>
<td>243</td>
<td>106</td>
<td>62</td>
<td>411</td>
</tr>
<tr>
<td>Nambucca</td>
<td>87</td>
<td>66</td>
<td>30</td>
<td>183</td>
</tr>
<tr>
<td>TOTAL</td>
<td>559</td>
<td>308</td>
<td>191</td>
<td>1058</td>
</tr>
</tbody>
</table>

Clarence Valley data for 2001 is the combined data for Copmanhurst, Grafton, Maclean (including Yamba) and Pristine Waters; in the 2006 Census, this was reported as Clarence Valley.
This data indicates an increase of 863 Indigenous people in the project area between 2001 and 2006, with the number of Indigenous people aged 45 and above having increased by 279. Table 3 shows that the percentage of the Indigenous population in the project area aged 45 and above in 2006 was 17.75% (range 16.91% in the Clarence Valley to 23.13% in Bellingen); this contrasts starkly with the non-Indigenous population, where the percentage of the population aged 45 and above was 50% in Bellingen; 49% in the Clarence Valley, 45% in Coffs Harbour and 58% in Nambucca.

In interpreting this data it is important to consider that not all Indigenous people so identify when completing the Census, possibly because many years of discrimination have made them hesitant to do so. Maddocks and Rayner (2003:S17) noted that “[a]t the 2001 census, Indigenous Australians comprised 2.4% of the total Australian population – double the proportion identifying themselves as Indigenous in the 1986 census” (and clearly, judging by birth records, not the result of an ‘actual’ doubling of the Indigenous population).

In addition, some of the Workshop Service Providers suggested that, if a large number of Aboriginal people were living in one house at the time of the Census, they may have been reluctant to record everyone who was there because of fear of ‘bureaucratic’ responses to too many people living in one house. However, a staff member of the local Indigenous Coordination Centre said that this issue had been considered and the Aboriginal person who collected much of the Census data in the study area went to some trouble to reassure Aboriginal people that this would not be problem for them.

Despite this, staff of a number of the Aboriginal Medical Services expressed the view that the Indigenous population to whom they provide services is actually more numerous than is demonstrated by the Census data, based on patient records held and general observations. However, one AMS CEO noted that, because AMS patient records are not currently computerised, it is possible that a new record could be made for a patient where a record already exists, e.g. if the patient has forgotten that s/he visited this service previously, or has changed his/her name, or uses a tribal name where previously s/he did not. Therefore, while the Census data is the only ‘useable’ data currently available, it would be reasonable, when determining need in this study, to take the Census data and make an allowance for under-estimation. We have conservatively made a 10% allowance for this under-estimation.
Thus, based on the 2006 data as shown in Table 3 above, Table 4 provides the estimated number of older Aboriginal people living in the project area:

Table 4: Estimated Number and Percentage of Older Aboriginal People in the Project Area LGAs 2006

<table>
<thead>
<tr>
<th>LGA</th>
<th>2006 Total</th>
<th>Total 45+</th>
<th>Total Indigenous All Age Groups 0+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45-54</td>
<td>55-64</td>
<td>65+</td>
</tr>
<tr>
<td>Bellingen</td>
<td>44</td>
<td>22</td>
<td>15</td>
</tr>
<tr>
<td>Clarence Valley</td>
<td>208</td>
<td>128</td>
<td>94</td>
</tr>
<tr>
<td>Coffs Harbour</td>
<td>267</td>
<td>117</td>
<td>68</td>
</tr>
<tr>
<td>Nambucca</td>
<td>96</td>
<td>73</td>
<td>33</td>
</tr>
<tr>
<td>TOTAL</td>
<td>615</td>
<td>339</td>
<td>210</td>
</tr>
</tbody>
</table>

Another issue that must be considered when assessing need from population data is that Aboriginal and Torres Strait Islanders have a reduced life expectancy and often poorer health status than the general population. This tends to lead to requirements for support at an earlier age. In planning services for older people the Commonwealth Government uses population estimates for the general public aged 70 years and over and for Indigenous people it is 50 years and over (ABS:AIHW, 2005:222) whilst the eligible age for ACAT assessment for Aboriginal people is 45 years and over (see Section5- Service Provider Interview 5). The NSW Government, because of the significantly lower life expectancy of Aboriginal people, also defines older Aboriginal people as those aged 45 years or older (NSW Dept of Premier & Cabinet, 2006:7).

The use of a 45 years and over definition of older Aboriginal people was supported by Service Providers operating in the project area:

*I have quite a few (clients) in their late 40s and the oldest I have got is about 74, you don’t get many over their mid 70s. The majority would be in their late 60s. However, it’s surprising how many in are in the late 40s, early 50s with chronic diseases (Service Provider 2[SP2]).*

*Their ages vary but most of the Indigenous people I would see would be between 45-55 years (Service Provider 3[SP3]).*
One of the saddest things I had last year was this Aboriginal guy who was young, 2 years before he was surfing but he now had chronic liver failure because of alcohol problems he had. Although he had knocked off the alcohol a couple of years before, he had developed early dementia. It was actually very emotional for me... as he was such a beautiful guy but he was very disruptive here (in the hospital). So we can see them as early as their mid 40s, early 50s, unfortunately for a lot of them alcohol abuse will set them off with early dementia – it’s very common and very tragic (SP3).

PB 3.2: Summarise Existing Research and Documentation re: Social & Cultural Trends and Expectations - (Outcomes: Understanding of client expectations as evidenced in existing research).

((NOTE: whilst this section of the Report covers existing research, findings from interviews with Local Service Provider have also been included where they exemplify the research.))

Significant issues identified in the available literature regarding Aboriginal social and cultural trends and expectations include:

3.2.1 Key historical factors which still impact on Aboriginal health;
3.2.2 The importance of understanding and acknowledging Aboriginal beliefs regarding health, dying, death and burial;
3.2.3 Fear of relocation associated with health care;
3.2.4 The importance of kin and the extended family;
3.2.5 Cultural and social communication issues;
3.2.6 The role that older Aboriginal people play in their communities; and
3.2.7 The diversity of Aboriginal culture.

PB3.2.1 Historical Factors

Researchers recognise that many historical factors, or life experiences, have shaped Aboriginal people and continue to impact on their culture and expectations. These include: restricted access to education, restricted opportunity for employment or access only to restricted types of employment, and poverty (Collis-McAnespie et al 1997; Ramanathan & Dunn 1998); forced dispersal of families, removal of children and permanent loss of contact with other family members, including mass forced relocations resulting in loss of homelands (Collis-McAnespie et al 1997; Dance et al 2004; Jackson & Ward 1999; Jones 2006; Ramanathan & Dunn 1998; Roberts 2007; Warburton & Chambers 2007); overt
racism and segregation of Aboriginal and non-Aboriginal people in schools, theatres, and both private and public spaces (Jones 2006:8; Ramanathan & Dunn 1998); violence and loss of human rights (Collis-McAnespie et al 1997; Warburton & Chambers 2007); attempted eradication of Aboriginal cultures and languages and forced assimilation with a foreign culture (Dance et al 2004; Jackson & Ward 1999; Jones 2006; Warburton & Chambers 2007) and Aboriginal Australians allowed to vote only since 1967 (Ramanathan & Dunn 1998). For many Aboriginal people, these experiences have caused overwhelming pressure on their sense of identity and connection to country, and on their spirit, resulting in deeper problems of cultural and identity erosion (Jackson & Ward 1999; Jones 2006; Roberts 2007). As explained by one local Service Provider:

There is a whole middle generation of Aboriginal people missing and thus there’s poor societal structures; this is even worse for smaller Aboriginal populations like the Gumbaynggirr because there are then even fewer opportunities for leaders to come through (Service Provider 4 [SP4]).

**The Impact of Historical Factors on Aboriginal Health:** Collis-McAnespie et al (1997), Dance et al (2004), Jackson and Ward (1999) and Roberts (2007) link the broader socio-economic and political factors, such as poverty, forced removal and relocation of families and children, lack of access to employment and education and experience of racism, to current emotional and social needs of Aboriginal people, a variety of serious health concerns and a seriously shorter life expectancy. Disempowerment has been accepted as a causative factor in poor Aboriginal health by the Royal Australasian College of Physicians in its Darwin Declaration (1997):

...the health of Aboriginal and TSI Australians is disastrously poor compared with other Australians, and … the fundamental cause is disempowerment, due to various factors including continued dispossession from land, cultural dislocation, poverty, poor education and unemployment (cited in Jackson & Ward 1999:2 of 9).

**PB3.2.2 Aboriginal Beliefs Regarding Health, Dying, Death and Burial**

**Aboriginal View of health:** Although it is acknowledged that there has been a shift in recent years in the wider community to understanding health as more than the absence of disease, (highlighted in the 1986 Ottawa Charter) there remains a focus on the individual. In contrast, the 1990 National Aboriginal Health Strategy (NAHS) developed a much broader – and widely accepted - definition of health as perceived by Aboriginal peoples:
Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life (cited in Jackson & Ward 1999:2 of 9).

Thus, Aboriginal culture recognises the importance of the whole of community to health and places much less emphasis on the individual than is commonly the practice in environments such as hospitals, “where Anglo Australian values predominate” (Jones 2006:7).

**Aboriginal Beliefs about Dying, Death and Burial:** Jackson and Ward (1999) and Roberts (2007) draw attention to the importance to Aboriginal people of their links with the land, and how this emotional and spiritual link is powerfully intertwined with Aboriginal health and well-being, as well as to dying and death. Aboriginal people have strong beliefs and customs surrounding death and dying (Ramanathan & Dunn 1998). Burial holds particular cultural significance, with a great and enduring need to be buried in the home town or birthplace (Collis-McAnespie et al 1997; CHSD 2003). In fact, fear around death and burial away from home town or birthplace is often a serious and significant concern (Collis-McAnespie et al 1997) as some Aboriginal people believe that if they were to die in a city hospital, their spirit would never return to their homeland (Ramanathan & Dunn 1998).

As further explained by a Service Provider from the project area:

*There’s a fear from a lot of the Elders if they come in here (hospital), they may not leave, so they put off coming and by the time they come it's really affected their health. We tend to see people at an acute stage. They usually leave it until the last moment before they access here. Some of them have the view ‘if I go there I'm not going to leave - I could die there’*(Service Provider 5[SP5]).

**PB3.2.3 Fear of relocation**

A strong theme from Aboriginal palliative and hospital care research is that the majority of Aboriginal people experience fear and discomfort in association with Western medicine (McGrath et al 2007). This is particularly the case when they are relocated to metropolitan hospitals, an experience variously described as frightening, isolating and overwhelming (Collis-McAnespie et al 1997; Ramanathan & Dunn 1998). Service Providers from the project area also identified this as an issue:

*I think they do their best, but last year there was an Aboriginal boy (who was a long term inpatient) and it just got to me, it’s not so much Area Health but the system. In the end I got an Aboriginal worker to take (the boy) out, but it took a*
lot of work on my and another worker’s part to get through to the medical ward that he wasn’t going to handle just sitting there, day in day out, and he needed activities. More so because of the nature of him and his culture. He kept going for walkabout too. I still think the (Area) Health Service has a big gap in covering that. I always worry when I have any of my Aboriginal people… in hospital. Acute Care services are just so foreign to their culture. It’s bad enough for mainstream but I think it’s 10 times worse for Indigenous people (SP3).

...a lot of the Elders when they come, (to the hospital) they don’t want to stay for a long period, they want to go back home (SP5).

Furthermore, the impact of relocation/dislocation of a family member creates stresses from many sources to both the relocated person and their extended family; these include financial, transport and accommodation needs for visiting family members, support mechanisms for the patient and for other family members, loss and grief, and difficulties associated with communication among family members (Collis-McAnespie et al 1997).

McGrath et al (2007) maintain that Aboriginal peoples’ fear of Western clinical medicine is exacerbated by differing cultural ideas of knowledge ownership and transfer. Aboriginal people believe that unless the person providing the care is recognised traditionally as belonging to the knowledge of healing (i.e., owning the knowledge) they cannot undertake healing activities. However, Western clinical medicine is not seen to be respectful of these traditional Aboriginal understandings of healing knowledge and ownership (McGrath et al 2007). Thus, medical practitioners and palliative care nurses in hospitals are sometimes perceived to be inappropriate in their approaches to family and patients (Collis-McAnespie et al 1997).

This had also been the experience of one of the Service Providers from the project area:

Some hospital staff can sometimes show poor understanding if (Aboriginal) clients are late for appointments or if they don’t turn up. I often explain this is just how it is or there maybe reasons such as a crisis in the family or transport and they can’t get there. I do think a lot of the nursing staff still need to do cultural awareness (training)... (SP2).

PB3.2.4 The Importance of Kin and Extended Family

Kin terms are extremely important among Aboriginal people, as they situate one’s identity and create social networks, regardless of whether the kinships are biologically or socially created (Warburton & Chambers 2007). The family networks can be extensive (McGrath et al 2005) and Aboriginal people expect close family members to remain highly involved in
the end stage of a person’s life (Jones 2006). There is a need for the extended family to pay their respects, even if this involves travelling long distances (Collis-McAnespie et al 1997; McGrath et al 2007). The connection to family is very apparent for older people in the project area.

Most (Elders) live with their families in households that have multi- generations living in them. They stay with family or have family come and stay with them (SP2).

PB3.2.5 Cultural and Social Communication Issues

There is a culture of silence and contemplation in Aboriginal communities, which can lead to misunderstanding by non-Aboriginal health-care workers. “Silence does not mean assent, it is usually the opposite” (GP Speak 2000:2). However, “Indigenous people can feel frightened and intimidated when out of their community [e.g. in a health care facility] and this will impact on their communication” (McGrath et al 2005:309). Furthermore, older people often do not like to trouble others with their problems; it may be a problem they are ashamed of, or they may perceive innumerable hurdles (for example, family commitments, transport or financial issues) to overcoming their health problems (GP Speak 2000:2).

This was also supported by Mr Tony Perkins from YACL when discussing the survey and approach used to interview older Aboriginal people (See Section PB5.1A). Mr Perkins advised that older Aboriginal people are unlikely to express any difficulties or problems they are encountering when asked direct questions about how they feel or find a situation/service/person; this is especially so where older Aboriginal people are dependent on their families.

Boustany (2000:2) highlights the impacts of communication problems in the hospital system, specifically the Emergency Department:

…[Emergency] where the [Aboriginal] person may first have contact with the medical system, are notorious for hurried culturally insensitive assessments and miscommunication, sometimes resulting in misdiagnosis and, as in any state of trauma and fear, the perceived opinions of others has a profound effect. These daily interactions, where profound verbal and non-verbal communication differences cause bilateral confusion, thus compound collective unconscious beliefs. Here, at the coalface, skin colour and language differences can generate subtle role-plays of presumed inferiority, and promote sensations of powerlessness. This effectively prevents the patient from actively advocating their own needs and feeds into the endless cycle of fear and psychological isolation, predisposing to illness in itself.
Section 3.2.3 (above), highlighted that the communication of information about healing in the traditional Aboriginal system is governed by a notion of “knowledge ownership”. There are strong Aboriginal cultural beliefs and practices guiding communication, with rules about the ‘right’ individuals within the social system who are deemed appropriate to share healing knowledge, and there are also rules about the ‘right’ people with whom this knowledge may be shared (McGrath et al 2007). Thus it is important for the story to be communicated by specific people to the appropriate people both in the extended family and within their community (McGrath et al 2005).

Investigating cross-cultural communication issues, problems and solutions faced by health care workers and Aboriginal patients and their families in a palliative care setting, McGrath et al (2005:312) assert that

In a medical setting, it is important to communicate with Indigenous people through the medium of family meetings, and, if needed, with an interpreter. Individuals from the extended family can also be called upon to help explain information. Indigenous people should be allowed to decide the attendance at the family meeting so the right people are there.

Local Service Providers in the project area did not feel that this was always required; although they were generally happy to have family involved, the extent to which that occurred primarily depended on their clients’ wishes:

*When discharge planning I mainly deal with the client; if they are quite capable of making their own decisions about what is required at home then it’s their choice to involve their family. If the client is not capable then it’s the family I deal with* (SP5).

*...if a client’s got capacity, that’s the number one person I’m listening to and I’ll take in their carer or whatever. With Indigenous people I tend to take on more with the family than I would with mainstream and when I say ‘family’ I mean it might mean a third cousin but for Indigenous people that’s family. In mainstream they don’t acknowledge that, family is only direct people. I’ve always taken that on. If a client said to me ‘my first cousin, I want him here’, I’d say ‘great mate that’s really good’* (SP3).

*The ACAT assessors are happy to have family there and palliative care usually involves the family, they have to, they are pretty good. ACAT and Pal Care staff will liaise with us (Aboriginal Health) and we usually know the family* (SP2).
PB3.2.6 The Role of Older Aboriginal People in their Communities

Exploring the social and cultural roles played by older Aboriginal Australians within their communities, Warburton and Chambers (2007:6) found that they are respected for surviving a “lifetime experience of racism, prejudice and segregation.” The roles they undertake have adapted over time to contemporary circumstances and include: identifying and continuing kinship relationships; guiding and supporting the young; transmitting cultural knowledge; and life experiences.

Warburton and Chambers (2007:4-6) recount that older Aboriginal people invest immense time and effort into their communities and have a crucial role in those communities, including:

- passing on cultural knowledge, laws and practices (including Aboriginal songs and dances) and preventing cultural loss, particularly as generational knowledge is transmitted orally and often along gender lines;
- influencing young people’s lives, through the teaching and maintenance of culture, caring for and educating the young, providing positive identities and role models, and thus shaping identity and keeping the young out of trouble; and
- providing extensive knowledge of Aboriginal identity and kinship-based connection to land, situating Aboriginal people’s place within the world, and instilling a sense of self and community.

Thus, Warburton and Chambers (2007:6) assert that the role of older Aboriginal people remains essential to retaining cultural identity and the link with the past:

Many have the view that the culture, with its associated principles and spiritual belonging, can help young Indigenous people deal with the major social problems that they face and is therefore crucial to the future.

PB3.2.7 The Diversity of Aboriginal Culture.

A significant feature of contemporary Aboriginal identity is a high level of intra-cultural diversity whereby the strength of the association with traditional Aboriginal culture varies greatly from person to person (Collis-McAnespie et al 1997; Jones 2006). Hence, cultural responses to spiritual and other matters will vary considerably, and may even present completely opposing viewpoints (Collis-McAnespie et al 1997). Health care professionals need to remain responsive to individual Aboriginal people’s needs without stereotyping or generalising across Aboriginal communities (Collis-McAnespie et al 1997; Jones 2006).
Instead, “[t]he dual recognition of both individual and cultural identity must be carefully managed on a case by case basis” (Jones 2006:7).

One example of health services dealing appropriately with Aboriginal cultural diversity in action is outlined by Roberts (2007:5):

A new program, [the Aboriginal and Torres Strait Islander Cultural Awareness Program] put together in consultation with Ngayundi Aboriginal Health Council and the Bundjalong Elders’ Council, it builds on existing programs and can be adapted to the area in which it is being run to make sure it reflects local history and experience.

PB 3.3 Summarise Existing Research and Documentation Re: Specific Health and Aged Care Needs. - (Outcomes: Understanding of Previously Recognised Health and Aged Care Needs of Older Aboriginal People).

( NOTE: As in Section 3.2, whilst this section of the Report covers existing research, findings from interviews with Local Service Providers have also been included where they exemplify the research.)

As previously noted, there is a scarcity of academic literature in relation to health care needs of older Aboriginal people. Information in this section of the Report will therefore also rely on Commonwealth, State and Local Government reports and other relevant material.

This part is in two Sections: Section 3.3.1 provides some data on Aboriginal illnesses and disease; Section 3.3.2 provides insight into emergent themes from research into Aboriginal general health care, aged care, and palliative care.

PB3.3.1 Aboriginal Illness/Disease

In the 2006 Report of the Chief Health Officer of NSW Health, *The health of the people of New South Wales*, Chapter 3.1 reports on the health of Aboriginal and Torres Strait Islander peoples. In summary, that report identifies the following:

- Around 134,900 Aboriginal people live in NSW, making up just over 2% of the total population and 29% of the total Australian Aboriginal population
- Relative socio-economic disadvantage places them at greater risk of exposure to behavioural and environmental health risk factors
• They are more likely to die at younger ages than the general population (those aged <25 = 12% of deaths of Aboriginal people cf 2% of non-Aboriginal people)
• The main causes of death for Aboriginal people are the same as for non-Aboriginal people, i.e., cardiovascular diseases and cancer; but Aboriginal people are twice as likely to die from diabetes or injury as non-Aboriginal people
• Hospital admission rates are higher for Aboriginal people, especially for renal dialysis, diabetes, chronic respiratory diseases and alcohol-related conditions
• Life expectancy at birth is 60 for Aboriginal men (cf 79 for non-Aboriginal men) and 65 for Aboriginal women (cf 81 for non-Aboriginal women)
• Just under 3% of Aboriginal people in NSW are aged 65 or above cf 13% for non-Aboriginal people.

• Aboriginal death rates – 2.7 times total non-Aboriginal male population, 2.4 times total female population
• There is no National data source for conditions treated by primary healthcare providers such as Aboriginal health workers or nurses
• Death rates were higher for Aboriginal people than for Australians as a whole for almost all causes of death
• Kidney disease is more prevalent among Aboriginal people than among other Australians
• Diabetes is a significant health problem for Aboriginal and Torres Strait Islander peoples
• There are over twice as many deaths associated with mental disorders among Aboriginal people than for other Australians
• Suicide accounted for almost three times as many deaths for Aboriginal males and twice as many deaths for Aboriginal females than for the general population
• Data suggests that dental problems, tooth extraction and edentulism are more common among Aboriginal people than other Australians
• Health risk factors for Aboriginal people include: low birth weight, obesity, poor nutrition, smoking, alcohol and other drug use.
• Housing and living conditions have been identified as a major factor affecting the health of ATSI peoples, inadequate and poorly maintained infrastructure, and access to clean water.

• Aboriginal people experienced lower levels of access to health services than the general population, even though they were twice as likely to be hospitalised.

Data such as the above supports the claim by Boustany (2000:1) that Aboriginal health in Australia remains at:

…a fourth world standard. That is, the deplorable conundrum of third world-associated health problems, e.g. higher infant mortality rates, higher maternal mortality rates, lower average life expectancy and an increased prevalence of malnutrition and a variety of infectious diseases, in combination with higher rates of western lifestyle problems, e.g. diabetes, heart disease, cancer, chronic respiratory disease, drug and alcohol abuse and mental ill health.

Service Providers in the project area advised a similar health profile for older Gumbaynggirr people. All those interviewed noted the prevalence of chronic illnesses amongst their patients/clients.

The majority have chronic illnesses – heart disease, diabetes, respiratory disease, kidney/renal disease, a lot of this comes from alcohol abuse, though not all of it. There are some with heart disease and diabetes that are more pronounced because of their alcohol abuse and some liver failure too. Respiratory illnesses too because of smoking and there’s a couple here from Coffs that worked at Baryulgil (Ex – asbestos miners). Also there is another one (illness), it’s mental health, I have quite a few mental health clients, some that have schizophrenia etc but most of these are not yet 45. Mental health is a growing issue (SP2).

PB3.3.2 Specific Aboriginal Health and Aged Care Needs

Emergent themes around which the results and recommendations in this section are presented include: kinship, culture and terminal illness, communication issues, Aboriginal Health Workers and associated employment issues, current needs, transportation, and other barriers.

**Kin/Extended Family:** The important role of the extended Aboriginal family in decision-making and caring for those in need of palliative care was discussed in section 3.2.5. Collis-McAnespie et al (1997) and Ramanathan and Dunn (1998) report that terminally ill Aboriginal people and/or their carers prefer to remain self-reliant and need privacy during the terminal phase of life. Thus, although they were aware of health services available to
them, many Aboriginal people preferred to keep as much of the care required within the family for as long as possible. Local Service Providers explained that this was also commonly the case with older Aboriginal people in the Gumbaynggirr Nation:

*The CACP philosophy fits really well with Aboriginal people its flexible, it means they can stay at home, live with their family and have some kind of say over what they get. It works really well... Residential care is recommended only as a last resort and with a lot of deliberation (SP3).*

*Generally in Indigenous families the daughters are the carers. And they are there (all day) because their mother or father can’t be on their own, and they do the showering, lifting, turning cleaning, and cooking..... However because I visit them in their homes, I can usually see when the family is basically going to fall in a heap and I will usually say: ‘Do you think you want some respite?’ or ‘Do you want someone to come in and shower Mum or Dad?’ But a lot of them say no. because they know their parent won’t do it (SP2).*

A report by Collis-McAnespie et al (1997:31) found a perception amongst Aboriginal patients that hospital staff “have difficulty accepting the Aboriginal extended family ‘coming and going from the hospital to show their respect’ for the patient”, adding to the reasons Aboriginal people may choose not to enter hospital. One local Service Provider described a common experience for Aboriginal families when a family member is in hospital:

*It’s...even things like when family come to visit and ...we’ve had 10 of the family turn up with the dog and then I have really had to negotiate hard (with hospital staff) (SP2).*

**Death/Dying/Family Care/Carer burden**: Strong Aboriginal beliefs and customs surrounding death and burial, and in particular their fear of dying and/or being buried away from their hometown or place of birth was discussed in section 3.2.3 These beliefs may result in conscious decisions by Aboriginal people to avoid formal health services (Collis-McAnespie et al 1997). As noted by one local Service Provider: “they are usually really, really sick by the time we get to see them” (SP3).

Research by Collis-McAnespie et al (1997) into terminally ill Aboriginal people, with interviews of the patients and their carers revealed that family care was preferred by both the carer and the person with the terminal illness. As a local Service Provider explained:

*One lady I had, her husband went direct to (X place) for respite and he actually died there and she felt terrible that she wasn’t with him. This was after a couple of years of her slogging away trying to look after him and then she broke her leg. But she’s still never forgiven herself*  (SP2).
In fact Collis-McAnespie et al (1997:32) assert that “[u]nless expressed otherwise, the terminally ill Koori will prefer to receive palliative care, and die, at home”. However, that study identified that there are many costs associated with this type of care, especially for the carer. Carer burdens include: financial hardship, emotional drain, dealing with ‘anticipatory grief’, unresolved grief from other family deaths, and social isolation (Collis-McAnespie et al 1997).

Local Service Providers also see this reluctance to use mainstream health services played out with a real reluctance to access mainstream respite care (See p.45).

**Communication:** McGrath et al (2005:306) undertook to “explore communication issues faced by health care workers and Indigenous patients and their families in a palliative care setting”. Their results highlighted the struggle associated with effective communication for everyone involved, i.e. Aboriginal patients, extended family, Aboriginal Health Workers (AHW) and non-Aboriginal health care staff, “when working in a cross-cultural setting at the interface of Indigenous and Western health care” (McGrath et al 2005:306). As further described by a local Aboriginal Health Worker:

> I’ve come across some really ignorant doctors, not only for Aboriginal people but for all people. They put themselves on a pedestal and you can’t talk to them. I once said to one young doctor: “I don’t know who you are…. but I’m asking you a question. What puts you above anyone else? I’ve got a family out here in the hallway that are freaking out and want to know more and I don’t understand the terminology you’re using. All I’m asking you is that you please explain it to them – it will take 5 minutes of your time” (SP5).

Collis-McAnespie et al (1997) report many examples of the vulnerability of Aboriginal patients and their associated lack of personal advocacy. Several Aboriginal participants in their study “commented that they were ‘too scared’ to take up issues, request services or ask for explanations from hospital workers” (Collis-McAnespie et al 1997:33). The participants (both patients and health workers) felt that some of the problems were due to the language barrier between Aboriginal and non-Aboriginal people – many Aboriginal people do not speak English, or do not speak it well enough to understand the health workers information.

Local Service Providers from the project area did not feel that this was an issue for most older Gumbaynggirr people because, for many, English was their first language. However one Service Provider did say that she had a client who was dementing and he had lost most
of his English and had gone back to his Gumbaynggirr language. This is also a common occurrence in migrant population groups and has implications for who should be taking care of people with dementia.

The custom of Aboriginal people agreeing to questions even if they do not understand what is being asked of them was also identified as a barrier to effective communication – “lack of or very short answer can lead to a gap in service delivery for patients and their carers” (Collis-McAnespie et al 1997:34).

As explained by one local Service Provider:

> At the hospital, with the clients I try where I can to come with them for their first clinic visit. I like to come at first to settle them in. If they haven’t had a proper introduction to start they are likely not to come back. There’s one fellow who comes to the wound clinic, he’s been coming every week for the last three months and I came with him the first time and he’s fine now, he’s absolutely rapt in it and they all love him. He’s a Bundjalung man and he’s now teaching the wound care nurse his language (SP2).

Some of the Aboriginal participants of Collis-McAnespie et al (1997) study also complained of poor communication by health and medical staff. Information about treatment, illness, prognosis and care options was often inadequate, thus provision of information and education about a person’s illness, treatment and care was a common need.

A local Aboriginal Health Worker also reported a problem relating to language level:

> Outside of in-patient rooms there is a medical chart with notes - if something is written in medical notes and I don’t understand it I go to nursing staff and say ‘If I don’t understand it, the patient won’t understand it and the family won’t understand it’. It could be a simple thing like flu or bronchitis - So why put a big word on the chart that I don’t understand? They laugh at me and I laugh too - but then I can walk in (to the patient and family) and say ‘you have a severe case of bronchitis or asthma’ (SP3).

More recent research has tried to find solutions to these problems, and has identified that “an open and honest exchange of information between health care worker and patient is needed” (Jones 2006:7).

Local Service Providers also commonly called for more cultural awareness training but even if there were more cultural awareness some Service Provider believed there were other issues that would be very difficult to resolve.
I’d love to see a hospital unit away from the hospital for Indigenous people to be honest. The local AMS is just fantastic, Aboriginal people are happy to go there because they don’t feel intimidated. But here is the last resort to get them into hospital. I think we need to change our environment and the way that nurses treat people and the whole system. I think people try their best here but the system is not set up” (SP3).

**Building an Aboriginal Workforce/Aboriginal Health Workers:** The need to recruit and train Aboriginal people to provide care and support to older Aboriginal people was recognised in the 2007-2008 Federal Budget. Aged & Community Services Australia (2007:5) noted that

120 Indigenous Australians currently working in the Community Development Projects (CDEP) will be employed as either respite carer positions or in the home and community field. Thirty CDEP positions in remote areas will be converted, and other positions will be created in HACC agencies to maintain service levels when the CDEP is withdrawn from urban and regional areas from 1 July 2007.

Collis-McAnespie et al (1997) and McGrath et al (2007), agree that AHWs have a positive and fundamental role in Aboriginal health care. A qualitative project by Collis-McAnespie et al (1997:33), which worked with 21 terminally ill Aboriginal people and their carers, identified that AHWs:

- are generally held in high esteem;
- have critically important roles, including the need for someone to provide family with emotional support and comfort during and after death;
- contributed to patients feeling ‘safe and comfortable’ as their understanding of Aboriginal culture played a big part in the healing process; and
- not only provided personal care and advice relating to issues surrounding terminal illness, but also appeared to give a great deal of emotional support both during the terminal phase and after death. This support, often simply ‘a cuppa and a smoke’ was highly valued by participants (Collis-McAnespie et al 1997:33)

More recently, McGrath et al (2007) reported on 72 qualitative interviews with Aboriginal patients and carers in the Northern Territory and the health professionals who care for them. The strong evidence from participants in this research (ibid: 432–434) is that AHWs:

- are appreciated for their valuable contribution to the organisations for which they work;
• are perceived as a positive solution to reduce the sense of fear and alienation for Aboriginal people, which is especially important during the sensitive and distressing time of coping with terminal illness;
• can interpret not only the spoken but also the non-verbal language of Aboriginal people;
• assist in overcoming barriers, and can negotiate the disparate social and knowledge systems involved when traditional Aboriginal and Western health systems interface;
• have a good understanding of Aboriginal patients’ spiritual, cultural, social and physical needs; and
• are successful in encouraging Aboriginal people to use health centres through informal networking.

According to these researchers, Aboriginal people would prefer to be cared for by members of their own community, family members or members of their clan group or tribal group.

The advantage of AHWs during the distressing and sensitive time of end-of-life care is that they are able to understand both the spoken and non-verbal language of their people, and they are able to negotiate the indigenous knowledge system and cultural beliefs. (McGrath et al 2007:437)

The employment of AHWs also contributes to Aboriginal empowerment “because part of community participation and control and empowerment is employing Aboriginal people.” (McGrath et al 2007:434). As a local Aboriginal Health Worker described:

*The North Coast Area Health Service has Aboriginal Health Workers and they are more accessible. There’s Aboriginal Health that does health promotion and then Aboriginal Workers like myself under mainstream managers working in clinical service areas, it’s great to have both. Being here for so long I have built up rapport with a lot of people and I’m often called to help out in many areas (in the hospital)… Part of my role is to put things into place, e.g. if it’s a long term illness that requires changes to payment I will talk to the Aboriginal worker in Centrelink. Or I will talk to the Department of Housing if they need relocation if where they are living is too noisy or they live on a mission and need to relocate to a safe place. Referrals to Nursing Homes, I usually leave it up to the clients and families (SP5).*

Local non-Aboriginal Service Providers were also generally very supportive of the employment of AHWs.
I have been very critical … of the medical profession – doctors – I have seen some incredible insensitivity in dealing with Indigenous people. One thing that helps is people like X (Aboriginal Hospital Liaison Worker) who does support, he was brilliant when we had X in last year because he is Aboriginal and was therefore very tuned in with how X was feeling and he was able to get him out. I remember one day watching one of the Drs trying to explain to X what was going on and X was very confused and it was sort of like ‘Urgh!’ They need training, the Doctors need training I would say (SP3).

I’d love to see more increase in community nursing … it would be lovely to see an Indigenous Registered Nurse. And I think it would be really good to see more health workers who are Indigenous working in the community; that just works so much better (SP3).

I think there needs to more health workers to check on the Elders. They do have a (Indigenous) health worker working up there (in Corindi) but I do think they need more than just her. If there were these workers they could check on the Elders a few times a week to make sure they were going to their appointments and stuff. Diabetes is particularly very hard for people to manage. There are the diabetes educators here at the hospital but there’s a lot that aren’t getting the education they need. And heart problems of course. They really have to be educated beforehand about what to look for. Smoking is a big one too. All these things have been addressed, but I think (Aboriginal) Health Workers need to be out there doing all of that. There’s just not enough (Aboriginal) Health Workers (SP2).

(NOTE: ETC Ltd, one of the collaborating organisations in this project, recently received funding to train 40 Aboriginal people to Certificate III Aged Care Work and it is anticipated that a number of these people could, in the future, be employed within this project).

Aboriginal Health Worker Employment Issues: McGrath et al (2007) reported on the value and importance of AHWs in the health care system. They argued that employing AHWs may assist in reducing the constant turnover of workers who come from outside the small, remote Aboriginal communities, and may also help to empower the communities from which they are employed. During their research, participants highlighted the need for a culturally supportive and flexible workplace for AHWs…. An important part of the provision of support was stated [by participants] as ensuring that AHWs are in a work environment that understands traditional Indigenous cultural issues. A most significant issue in regard to end-of-life care is to understand the cultural imperative that Indigenous people have to attend family funerals. Without understanding, the issue of funeral attendance can be the cause of staff turnover and instability. …when trying to get them to stay in the workforce, attending funerals is not taken into consideration. So therefore they’re pushed by their family and they end up pulling out of those jobs because it doesn’t support that cultural side (p435).
Examining the role of the AHW, McGrath et al (2007) found that it is often undefined and unclear, particularly with regard to being employed as liaison officers or interpreters or as clinical workers. Some participants in their study argued that an emphasis on clinical skills is not necessary and the most important aspects of the work are: a social liaison and support role, cross-cultural liaison role, and someone to assist in relationship and knowledge ownership issues.

You need the right person who’s the right kin, who has the right understanding, who has the ownership of that knowledge, to be the person there. And to some extent maintain a distance from the clinical side of things” (McGrath et al 2007:436).

Local Service Providers mostly viewed kin relationship between older Aboriginal people and workers as helpful but not a pre-requisite and cited a range of other factors such as having the necessary skills, being committed and there being a continuum of care as more important in the care of older Aboriginal people. Also, in the interviews conducted several examples were given of non-Aboriginal people working closely with and trusted by the local Aboriginal people.

We’ve got a lot of stolen generation people in this area and there’s been a lot of breaking of the kinship. In some areas they have tried to re-establish that… particularly at Bowraville, it’s really quite tragic what’s happened there. In its place what’s needed is something like continuum of care. You don’t need to be Gumbaynggirr because I think with good education you can get around that. I would hate to see people locked into that because then you can’t be flexible and I think it’s more important to be flexible. You don’t have to be Aboriginal either; I’ve never had that problem (SP3).

If you can have Aboriginal nursing staff then that’s good but it would depend if they can meet the criteria for skills needed. This is the most important thing. You could prioritise staffing for Aboriginal workers (at the Moonee Centre) but if there are non-Indigenous workers who have the skills and are committed to Indigenous health – I think that’s great (SP5).

Aboriginal Elders are not too fussed who looks after them (Aboriginal people or non-Aboriginal people) just as long as they know how to care for them (SP4).

AHWs require clear job descriptions to define their role, both for themselves, other hospital staff, and for the patients and families in their care. Mawson et al (2007:26), outlining the challenges experienced by Aboriginal people in establishing an Aboriginal Community-Controlled Health Organisation, note that:
Maintaining professional boundaries around staff members when at work and clarifying their roles and responsibilities to their employer separately from their role as a community member continues to be a challenge.

After exploring this issue from a variety of perspectives, McGrath et al (2007:435) recommend that “there be an emphasis on the diversity and holistic nature of that work” i.e., that AHWs focus on a supportive role rather than on clinical duties.

A local Aboriginal Hospital Liaison Worker felt that his role was primarily to be “the link person between in-patients and doctors and nurses” and “to puts things into place” (SP5).

Current health-related conditions: A decade ago, Collis-McAnespie et al (1997) linked lack of services, providing sanitation and severe living conditions on reserves and stations to the current [at that time] experience of Aboriginal illnesses such as renal disease, which may result in the need for palliative care. It appears that the situation has not improved. Jones (2006:7-8) reports that Aboriginal people today have poor health that has been directly linked to: “unmet housing needs; absent or structurally impaired kitchen, bathroom and laundry facilities; malnutrition; unemployment; and poor education retention”. These problems are compounded by household crowding (Jones 2006). As further explained by local Service Providers:

The challenges (for Elders living in extended family households) are: hygiene, nutrition providing support services …such as the need to be taken to important appointments, bathing. A lot of times the Elders probably wouldn’t be in here (hospital) if the family were doing these things (SP5).

Jackson and Ward (1999:3) assert that Aboriginal health is not just the domain of the healthcare system.

By accepting the need for an approach that is multifaceted and covers all aspects of people’s lives, including housing, education, employment and social justice, we can then understand that physical and symptomatic relief of disease will not in itself redress the burden of Aboriginal ill-health.

Interviewing 98 older (45 years +) Aboriginal people in the ACT and surrounding region and assessing their needs for residential care, aged care and other services using the Resident Classification Scale, Dance et al (2000; 2004) reported on current and future levels of needs. According to Dance et al (2004:581-582):
70% (of participants) required a low level of care and 4% needed a high level of care. 27% of participants reported that they needed help or more help now because of their health problems. The greatest current need was for help with yard work (42%) and the greatest anticipated future need was for cooking (76%). While most of those requiring assistance were 55 years or older, noteworthy proportions of those between the ages of 45 and 54 also required help.

Other needs identified by Dance et al (2000:ix) included:

- Adequate provision of hygiene care
- Home modifications and renovations
- Food services
- Transportation to health care services
- Respite care
- Dental services
- Counselling services

Local Service Providers also explained that whilst older Aboriginal people commonly lived with their families in multi-generational households, this could be either a benefit or a challenge for older people in getting their needs met.

When I first came into this job I was surprised by how well some of the Elders were cared for and sometimes it can be a very big demand on families (SP2).

It makes me think of a lady … living at X - she was living with probably about 10 other relatives and they were very reliant on her pension. The family were very keen to keep mother at home because they were reliant on her pension. And I have seen that over the years, it is a bit if a concern, particularly where there is alcohol involved. … it’s really quite difficult when you have those kinds of issues (SP3).

...we’ve got a case currently where the family have promised this and that but no-one has really come to the fore to take responsibility, which needs to happen before this lady can be discharged. The importance of knowing what needs to be done with the tube and wound care and the cleanliness and it has to be a day and night thing, so she will need a fulltime carer. And they are all saying yes, yes, yes but no-one yet has actually come forward to take that commitment on. She won’t be able to leave until someone does. If the family want her to stay in this area, then they have to understand what’s required… She needs a clean, quiet environment and she has to be checked on all the time. It’s educating - getting the family to understand the importance of why this needs to be done (SP5).
Dance et al (2000; 2004) also reported that a barrier to good health care for a high proportion of their respondents was that they were not aware of local services that might be of assistance, or of existing information that could help them locate and access local services.

Local Service Providers also agreed that often Aboriginal people did not know about services or how to access them.

... everything is here (in the hospital) for both Aboriginal people and mainstream; just got to know how to access it. Providing they know that the services are here and are able to access them. The issue for a lot of Aboriginal Elders is they are not aware, this is where (Aboriginal) Health Workers can come into it; they can provide that information to them (SP5).

We need to sit down with not just Elders but any Aboriginal groups and go through what’s required to be eligible for a Package. A couple of years ago I talked to the Yarrawarra Elders and went through and spelt it out. But it’s not being done regularly. We need to look at areas like Yarrawarra, Wongala and Galambila and those sorts of Centres, those are the ones we should be contacting (SP3).

**Transport:** Remoteness of older Aboriginal people from the point of service delivery and lack of transportation are often major barriers in getting health care (Collis-McAnespie et al 1997; Dance et al 2000). Boustany (2000) noted that Aboriginal people in rural areas were less likely to live within 25 km of services and facilities and more than half had to travel more than 50km to a hospital, which correlates directly with poor health outcomes.

Transport was identified as a major issue by everyone involved in the current project. The local Service Providers mostly thought that transport was adequate for those older Aboriginal people living close to the Coffs Harbour city area or for one-off trips to hospital.

For attending health appointments Elders generally use Community transport or Galambila’s transport service or rely on family members (SP2).

Generally it’s not too bad - a lot of the young ones like to bring down their grandparents or uncles/aunties (to hospital) if they’ve got their car or licence. I see a lot of them come in and they stay and see what’s going on (SP5).

However, in the outer parts of the project area lack of transport was seen as a problem:

Transport issues are particularly common, especially out in the Corindi area – where no transport seems to be available. Whenever I go out there I’m forever arranging transport for Elders to come in for their appointments. I’ve got to do it, they don’t seem to have anyone out there to do the transport and I’ve been saying it for years (SP2).
Another transport-related issue that needs to be considered is that Aboriginal people in residential facilities usually have little money to go towards necessary transport after other costs are incurred. Travel to cultural events, funerals, family and Elders’ gatherings is essential to the well-being and health of older Aboriginal people. Families are largely relied upon to transport their Elders to these events, placing additional financial pressure on family resources. Also, part of the Aboriginal culture is for more than one family member to accompany an Aboriginal person on a medical trip especially over long distances, which can increase the cost of transport.

**Other Barriers:** Other barriers to accessing health care include:

- Significant language barrier (McGrath et al 2007:433); and
- Lack of:
  - money (for medications and/or a fridge to put them in);
  - social supports;
  - self-advocacy; and
  - being caught between cultural paradigms.

(These issues have been identified in particular for Aboriginal women [Boustany 2000]).

**PB3.4 Recommendations for the Moonee Site**

Based on the above findings from the literature, most of which appear also to reflect the situation in the project area, when identifying service provision for older Aboriginal people in the study area, consideration should be given to the need for:

- more in-home support (Collis-McAnespie et al 1997) and assistance with the burden on carers (CHSD 2003).
- health workers in mainstream services require cultural awareness training to ensure they: can show cultural respect and sensitivity, increase their interpersonal communication skills, and demonstrate empathy with the Aboriginal perspective (McGrath et al 2005).
- training and subsequent employment of more AHWs to assist with the provision of health care and help improve communication between health professionals and Aboriginal people (Collis-McAnespie et al 1997; McGrath et al 2007)
• doctors to be taught about Aboriginal culture and for this to be included as part of their training as well as effective communication skills (Collis-McAnespie et al 1997).

• ongoing education to be given to the Aboriginal community about their entitlements to services (Dance et al 2000; 2004).
SECTION 4

PB4 – SUPPLY AND DEMAND MATRIX

PB4.1 Develop a Matrix Showing the Inter-Relationship Between Existing Programs and the Identified Demand for Aboriginal Aged Care Services and Programs.

PB4.1.1 Planning Data/ Population Estimates for the Project Area

The Department of Health and Ageing’s (DOHA) planning ratio for aged care places is 113 for every 1,000 older people in the population, comprising 88 residential care places (44 ‘high care’ and 44 ‘low care’) and 25 community care places (including CACPs, EACH and EACH Dementia). Applying this ratio to the estimated number of older Aboriginal people currently living in the project area aged 45 years and over, i.e., 1,164 persons (see Table 4), the number of Aboriginal-specific places should be 132 (51 ‘high care and 51 ‘low care’ residential places and 30 community places). There are currently no Aboriginal-specific residential places but there are 68 community places (10 of these being provisional) in the project area. DOHA advised that this unequal distribution of service types with low levels of residential care and community care places exceeding the benchmark level is a fairly common situation in Aboriginal communities, reflecting higher demand for community care which, in some cases, is substituted for low level residential care places. This is also in line with our findings from the research and interviews conducted with Service Providers.

PB4.1.2 Existing Programs – Summary

Non-Government Aboriginal-Specific Health Services Operating in the Project Area:

North:

- Bulgarr Ngaru Aboriginal Medical Service (AMS) based in Grafton and servicing north of Corindi Beach.
- Weekly morning outreach clinic run at the Yarrarwarr Aboriginal Corporation at Corindi Beach. Clinic run alternate weeks by either a GP from Woolgoolga and Northern Beaches Medical Centre or a GP from Galambila AMS, also attended by the Aboriginal Health -Community Nurse from the North Coast Area Health Service.
Central:
- Galambila AMS based in Coffs Harbour and servicing the Aboriginal community from Corindi in the north to Urunga (south of Coffs Harbour) and west to Dorrigo and Ulong.

South:
- Bawrunga AMS based in Bowraville and running two other clinics in the Nambucca region at Nambucca Heads and Macksville.

Aboriginal-Specific Aged Care Support Services in the Project Area:
North:
- Community Programs Incorporated based in Grafton providing social support, meals and running groups.
- Home Care Services of NSW - Aboriginal Home Care: DADHC’s Grafton based Aboriginal HACC Service, providing home help, personal care and respite by and for the Aboriginal communities in the Clarence Valley.

North & Central
- Home Care Services of NSW - DADHC’s Aboriginal HACC service that operates from Casino and has a branch in Coffs Harbour providing practical assistance in order to promote independent living of older Aboriginal people in their own homes. Services include: domestic assistance; personal care; respite care; minor home maintenance and a linen service.

Central:
- YACL - providing social support and running a day-activity group for older Aboriginal people at the Moonee Centre.
- AbCare - Aboriginal Social Support Program- Funded by DADHC. The program’s purpose is to advocate on behalf of and provide regular social activities/outings for older Aboriginal people and their carers, to assist them to remain in their own homes. Services include: home help and maintenance; day care centre; transport; nursing assistance; carer respite; referrals to other carer relief agencies and regular group health checks (Galambila).
South:
• Ngambaga Bindarry Girwaa Community Services for Aboriginal people in the Nambucca Valley, for frail older people and their carers. Provides Wheels to Meals – transport to meals in different settings (BBQ’s, outings, bush, beach), emergency relief, advocacy, referral, transport, centre-based respite (transport and meals provided) and activity days.

Aboriginal- Designated Community Aged Care Places in the Project Area:
North, Central and South
• Nambucca Valley Community Services Council – Aboriginal Community Aged Care and Aged Care at Home provide CACPs, EACH and EACH Dementia Packages for Aboriginal people living from Corindi Beach to Macksville.

Central
• Coffs Harbour Nursing Service – providing 3 CACP for Aboriginal people living in the Coffs Harbour area.
• Carexcell – provisional allocation of 10 CACPs for Aboriginal people in the Coffs Harbour area⁶.

Aboriginal-Specific Residential Respite Operating in the Project Area
North - none
Central – none
South - none

PB4.1.3 Supply and Demand Matrix for the Project Area
The matrix (Table 5) has been compiled using data from both the DOHA’s Service List (as at 30/6/07) and non-residential services identified as part of the Scoping Study’s Regional Providers research.

The purpose of the matrix is to identify the current regional spread of resources with specific emphasis on how these services may overlap with service opportunities at the Moonee Centre.

Table 5: Supply and Demand Matrix *(see pages 44 and 45)*

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⁶ One interviewee advised that Community Care Options takes Aboriginal clients for their mainstream CACPs.
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<th>DADHC Social Support</th>
<th>Aboriginal Health Clinic</th>
<th>Transport Services</th>
<th>Home Maintenance</th>
<th>Centre based Day Care</th>
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Indicates Aboriginal-specific service
PB4.2 Identify key service gaps

Based on workshops, consultations and interviews conducted with local Service Providers, the following assessment of current services was made and gaps identified:

**Health**

Service Providers generally agreed that AMS were being well used by older Aboriginal people and that the health care needs of older Aboriginal people living in the project area, especially those who lived near an AMS, were generally well met

> A lot of them go to Galambila. …. generally, except those from Corindi who attend the weekly outreach clinic or go to the Woolgoolga Health Centre to see Dr X, (but mostly) those (Aboriginal people) living in the central part of Gumbaynggirr Nation go to Galambila. Those living in Grafton, Bowraville and Nambucca would use their respective Aboriginal Medical Services. A few come from as far as Lowanna and Ulong to use Galambila (SP2).

> Some of them, because of their age and because they have been with their GPs a long time use their local GPs, but increasingly it’s now the local AMS. Becoming more popular because the AMS do bulk billing and provide transport to and from (SP5.)

> Galambila’s just fantastic, Aboriginal people are happy to go there because they don’t feel intimidated (SP3).

However, one Service Provider also identified some Aboriginal communities within the project area where she believed there were significant health service gaps:

> Some particular communities are very under-serviced like the ones that live down at Happy Valley in the huts (they have no hot water or electricity). The (Local Government) Council built the huts, they are located down at the back of the jetty. They are usually the ones that get a bit drunk and they don’t receive anything (SP2).

> The Yarrawarra/Corindi area … is also under-serviced. Some days I go up to Yarrawarra and I should be there all day but I can only spend half a day (SP2).

**Day Activities**

Most Service Providers did not comment on the current level of Aboriginal-specific day activities. YACL’s Mr Perkins advised that there was currently work happening amongst three key Aboriginal-specific day activity providers i.e. YACL, Community Programs Incorporated and Ngambaga Bindarry Girwaa Community Service, to take a regional approach in the provision of social activities for older Gumbaynggirr people. Plans are currently in place for a monthly link up with participants of both YACL’s and Community
Programs Inc’s day activity programs. There is also an intention of extending this in the near future to include participants of the Ngambaga Bindarry Girwaa Community Service day program. It is anticipated that in exploring this regional approach the organisations involved will also investigate whether cost efficiencies can be made.

**Community Care Packages and Aboriginal Home Care**

Generally, local Service Providers believed that the CACP and EACH Packages are what is most appropriate and most in demand in terms of support for local older Aboriginal people.

*I assess for all Indigenous people (in the North and Coffs Harbour area) and I would say it's very, very rare for me to assess for residential care, it’s nearly always CACP … or an EACH Package (SP3).*

*The majority of them are receiving some home care and through this they are getting help with shopping, cleaning, and showering. Most would be getting CACPs. In the younger group (45-55) there may be a few that have been missed but I try and refer them (SP2).*

As previously mentioned, the majority of Aboriginal-specific Community Care Packages in the area are being provided by Nambucca Valley Community Services Council (Table 1) which provides services to older Aboriginal people from Corindi Beach in the north to Macksville in the south. Some Service Providers felt that this service area was too wide to operate optimally.

*I also liaise closely with the Nambucca Aboriginal Aged Care (Nambucca Valley Community Services Council) because we have mutual clients. I often liaise with them and say: 'so and so needs this’ or ‘I think X is unwell’. They provide EACH and CACP for Aboriginal people. They have clients in Corindi (1 worker up there), Coffs, Urunga, Nambucca and Macksville, they cover a fair area (SP2).*

*They are funded to cover the whole area and they are providing Packages up at Yarrawarra. I do worry. I think it’s pretty hard to expect a Coordinator sitting in Macksville to be able to fully coordinate up in Yarrawarra (94 kms away)(SP3).*

Some Service Providers felt that with the growing number of younger Aboriginal people with chronic disease in the project area, the need for additional Community Care Packages will almost certainly increase in the future.

*Packages are not always available and sometimes you have to wait but they (Nambucca Valley Community Services Council) do try and accommodate as much as they can. Probably there are not enough Packages and this is certainly*
likely to get worse in the near future, giving the growing number of Aboriginal people getting chronic diseases much earlier (SP2).

In terms of demand, one Service Provider questioned whether the planned provisional CACPs for the project area might be in excess of needs. The waiting period (for Aboriginal-specific) Packages varies but at the moment it’s not too bad. My one concern about those new Packages coming on line here is I think we are going to struggle to fill them. The reason is the biggest demand is high care which is EACH. Nambucca Valley Community Services Council has some EACHs down in Nambucca. I’ve only got 1 client for a CACP. Usually it’s a really short wait (for CACPs). The EACH is the same, I could get an EACH tomorrow, because (Nambucca Valley Community Services Council) has got them. Mainstream is different. I reckon we are going to struggle to fill the new Packages (SP3).

However, the project team believes that the Community Care Packages currently available (and provisionally allocated) for the project area have the potential to be used innovatively to address the existing and urgent need for respite.

In the central part of the project area, in-home support is provided by Aboriginal Home Care, Service Providers and the Package Providers. In all these services there appear to be significant shortages of staff to deliver services and Service Providers want to see increased resourcing.

I just don’t think there’s enough Aboriginal workers doing home care support work given the demand. There’s two workers I come across in the community, they are both female, so there’s not enough males, and they are both run off their feet. One of them has just gone off on leave as she really needed some time out. They come from the two different services, the Nambucca one and the Coffs one, and Home Care Coffs Harbour. There used to be more male workers but not currently (SP2).

The challenges of providing in-home care support to older Aboriginal people and the importance of having Aboriginal-specific Service Providers do this work was explained by one Service Provider:
I think it’s very difficult [for Providers] and I think it’s a very fine line that they walk. It’s like the lady at X that’s got 10 of her family living there and the housekeeping [allocation] is up to 4 hours a week, for most people its only 2 hrs a fortnight but because there is 10 people [it is initially allocated at 4 hours]. The workers had to clean the house for ten people. In the end the Package people said ‘No we can’t do that, we are just going to clean your room, the toilet and the kitchen’. The family wanted everything else cleaned but when you look at the guidelines you can’t do that because Packages are for individual persons. Of course you support the carer too but you can’t support eight other people as well. But it’s hard, you’ve got to get the rapport [with a family first], and you can’t go in there boots and all going: ‘We’re only going to do this’. So I think it takes a really special Provider, someone very in tune with Indigenous people and their families to really make the service work (SP3).

**Respite**

As discussed above, respite was seen by most Service Providers as something generally not well understood by older Aboriginal people living in the project area and hence it was currently rarely utilised.

The last assessment I did at X, I asked an old bloke… about respite. I explained it as a little holiday – but they just don’t want to leave home. That’s why they get the Packages because they don’t want to leave home. I don’t think they really get the concept of respite (SP3).

A lot of them won’t go to respite in mainstream; they don’t like it, because it’s not with their own people. … To be honest they don’t much like the idea of it and would prefer to stay home. I only refer occasionally but have broached it often but there’s not great take-up. Many Elders and their families are just not very comfortable with the idea. Some believe that they are going to have to stay there and suspect that they won’t come home (SP2).

Some are referred down to Booroongen Djugun in Kempsey but most don’t want to go outside of this area, their tribal boundaries of Gumbaynggirr. In my experience, the question is: ‘Why haven’t we got something here for the Elders, where they can go to something like a retirement village?’ (SP5).

However, whilst respite is not currently either well understood or much utilised by older Aboriginal people, all Service Providers interviewed felt that Aboriginal–specific respite was a significant service gap across the entire project area (see Services below).

**PB4.3 Service Providers’ Recommendations for the Moonee Site**

Service Providers were asked about the appropriateness, or not, of the Moonee site for older Gumbaynggirr people and, if a Centre were to be developed, what services they would like to see provided. The following is a summary of their feedback.
Location

In most cases the Service Providers believed that the Moonee site was an appropriate place to site a Centre for older Gumbaynggirr people.

(The location is good) because it’s central, it’s in the area, they know they’ll see their families. If they’ve been going there for respite and they know the place, know it’s a good place and there are Aboriginal carers, maybe they would feel OK about going there on a permanent basis (Service Provider 6 [SP6]).

I’m sure because then they would be able to access services more easily, especially as access to transport has been identified as a problem. I don’t know if anyone has talked to the Yarrawarra Corporation on how they feel about Moonee; it’s a bit of a way for them. Wongala, it’s still a bit of a way. But then again its (Moonee Centre) half way for both of them (SP3).

Yes I think so. Of course, if you could have it in Coffs... but for Corindi people, Moonee is somewhere in between. It would be great. Somewhere to go when they need a break. (SP2).

By providing day activities at Moonee it will create a captive population and from this you are able to do things. All people attending Moonee will have health needs and the Centre would provide an opportunity to begin to address them (SP4).

Services

In terms of potential services at the Moonee site, Service Providers generally supported the need for respite, especially short term.

…if we had Aboriginal-specific respite and Aboriginal-specific day care where the community and Elders are behind it I reckon that would work really well (SP3).

Would like to see a big comfortable place, that people feel comfortable to go to, that fits in with cultural ways and where they feel relaxed. Not to be taken out of their homes and it’s the last place they go before “the next stage” (death?). That’s really cruel. If they could come in there to take a break from their families, if they need that special care for maybe 2 days, a week that would be good (SP6).

If services were to be provided at a Centre, you would need to ensure there was transport to get them there. I don’t think they need a nursing home because a lot of them won’t go to a nursing home anyway. Maybe a Day Centre, doing activities. I think you could have a medical outreach service. I don’t think you’d need an actual doctor there or that sort of stuff (SP2).
I think Day Care, respite. I reckon you could possibly have residential respite there if it were set up for Indigenous people. Something like the Waratah Respite Centre, overnight respite, something short-term where people book in for 3 weeks or whatever…. Where the Waratah Respite Centre works so well, and this is why I think the Indigenous people would like it is, … I had a client the other day, the carer needs some respite and he has booked some respite for later in the year, I said to the family: ‘Why don’t you get Mum into the Day Care now?’ So she goes to the Day Care where the respite is, she gets to know the staff, they get to know her. Then they say: ‘Oh you will be coming to stay with us later in the year’ and it works beautifully. …It’s that continuum of care. I reckon if the Moonee people duplicated what Waratah Respite Centre are doing I think they would do really well (SP3).

However the ACAT Assessor, whilst supportive of short term respite, could see many challenges in providing it under existing funding sources.

My only concern is we’re (ACAT) not an emergency service. If it’s to be funded by the Department it would need an Aged Care Client Record (ACCR) and the thing is, like all ACAT assessors I’m extremely busy; occasionally I will do an assessment within 48 hours for respite but that’s very rare. Funding really doesn’t suit crisis respite; (the Moonee Centre) could only do that if it were funded by something that didn’t need the ACCR. Carer Respite can do in-home respite and they used to be able to do it over a weekend, so you should probably talk to Carer Respite about their in-home respite (SP3).

**Essential Requirements**

Transport was highlighted as a key issue that would need to be addressed.

*For a Centre like Moonee to succeed it would need to have transport and be prepared to look in several places for clients and accept that ‘no shows’ will be common (SP4).*

**Opportunities**

One Service Provider saw the Moonee site as a potential hub for Aboriginal-specific aged care services and an ideal informal environment for education of both older Aboriginal people and workers.

*It’s quite often more financially viable for services to co-locate. So whether you’d look at your Aboriginal Meals-on-Wheels, and Aboriginal Home Care; if they were all based at that same place I reckon that could work really, really well (SP3).*
[Moonee could provide a] relaxed atmosphere for education, have a cup of tea and let me talk all about Packages and I like working like that (SP3).

...we say to mainstream (clients) ‘ring Carelink’, but a lot of Aboriginal people don’t have phones for a start and I think if they can access an information service there (Moonee Centre); you’ve got your day care, your respite plus your information (SP3).
SECTION 5: LOCAL ABORIGINAL COMMUNITY AND REGIONAL SERVICE PROVIDER CONSULTATIONS

This Section of the Report deals with Project Brief Item 5: Local Aboriginal community and regional Service Provider consultations.

(NOTE: As these consultations were relevant to a number of the previous sections, some of the information has been reported there).

PB5.1: Summarise the findings of prior and ongoing consultations with older Aboriginal people and Communities in regard to service needs that could be potentially addressed at, or from, the Moonee Centre.

(NOTE: This item was not part of ASLaRC’s original brief, however it became apparent that the Aboriginal Research Assistant employed to undertake this role was experiencing difficulties in implementing it (e.g. after he had spent several months ‘sitting down and having a cuppa with the old people’ he could not provide any information at all about the outcomes of those discussions) and assistance was clearly required to complete this Section. Therefore a brief questionnaire/discussion guideline was developed by ASLaRC to assist local Aboriginal Service Providers to gather some basic data about the health and care needs of their older Aboriginal clients (see Appendix 7). In addition, ASLaRC’s Director and an ASLaRC Research Assistant conducted face-to-face interviews with three Aboriginal Elders and six Service Providers (See PB5.1.2)

PB5.1.1 Survey Findings

(NOTE: The survey questionnaire/guideline was based on the work of Dance et al (2000) who undertook a study into the need for residential aged care and other services of the older Aboriginal population in the ACT and surrounding region.)

Survey Outcomes for this Project:

In total, 24 older Aboriginal people participated in the survey, which was administered by staff from Yarrawararra Aboriginal Corporation and Galambila AMS.
Participant Characteristics:

- Gender: 15 female; 9 male
- Age Range: 40-49 = 3; 50-59 = 9; 60-69 = 9; 70 and above = 3
- Residence Location: Woolgoolga = 8; Coffs Harbour = 7; Corindi = 4; Sawtell = 3; Toormina = 1; Lowanna = 1.
- Aboriginal Tribal Group identified with: Gumbaynggirr = 17; Gumbala Julipi = 2; Bundjalung = 2; Kamilori = 1; Dunghutti = 1; Not stated = 1
- Main language spoken: All participants said that their main language was English.
- Living arrangements: Alone = 5; With spouse only = 8; With spouse and other family = 5; With family but no spouse = 6

Health Services Accessed in past 12 Months:

- GP visits: All 24 participants had visited a GP in the period specified; 12 participants had visited between 6 and 9 times; 9 had more than 10 visits, with the most frequent being “fortnightly”; 3 participants said that they had visited a GP but did not specify how many times
- In-patient: 8 participants had been an in-patient in hospital; number of occasions of hospitalisation ranged from 1 to 5.
- Out-patient: 12 participants had sought treatment as an out-patient; 6 had attended the AMS Clinic, 2 had attended a hospital and 4 did not state where they had obtained out-patient services; number of occasions of out-patient service ranged from 2 to 15. (NOTE: Out-Patient at Clinic appears to have been for allied health or GP services).
- Specialist visits: Only 6 participants reported having visited a specialist. These included: Endocrinologist = 2; Cardiologist = 1; Orthopaedic specialist = 1; Dental prosthetic specialist = 1; not stated = 1. Five of the 6 respondents indicated how many times they had been to this specialist; in 4 cases it was once only and in another it was 3 times.
- Allied health visits: participants had received services from: a physiotherapist x 5 (frequency 1-9 visits); a podiatrist x 3 (2 once only and 1 ‘often’); 1 participant had seen a social worker 8 times; and 12 participants had received a range of allied health services, including community nurse x 6; dietician x 1; chiropractor x 1; diabetes adviser x 1; not-specified x 3. Frequency of visits, where stated, ranged
from 3 times per week to once every 2 months. (A comment from one participant was that the dietician used to provide a very good service but the program ran out of money).

- Difficulty accessing services: 14 participants reported difficulty accessing services. In the majority of cases (n=12) this difficulty related to transport, in particular to access dental care and pharmacy services. A number of respondents considered having to rely on family or others for transport, or using public transport, as a problem. (NOTE – Transport is also a commonly cited issue for older non-Aboriginal people living in regional and rural areas of Australia.) While 2 respondents said that transport was not a problem when the doctor or other health care provider was at their AMS or clinic, it was problematic if care was required at other times. Only 1 person specified an access problem other than transport and that was “sometimes there is a long wait for support services”

Health Conditions:

- Diagnosed health conditions: 19 participants reported specifically-diagnosed health problems, 1 person was “not sure” and 4 said that they had not been diagnosed with any specific condition. In some cases the person had multiple problems. Diagnosed conditions included: osteoarthritis, osteoporosis, arthritis or back pain x 9; diabetes x 7; hypertension/high blood pressure x 4; cardiomyopathy, angina or heart problems x 3; asthma x 2; epilepsy x 1; and anaemia x 1 (N = 27 because of multiple conditions experienced by some participants).

Other Support Services:

- HACC services: 19 participants received services from HACC. These included: social support x 14; transport x 3; home care/cleaning x 2; 1 participant did not specify the services received and one person’s response to this question was that they receive an EACH Package. Again, some participants received more than 1 service.
- Meals-on-Wheels: Only 1 participant reported receiving this service.
- Support services other than HACC: 14 participants received support from services which they identified as ‘other than HACC’. These were: Land Council x 4 (e.g. yard maintenance); Yarrawarra x 3; YACL x 1; Aboriginal Home Care x 2;
Aboriginal Aged Care x 1 (this person expressed concern that the service may not continue due to lack of workers in the area); Community Transport x 2; and 1 each of Coffs Nursing Contract; Macksville Health Services; personal carer; and Community Care Options.

**Need for Services:**
- Need for more care/support: 16 respondents (66%) indicated that they needed more help. Again, transport was listed by 5; others needed help with: housework, cleaning, home maintenance x 3; shopping, banking x 3; 1 participant said ‘any’ (which is taken to mean that any help would be useful). In addition, 5 participants said that they needed more help but did not specify what that was.
- Culturally appropriate help: Participants who said that they were receiving services (and some of those who were not!) said that the services they received were culturally appropriate (although 2 participants indicated that this was generally but not always the case).

**Transport:**
- Access to transport: In response to a specific question which asked about access to transport, 12 participants indicated that they had their own cars (although 1 of these people added “needs driver”); most participants accessed a range of transport including family and friends x 9 (some adding “when available” for these two options); social support coordinator’s own car (x3); Galambila transport (x1); Community transport x 1; public transport x 2; and ambulance x 5.

**Supported Accommodation:**
- Ever in Residential Aged Care Facility (RACF): None of the participants had ever been in a RACF.
- Current living situation: the final question asked participants if they were happy in their current living situation or whether they would like to move into supported accommodation and, if so, whether that would cause any problems for their family or whoever they live with. Almost all participants (n=20) said that they were happy where they were now living, 3 did not answer the question and 1 participant said
that they were not happy in their current situation but “hopefully moving to better accommodation”.

**NOTE:** Advice from one of the Aboriginal staff members who conducted the survey indicated that most of the older people would have been reluctant to acknowledge that they were not happy with their current living conditions, even if that was the case, particularly if they were living with family. Despite assurances that their names were not recorded on the questionnaire or anywhere else, and that everything they said would be kept completely confidential, it may be that some were still concerned about confidentiality issues).

**Other comments:** The survey provided space for additional comments.

- One group of comments related to the social gatherings and outings that are currently being provided under the HACC social support program which is now being run from the Moonee Centre each week. These included:
  - high satisfaction with the outings, the benefits of “getting together” with other older Aboriginal people and the positive impact that this was having on people’s sense of well-being;
  - the Moonee Centre is starting to be recognised as a meeting place and a place to socialise;
  - the majority would like more activities and outings – including to places of cultural significance further away than is now possible; again, lack of transport appears to be the biggest barrier.

- A second group of comments were observations made by the Aboriginal staff member conducting the survey and related to 5 (presumably the frailest) participants. These included:
  - a number of participants are likely to need supported living very soon, but pride means that that is not being acknowledged;
  - the supported living with services need to be planned now, before the person is in a crisis situation,
  - some families are under stress trying to provide care and support, and they are concerned about what will happen when the care needs increase;
  - in one case the participant is also concerned about who will provide them with care as “family too busy”.
Survey Summary: While the majority of participants in this survey had specific health problems and regularly visited a GP and/or allied health staff, they do not appear to be particularly frail or ill. Given that most of the surveys were conducted with patients at an Aboriginal Medical Service or clients at the Moonee Centre’s Day Activities program, it is possible that those who require most help and support were not included in this survey because they are unable to access those services/activities. For those who did participate, the overwhelming need appears to be for better access to transport, which in turn would provide better access to health care, shopping and social support.

Issues Relating to the Survey
The questionnaire was never intended to be administered as a strictly controlled, random sample research survey but was meant to assist the interviewers from Aboriginal Service Providers with ‘prompts’ to encourage discussion. While this was explained to the five staff from Service Providers’ organisations who undertook the 24 face-to-face interviews with older Aboriginal people, it appears it was still used in a strict questionnaire format. The interviewers were selected because they were known to have strong links with older Aboriginal people through their organisation’s programs or services – although these were primarily from services that operate in the central part of the Gumbaynggirr Nation. In addition, interviewees were a convenience sample as they were recruited from older Aboriginal people who attended the above services. Nevertheless, The YACL project team believes that the 24 respondents interviewed accurately reflect the diversity of the geographical area, although possibly not the whole target group, as those older Aboriginal people who were too unwell to attend a clinic or other place where the interviews were conducted would have been under-represented in the sample.

It is also difficult to be certain that the responses of the interviewees accurately reflected their true situations:

...questions that ask whether a person is happy with their current living conditions ... would never be answered negatively even if they are unhappy with their living circumstances. This is because Elders living in multi-generational households are dependent on the people they live with and would be reluctant to express any difficulties/problems they are facing in their living arrangements. ... this type of response is because they fear that if they complain, or make others aware of their problems, that they will be left homeless: ‘this is all I’ve got, and if not this, where would I go?’ (SP1).
An additional problem with using the questionnaire as a straight question and answer survey, with the survey form being completed in front of interviewees, is that this kind of approach can be problematic with Aboriginal people, especially older people. A Service Provider explained that it was common amongst older Aboriginal people for there to be reluctance to disclose their views and concerns, unless it is to someone with whom they have built a trusting relationship. In particular, there is a general distrust of information-gathering processes, especially those where there words are taken down in writing, with fear that their responses could be tracked back to them, even when reassurances of strict confidentiality are given.

Problems with taking a formal approach when working with Aboriginal clients were also mentioned by another Service Provider:

*I have a lot of forms to complete but I am aware that many Aboriginal clients will close down if they are filled out in front of them. I have been told that one of the forms looks the same as the one they used to take their children away. So I often conduct assessments informally and fill in the paperwork later (SP3).*

The formality of the approach taken by the interviewers also possibly meant that where questions particularly relied on the respondents being comfortable, such as those that explored how content or not they were with a situation or service, these may not have been answered frankly. For example, Q18 asked whether the person was happy with their current living situation; several Service Providers thought it unlikely that this question would be answered negatively because many older Aboriginal people would see it as complaining and would fear possible consequences. It was felt that more open responses were likely to have been given for questions where the response did not directly require information about interviewees’ families or living arrangements –e.g. Q16.-transport.

An additional problem with the administration of the survey was terminology. As the survey was meant to be a discussion starter only, the questionnaire used terms commonly understood and used by Service Providers such as: ‘culturally appropriate’ and ‘supported accommodation’. It appears that these terms were probably used by the interviewers when conducting the survey and it is very likely that they were not understood by the respondents.
When the problems outlined above became evident to the Research Team, it was considered essential that, in order to obtain a fuller picture about the living conditions of older Aboriginal people in the project area and the issues they are facing, interviews needed to be conducted with Service Providers who commonly have older Aboriginal people as clients, (in addition to three interviews conducted up to that time with Aboriginal Elders).

PB5.1.2 Interviews:
Face-to-face interviews were held with 3 (female) Aboriginal Elders and 7 Service Providers (3 Aboriginal, 4 non-Aboriginal ). Some components of these interviews have been reported in other Sections of the Report but are also summarised here.

Major Findings from Interviews (presented in point form):

**Interview 1: Aboriginal Elder**
- Must build trust, cultural sensitivity from health care providers, otherwise people won’t even go to get their health assessed.
- Good communication is essential.
- At the Centre, if carers need a break, “match with a ‘carer for the day’” (e.g. a volunteer acceptable to the older person, right gender, culturally acceptable).
- If the Centre doesn’t provide high care, let the carer stay for the week as well, (e.g. for residential respite) with support from staff. Money may be available from Carer Respite program for that.
- (In response to question about family objections if person needs to pay 85% of pension to pay for respite): “*It is not the family’s money. The person should use it for their own care*”.

**Interview 2: Aboriginal Elders (2)**
(NOTE: These 2 Aunties said that they are part of a group of 7 women who are the recognised custodians of the land where the Moonee Centre is. They believe that where the Centre is located would be acceptable to most of the older Aboriginal people in this area).
- Independent Living Units – be careful, probably not a good idea (at least yet) – family, grandchildren will move in.
- Some of the older men might want to go fishing – or teach young ones fishing.
• Re: community care or medical and/or allied health services: “some of the older people get a bit angry if the service doesn’t run as it they think it should, e.g., if the person is late coming to their house – they see it as lack of respect”.

• There is a need for appropriate care that is culturally sensitive.

• Aboriginal Health Worker at CHHC could be asked to run a ‘Men’s Health’ session, maybe 1 morning a month, at the Centre.

• Access to major health care/treatment not available locally; e.g. one of these Elders had to go to Sydney for heart by-pass operation. (Although this applies also to non-Aboriginal people, being away from family/country may be particularly frightening for Aboriginal people and cost is major concern).

• Galambila had a successful program for rehabilitation post-major surgery, available 4 times a week – yoga, healthy cooking, light water aerobics and power walking on beach. Funds ran out and that program is no longer operating.

• Use of mainstream post-operative service - hospital pool – no other Aboriginal women there – felt uncomfortable. Stopped going.

• Director of Aboriginal Family and Community Care runs a Grandmothers’ Group which meets once a month to discuss issues and problems, and provide support for each other.

• (In response to a question about family objections if the older person needs to pay 85% of pension to pay for respite): “If the family objects that’s just too bad. The pension belongs to the older person and they should not miss out on good care because the family want their money”.

Interview 3: Aboriginal Aged Care Services (Service Provider 1)

• The YACL map boundaries were determined by the same language-speaking group. The map boundaries identify the area in the Mid North Coast of NSW where Gumbaynggirr people live.

• Pursuing a one-Nation approach to meet the identified needs of older Gumbaynggirr people is YACL’s goal. However the organisation’s strategy for meeting various identified needs (social, health, respite) differs according to the need.

• In respect of day activities, there is work currently occurring to achieve a regional approach, with plans in place for older Gumbaynggirr people participating in Clarence Valley Community Programs Services and the Moonee programs to meet
up monthly. There are also plans in place for this to happen with older Gumbaynggirr people in the south. This regional approach will also explore whether cost efficiencies can be made from providing a combined service and/or one administration centre.

- There is no plan to outreach from the Moonee Centre beyond the geographic boundary outlined for services. Within the project area, given the proposed level of service provision at the Moonee site and with other Aboriginal services currently being provided in the northern and southern ends of the Nation that target older Aboriginal people, there would be no need for any outreach services.

- The Moonee site is very centrally positioned within the Gumbaynggirr Nation and is thus well situated for the provision of future overnight respite service for older Gumbaynggirr people and for day activities and health services targeting those older Aboriginal people living in the central part of the Nation.

- It is common amongst older Aboriginal people for there to be reluctance to disclose their views and concerns, unless it is to someone with whom they have built a trusting relationship. In particular, there is a general distrust of information gathering processes, especially those where they are taken down in writing, as older Aboriginal people are often worried that their responses could be tracked back to them; this is commonly the case even when reassurances are given of respondent anonymity.

- Who takes the carer role can vary widely, sometimes it is an adult, a child, or a spouse, or other family member but these carers also often have serious health conditions, i.e. both people may be living on disability support pensions.

- Currently those living in multi-generational households are mostly cared for by family members, primarily because they are around and the Elder trusts them in that environment. If an Elder moved to independent living situation the carer role would likely change.

- Cultural respect and sensitivity by non-Aboriginal services primarily comes about from long-term relationships.
Interview 4: Community Nurse working with Aboriginal Communities living in Coffs Harbour and Bellingen LGAs (Service Provider 2)

- She views older as being 45 years plus. Has a caseload about 30 clients at any one time and 75% of these clients would be 45 plus with chronic diseases. Profile is changing; increasingly quite a few regular clients with chronic diseases who are in their late 40s and early 50s. Oldest client is 74, however not many over mid 70s. Majority would be in their 60s.
- Majority of her regular older Aboriginal clients are located in Coffs Harbour area: Wongala Estate near Park Beach Plaza - 10 there –sees 2/3, Urunga - 2 clients; Corindi/ Yarrawarra – 5/6 clients and Woolgoolga - 2 (but they have less regular home visiting).
- Older Aboriginal people mostly have chronic illnesses: heart disease, diabetes, respiratory, renal, liver failure and increasingly mental health. A lot of illness comes from alcohol abuse. Also respiratory - smoking related and from ex-workers at old asbestos mine near Grafton.
- Galambila AMS is the main health service used by older Aboriginal people; also Woolgoolga Health Centre. Corindi population is serviced by an outreach clinic which runs every Wednesday morning.
- She make referrals to ACAT and Nambucca Aged Care Service (she often liaises with this service - because they have a lot of mutual clients). The Nambucca service provides EACH packages and CACPs for Aboriginal people. It has clients in Corindi (1x worker), Coffs Harbour, Urunga, Nambucca and Macksville. Also Coffs Nursing Service, which is a Coffs-based service, has 2/3 EACH Packages designated for Aboriginal people (currently has 2 older Aboriginal people). She also makes referrals to NCAHS: diabetes educator, cardiac respiratory clinic and the occupational therapist.
- Hospital staff sometimes have poor understanding if Aboriginal clients are late for appointments or don’t turn up. Problems can be avoided if she attends with Aboriginal people on their first clinic visit, “if they haven’t had a proper introduction they are not likely to come back”.
- Transport issues are particularly common, especially out in the Corindi area, where no transport seems to be available. “Galambila will pick up people to attend medical appointments and clinics but have had experiences of driving out to
“Corindi and the people not being there”. She believes her clients, especially those living in the outer northern areas (Woolgoolga/Corindi), miss appointments because of a lack of transport. She believes the northern area is on the outer edge of Community Transport’s patch and not sure whether this area is really serviceable.

- Most older Aboriginal people live with their families in multi-generation households. Very few live on their own. For most living with their families, this means they get looked after; however there are a few where the family relies on them. Living with family often means they don’t need as much home care because family members do a lot of it. Many are very well cared for. Carers are mostly the daughters and they are doing the: lifting, showering, cleaning, cooking and generally being there. Many won’t accept help because don’t think their parent will accept it, especially if it were provided by non-Aboriginal workers. Often family just wants equipment but have to have an ACAT assessment and get a Package for this to happen.

- There are not enough Aboriginal workers doing home care support work, given the demand, currently just 2 female workers - run off their feet. Used to be more male workers but not currently.

- Many older Aboriginal people are grandparents and some have custody for grandchildren, but this is difficult for many of them as they are often too unwell to provide the proper care.

- Some particular communities are very under-serviced:
  - Happy Valley near the Jetty mostly has a transient population but there are also 5-6 Aboriginal people living there more or less permanently. It has no hot water or electricity.
  - Yarrawarra/Corindi – “the need is (such that) I could be out there all day on Wednesdays”. Older Aboriginal people in this area could do with more regular check ups than they are currently receiving. There is currently only one support worker in area – from Nambucca Valley Community Services Council.

- A Day Centre would be a good idea for the Moonee site, services could include: transport, health services provided on-site from Service Providers (including a weekly clinic) and social activities. “It is a central location that would well suit those living between Coffs and Corindi”.

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• She often discusses residential respite with her clients but there is not great take-up, “older Aboriginal people and their families not very comfortable with idea”. Also it is considered too costly - when they hear they have to ‘pay double’ i.e. continue to pay their rent as well as cover respite costs; “for many this is just not affordable”. Some believe that they are going to have to stay there and suspect if they go, they won’t come home. Many just don’t like the idea and would prefer to stay home. The amount of paperwork is also an impediment.

• Her few clients that have taken respite usually enjoyed it but were mostly referred to the Aboriginal-specific respite service in Tweed Heads or to mainstream respite services in Coffs. Respite in Coffs has been OK because in the past there have been other Aboriginal people there and some Aboriginal staff. Over the years, she has had clients take respite at Booroongen Djugun in Kempsey, however this is less common.

• If the Moonee site were to have respite, the type of respite needed is: day respite; overnight respite for short period (weekend); capacity for crisis respite – to cover situations where a son or daughter is sick, domestic violence situations and/or a family crisis. An Aboriginal-specific service like Moonee would help overcome some of the barriers to using respite.

• Services such as ACAT and Palliative Care usually liaise with Aboriginal Services about family. These services are used to working with other family members and are open to them attending meetings.

• There is a Gumbaynggirr Elders’ group at Wongala Estate that meets monthly. Organisations etc. can book themselves into these meetings to discuss ideas or potential new initiatives. However this group is not representative of all older Gumbaynggirr people. “Maybe not able to get a representative group of older Aboriginal people, especially given their poor health and shyness”.

• There needs to be more information/education about services, they are not very well understood by Aboriginal people.

• She is very supportive of more AHWs; if matched with health professionals they could do much of the work that currently gets missed or gets short measure – e.g. more regular home visits to older Aboriginal people, reminders about appointments, transport arrangements, health education.
Interview 5: Clinical Nurse Specialist on the Aged Care Assessment Team (Service Provider 3)

- Her current role covers north to Red Rock, west to Glenreagh, and south to Coffs Harbour. Other ACAT team members cover the southern end.

- As an ACAT assessor she has a lot of forms to complete, but is aware that many Aboriginal clients will close down if they are filled out in front of them. She has been told that one of the forms (a yellow one) looks the same as the one used to take children away, so she will often conduct assessments informally and fill in the paperwork later. She is aware that the ACAT process is very foreign for older Aboriginal people so tries to be as flexible as possible. ACAT assessments usually take place at home but have conducted some for older Aboriginal people out on the porch of the Yarrawarra Centre.

- Clients No’s: Any Aboriginal people over age of 45 are eligible for ACAT assessment or younger if a person has an age-related disorder. Not a big demand for Aboriginal assessments, only a small number undertaken, perhaps one or two a month, in six months about 8 assessments.

- Client profile: There are definitely more males than females. Lately she advised that they (Aboriginal clients for assessment) have all been men. She thinks about one in every 5 would be female. Their ages vary but most of the Aboriginal people she sees would be between 45-55 years.

- English skills- Most of her Aboriginal clients speak English well but she occasionally comes across someone that does not have very good English skills.

- Referral for assessments: she has had a few from Galambila although not many but increasingly. Most referrals come from the NCAHS Community Nurse and Nambucca Valley Community Services Council through their Aboriginal Packages. Nambucca referrals come from clients they have ‘on the ground’ but the service is struggling to fill these Packages.

- Living arrangements of older Aboriginal people:
  - At Yarrawarra, most older Aboriginal people are living with family members or in the men’s house.
  - The ones that have been assessed who live in Coffs Harbour are mostly living in Department of Housing accommodation and they are usually always living with other family members. These households are typically multi-generational.
• Health profile of older Aboriginal people: most common conditions- alcohol-related dementia followed by diabetes and heart disease.

• Health services being accessed by older Aboriginal people: she liaises with (a GP) at Galambila AMS and with (another GP) at the weekly Yarrawarra outreach clinic.

• Barriers to accessing aged care services: There are still big problems; people are very reluctant (to have an ACAT assessment), and this happens in the mainstream too, they all think ACAT assessors are going to put them in a nursing home. Assessors approach is important, that’s why she works closely with Aboriginal workers. Would never ever go into an Aboriginal person’s home without first checking with the person referring and having ‘really sussed out’ the situation. Thinks there is a big fear there and is very sensitive about the forms when assessing clients, knows that can be very, very daunting and tries to avoid doing them in front of clients. More education is needed to break down those barriers.

• Transport use profile: There is a good set up with Community Transport especially in Nambucca where they have a specific Aboriginal Transport service with an Aboriginal driver, which she think works really well. In Coffs Harbour it’s not too bad. “… a lot of Aboriginal are really loathe to access services and this is for lots of reasons not just transport e.g. just cost. Here again education is needed”.

• Care needs of older Aboriginal people: Unfortunately a lot of the people ACAT (assessors) see have very complex health needs. She believes their care should be matched with their culture and their wishes need to be number one. If she were setting up a Package for an Aboriginal person compared to mainstream she would take a really different approach. “For example, a mainstream Package would be coming in every day for a shower and taking person out once a week on average; an Aboriginal Package may be coming in everyday to take person out and shower once a week. Keeping older people connected is really important for all but keeping the social network and family contacts going is particularly so for Aboriginal people”. It is important to involve the family and the extended family in planning because of the chronic health problems of many older Aboriginal people which often require quite a lot of support. It is “very, very rare” for her to assess an Aboriginal people for residential care it’s nearly always CACP or EACH Package.

• Level of care needs of older Aboriginal people before an ACAT assessment: Usually they are not getting much at all. Some may have had HACC services before
but most she sees are not. A key service provider in this area is the Manager of Aboriginal Home Care, “he is fantastic”.

- **Assessment of service by Service Providers:** She knows of a worker up at Yarrawarra, who works for one of the community care providers and “*she does everything for everyone*”. The Nambucca service is funded to cover the whole Mid North Coast area and they are providing Packages up at Yarrawarra. She thinks “…it’s pretty hard to expect a Coordinator sitting in Macksville to be able to fully coordinate up to the Corindi area, is not having a go at the service; just knows it’s a physical impossibility”.

- **Referral to community care service providers:** The majority of the time ACAT will go to the Aboriginal Provider i.e. Nambucca Valley Community Care. Community Care Options is also keen to take on Aboriginal people but she doesn’t think they have got any Aboriginal workers; thinks “*they have got a few mainstream CACPs that Aboriginal people are accessing. They are always keen; they say they will give priority even though they have a waiting list of 300 (mainstream clients) waiting for a Package*”.

- **ACAT Recommendations for older Aboriginal people:** She usually recommends CACP or EACH; the philosophy of Community Care Programs fits really well with Aboriginal people, “it’s flexible and it means they can stay at home, live with their family and have some kind of say over what they get. It works really well”. She has only ever done a handful of permanent high care assessments for Aboriginal people because “*they usually don’t live long enough to need it*” and the ones she sees all want to stay at home so that’s what ACAT try to do. “*Sometimes residential care is recommended but usually only as a last resort and with a lot of deliberation. In these cases, it’s interesting, they usually don’t live long enough to get into a nursing home, because of the waiting period and the fact that they are usually really, really sick by the time ACAT get to see them. What happens is they will wait in hospital in Coffs Harbour and then they will be shoved out to Bellingen*”. She thinks it is actually not bad for older Aboriginal people “*out there*”, as they stay at Hartley house which is home-like but she worries about the family trying to visit.

- **Availability of Community Care Packages:** Varies but not too bad. She has concerns about the new Packages (Carexcell’s/YACL’s) coming on line as she think there will be a struggle to fill them. The biggest demand is high care which requires
EACH. She only has 1 client at the moment assessed for a CACP. In terms of supply “usually it’s a really short wait. The EACH is the same, could get an EACH tomorrow because Nambucca has them. Mainstream is different”.

Thinks these additional CACPs will result in inappropriate referrals i.e. people being referred for ACAT assessment “who are quite fit, in the effort to try and fill them”.

- Knowledge and understanding of services amongst older Aboriginal people: “Need to sit down with not just older Aboriginal people but any Aboriginal groups and go through what’s required to be eligible for a Package”. A couple of years ago she talked to the older Aboriginal people at Yarrawarra and went through and spelt out the Community Care Programs. But it has not being done regularly, “need to look at areas like Yarrawarra, Wongola and Galambila and those sorts of Centres, these are the ones we should be contacting”.

- Older Aboriginal people’s attitude to residential respite: When she is doing a Community Care application, she will talk about respite but “older Aboriginal people are very reluctant, very reluctant”. She sees the obstacles as being the same as mainstream, in that people are reluctant because it’s “going into an aged care facility”. “That’s why they get the Packages because they don’t want to leave home. One of the places respite does work well is the Waratah Centre. They are small and therefore it is a really appropriate place to put Aboriginal people for respite, Woolgoolga is quite good too”. But she has never experienced a high demand “probably only has one older Aboriginal person a year go into respite, they are very low numbers”. Also Aboriginal people do not really get the concept of respite, “so that’s another thing we need to educate the community on”.

- Older Aboriginal people’s attitude to day respite: “In Coffs Harbour the best Day Care is at Waratah but don’t know if they have got any Aboriginal people using it, here again you might find one or two”. She would like to see more encouragement for Day Care, “there seems to be a really good opening for Aboriginal-specific day care”.

- Service needs/ Gaps: She believes if there were Aboriginal-specific respite and Aboriginal-specific Day Care established at the Moonee Centre, and the community and Elders were behind it, “it would work really well”. She would also like to see an increase in community nursing; “it would be lovely to see an Aboriginal
Registered Nurse”. She would also like to see more health workers, who are Aboriginal, working in the community, “that just works so much better”.

- Assessment of appropriateness of services at hospital for older Aboriginal people: The hospital staff do their best, but “it’s bad enough for mainstream and therefore it’s 10 times worse for Aboriginal people. Even things like when family come to visit one has to negotiate, when we’ve had 10 of the family turn up with the dog and we have really had to negotiate. Would love to see a hospital unit away from the hospital for Aboriginal people. Galambila’s just fantastic, Aboriginal people are happy to go there because they don’t feel intimidated. But hospital is the last resort for them”. There is a need to change the hospital environment and the way that nurses treat people; the whole system. She thinks people try their best but the system is not very user-friendly for Aboriginal people.

- Moonee site - Location: “it’s a bit away for Yarrawarra and Wongala people but then again its half-way for both”.

- Moonee Site - Recommendations for Services: She would like to see Day care and residential respite set up for older Aboriginal people. “Something like the Waratah Respite Centre, overnight respite, something short-term where people book in for 3 weeks or whatever. Waratah Respite Centre works so well because it’s got the range of services to provide a continuum of care. If you have Aboriginal Aged Care Packages and that same Service Provider also provides respite whether it be in-home or residential, you’ve got the ‘continuum of care’”. She has dreams of “a worker, ‘Susie Brown’ going to sees ‘Joe Bloggs’ and helps him with his shower and all that and gets him off to day-care and then later in the day she’s there on a shift (at the Centre). Then when it comes to residential respite you’ve got the continuum of care”. That sort of set up would work really well, particularly for Aboriginal people because they like to have that familiarity. Believes if the Moonee people duplicated what Waratah Respite Centre is doing it would do really well.

- Moonee Site – Challenges: She has significant concerns, if Moonee were to offer crisis / weekend respite, as getting the assessments done for this would be very difficult. It would be her doing all the paperwork and ACAT is not an emergency service. “ACAT funding really doesn’t suit crisis respite could only provide this if it were funded by something that didn’t need the ACCR. Carer Respite can do in-home respite and they used to be able to do it over a weekend, so you should
probably talk to Carer Respite about their in home respite”. She believes the way forward for the Moonee Centre would be if they could establish some arrangement with Carer Respite.

- Moonee Site - Opportunities: “We say to mainstream (clients) ring Carelink but a lot of Aboriginal people don’t have phones for a start and so if they could access an information service at Moonee that would also be great; then you’ve got your Day Care, your respite plus your information”. She also believes it’s quite often more financially viable for services to co-locate, e.g. Aboriginal Meals-on-Wheels, and Aboriginal Home Care could be sited at Moonee. “If they were all based at that same place believes that could work really, really well”.

Interview 6: General Practitioner working with Aboriginal communities in the northern part of the project area (Service Provider 4)

- If a proper needs analysis were conducted it would show that several of his patients in the northern area have high unmet care needs. He estimates that he has 6 patients that have care needs requiring Packages and of these, 3 would be high care needs.

- There is a high need for health services amongst older Aboriginal people e.g. dental – patients at Yarrawarra currently book into Grafton AMS where there is an Aboriginal dentist. Clinic demand at Yarrawarra has dropped off slightly since YAC’s office was relocated to Coffs Harbour.

- For Yarrawarra residents, accounts have been arranged at the Woolgoolga Pharmacy - to help ensure that medications are provided. He will often, as a starting point, get his nurses to undertake Aboriginal health assessments.

- Commonly grandmothers will not only have caring responsibilities for grandchildren but often be the carer for their children, who commonly have serious health conditions.

- At Yarrawarra there are two types of dwelling:
  i. single men’s quarters – single rooms and one male living in caravan or sometimes his car
  ii. houses – 3 houses - comprising:
     a. house A- Grandmother, Daughter and 7 children –
     b. house B- Grandmother and Daughter
     c. house C – Mother and daughter.
By providing Day Activities at Moonee, it will “create a captive population and from this you are able to do things”. He believes all people attending Moonee will have health needs and the Centre would provide an opportunity to begin to address them.

For a Centre like Moonee to succeed, it will need to have transport and be prepared to look in several places for clients and accept that no shows will be common.

He would be happy to provide clinic service at the Moonee site – “it doesn’t matter where I see my patients”.

He thinks that “Older Aboriginal people are not too fussed who looks after them (Aboriginal people or non-Aboriginal people) just as long as they know how to care for them”.

There is a need for respite – all types of respite, “but the challenge will be to get older Aboriginal people to use it”. He knows of one Elder who “won’t take respite because he is worried about security, that young ones might take his things while he is away”. He stressed that issues such as these would need to be addressed. He is aware that sometimes older Aboriginal people up at Yarrawarra, both the men and women, go to the old camp for a break, (located between Yarrawarrah housing and the beach).

Education and information is needed for both Service Providers and Aboriginal people to keep everyone up-to date on what aged-care services are available and how to access them; for Service Providers this would need to be web-based. For Aboriginal people, “education needs to be opportunistic and relevant e.g. if meals are going to be provided at Moonee Centre this would provide an opportunity to do education on healthy-eating”.

He stressed “Whatever the model of service developed for Moonee, it is important that there are measures/processes in place to assess the model”.

Interview 7: Aboriginal Hospital Liaison Officer (Service Provider 5)

He has contact with Aboriginal people through his position: he has a list of those in the hospital everyday, in-patients and day-patients, who identify at admission as Aboriginal or Torres Strait Islander. He visits all those, except those in the Mental Health Unit, (which is a designated specialised area and has its own Aboriginal worker). He estimates he has 200 plus clients a year but “that would be broader than just those from the Gumbaynggirr Nation because older Aboriginal people also
come up from Macksville, Nambucca and Bowraville. A lot of older Aboriginal people will be admitted to Macksville hospital but if the condition is anything serious then they come to Coffs Harbour hospital”.

- Population Profile of clients: He estimates the average age is mid 50s and above, ranging up to 70s, “there are very few above 70, just a handful”. There are more males than females presenting.
- Living arrangements of older Aboriginal people: He mainly becomes aware of the living arrangements of those older Aboriginal people with complex medical conditions over time “where we have to involve ACAT and Aged Services and, so upon discharge planning, we ask ‘Is everything Ok at home?’” Most of the older Aboriginal people he sees live with their families and these are usually extended families. He also has had some clients coming from nursing homes and mainstream aged care facilities. “Some are referred down to Booroongen Djugun in Kempsey but most do not want to go outside of this area, i.e. the tribal boundaries of Gumbaynggirr”. He asks “why there is not something here in the Gumbaynggirr Nation for the older Aboriginal people where they can go, something like a retirement village”.
- Challenges of older Aboriginal people living with extended family: He sees these as: hygiene, nutrition, getting the family to provide support e.g. the need to be taken to important appointments, bathing. He thinks “a lot of times the older Aboriginal people probably wouldn’t be in hospital if the family were doing these things”.
- Issues for older Aboriginal people accessing health services at the hospital: He sees there being a lack of basic cultural understanding from the staff and that can be a barrier for older Aboriginal people. “We have also have men and women’s business stuff”. “There’s a fear from a lot of the older Aboriginal people if they come in here, they may not leave here, so they put off coming and by the time they come it’s really affected their health”. At the hospital they tend to see people at an acute stage. “Some of them have the view if I go there I’m not going to leave - I could die there. This is not a common experience but when it happens, it’s serious”. “Also a lot of the older Aboriginal people when they come don’t want to stay for a long period, they want to go back home”.
- Transport situation for older Aboriginal people: Some have the support of family or friends’ cars. “A lot of the young ones like to bring down their grandparents or
uncles/aunties if they’ve got their car or licence. Has seen a lot of young ones come in and stay and see what’s going on”. Some older Aboriginal people also access public transport; others access health services by using community transport and he also knows of one patient who uses the ambulance service.

- Care Needs of older Aboriginal people: There is definitely a need for more community nursing. “Community nurses do a lot of really good stuff they are the ones during home visits that can pick up any health changes or diet or whatever”. He also sees it as important that specialist’s appointments for older Aboriginal people are kept, if not their condition often becomes worse “it’s not like missing a GP appointment”.

- Unmet care needs of older Aboriginal people: At admission, he is usually not aware of the family situation and sometimes “it’s only when family is meant to be collecting their Aunty or Uncle or Grandmother and they don’t show that situation is made apparent”. He thinks things have really got to change in some Aboriginal families – he spoke of a current client where the family “have promised ‘this and that’ but no-one has really come to the fore to take responsibility which needs to happen before the patient can be discharged. It’s education - getting the family to understand the importance of why this needs to be done”.

- Use of Respite: From what he can gather, (mainstream respite services) just do what needs to be done but he thinks Aboriginal people need their own respite care services to go to.

- Health Service gaps: He believes everything is here (at the hospital) for both Aboriginal people and mainstream; “just a case of knowing how to access it. If they knew what services were here they would be able to access them”. The issue for a lot of older Aboriginal people is they are just not aware, “this is where health workers can come into it; they can provide that information to them”.

- Issues for Aboriginal people in hospital: “men’s and women’s business is definitely one(issue)”. He has also come across some really ignorant doctors, not only for Aboriginal people but for all people. “The good thing about my role here is that if I get upset or pissed off I go straight to the General Manager”.

- Moonee Site- service needs: Should provide rooms to accommodate for long-term residential care and short-term. Also “provide respite similar as they have set up down at Booroongen Djugun in Kempsey, a place where they are looked after and
cared for”. “Maybe Moonee could be a Multi-Purpose Centre and include the provision of day respite, so the older Aboriginal people that are still being cared for by family could go out there and talk to other older Aboriginal people”. “A nice meeting area would be great too, where older Aboriginal people could sit down and interact with one another”.

• Moonee Site- Respite Services: Emergency respite / short term respite is most needed, because “in any Aboriginal community if a death occurs outside the community a lot of people will just get up and go. May leave older people on their own; this may or may not be the case, but would be good if they could be left somewhere safe”.

• Moonee Site - Staffing: It could be staffed by either Aboriginal or non-Aboriginal workers. He would prefer more Aboriginal nursing staff. “Aboriginal people should be given first chance for employment, if there are any of our people with those skills. If you can have Aboriginal nursing staff then that’s good but it would depend if they can meet the criteria for skills needed. This is the most important thing”. He suggested prioritising staffing for Aboriginal workers “but if there are non-Indigenous workers who have the skills and are committed to Aboriginal health – that’s great too”.

• Carers: He sees the patient’s immediate family usually taking this role; the carer role should be undertaken by someone that wants to do it, “someone has to make a commitment to being the carer”. “Not everyone wants to take on the responsibility, when they come to health service or other service and find out about the condition of their relative. They say ‘oh that’s a big ask’. ‘Day and night?’ Then you’ll soon see them shying away”. He has had a few patients that have needed 24 hour care and the younger ones or immediate family say: “I can’t do that’. Whoever is responsible must be committed and be willing to care for them day and night”.

• AHWs: “A lot of Aboriginal people are reluctant to talk with mainstream workers, but in 9 out of 10 cases the Aboriginal worker already knows them and their families and already have their trust and so can give that information and explain to the family what people/ services are here to do. We are the link persons that can gather the information and forward it on to whichever service whether it is ACAT, aged care or discharge planning or the AMS, local GPs and Community nurses. So everyone involved fully understands”.

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Interview 8: Aboriginal Service Provider – a local woman with strong ties in the Aboriginal community; runs Day Activities at Centre (Service Provider 6).

- Most clients at the Moonee Social Support program are Gumbaynggirr, the main local group.
- Although this interviewee is a ‘local’ she does not know a lot of the older people in Coffs Harbour and is using contacts with people she does know to get to the ones she doesn’t. “A lot of them are frightened and shy” but when advised of her family background they are more comfortable with her. Having family links, connections makes it easier. “Most of them, you find out that they are related to you anyway”.
- (Numbers attending Day Activities at Centre). About 29, 30 on the DADHC (computer) system, all 45 or over. Centre activity day sometimes clashes with clients CDEP day but Centre only has access to the Community Transport bus one day a week, so some miss out. Some changed CDEP day to fit in Centre day.
- Uses own car to take people shopping on other days.
- Community Transport works well but some of the older Aboriginal people ask for a different day – or for a bus trip outside this area but there are restrictions on the Community Transport bus. The Community Transport Coordinator said he could hire a bus for them for other days but then “it all comes back to money”.
- Need to build up other activities at the Centre. If people only know about bus trips, that’s what they’ll say they want. Then you have the problem of over-spending the budget.
- Possibility of Grandmothers’ group. There is one in Coffs Harbour.
- Original idea for bus trips was to “just get them out of their houses and take them to interesting places”. DADHC provided a list of other things she could do with the older people. Now she takes them shopping and to doctors’ appointments and funerals if they can’t get there by themselves.
- She wanted to put out flyers to tell people what the Centre can provide but does not want to cut across what Galambila offers (for Coffs Harbour people), where a service already exists. There are fewer services in Corindi area. (Reflects survey findings – doctor not there every day, limited access). To go to Coffs Harbour by taxi, e.g. to get medication or do shopping, is about $60 return. “They can’t afford it, it’s a lot out of the pension”. When she takes them shopping they can be a bit
more relaxed and do what they like. She doesn’t rush them. They can take their
time.

- She plans to visit other Centres (not necessarily Aboriginal) to see what activities
they provide.

- (In response to a question about older people passing on some traditional skills to
the young ones). She can’t use the project money on young ones but if a day is
happening for older people at the Centre, there’s nothing to stop young ones coming
there – and that will help to build up respect for the older people.

- Respite rather than permanent. Could be permanent when people are used to it,
know who works there – Aboriginal carers would be great, especially if they are
related to the older people.

- Independent Living Units? Yes.

- (In response to a question about family objections if person needs to pay 85% of
pension to pay for respite): “It could be a problem. I don’t know how you could get
around that.” (Agreed to ask people about this “if the opportunity comes up”).

- (Re: other activities at the Centre): It will help them to feel comfortable there if
they need to come for respite. Now having BBQs, use one of the rooms for craft
days, card games – not just bus trips, boat cruises. Maybe have movie days at the
Centre with a cup of tea. Other ideas: Take photos on outings. Recording stories;
make recipe book with photo of person who provides recipe. She asked people if
they would like a dance once a month, at Corindi. Yes – old time dances, barn
dances, maybe a disco sometimes – take a plate. “They don’t want traditional
dances or traditional food all the time”. They will also have training at Moonee for
Aboriginal Elders’ Olympics.

- One lady in a wheelchair, her husband is her carer, he takes her to Kookaburra
House at Waratah Centre. The carer asked, ‘When is this place going to be up and
running?’ “It would be lovely if (his wife) could come out here and stay, amongst
her own people and be looked after and give him a bit of a break”.

- Others also asking ‘When is it going to be up and running?’ “Some people are dead
set against going into ‘places like that’ but if you can coax them in to the Centre
and they get to be a part of it and see what is happening there, it might be a way of
them feeling OK about coming there later on”.

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• Now there are Day Activities at the Centre but good to add Day Respite soon (give carers a break and some of those people could join in Day Activities).

• Community nurse knows the more isolated older people in this area; she is going to talk to them about the Centre. The nurse can identify unmet health care needs. (This Service Provider) can talk about social needs. She is fairly sure there are people in Coffs Harbour who need respite care but she has not managed to track them down yet. The Community nurse will know them, or know of them.

• Re: older people – “you have to be respectful to them. If you are out of line they’ll tell you”.

• Some are likely to need supported accommodation. For example, “there are a couple out at Corindi, they’re with family but they are getting on and if their illnesses get worse they may need more care. They are pretty stubborn (the 2 she knows), and they are determined they’re not going anywhere – they know what’s going to happen but they know where they want it to happen. But Moonee is still part of ‘country’ and if they come to the Centre for activities, and then, e.g. if the family has to go to funeral a long way away and they are not well enough to go, and they have their first respite that way, then they might get to be more comfortable with the idea – or they may not”.

• “One Uncle won’t come on the program at all – medical reason behind it – he would never want her (his niece) to know about it – too embarrassed”. Maybe she’ll get another man to talk to him.

• Another man will go to the Centre or on trips if (this person) and her sister are there but gets frightened if they are not. But he always says, ‘it’s just for this one day’.

• Centre has general community acceptance.

• Centre needs a car, and a bus as well.

Notes from previous Interview with Aboriginal aged care Service Provider in Nambucca (Service Provider 7)

• Most of the older Aboriginal people live in public housing or land council houses; sometimes no accommodation available,

• Other problem – housing not appropriate for older people, e.g., no handrails, puts people at risk of falls.
• A lot of older Aboriginal people are living with their families where there are a lot of young children and overcrowding.
• Move into residential care means family does not have access to older person’s pension to contribute to household costs, and family may be reluctant to agree to such a move.

PB5.1.3: Service Mapping and Gap Identification Workshops with Service Providers
To assist in identification of services in local area, two Mapping and Gapping workshops were held with Service Providers servicing the local older Aboriginal community. A total of 26 service agencies were identified and invited to both workshops. (See PB2.3 for listing of Service Providers). All identified Service Providers, irrespective of whether or not they attended the workshops, were provided with copies of the workshop Minutes and invited to provide feedback.

Notes from Workshop 1: Held 20 September 2007, at Coffs Harbour Education Campus
• Staff from 8 Service agencies attended.
• The first draft of a local area map was presented and suggestions made as to further information required on it and place name changes.
• ACAT services and the region covered were explained.
• Coffs Harbour Community Transport services and the region covered were explained.
• Key impediments for older Aboriginal people accessing respite services were identified and included:
  o high cost of respite care and potential negative impact on family household income;
  o delivery of respite care often not flexible, most commonly provided in 2 week Packages;
  o lack of cultural awareness from respite care workers; comfort level of older Aboriginal people when receiving care from non-Aboriginal workers; and
  o having to deal with high levels of bureaucracy (form filling –in) to access services.
• Key contacts, other relevant services and opportunities were identified and included:
• Aboriginal CACP and EACH programs being administered by Nambucca Valley Community Care;
• meetings being run for HACC Service Providers by Mid North Coast Regional Council for Social Development;
• Mid North Coast Community Care Options’ support program for older Aboriginal people;
• training of Aboriginal people in Certificate III Aged Care Work; as part of training, possibly will do work experience at Moonee Site; and
• site visit to Rose Mumbler site in Nowra that provides 18 respite beds was recommended.

• Identification of possible activities for inclusion in the Moonee Centre’s program of services were identified and discussed:
  • support for recognition of prior learning for Aboriginal people who are, or have been carers, when undertaking Aged Care training;
  • establishment of a pool of volunteer carers to support aged care staff;
  • establishment of an Aboriginal Grandmothers’ Group;
  • establishment of partnerships with key local health and aged care providers e.g. Galambila Aboriginal Health Service, Mid North Coast Division of General Practitioners and North Coast area Health Service; and
  • facilitated bi-monthly meetings with organisations providing services to older Aboriginal people with a focus on service provision and the gaps.

Notes from Workshop 2: Held 15 November 2007, at Coffs Harbour Education Campus

• Staff from 7 service agencies attended.
• A revised service area map was presented and following discussion, some additional place names were included.
• Problems around accessing community transport for the DADHC activities program currently being run at the Moonee site were discussed and some possible solutions suggested: establishing if other organisations have buses that could be hired; partnering with other organisation(s) to purchase a bus that could be used by the partner organisations.
• Issues around training of Aboriginal people in Aged Care and Aged Services were discussed including:
  o support for a Recognition of Prior Learning (RPL) program for those people who have previously cared for a relative to enable them to gain accreditation for their skills; and
  o possibility of drawing on Federal Government’s Work Skills vouchers that provide $3,000 for people aged over 25 years with year 10 or less for training and skills development.

• Identification of possible activities for inclusion in the Moonee Centre’s program of services were identified and discussed:
  o Aunty and Grandmother’s Group ‘time out’ program based on a program developed in Queensland;
  o YACL’s intention to run, as part of its current day activity program, Men’s and Women’s days in 2008.

• Draft of a survey presented to be used by YACL and ETC to identify social, cultural and spiritual needs of older Aboriginal people.

• Issues discussed around the 10 CACPs (awarded to Carexcell to auspice and manage on behalf of YACL until such time as YACL becomes a registered aged care provider) including:
  o non-viability of the 10 Packages as a program;
  o possibility of sharing resources with YACL’s DADHC program to improve CACP viability;
  o need to develop a YACL Community Care program that addresses program viability and looks at accessing EACH Packages;
  o importance of partner alignment for small services like YACL.

• A Senior Officer from the Department of Health and Ageing discussed the importance of working closely with the Indigenous Coordination Centre (ICC) in developing YACL and the need to be innovative in developing a multi-purpose approach. Possible funding sources were identified including the ATSI strategy for community-based respite care and Shared Responsibility Agreements, although it was acknowledged there were some constraints associated with accessing such funding.
SECTION 6: PREFERRED FUTURE SERVICE MODEL –
INCLUDING NATURE AND SCOPE AND FINANCIAL FEASIBILITY

(NOTE: This Section of the Report deals with Project Brief Items:
PB 6 - Define potential future service models - within the region and specific to Moonee
PB 7 – Detail the Nature and Scope of a preferred flexible aged care service model
PB8 – Impact Analysis).
(NOTE: PB6.2 onwards in this Section of the Report was prepared by Mr Lyal Allen, principal of Carexcell.)

PB6.1 Detail Preferred Future Service Model

PB6.1.1 Research Findings

Based on the evidence collected, there is a demonstrated need for an aged care Service Centre, operated by an Aboriginal organisation, for older Aboriginal people living in the Gumbaynggirr Nation. The need for an Aboriginal-specific residential respite service for older Gumbaynggirr people is also a clearly identified service gap within the overall project area. The project team recognises the significant challenges that establishing a well-utilised Aboriginal–specific residential respite service presents, including:

• a mature Aboriginal organisation to operate it;
• the achievement of community trust; and
• improved understanding amongst the Aboriginal community about the nature of respite services.

For trust and understanding to be achieved, the project team believes that service delivery needs to:

• be delivered at single location, i.e. the establishment of a Centre
• follow a continuum of care approach, ensuring that when workforce planning, staff are able to work flexibly across both outreach programs (e.g. Community Aged Care Packages) and onsite programs/services.
• access and maintain close links with established Aboriginal-specific Service Providers already operating within the target region
• maintain close liaison and draw on the expertise of a broad range of allied health professionals
• access and maintain close links with educational and employment agencies operating within the region so as to ensure Aboriginal persons seeking employment and training have appropriate access and to work with these organisations in the provision of cultural awareness for persons likely to work in areas of Aboriginal Health Care.

The Moonee site appears to be a satisfactory location for the development of such a Centre for older Aboriginal people within the Gumbaynggirr Nation, being centrally sited within the Nation and having existing infrastructure that can, with modest refurbishment, be made appropriate for this purpose.

The findings from this study (Sections 1-5) support the concept of the evolutionary/staged development of aged care services within the Gumbaynggirr Nation, starting with a base level of services for which there is an identified current need and gradually extending these services over time. This service development would involve ongoing consultation and work with the older Aboriginal people and their families to ensure that services that are developed meet their needs and address their fears.

Whilst establishment of a residential respite service for all older Gumbaynggirr people living in the project area is the overall goal for the development of the Centre, it will also need to provide other Aboriginal-specific aged care services if the Centre is to have a life. These would be more focussed on addressing the social, care and health needs of older Aboriginal people living in the Coffs Harbour LGA, a region identified within the project area as being less adequately serviced than the northern and southern ends of the project area.

**PB6.1.2 Nature of Services - Innovation**

A key feature of the proposed future service model is the establishment of a new Aboriginal-specific aged care service called ‘Home Away From Home’ (HAFH) Packages. This would require a new type of Community Care Package for Aboriginal-specific respite including: day respite, crisis respite and step-down respite (for up to 28 days). It is envisaged that this Package would be accessed through an ACAT assessment and would be in addition to the provision of a CACP, EACH or an EACH-Dementia Package. Given that cost was identified as a prohibitive factor in older Aboriginal people using respite, ideally
the fee structure would be the same as that used for Community Care Packages (i.e. that fees must not exceed 17.5% of the maximum basic rate of the pension). However, it is acknowledged that this pricing structure may make the HAFH service financially non-viable, in which case the fee arrangements may need to be set at a similar level to that prescribed for normal residential aged care respite services – (i.e. Residential High / Low respite rates).

The proposed service would be highly flexible in nature offering a mixture of:

- Day respite
- Overnight respite
- Weekend respite
- Short term stay respite

An important element of the program would be that, whilst on-site, those receiving HAFH Packages could benefit by having access to the range of other services offered through the Centre. These could include participation in the Day Activities of the Social Support Program, access to the CACP Co-ordinator in the planning of ongoing care needs, access to visiting allied health professionals and sharing in Centre-based cultural activities.

**PB6.1.3 Impact Analysis**

The project team sees HAFH Packages as addressing the following identified issues/gaps:

- the fact that the majority of older Aboriginal people in the project area live with their families in multi-generational households and these households are busy and can also be stressful and chaotic and therefore it is difficult to get adequate rest;
- many older Aboriginal people are often isolated from people their own age;
- those carers providing good support are usually doing everything but are reluctant to take up in-the-home support because they believe that the older person would not accept it;
- many of these devoted carers often have chronic health problems as well;
- many older Aboriginal people need more regular health care support to assist them to manage their health;
- the breakdown of cultural and social supports and the complexity of family structures in Aboriginal communities can make it extremely difficult for providers
to give adequate care and support to older people and their carers even when their needs have been identified and assessed and support services put in place;

- the cultural importance and obligation for Aboriginal people to attend funerals can at times result in large numbers of the community needing to leave the area and this may result in those older people too unwell to travel being left behind with limited or no support; and

- the reluctance of older Aboriginal people to stay in hospital combined with the difficulty in some families to have someone willing to take up short-term full-time caring responsibilities whilst the older person recuperates, often results in the older person’s needs being unmet in either situation.

Over time, and with the benefit of positive experience, the success of the HAFH initiative is expected to lead to a wider acceptance of culturally-appropriate residential aged care and provide opportunity to expand the Centre-based programs to potentially include a limited number of places which, in effect, could become short-to-medium term residential care places (i.e. greater than 28 days duration).

PB6.1.4 Scope of Services and Staged Planning

The proposed future service model and staged planning for the Moonee Centre for older Aboriginal people is as follows:

Immediate and short term (July 08- June 09)

1. Continuation of DADHC-funded social support activities (as currently being run by YACL at the Moonee Centre) with ongoing linkage building to other day-activity programs for older Aboriginal people in the north and south of the Nation.

2. Continuation of Centre support (as currently being provided by YACL) including cleaning, catering and maintenance.

3. Roll out in August 2008 of Carexcell/YACL’s 10 new CACPs - with an office and the staff to be based at the Centre.

4. Expanded DADHC-funded day activities from 1 day to 2 days per week.

5. Establishment and provision of ‘Home Away From Home’ (HAFH) service - Phase 1:- provision of day respite.
6. Establishment and provision of a weekly health clinic by visiting health service providers.

7. Establishment of a Resource /Education / Information service within the Centre

8. Extension of Community Care Places to trial provision of EACH & EACH-Dementia Packages in Coffs Harbour LGA.

9. Up-scaling of Centre support provided by the Aboriginal organisation to cover cleaning, catering and maintenance to support the running of (a) HACC related activities, (b) HAFH Phase 1, (c) the provision of an outreach health clinic and (d) running of an office for the provision of Community Care Packages.

(NOTE: the provision of the following services would require the refurbishment of the Moonee Centre to be completed and the Aboriginal provider organisation to have been determined).

**Medium Term – July 09-Dec 10**


11. Up-scaling of Centre support being provided by Aboriginal organisation to cover cleaning, catering and maintenance to support running extension of HAFH into Phase 2.

**Long term – Jan 2011 onwards**

12. Establishment and provision of HAFH service – Phase 3: step-down beds – up to 28 days residential respite, including the appointment of a suitably qualified on-site care provider / caretaker.

13. Provided the trial outlined at 8. above, is successful, extension of Community Care Places (CACP, EACH and EACH-Dementia) based on established and projected older Aboriginal population needs in Coffs Harbour LGA.

14. Provided there is an extension of Community Care Places, up-scaling of Centre support being provided by Aboriginal organisation to cover any additional cleaning, catering and maintenance required.

The service model is represented diagrammatically as follows:
Diagram 1: Proposed Future Service Model for the ‘Moonee Centre for Older Aboriginal People’

PB6.1.5 Moonee Centre - Site Usage

The Moonee site, as discussed above would, with modest refurbishment, would be an appropriate site for the provision of the aged care services as outlined at 6.1.4. The refurbishment required (See Diagram 2) would include:

- Room 1: Visiting Health Clinic Room – for outreach clinics/ site visits from health and other support services, using 1 existing motel room. Minimal refurbishment required.

- Rooms 2 & 3: Establishment of Moonee Aged Care Offices – Room 2 for Community Care services including CACP & EACH Package administration and HAFH services. Room 3 an office for staff providing DADHC-funded Day Activities and site administration by Aboriginal Provider organisation. Using 2 existing motel rooms, rooms already interconnected and telephone lines already in room 3. Minimal refurbishment required.

- Rooms 4&5: Establishment of Day Activities area (and overnight lounge when residential respite commences) using 2 existing motel rooms (wall removed already, male and female toilets). Minimal refurbishment required.
• Establishment of indoor /outdoor room with kitchenette extending from Day Activities area (Rooms 4&5) and accessed through sliding doors. New structure.
• Rooms 6/7/8/9- Home Away from Home Rooms for day and overnight use, using 4 rooms. (2 single separate rooms [room 6 &9], 2 rooms interconnecting door existing already [rooms 7&8]). Minimal refurbishment required.
• Caretaker’s residence-Next door to Room 1 currently has an operating kitchen adequate to meet the needs of the level of activities being recommended. No Refurbishment required.

The service model is represented diagrammatically as follows:
Diagram 2 – Moonee Centre – Site Usage

Moonee Centre for Older Aboriginal People

Demonstrating the proposed uses of the centre, including an indication of the minor upgrade &/or additions required.
PB6.2 Financial Feasibility

In examining the financial feasibility of any proposed service delivery models based at the Moonee site, consideration needs to be paid to:

- Establishing an appropriate rate of return to YAC (as owner of the land)
- The cost of capital works required to be carried out on the property to render it suitable for service delivery and
- The ongoing financial viability of service provision through both recurrent funding streams and client contributions.

These are examined under the following headings:

PB6.2.1 Moonee Centre – Return on YAC’s Land Investment

The site at Moonee was purchased by YAC in 2004. Apart from routine maintenance and repair and minor modifications to render it suitable for the conduct of some DADHC Social Support activities the site has remained in a similar condition and state of repair as at the time of acquisition.

In line with normal investment guidelines it would not be unreasonable for YAC to expect both capital appreciation and a commercial rate of ‘rental return’ on its investment once the programs using the site become fully established.

Despite the above reasonable expectation, it is understood that an agreement for YACL to lease the property from YAC has been entered into on the basis of a ‘nominal rental’ and that formal lease documents have been prepared and executed, but not at this time formally registered as taking effect. In the period since acquiring the site YAC has carried the cost of outgoings and maintenance of the property, a responsibility that would pass to YACL on registration of the lease.

For the purpose of this study it has been assumed that the YAC sponsorship of the programs will continue throughout the program development phases and that the only financial benefit to YAC would flow through capital appreciation on its land investment.
It is however noted that as part of the study, cost estimates have been prepared to quantify the anticipated outgoings which will be required to sustain the ongoing operation of the Moonee Centre. These costs inclusive of rates, electricity, insurances, accountancy, auditing, memberships / subscriptions, staff and transport costs, depreciation etc. (but not including program costs), are estimated to be in the order of $75,000 per annum.

**PB6.3 Moonee Centre – Capital Works**

In its present condition, the site comprises a modest caretaker residence with entry carport and workshop / shed, outdoor “gazebo / BBQ area” and pool along with:

- 3 x individual ‘motel rooms’,
- 2 x 2 interconnected ‘motel suites’ and
- 1 x larger space created by removing the internal wall between 2 former motel rooms.

**PB6.3.1 Sustainable Regions Funding**

A number of studies have previously been undertaken into the cost of upgrading the Centre to render it suitable for the delivery of services to older Aboriginal people. The most detailed of these studies was provided in support of the recent application for funding under the Sustainable Regions program.

Key components of the defined capital works under that application included:

- Project management costs - $25,000
- Construction of access roadway - $64,675
- Upgrade & fit-out of existing buildings (including equipment) - $232,910
- Construction & fit-out of Day Care Centre - $76,820
- Site supervision & contingencies - $37,200
- **Total = $436,605** (ex GST and excluding contributions from other sources including YAC, ETC and DSRD)

In visiting the site on 7th November 2007; then Minister Mark Vaile announced the grant of $470,000 toward the upgrade of the Centre. However, subsequent to the 2008
Federal Budget this allocation has now been withdrawn, leaving these works unfunded. (NOTE: the Mid North Coast Area Consultative Committee and others are currently pursuing alternative funding to replace this).

**PB6.3.2 Other Identified Capital Works Relating to the Moonee Site:**

*Site access* - In addition to the above the capital costs, the process for securing ‘safe access’ off the Pacific Highway has remained uncertain. Options which have been carried forward in discussions with the Roads & Traffic Authority and the Coffs Harbour Council have included:

- The construction of a protective median. The purpose of this measure was to, in effect, restrict access to and from the site to a northerly direction only, meaning that vehicles exiting the site would need to travel north approx 2.3km, undertake a right-hand turn, then, through a U turn off the highway, rejoin the Pacific Highway in a southbound direction. Similarly southbound vehicles wishing to enter the site would be required to pass the site, turn right into Killara Drive, undertake a U turn off the highway and access the site in a northbound direction.

- An alternative measure considered was the construction of a full ‘seagull median style’ intersection allowing vehicles to enter and exit the site from either direction.

- The completion of any design and/or costing of the above alternatives has also been frustrated by indecision in regard to the medium to longer term intention to widen the Pacific Highway to a dual carriageway and/or concern as to safety aspects of having direct access from this property onto the upgraded highway.

It is understood that, although to date discussed on many occasions; no formal agreement of the design has been approved, hence accurate costing of these measures is unknown.

Most recently, detailed discussions have been held with Council regarding the provision of an alternative access involving the creation of a right-of-way over private property at the rear of the Moonee site. Under this arrangement all existing access
rights of the property to the Pacific Highway could be withdrawn, with alternative access being provided via the created right-of-way connecting the property to Kumbaingen Close which in turn connects with Heritage Drive and Killara Drive which intersects with the Pacific Highway 800m south of the site. The Project Team considers this to be a preferred mode of access to the site, reducing the traffic hazard for clients and service vehicles accessing the Moonee Centre.

For the purpose of this study it is assumed that any withdrawal of existing access rights the property has in relation to its highway frontage would need to be compensated for through the provision of a safe alternative access. Hence - although ensuring long term safe access to and from the site has significant capital implications – the responsibility for resolving this particular issue is seen as external to the project cost estimates. Allowance does, however need, to be made for appropriate signage and cautionary measures which will ensure that those utilizing the site do so with safety.

**Water Supply** – Although a major high pressure water service main traverses the front of the site, the property is currently reliant on collected tank-water. It is understood that additional security in relation to the water supply was not provided for under the Sustainable Regions Grant and hence additional capital is required for this item. (Allow $30,000).

**Temperate - Hot Water System** - The current hot water system for the former motel rooms comprises a diesel powered boiler system which is both inefficient from an energy consumption viewpoint and unsafe in that its temperature is unregulated. An allowance to fully replace this system should also be made as funds to undertake this work were also not included in the Sustainable Regions Grant. (Allow $15,000).

Completion of the above works to upgrade the existing infrastructure is required prior to the centre becoming suitable for the delivery of any formal on-site respite programs.

Additional capital will be required if the Centre is to be expanded to provide greater than 4-5 Respite places.
PB6.4 Financial Viability of Service Provision

The recommendations arising from this report identify opportunity for the Moonee Centre to host the following services.

- DADHC Social Support Program - Office and Day Centre,
- Commonwealth CACP Program – Administration office,
- Allied Health Support Services – Office & Day Clinic facilities,
- ‘Home Away From Home’ – innovative respite care program.

Commentary on the financial viability of each of the above programs is set out hereunder. A detailed cost break-down on each of these programs as well as the financial impact of growing each service as proposed can be provided by Carexcell’s Lyal Allen of upon request.

**PB6.4.1 DADHC Social Support Program - Office and Day Centre**

The existing DADHC Social Support Program commenced with an initial capital Grant of $5000 toward its administrative establishment costs and a grant of $50,000 in recurrent funding based on a projected client base of 30 persons.

During the 2007/2008 year an additional sum of $27,500 became available as a one-off allocation under the Community Development Employment Projects (CDEP) initiative, allowing for employment of the Co-ordinator full-time. The availability of both the recurrent funding and the one-off allocation has provided opportunity for the program to become firmly established and most importantly a very significant increase in the frequency and quality of Social Support program being delivered to older Aboriginal persons. (NOTE: Unless additional funding is secured, this program, will after 30 June 2008, revert back to being funded by DADHC only with the Coordinator position returning to a 0.4 EFT position).

The advantage and benefits of having this program based at the Moonee Centre are well documented in the body of research within this Report and having now firmly established both the expertise in operating this service and the confidence of care recipients, the potential to grow and expand this service is obvious.
In operating a service of this kind it is important to recognize that such a service is neither structured nor intended to return a ‘surplus’ in financial terms. Under the service objectives, any cost efficiency or saving made in its operations should translate into additional service or benefit to clients.

It is therefore not contemplated that the operations of the DADHC Social Support Program as it presently exists or in its projected growth will return any significant ‘profit’ toward the operation of the Moonee Centre. The program will of course cover its proportion of Centre operating expenses including phone, electricity and cleaning.

**PB6.4.2 Commonwealth CACP Program – Administration Office**

Arising from the 2007 Aged Care Approvals round, Carexcell Pty Ltd was awarded 10 Community Aged Care Packages to operate out of the Moonee Centre. At the same time the Commonwealth allocated a capital grant of $42,500 (ex GST) toward the establishment of the service. Under an agreement between Carexcell and YACL, Carexcell will operate this service pending YACL attaining approved provider status at which time the service will fully transfer to YACL.

Work is now well advanced toward commencement of the CACP service on 1st August 2008 and it is intended that administration of the packages will be based at the Moonee Centre.

The co-location of the DADHC and CACP programs at the Moonee Centre will enable a high level of interaction between staff operating these services and ensure that client care needs are well co-coordinated.

In commencing this service it is recognized by all parties that 10 only places is below a level normally expected to achieve financial viability. In the short to medium term, subject to proven demand it is planned to seek additional CACP and/or EACH packages which would certainly increase the potential of the service to operate with improved financial viability.

For the purpose of the financial analysis a surplus in the order of $3,500 per annum (i.e. $350/care place per annum) has been projected.
PB6.4.3 Allied Health Support Services – Office and Day Clinic Facilities
This important initiative is viewed as being of benefit both in bringing services to a convenient location for the client base whilst at the same time enabling the Centre to become recognised as a location where a diverse range of services are available. The integration and co-location of DADHC / CACP & Allied Health services will enhance the reputation of the Centre and enable some clinic services to be delivered concurrently with other day activities etc which are in place.

Those delivering services through this initiative are expected to be drawn from a wide range of existing programs such as those funded through Galambila and other programs and apart from a nominal fee to cover the cost of supply of electricity and visitor office accommodation this activity will not contribute significantly toward meeting the overall costs of operating the Centre. A ‘nominal rent’ to cover power / phone / services and a contribution toward insurances has been assumed at $50/week X 52 = $2,600 per annum.

PB6.4.4 Home Away From Home – Innovative Respite Care Program
With minor upgrade and refurbishment of one or more existing ‘motel rooms’, the HAFH initiative could commence limited daytime operations and provide assistance to those requiring out-of-home day respite. However to commence any overnight or short term stay HAFH respite style services will require significant capital to be expended and competent staffing to be in place.

**Capital Requirements:** For the purpose of this report it is assumed that capital to the level previously approved under the Sustainable Regions DOTARS Grant would be required.

**Staffing Requirements:** One of the very significant advantages of the Moonee Centre is the existence of a fully functional ‘Caretakers Residence’. This residence is currently occupied by ‘live-in’ caretakers who exercise responsibility for the maintenance of the property. As planning for commencement of the overnight and/or longer term residential nature of the HAFH program progresses, it will become necessary to ensure that the ‘live-in’ caretaker(s) comprise either a person or persons
suitably qualified and experienced in the delivery of aged care services and that provision for relief assistance is available.

Preliminary modeling of this service has made the following assumptions and/or led to the following conclusions:

- It is assumed that recurrent funding would be provided at a level not less than that provided for residential low care respite – currently $34.22 per place day.
- In light of the low socio-economic status of the target clientele – it is also assumed that many clients will be either unwilling or unable to meet the normal cost of daily care fees based on the 87% pension – and therefore an average 50% fee recovery has been assumed.
- In light of the small number of places to be made available at the commencement of this service (nominally 1,000 place days per annum) a 75% occupancy rate has also been adopted.
- It is also assumed that a salary would be paid to the resident caretaker in accordance with the Charitable Sector Award as a live-in housekeeper.

Preliminary modeling suggests that with only 1,000 respite place days (using 4 accommodation units) the service would require additional supplementary funding in the order of $30,000 to render it financially viable.

The modeling also suggests that with only 4 accommodation units the position of ‘live-in’ caretaker is severely underutilized and that a break-even outcome could be achieved if around 12 accommodation units were in place. The difficulty here, however, is that short of proving the unmet demand and achievable occupancy rates it is likely that the 12 units would require a client base of around 150 persons within the target region seeking respite accommodation at some point within any given 12 month period. The population figures identified in this report would not support such a conclusion.

In summary therefore, the preliminary financial modeling suggests that the HAFH initiative will require additional supplementary funding in the order of $30,000 per annum as a commencing service and that this figure could be reduced if additional
accommodation units were provided and a proven demand for services were established.

**PB6.4.5 Other Centre Based Operational Costs**

The above text outlines the projected financial outcomes for each of the respective programs. It must be recognised however that other Centre-based costs need to be brought to account in the operation of a Centre of this character (as discussed at PB6.2.1). It is estimated in the case of the Moonee Centre that these costs could range between $50,000 and $60,000 per annum.

**PB6.4.6 Summary of Financial Feasibility Modeling**

The Moonee Centre as proposed brings to a geographically and socially important place a range of small but very much needed services for older Aboriginal people living within the region. The Centre is remote from the major CBD areas, but is positioned in culturally-appropriate country.

Each program proposed for the Centre addresses an identified need within the target region. Individually, some programs are self supporting (DADHC & CACP) but other programs such as the planned growth into respite / HAFH programs would appear to be unsustainable without ongoing supplementary funding.

For the Centre to operate within Health and OHS guidelines, significant capital will need to be expended. The restoration of the former DOTARS Sustainable Regions Grant ($470,000) would go a long way toward providing the required capital.

Whilst it is apparent that the DADHC, CACP and visiting Allied Health programs could conceivably operate and be self sustaining from the Moonee Centre, their effectiveness will be seriously compromised if these are the only services to be provided through the Centre.

Detailed operational budgets for each of the above are available on request from Carexcell’s Mr Lyal Allen.
SECTION 7: GOVERNANCE AND ACCOUNTABILITY MODEL

This Section of the Report deals with Project Brief Item 9: Governance and Accountability Model. (NOTE This Section of the Report was prepared by Mr Michael Close, ETC).

PB 7.1 Corporate Governance – Aims

Corporate governance is how people lead and run their organisations. Corporate governance is mainly the responsibility of the board as a group. The governing board performs its duties with the support of management and staff, in line with members’ wishes, the constitution and the law, and ideally in partnership with stakeholders.

Corporations will be in a good position to build and develop in a healthy way if they:

- have clear objectives and functions
- operate in ways that respond to and accommodate their particular circumstances
- have members who understand their constitution (rules).

The size of the corporation makes a big difference to how corporate governance is practised. In small corporations with very little funding and few liquid assets, informal arrangements can work well. Medium to large corporations (that is, where income is over $100 000) need to formalise their practices more if they are to survive and be successful. The trend towards growth in the size of Aboriginal corporations means that the process of formalising corporate governance practices as corporations grow is important and a key to improving governance in the near future. At the same time, small corporations should not be over-burdened with unnecessary red tape.

For medium and large corporations, more formal arrangements need to be in place if the board of directors is doing its job well. The focus of the board of directors should be on clarifying with members the direction (aims) of the corporation, then deciding on the best roads to get there (goals) and driving to achieve these aims and goals. The challenge of mapping clearly the direction and the roads that the corporation will take is a big job and should not be underestimated. The governing committee/board also
needs to focus on overseeing the implementation of the goals through management, including having a say in the employment of the Executive Officer and keeping a constant eye on risks and whether they are being managed well. Boards for medium to large corporations need to avoid micromanaging (a common mistake); instead, they should steer the organisation.

Most corporations under the CATSI Act have limited liability, which means that members do not usually have to contribute to the debts of the corporation if it fails. However, directors can be held liable if they have not fulfilled their duties.

The policy’s other ‘pillars’, which are increasingly being recognised as important to Aboriginal corporations, are:

- respect for members’ rights
- agreement about and use of effective internal dispute resolution mechanisms for corporations
- availability of timely and accurate reporting to directors
- self monitoring
- an agreement about to whom accountability is owed, which is put into practice
- agreed decision-making principles
- the need for the directors to be equally representative of various interest groups, balanced with other requirements for skills and independence
- transparency in structure and decision making
- active and persistent conflict-of-interest management, particularly by the directors as a whole and individually
- up to date and relevant goals and strategies for the corporation

PB 7.2 Overview of YACL’s Governance and Management Structure

To be successful, the Directors of a corporation must run it properly and effectively with the help of management and staff. The Enterprise and Training Company Ltd
(ETC) is developing ways to help corporations, such as YACL, run effectively and to provide assistance with complementary business advice and support. This help depends on the goals of the corporation, its size and other issues.

This Report’s research into the provision of Aged Services for Older Aboriginals (at and from the Moonee site) has identified some potential barriers to coordinating and facilitating corporate governance by the YACL.

Some of the barriers include (but are not limited to):

- Determining how many representatives are elected to form a Board,
- Determining the criteria for selecting a Board,
- Deciding on a Board structure,
- Record keeping of members and their up to date contacts,
- Education on the role and responsibility of members,
- Maintaining a sound knowledge of their Constitution,
- Maintaining an up to date knowledge of their financial position and assets,
- Keeping an awareness of government taxes and changes,
- Maintaining appropriate insurances,
- Ensuring attendance where possible at all meetings,
- Keeping an accurate recording of minutes, and
- Ensuring an annual general meeting is held each year.

ETC have offered to engage a suitably qualified organisation to facilitate training for the elected Board of YACL.

The training will include ongoing relationship management and feedback to the Board of YACL to ensure there is an appropriate level of expertise maintained.

**PB 7.3 Proposed Governance and Management Model for YACL**

ETC have proposed a model (see below) which outlines the proposed structure of reporting and support to facilitate better outcomes for YACL.
Diagram 3: Proposed Governance and Management Model for YACL

Yarrawarra Aged Care Limited (YACL)

BOARD OF DIRECTORS
- Tony Perkins – Chairman
- Julie Perkins – Chair YAC
- Jim Hurley – (Deputy EO – Galambila)
- Maria Wilson – YAC Administration
- Angela Cowan – Dept. of Housing

Enterprise and Training Company
- Administration, Training, Education & Human Resource Management Support
- DADHC – oversee weekly activities & undertake compliance reporting
- Project Manage Site improvements at Moonee site (Dependent upon receipts of funding)

HRB Accounting
Bill Herd – Accounting, Auditing & Corporate Administration Services

Carexcell
- CACP – delivery current 10 CACP’s to commence August 2008
- CACP – on-going development of program, including possible EACH packages and proposed HAFH packages
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Appendix 1: Project Brief – Detailed break-down of Key Responsibilities

<table>
<thead>
<tr>
<th>Task</th>
<th>Lead Role</th>
<th>Key Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 – Project Brief &amp; Administration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>• Develop detailed brief for Scoping Study</td>
<td>YACL/LA</td>
</tr>
<tr>
<td>1.2</td>
<td>• Prepare cost estimates for component parts of the study</td>
<td>LA</td>
</tr>
<tr>
<td>1.3</td>
<td>• Allocate key responsibilities, monitor progress, and ensure timely completion of the study</td>
<td>LA/SCU (ORE)</td>
</tr>
<tr>
<td>1.4</td>
<td>• Report acquittals to Department Health &amp; Ageing</td>
<td>ETC</td>
</tr>
<tr>
<td><strong>2 – Define the Study Region &amp; Profile existing indigenous aged care service providers.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>• Define the study region</td>
<td>SCU - ASLaRC</td>
</tr>
<tr>
<td>2.2</td>
<td>• Define and document the geographic spread of existing service providers &amp; summary profile their organisations in terms of service type, funding source/s &amp; numbers of clients serviced and geographic coverage of the service</td>
<td>SCU - ASLaRC</td>
</tr>
<tr>
<td>2.3</td>
<td>• List key contacts, number of personnel engaged in service delivery and any specific expertise developed by the service.</td>
<td>SCU - ASLaRC</td>
</tr>
<tr>
<td><strong>3 – Define the Demand</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>• Provide summary demographic analysis including population and age cohort trends &amp; projections</td>
<td>SCU - ASLaRC</td>
</tr>
<tr>
<td>3.2</td>
<td>• Summarise existing research &amp; documentation re Social &amp; Cultural trends and expectations</td>
<td>SCU ASLaRC)</td>
</tr>
<tr>
<td>3.3</td>
<td>• Summarise existing research &amp; documentation re specific health and aged care needs</td>
<td>SCU - ASLaRC</td>
</tr>
<tr>
<td><strong>4 – Supply &amp; Demand Matrix</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>• Develop a matrix showing the inter-relationship between existing programs and the identified demand for indigenous aged care services and programs.</td>
<td>SCU - ASLaRC</td>
</tr>
<tr>
<td>4.2</td>
<td>• Identify key service gaps</td>
<td>SCU - ASLaRC/YACL</td>
</tr>
<tr>
<td>4.3</td>
<td>• Identify specific geographic regional needs &amp; opportunities</td>
<td>YACL / SCU - ASLaRC</td>
</tr>
<tr>
<td><strong>5 – Local Indigenous Community &amp; Regional Service Provider Consultations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>• Summarise the findings of prior and ongoing consultations with Indigenous Elders and Communities in regard to service needs that could be potentially addressed at – or from the Moonee Centre.</td>
<td>LA / YACL</td>
</tr>
<tr>
<td>5.2</td>
<td>• Convene workshop with existing service providers/agencies to discuss findings of the service matrix and discuss strategies and/or service models they consider could address the needs of indigenous elders</td>
<td>LA / YACL / SCU - (ORE &amp; ASLaRC)</td>
</tr>
<tr>
<td>Task</td>
<td>Lead Role</td>
<td>Key Outcomes</td>
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<tr>
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</tr>
<tr>
<td>6 – Define potential future service models – within the region &amp; specific to Moonee</td>
<td>LA / SCU (ORE &amp; ASLaRC)</td>
<td>Clarity of understanding re regional service gaps and opportunities.</td>
</tr>
<tr>
<td>6.1</td>
<td>• From the above research – write-up a concise description of the scope and character of indigenous aged care services which could be effectively developed for the region</td>
<td>LA / SCU (ORE &amp; ASLaRC)</td>
</tr>
<tr>
<td>6.2</td>
<td>• Separate out short and longer term strategies</td>
<td>LA / JS</td>
</tr>
<tr>
<td>6.3</td>
<td>• Define which of these services directly relate to the Moonee site as being either centre based or having potential for efficient delivery from Moonee as an administrative base.</td>
<td>LA / SCU (ORE &amp; ASLaRC) YACL / ETC</td>
</tr>
<tr>
<td>7 – Detail the nature and scope of a preferred flexible aged care service model</td>
<td>LA / SCU (ORE &amp; ASLaRC)</td>
<td>Understanding of the nature and scope of a preferred service model</td>
</tr>
<tr>
<td>7.1</td>
<td>• Define the aged care elements including type and mix of services to be incorporated into a preferred service model</td>
<td>LA / SCU (ORE &amp; ASLaRC)</td>
</tr>
<tr>
<td>7.2</td>
<td>• Define the target clientele including health / care needs, entry / exit criteria, service accessibility and affordability</td>
<td>LA / SCU (ORE &amp; ASLaRC)</td>
</tr>
<tr>
<td>7.3</td>
<td>• Define the staff and resources required to operate such a service</td>
<td>SCU (ORE &amp; ASLaRC) / LA</td>
</tr>
<tr>
<td>7.4</td>
<td>• Prepare a financial feasibility model for the establishment and ongoing operation of the preferred service.</td>
<td>LA / ETC</td>
</tr>
<tr>
<td>8 – Impact analysis</td>
<td>LA / SCU (ORE &amp; ASLaRC) / ETC</td>
<td>More co-ordinated approach and regional co-operation</td>
</tr>
<tr>
<td>8.1</td>
<td>• Summarise likely impact of recommendations on existing service providers</td>
<td>LA / SCU (ORE &amp; ASLaRC) / ETC</td>
</tr>
<tr>
<td>8.2</td>
<td>• Summarise likely impact of recommendations on the future of the Moonee Centre</td>
<td>LA / SCU (ORE &amp; ASLaRC) / ETC</td>
</tr>
<tr>
<td>8.3</td>
<td>• Summarise likely impact of recommendations on other currently un-serviced communities</td>
<td>LA / SCU (ORE &amp; ASLaRC) / ETC</td>
</tr>
<tr>
<td>9 – Governance &amp; Accountability model</td>
<td>YACL / SCU-ORE / ETC</td>
<td>Effective governance and management structure</td>
</tr>
<tr>
<td>9.1</td>
<td>• Recommend a clear Governance model to oversight the planned service structure</td>
<td>YACL / SCU-ORE / ETC</td>
</tr>
<tr>
<td>9.2</td>
<td>• Develop a clear Strategic &amp; Business Plan for the service/s</td>
<td>YACL / SCU-ORE / ETC</td>
</tr>
<tr>
<td>9.3</td>
<td>• Facilitate the required organisational change.</td>
<td>YACL / SCU-ORE / ETC</td>
</tr>
<tr>
<td>10 – Reporting of Scoping Study Outcomes</td>
<td>YACL / SCU-ORE ETC / LA</td>
<td>Concise summary of key findings with recommendations</td>
</tr>
<tr>
<td>10.1</td>
<td>• Prepare detailed report with summary recommendations</td>
<td>YACL / SCU-ORE ETC / LA</td>
</tr>
<tr>
<td>10.2</td>
<td>• Publish summary findings &amp; circulate to participant organisations &amp; communities</td>
<td>YACL</td>
</tr>
</tbody>
</table>
Appendix 2: Map of Area covered by YACL Project

A representation of Gumbaynggirr Country for the purposes of the YACL Project: To deliver aged care services for older Aboriginal people.
## APPENDIX 3: OLDER ABORIGINAL PEOPLE IN RESIDENTIAL AGE CARE FACILITIES

<table>
<thead>
<tr>
<th>AREA</th>
<th>RACF</th>
<th>Does the facility currently have any older Aboriginal people in residence? If yes, how many and how long?</th>
<th>Does the facility have any guidelines or specific policies regarding caring for older Aboriginal people?</th>
<th>Is the facility suitable for caring for older Aboriginal people?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellingen</td>
<td>Bellorana Nursing Home</td>
<td>Did not answer</td>
<td>Did not answer</td>
<td>Did not answer</td>
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<td></td>
<td>Bellorana Hostel</td>
<td>Did not answer</td>
<td>Did not answer</td>
<td>Did not answer</td>
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<tr>
<td></td>
<td>Dorrigo Multi- Purpose Centre</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td>Coffs Harbour</td>
<td>Coffs Harbour Legacy Nursing Home</td>
<td>Yes – 1 male, 5 years 1 female, 4 weeks respite</td>
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<td>YES</td>
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<td></td>
<td>Coffs Harbour Masonic Village</td>
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<td>Did not answer</td>
<td>Did not answer</td>
</tr>
<tr>
<td></td>
<td>Coffs Harbour Nursing Centre</td>
<td>Did not answer</td>
<td>Did not answer</td>
<td>Did not answer</td>
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<tr>
<td></td>
<td>Coffs Haven</td>
<td>Did not answer</td>
<td>Did not answer</td>
<td>Did not answer</td>
</tr>
<tr>
<td></td>
<td>Mater Christi Aged Care Facility</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>St Augustine’s Nursing Home</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>St Josephs Hostel For The Aged</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Villa Monica (self care units)</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Woolgoolga Aged Hostel</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td>Location</td>
<td>Service Name</td>
<td>Had Long Term Client</td>
<td>Long Term Female Client Died</td>
<td>Cultural Awareness Programs</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------</td>
<td>----------------------</td>
<td>------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Grafton</td>
<td>Clarence Nursing Home</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Clarence Village Hostel</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Grafton Aged Care Home</td>
<td>No (had a long term female client, died Dec 06)</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Ozanam Villa Hostel</td>
<td>1 female (18 months); 1 male on respite with a 4 week stay</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>St Catherine’s Villa</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Maclean</td>
<td>Lower Clarence Aged Hostel</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>Mareeba Nursing Home</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td>Yamba</td>
<td>Caroona Aged Care Hostel</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>#Riverside Garden Hostel</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>#Riverside Gardens Aged Care Centre</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
<tr>
<td>Macksville</td>
<td>#Autumn Lodge</td>
<td>NO</td>
<td>NO *</td>
<td>YES</td>
</tr>
</tbody>
</table>

* The above services in Nambucca Heads and Macksville are all under one organisation

* Denotes basic cultural awareness programs are in place.
Appendix 4:

ABORIGINAL MEDICAL SERVICES (AMS)
AND SERVICES THEY PROVIDE IN THE AREA COVERED BY THE
YARRAWARRA AGED CARE LTD MOONEE PROJECT

May 2008

BAWRUNGA AMS BOWRAVILLE: NAMBUCCA LGA

BULGARR NGARU AMS GRAFTON: CLARENCE VALLEY LGA

GALAMBILA AMS COFFS HARBOUR: COFFS HARBOUR LGA

PLUS - DURRI AMS KEMPSEY: KEMPSEY LGA (Auspicing Organisation for Bawrunga AMS).
CONTEXT: The three Aboriginal Medical Services in the study area are currently auspiced by Durri Aboriginal Medical Centre in Kempsey. Therefore, services provided by Durri are also presented here. However, it is expected that Galambila AMS will become a stand-alone service from 1 July 2008.

1. BAWRUNGA AMS
53 High Street
Bowraville NSW 2449
TEL: 6664 7506; FAX: 6564 7509
Hours Monday to Friday 8.30-5 pm Thursdays-5.30-8 pm Saturdays 9am-1 pm
Bawrunga is a stand-alone service offering a General Practice service and referrals to specialists.

Geographic coverage: three clinics in the Nambucca Region - at Bowraville, Nambucca Heads and Macksville.

Staffing: One full-time doctor and one part-time doctor, as well as 10 staff and volunteers.

Services Provided - Preventative health education, addressing early childhood nutrition and parenting, acute health issues, diet, substance abuse, healthy lifestyles and youth related issues. Arts and craft are also runs out of the Bowraville centre.
2. BULGARR NGARU AMS
131-133 Bacon Street
Grafton NSW 2460
TEL: 6643 2199; FAX: 6643 5207

Geographic coverage: The service is situated in Grafton and provides Outreach clinics to Baryulgil, Malabugilmah, Yamba and Maclean.

Staffing: The Medical Team includes 4 General Practitioners and the specialist services of a physician and a paediatrician. They are assisted by 2 Nurses and the Aboriginal Health Outpost Worker of the community. A full-time dietician, dentist, audiologist and sexual health worker. Mental Health worker. An optometrist visits twice monthly

Services Provided: General Practitioner service and clinics (diabetes – monthly, drug and alcohol clinics –daily) mental health worker, Adult & children dental services; Podiatry, Optometry, dietician, visiting respiratory specialist, visiting general physician.
3. **GALAMBILA AMS**

Corner Harbour Drive & Boambee Street  
Coffs Harbour NSW 2450  
TEL: 02 6652 0800; FAX: 02 6652 2563  
Hours: Monday to Friday 9am -12 noon; 1.30-4.00pm appointments only  

**Geographic coverage;** Service is situated in Coffs Harbour and services the Aboriginal community from Corindi in the north to Urunga and west to Dorrigo and Ulong.  
Fortnightly outreach clinic to Yarrawarra Aboriginal Corporation Red Rock Rd, Corindi Beach

**Staffing:** 2X fulltime General Practitioners and 1x weekly Community Nurse ,1x weekly physiotherapist, 1x weekly podiatrist; 2X psychologists-1X weekly &1x fortnightly; 1x monthly Psychiatrist; 1xmthly Audiologist, 1x weekly D&A Counsellor; 1x bimonthly optometrist; 1x weekly speech therapist ; 3mthly endocrinologist; 1mthly echocardiogram technician

**Services Provided:** General Practitioner Clinics, Chronic Disease Program; Diabetes specialist clinic, Renal clinic; D&A counselling & other visiting specialist services – audiology; endocrinology; optometry; physiotherapy; podiatry, psychiatry, psychology, speech therapy. Programs: Fruit and vegetable co-op-weekly; Spring into shape program ---on going throughout the year.
4. **DURRI AMS**

1 York Lane  
PO BOX 136  
Kempsey NSW 2440  
TEL: 6562 4919; FAX: 6652 2563

The AMS is open Monday to Friday 9am to 5pm. There is no out-of-hours service, with patients accessing after-hours and weekend care from Kempsey Hospital.

**Geographic coverage:** The service is based in Kempsey and services the Macleay Valley

**Staffing:** 3 full-time and 1 part-time General Practitioners; twice weekly D&A Counsellor; twice weekly Audiologist; 3 times per month Optometrist; three times per week Diabetes specialist two times per week; 1 fulltime dentist.

**Services Provided:** General Practitioner Clinics, Chronic Disease Clinic; Men’s Health, Women's health, Vascular Health; Sexual Health, Mental Health, D & A counselling and other visiting specialist services: Audiology, Optometry.
Appendix 5:

NORTH COAST AREA HEALTH SERVICE
ABORIGINAL HEALTH SERVICES

In the Yarrawarra Project Area

May 2008
Grafton Community Health - Aboriginal Health
Aboriginal Health Education Officers provide health education, health promotion, community development and information and referral to other services.

Aboriginal Vascular Health Nurse provides screening, follow up, information and referral and group work to Aboriginal people and communities for a range of vascular and cardiac issues.

Address: Arthur Street, Grafton, 2460
Phone (02) 6640 2402
Fax (02) 6640 2422
Email ch-gbh@nrhs.health.nsw.gov.au

MacLean Community Health - Aboriginal Health
Aboriginal Health Services provide health education, health promotion, information and referral to Aboriginal communities, aimed at assisting them to access health and other related services within the Clarence Valley. Services are provided by both male and female health workers.

Aboriginal Health Education Officers provide the following services:
* Assist in arranging transport through Clarence Valley Community Transport Inc for health related matters
* Liaise with other agencies on behalf of clients.
* Assist members of the community with health related appointments.
* Advocacy with clients.
* Develop and implement programs to promote health and well-being.
* Consult with Aboriginal communities to identify local health needs.
* Network with services to ensure that services, programs and projects are culturally appropriate and accessible.
* Promote Aboriginal cultural awareness to health and other agencies.

Aboriginal Vascular Health Nurse:
The program raises awareness and promotes the benefits of a healthy lifestyle to assist in reducing the risk of vascular disease. The program also aims to improve self-management of people with chronic conditions working in partnership with Bularr Ngaru AMS.
Outreach services: Iluka, Yamba, Grafton, Baryulgil, Malabugilmah and surrounding areas.

**Address:** Union Street, PO Box 93, Maclean 2463  
**Phone** (02) 6640 0123  
**Fax** (02) 6645 4842

**Aboriginal Health Service – Coffs Harbour Campus**  
Includes community nursing  
Coffs Harbour Health Campus  
345 Pacific Highway  
Coffs Harbour NSW 2450  
Tel: 02 6656 7845  
Mob: 0439 882 834

**Aboriginal Health Liaison Officers**  
Available at hospitals within North Coast Area Health Service

There to ensure Aboriginal community can fully utilise the hospital system. Provide linkage between the community and the hospital. Provide advocacy and support for Aboriginal inpatients and their families; liaison between MNCAHS, especially the acute care facilities, and the Aboriginal clientele and community; creation of a culturally appropriate environment for Aboriginal people to receive health care; and assist with discharge planning and care plan intervention for hospital based Aboriginal clientele.
Appendix 6:

ABORIGINAL GROUPS AND AGED SUPPORT SERVICES

Local Government Areas

From

Clarence Valley to Nambucca

May 2008
# ABORIGINAL GROUPS AND AGED SUPPORT SERVICES

## Coffs Harbour Local Government Area (LGA)

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>SERVICES PROVIDED</th>
</tr>
</thead>
</table>
| **Abcare Australia- Aboriginal Support Program**  
Aboriginal Community Family Care Centre,  
Community Village  
22 Earl Street (PO Box 521)  
Coffs Harbour NSW 2450  
Tel: 02 6648 3680  
Web Site: www.abcare.org.au  
Monday-Friday 8.30am-4pm | The aim of this service is to help aged people and their carers maintain independence at home. The service offers advocacy, referrals and social support through recreational outings (The Department of Aging, Disability and Homecare fund the program). |
| **Aboriginal Wheels to Meals Service**  
Community Village  
22 Earl Street  
Coffs Harbour NSW 2450  
Tel: 6648 4685 | This service is aimed at the elderly Aboriginal Community and people with disabilities. It is to give their carers a break and to get the clients out for the day to enjoy other company while sharing a meal and an outing together. |
| **Coffs Harbour, Bellingen & Nambucca Community Transport**  
Shop 8, Parklea Arcade,  
13-15 Park Avenue (PO Box 737)  
Coffs Harbour 2450  
Tel: 02 6651 1137 | Provides transport assistance for frail aged people (Aboriginal people over 45 yrs), people with disabilities and people who live in isolated areas. |
| **Coffs Harbour Home Nursing Service**  
22 Azalea Avenue  
Coffs Harbour 2450  
Tel: 6652 9155 | General provider operating 3 CACP places for Aboriginal community in Coffs Harbour LGA |
| **Home Care Services of NSW – Aboriginal Home Care**  
72 Grafton Street (PO Box 550)  
Coffs Harbour 2450  
Tel: 6659 1360 | Funded and operated by DADHC provides, people with practical assistance in order to promote independent living in their own home, offers: personal care, respite, domestic help, shopping and some meal preparation. |
<p>| <strong>Nambucca Valley Community Services Council</strong> | See Nambucca LGA below |</p>
<table>
<thead>
<tr>
<th><strong>Yarrawarra Aged Care Service</strong></th>
<th><strong>Yarrawarra Aboriginal Corporation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Moonee Beach 1579 Pacific Highway</td>
<td>Red Rock Road Corindi NSW 02 6649 2669</td>
</tr>
<tr>
<td>Coffs Harbour NSW 2450 Tel: 02 6651 6333</td>
<td>Provides an outreach service from Galambila AMS every Wednesday from 9am-12 noon. All Galambila services can be accessed through this service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Waratah Respite Centre</strong></th>
<th><strong>CLARENCE VALLEY LGA</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Coffs Harbour Community Village 22 Earl Street</td>
<td><strong>Home Care Services of NSW – Aboriginal Home Care</strong> 9 Skinner Street South Grafton NSW 2460 Tel: 02 6642 4518</td>
</tr>
<tr>
<td>Coffs Harbour NSW 2450 Tel: 02 6648 3610</td>
<td>Funded and operated by DADHC provides, people with practical assistance in order to promote independent living in their own home, offers: personal care, respite, domestic help, shopping and some meal preparation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Community Programs Incorporated</strong></th>
<th><strong>NAMBUCCA LGA</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>3-7 Prince Street (PO Box 889) Grafton NSW 2460 Tel: (02) 6642 7257</td>
<td><strong>Ngambaga Bindarry Girwaa Community Services</strong> 22 Wallace Street Macksville NSW 2447 Tel: 02 6568 2382</td>
</tr>
<tr>
<td><a href="http://www.communityprograms.org.au">http://www.communityprograms.org.au</a></td>
<td>Provides meals on wheels, referrals for transport, activity days and centre based respite, on going respite for carers, social support for older aboriginal people</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Nambucca Valley Community Services Council</strong></th>
<th><strong>Nambucca Valley Community Services Council</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>22 Wallace Street Macksville NSW 2447 Tel: 02 6568 4430</td>
<td><strong>Ngambaga Bindarry Girwaa Community Services</strong> 22 Wallace Street Macksville NSW 2447 Tel: 02 6568 2382</td>
</tr>
<tr>
<td>Monday to Friday 8.30am – 4.30pm</td>
<td>Provides meals on wheels, referrals for transport, activity days and centre based respite, on going respite for carers, social support for older aboriginal people</td>
</tr>
</tbody>
</table>

Commonwealth only funded Aboriginal specific places provided 35 CACPs and 10 EACH places in the Nambucca, Bellingen and Coffs Harbour LGAs.
APPENDIX 7: Care and Support Needs of Older Aboriginal People

MOONEE ELDER CARE PROJECT: COMMUNITY CONSULTATION PRO- FORMA

For use with Aboriginal Elders and Other People Who Work with and/or Care For Aboriginal Elders

The purpose of this document is to guide the consultation process which aims to identify the health care and social, cultural, spiritual needs of Aboriginal Elders and the extent to which these needs can be met from the Moonee Centre.

Demographic Data: Please collect the following information, so we can build up a picture of who has provided the information and what perspective they are coming from.

NOTE: Do NOT write the person’s name or any specific identifying information on this form.

Please circle one answer for each of the following:

1. Is the person being interviewed male or female? Male Female

2. What age group does the person belong to?
   - Less than 40; 40-49; 50-59; 60-69; 70 or older.

3. Where does the person live? (Closest Town)
   ………………………………………… ………………

4. What Aboriginal group does this person identify as?
   …………………………………………………………….

5. What is the main language spoken by this person?
   …………………………………………………………….

6. If the answer to Q5 is not English, does this person speak and understand English easily?
   Yes No

7. Who does this person live with?
   - Lives alone; Lives with spouse only; Lives with spouse and other family;
   - Lives with family (no spouse); Other (please specify)
   ………………………………………

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**Health-related data:**

8. In the last 12 months, has this person:

   (a) been to see a GP? Yes (How many times?) …………..   No
   (b) been an in-patient in hospital? Yes (How many times?) …………..  No
   (c) been treated as an out-patient at a hospital or clinic?
       Yes (How many times?) …………..  No
   (d) been to see a specialist? Yes (How many times?) …………..  No
       If Yes, what sort of specialist was that? ……………………………

   (e) received treatment of help from
       (i) a physiotherapist ? Yes (How many times?) ……… …..  No
       (ii) a podiatrist? Yes (How many times?) …………..  No
       (iii) a social worker? Yes (How many times?) …………. .  No
       (iv) any other allied health professional? (Please specify)………………

       Yes (How many times?) …………..  No

9. Has this person ever had any problems accessing health –care? Yes   No
   If Yes, please list those problems here ………………………………………
   ………………………………………………………………………………………
   ………………………………………………………………………………………

10. Has this person been diagnosed with any specific illness or health problem? Yes   No
    If Yes, please list those health problems here
    ………………………………………………………………..
    ………………………………………………………………………………………
    ………………………………………………………………………………………

11. Does this person receive any services from HACC? Yes   No
    If Yes, please list those services here …………………………………………..
    ………………………………………………………………………………………
12. Does this person receive Meals on Wheels?  
   Yes  No  
   If Yes, do they like the food that is provided?  
   Yes  No

13. Apart from HACC services, does this person receive help with any of the following? (If you circle Yes for any of these, please write beside it who provides that help)

<table>
<thead>
<tr>
<th>Service</th>
<th>Who provides it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Housework</td>
<td></td>
</tr>
<tr>
<td>(b) Yard or garden</td>
<td></td>
</tr>
<tr>
<td>(c) Home maintenance</td>
<td></td>
</tr>
<tr>
<td>(d) Shopping</td>
<td></td>
</tr>
<tr>
<td>(e) Cooking</td>
<td></td>
</tr>
</tbody>
</table>

14. Which of the following statements is most true for this person? (Please tick one)
   (a) They think they have enough help
   (b) They would like more help with (please specify)  

15. Are they services they receive culturally appropriate?  Yes  No
   If No, or if the person is unhappy with the service for some other reason, please specify why that is  
   .................................................................................................................................

16. Health-related transport: If this person has to go to a doctor or hospital, how do they usually get there?
   (a) Own car
   (b) Family member or friend drives them
(c) They use Community transport

(d) Other (please specify) ……………………………………………………………

17. Has this person ever gone into respite care in a hostel or nursing home? Yes  No
   If Yes, please provide details, where, how long for, reason for going there
   ………………………………………………………………………………………………

18. For this section of the questionnaire, please ask the person about their current living
   situation, including:
   whether they are happy where they now live,
   whether they would like to move into supported accommodation
   any problems that would cause for their family or whoever they live with
   Any other comments that the interviewer thinks is relevant.

   Note: If the person being interviewed is not the Aboriginal Elder themselves, please note
   here who is providing the information
   ………………………………………………………………………………………………

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