Fairer health: Case studies on improving health for all

VicHealth

A Victorian Government initiative

Victoria The Place To Be

Fairer health: Case studies on improving health for all

Accessibility

If you would like to receive this publication in an accessible format, please phone (03) 9096 7126 using the National Relay Service 13 36 77 if required, or email social.policy@dhs.vic.gov.au

This document is also available in pdf format on the internet at www.health.vic.gov.au/healthpromotion

Published by the Victorian Government Department of Human Services, Melbourne, Victoria

This document may also be downloaded from the Department of Human Services website at: www.health.vic.gov.au/healthpromotion and the VicHealth website at www.vichealth.vic.gov.au

Authorised by the State Government of Victoria,
50 Lonsdale Street, Melbourne.
August 2009.

Project Manager: Lucy Medley

Project Group: Rebecca Armstrong (McCaughey Centre, University of Melbourne), Mark Boyd (VicHealth), Kellie Horton (DHS), Sue Psalios (DHS), Dave Trudinger (DHS) and Clodagh Walsh (DHS).

Minister's foreword - action for fairer health

What are health inequalities, and why do we as Victorians care about them?

The expression 'health inequalities' is a shorthand way of describing both the fact that different people experience better or worse health depending upon their life circumstances, and the fundamentally unfair, undesirable and unproductive impact this can have on individual lives and our community.

While the health of Victorians is generally very good, research has shown that some people in the community are being left behind. Those with the least resources suffer the most illness, pain, chronic disease and reduced life expectancy. This means harder lives for them and their families. It means lower social and economic participation and higher health and living costs. This is especially true of Indigenous Victorians – for whom the gap is distressingly wide.

But it does not have to be this way. The Victorian Government is committed to reducing health inequalities and closing the gap. We have made it an explicit action in A Fairer Victoria, and provided $280 million over the next four years on top of the $1.5 billion already invested to improve the health and wellbeing of more Victorians. Our hospitals, community health centres and schools are already making a substantial contribution to reduced inequalities in health. We are building on these services and improving their reach and impact, but we can do more.

This guide showcases just a few of the many creative and innovative approaches to tackling health inequalities. They have been funded by a range of organisations - not all by the Victorian Government. Some programs reduce the disadvantage and discrimination that lead to illhealth and exclusion. Others promote health for all Victorians or focus on the quality, affordability and accessibility of services.

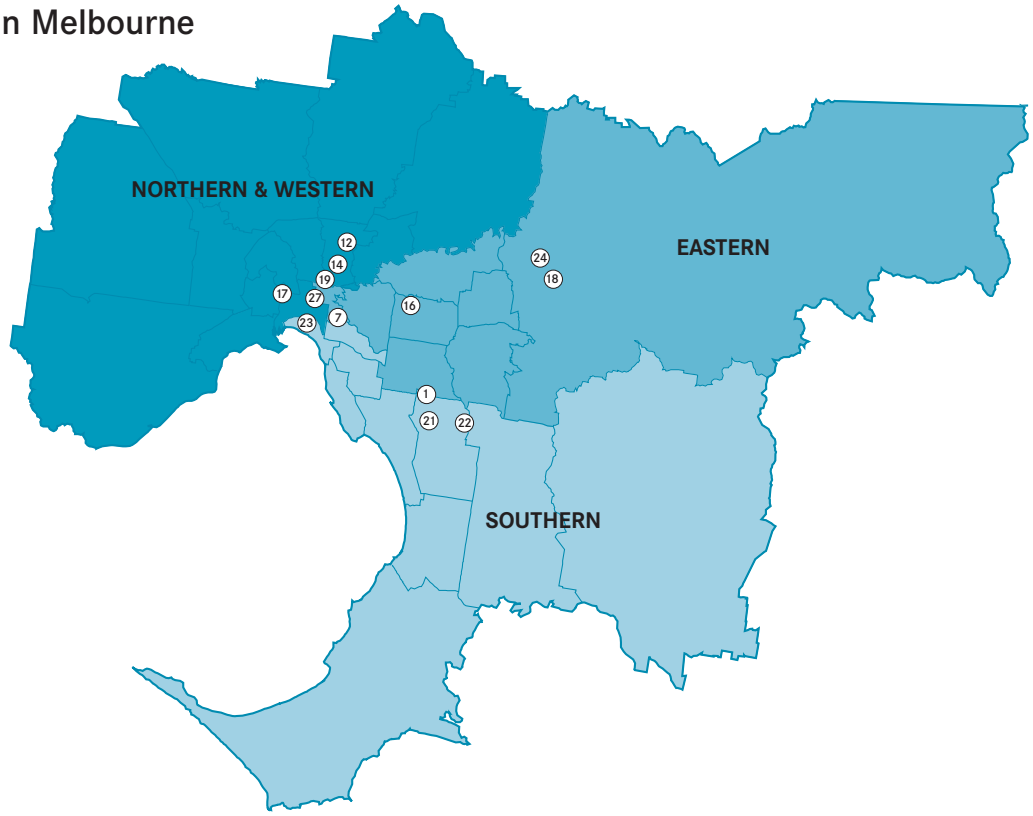
These case studies should inspire action and innovative thinking. They tell a story of what is possible. Victoria is known for its innovation in health. This guide demonstrates the strong foundation we have for continued action to promote greater equality in health.

The Hon. Daniel Andrews MP
Minister for Health

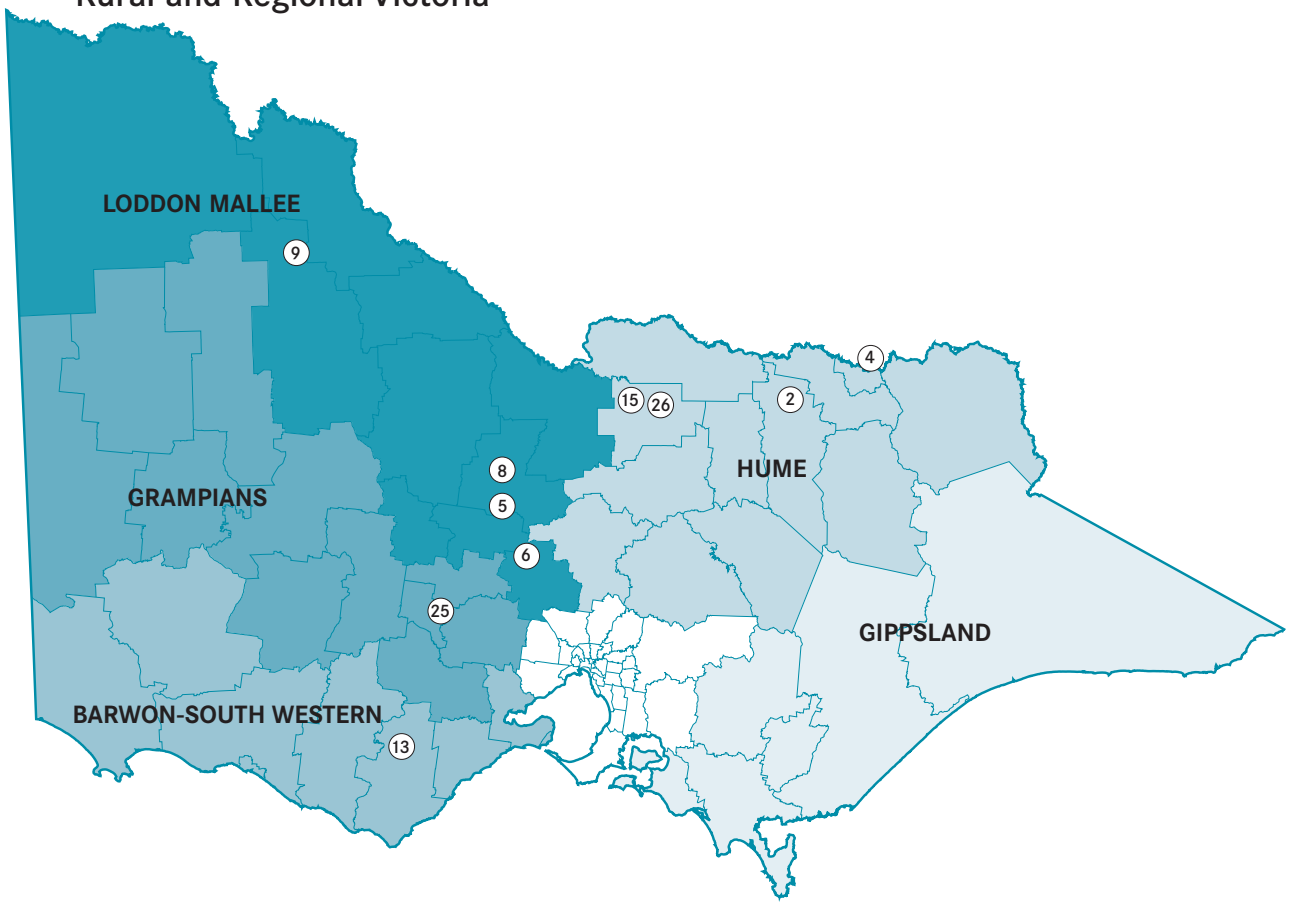
Contents

Location of case studies

Metropolitan Melbourne



Rural and Regional Victoria



Key to map:

1 The African Refugee Housing Orientation Program

2 Mental Health and Homelessness Partnership

3 Public Tenant Employment Program
(not shown, in various locations)

4 Connecting Young Parents

5 Connect Central

6 WayOut

7 Bridging the Digital Divide

8 Adds Up

9 Transport Connections –
Southern Mallee and Wimmera

10 Koori Courts
(not shown, in various locations)

11 The Bridge Project - Supporting Young People in the Justice System
(not shown, in various locations)

12 Darebin Alcohol Strategy

13 NEAMI Smoke-free psychiatric services

14 'Go for your life' Be Active, Eat Well

15 Braybrook Maidstone Healthy Canteen

16 Residents Making a Difference - Whitehorse

17 Rumbarlara Health Lifestyles Program

18 Paying Attention To Self

19 Smiles 4 Miles

20 The Comprehensive Health Assessment Program
(not shown, in various locations)

21 Refugee Health Nurse Program

22 Dandenong Asylum Seekers General Practice Clinic - General Practitioner Support to Asylum Seekers

23 General Practice Innovations Program

24 More Allied Health Services –
Eastern Ranges

25 The Ballarat Maternity Unit Indigenous Antenatal Program

26 Adolescent Antenatal Care and Education Program

27 Integrated Humanitarian Settlement Strategy Community Guides

1. What do the case studies reveal about action to reduce health inequalities?

Health inequalities have been measured and described in detail for a long time. There has also been some action to reduce these inequalities, although only recently has this action been evaluated or the impact on health equity described. Across the world each year, evidence of good practice grows as further evaluations and good practice tools are commissioned.

Selecting case studies for this guide has emphasised the common critical factors often present in programs that promote health equity. We asked the program managers to consider the factors that contributed to success and from their comments have identified 'learning points' for each case study. Five common threads in good practice that can be distilled from these learning points are explored below. The five common threads are:

Planning for impact

Nothing is more important than a coherent program logic identifying the intentions of an initiative and the steps required to get there. Three examples, *Colac Be Active Eat Well*, *Homelessness and Mental Illness Partnership* and *The Bridge Project* all had ambitious goals: improving the health and wellbeing of the Colac community, empowering young people to improve their life outcomes and reducing the incidence of people with co-occurring mental illness and homelessness. But each program was able to narrow its goals to strive towards particular impacts. They began with the end in mind and kept a focus on concrete benefits. As a result these case studies can point to specific achievements: lowering the weight gain (by one kilogram) and waist growth (three centimetres) of children in Colac, no readmission for clients and zero per cent re-offending rates.

Multi-sector approach

Partnerships are often identified as essential to good practice. The case studies included in this guide confirm the centrality of partnerships with a purpose. A multi-sector approach that includes health organisations as well as local government agencies, education services and non-government organisations was critical to the success of *Connect Central, Wangaratta Mental Health and Homeless Partnership Program* and the *Public Tenant Employment Program*. But multi-sector approaches also have limitations. A number of submitted case studies were not included in this guide because, while being able to point to extensive partnership processes and success in sustaining meetings, they could not identify impact for the community.

Community-owned

A consistent thread in the case studies is community ownership. This is often expressed through the metaphor of the journey: making sure everyone is travelling with you is essential to reaching the destination. Good examples of this are the *WayOut* program and the *Bridging the Digital Divide Program*, both of which incorporated extensive consultation and a participation/action research approach. However, this also presents a challenge to more evidence-based practice - if evaluation and experience points to the roll out of a particular approach, is this too top down to build community ownership? *Transport Connections* and *Residents Making a Difference - Whitehorse* both suggest that genuine participation and flexibility within the program to address local need can secure results for larger programs.

Rethink inclusion

Sometimes reducing inequalities can be supported by asking some simple questions that help programs think differently. The *Public Tenant Employment Program* identified that women were not accessing the program's employment opportunities. The program started by asking why and this has led to women's employment through the program going from six per cent to 28 per cent. The *Koori Courts* initiative has provided a way to overcome barriers in the justice system that alienated and excluded the Koori community. As a result the program has shown reduced levels of recidivism and improved participation in the administration of law. The implication of this thread is that substantial changes can be made through relatively low cost changes to existing programs.

Connect to the wider causes of health

A highlight in several case studies is the explicit connection made with the wider influences on or causes of health outcomes (the 'social determinants') by health-focused programs. In the *Healthy Canteen* and the *Community Guides* examples, success in health outcomes was supported by changes in broader social outcomes. Employment opportunities, leadership and social skills were created. Health and community workers were not acting outside their remit or expertise, rather they were thinking creatively about what the particular community needed and how health outcomes could be supported.

The selected case studies are intended to provide a starting point for thinking further about what action you can take to build health equity and inclusion. Good practice often builds from the learning points of prior experience. The five common threads, while not a guarantee for success, do appear to be associated with effective programs.

2. Reducing the disadvantage and discrimination that leads to illhealth and exclusion

This first dimension supports action on the economic and social circumstances that are the foundation of our health and wellbeing. Social and material disadvantage and exclusion have been demonstrated to drive unequal health outcomes. Poor health also compounds disadvantage, limiting participation in employment, education and the community.

The case studies presented in this chapter act on what is sometimes referred to as the wider influences or social determinants of health. There are both direct and indirect health impacts when programs can shape change in these wider influences. The examples selected reflect programs operated outside the health sector or where successful partnerships have linked health and other social policy expertise.

Where you can find out more about this dimension:

A Fairer Victoria (Victoria)

www.dpcd.vic.gov.au

Wilkinson & Marmot, The Solid Facts: social determinants of health

www.euro.who.int/InformationSources/Publications/Catalogue/20020808_2

Whitehead & Dahlgren, Leveling up: concepts and principles for tackling social inequities in health, Part 1

www.euro.who.int/document/e89383.pdf

Whitehead & Dahlgren, Leveling up: European strategies for social inequities in health, Part 2

www.euro.who.int/document/e89384.pdf

Health Nexus, Primer to Action: social determinants of health (Canada)

www.healthnexus.ca/projects/primingaction/PrimertoAction-EN.pdf

The African Refugee Housing Orientation Program

Adequate affordable housing supports health by providing shelter, stability and social connections.

In Melbourne and key regional centres the availability and affordability of housing has dropped to record lows. This situation has created particular difficulties for newly arrived migrants and refugees who are unfamiliar with the rules and practices of the rental market.

The Springvale Community Aid and Advice Bureau (SCAAB) worked with Consumer Affairs Victoria (CAV) on a program to support the local Sudanese community to better understand and navigate the rental housing market. The program has provided the opportunity for more secure housing.

The success of the program has enabled it to be offered now in other local areas like Ballarat and Geelong.

> ***'The project has created an opportunity to 1,965 community members to receive education and information on tenancy issues. It also created employment opportunities for 28 community members.'***
>
> *SCAAB Evaluation Report*

Contact

Rachel Smith
Indigenous and Multicultural Registrations and Community Engagement
Consumer Affairs Victoria
Phone: (03) **8684 6455**
Email: **rachel.smith@justice.vic.gov.au**

Aim

To maximise access to the private rental market and promote sustainable tenancies among the Sudanese community within the City of Greater Dandenong.

Target group

Sudanese community in the City of Greater Dandenong and surrounds. Speakers of Dinka, Nuer and Sudanese Arabic.

Inequalities dimension

Housing: limited familiarity and understanding of the highly competitive private rental market has created barriers for the Sudanese community to secure adequate and sustainable housing.

How did it work?

Structure:

The project was delivered by the Multicultural Consumers Unit of CAV and SCAAB. The Tenants Union of Victoria (TUV) developed the educational program content. The program was guided by consultation with community leaders and with property managers in the City of Dandenong.

Resources/Funding:

CAV provided $84,131 over 12 months for the delivery of the project.

Process:

Community leaders, settlement support workers and property managers provided input into the development of the training program. CAV developed a one-day intensive training program and an educational DVD. A project manager employed at SCAAB recruited three bilingual trainers from the community with language skills in English and one each of Arabic, Dinka and Nuer. Training was provided to the bilingual trainers in a 'train the trainer' format over three one-day intensives. Each of the bilingual trainers recruited approximately ten Volunteer Community Educators from each of their communities. The bilingual trainers assisted CAV facilitators to deliver the training to the community educators. The community educators were provided with resources and a script to deliver the information sessions throughout the community through church groups, community groups and individual homes.

What did it achieve?

Twenty-eight members of the Sudanese community were directly involved in the delivery of the project as community trainers and community educators. 1,965 Sudanese community members attended education and information sessions. Evaluation of the project also identified an increased exposure and experience of Australian workplace and employment opportunities for Sudanese community members involved in the project.

Who was involved?

SCAAB and CAV managed the involvement of the community, community leaders, property managers and the TUV.

Learning points

Paid bilingual educators provide an effective mechanism to engage communities while also supporting individuals into employment.

Mental Health and Homelessness Partnership

A significant proportion of people who are homeless also have mental illnesses. Some studies suggest that up to 75 per cent of the homeless population have at least one mental illness. Co-existence of homelessness and mental illness appears to be mutually reinforcing, harming the health of people and posing challenges for service providers.

Through this Wangaratta partnership program, services acknowledged the need to address the housing circumstances of the mentally unwell. The program identified that pressure on services and role boundaries encouraged service gaps. In response, through collaborative planning, the program pooled resources to develop new service tools and established a transitional house to ensure those exiting the acute psychiatric unit were supported into secure housing.

Contact

Ruth Davenport
Program Manager
Mind, Trinity Community Support Services
Phone: (03) **5723 1000**
Email: **rdavenport@mindaustralia.org.au**

Aim

Prevent homelessness leading to readmission at an acute psychiatric facility and support the health of homeless people in Wangaratta.

Target group

People admitted to Kerferd Unit, Acute Psychiatric facility (north east Wangaratta) who are identified as homeless or at risk of homelessness with little or no stable and/or affordable long-term accommodation options on discharge.

Inequalities dimension

Homelessness: Insecure housing impacts on mental illness.

How did it work?

Structure:

In July 2002 a reference group was established and comprised representation from the mental health, Psychiatric Disability Rehabilitation Service, homelessness, housing and Department of Human Services sector. The 12 month project commenced at the end of 2003 and a 0.6 EFT position was created to employ a Project Officer.

Resources/Funding:

Each partner, including the Department of Human Services committed funds and in-kind support to demonstrate commitment to ensure the success of this project.

Process:

Agencies involved in provision of mental health care and housing in Wangaratta used a reference group to explore the issues that surround homelessness for people with a mental illness. Data from Kerferd Unit, Acute Psychiatric facility at North East Health Wangaratta suggested that up to five clients (inpatients) at any one time might be homeless. Pressure on existing services and role boundaries meant that this client group was unable to be serviced adequately and in a timely manner by existing providers.

The project involved a collaborative approach to the improvement of service systems across sectors. This included the development of referral forms and pathways, providing education to a number of real estate agents and caravan parks, gaining a greater understanding of service providers in the region, and provision of a transitional property for clients experiencing homelessness exiting Kerferd.

What did it achieve?

Thirty clients were identified with housing and accommodation issues upon admission to Kerford. All 30 clients received housing assistance. There has been no re-admission for clients who managed to secure safe, sustainable housing and support.

Who was involved?

Outreach Connection Program, NE Health-Integrated Primary Mental Health and acute unit staff, Mind-Trinity Community Support Services, Rural Housing Network, Hume Region Homelessness Network, the Department of Human Services, Psychiatric Services Consumer Consultant, Psychiatric Services Carer Consultant, Office of Corrections and Central Hume Support Services.

Learning points

Service gaps can be eliminated by collaborative service planning and combining service knowledge of need.

Public Tenant Employment Program

Gender Focus

Unemployment has become entrenched in some households who live in public housing. Unemployment has a high social cost, creating poverty, limiting opportunity and preventing full participation in society.

To leverage the broader economic and social opportunities consequent on public procurement, contractors to the Government's social housing program are required to employ a percentage of public tenants. The Public Tenant Employment Program (PTEP) has been operating since 2005. The PTEP created jobs for tenants; however upon review it was found that only six per cent of the jobs were filled by women.

The PTEP gender lens program rebalanced the PTEP. The program has ensured female public housing tenants now can take full advantage of employment opportunities.

> ***'This is an example of an enterprising approach to expand a program beyond its original brief to ensure better access for women.'***
>
> *Anne Minos, Manager*

Contact

Anne Minos
Manager Public Tenant Employment Program
Department of Human Services
Phone: (03) **9096 5224**
Email: **anne.minos@dhs.vic.gov.au**

Aim

To reduce the high level of worklessness for women in public housing by creating employment opportunities.

Target group

Women who live in public housing.

Inequalities dimension

Unemployment: women in public housing were unemployed and unable to access employment opportunities.

There are 73,000 people of working age living in public housing in Victoria. Only ten per cent of public housing tenants are working full time compared with 36 per cent in Victoria. Fifty-six per cent of public tenants are women. With the initial brief of the program only six per cent of PTEP job vacancies were filled by women.

How did it work?

Structure:

The program originated from Neighbourhood Renewal and is based in Property Services and Asset Management Branch of the Housing and Community Building Division of the Department of Human Services.

Resources/Funding:

The gender lens required no funding in addition to the resources allocated to the PTEP.

Process:

The initial approach of the PTEP was to encourage building contractors to recruit public tenants. The aim was to encourage gradual acceptance of significant cultural change. This approach raised awareness and generated support from contractors. Mandatory tenant employment clauses in contracts were then introduced and are accepted now as a condition of doing business.

To increase women's employment, the PTEP worked with the Department of Human Services program areas that traditionally had high numbers of female workers. These areas included childcare and allied health. Training partnerships were developed with TAFEs and Registered Training Organisations to provide accredited vocational training to prepare female tenants for employment.

The women were then able to take advantage of employment opportunities in other human service contracts as well as private enterprise employment.

What did it achieve?

PTEP has assisted 450 people into work and 700 into accredited training. The program is delivering better employment outcomes for women. The proportion of women in employment has risen from six per cent to 28 per cent, and the proportion in training is now 63 per cent (2008).

Who was involved?

Partnerships were developed with unions, training organisations, welfare and job network agencies and a service agreement was developed with the Commonwealth Department of Employment and Workplace Relations.

Learning points

Addressing inequalities can begin by simply asking questions about who benefits from existing programs and why, plus developing strategies to address imbalances.

Connecting Young Parents

Participation and achievement in education is recognised as having the potential to increase health and wellbeing outcomes. Increasing time spent at school is a key factor in long term wellbeing, social inclusion and health.

Studies show young mothers from low socio-economic backgrounds can face multiple challenges, have fewer family supports and not be involved in the formal education system. If pregnant young women and mothers who are school aged do not complete year 12 they can experience limited employment or education outcomes throughout life.

The Connecting Young Parents (CYP) program was developed after research supported by Upper Hume Community Health Service (UHCHS) identified unmet needs among teenage parents and young pregnant women. The CYP program has provided a range of co-ordinated support services for young parents including an eight-week entry-point care course called 'Caring for Kids', based on the TAFE Certificate III in Children's Services.

Contact

Ilena Young
Coordinator - Young Parents Program
Gateway Community Health
Phone: (02) **6022 8803**
Email: **iyoung@gatewaycommunityhealth.org.au**

Aim

To meet the needs of young parents through engaging pregnant women and young parents with local support services (youth, health, education and others) in the Albury-Wodonga area.

Target group

Pregnant and parenting young people aged under 20 years of age.

Inequalities dimension

Education: Pregnant young women and young parents need additional support to overcome barriers to education.

How did it work?

Structure:

After the completion of two research projects in 2004, funding was secured in 2005 to develop the program. A project facilitator worked with local services to develop a strong and sustainable reference group. Different parts of the program for young people were then developed by smaller working groups.

Resources/Funding:

Department of Families, Housing, Community Services and Indigenous Affairs provided core funding of $139,000 over two and a half years for program implementation. This has been supplemented by additional funding received for complementary projects.

Process:

CYP has developed a program for young parents that simultaneously delivers multiple outcomes: social networks; parenting knowledge; and strong connections to education. The program provides support for individuals but also offers an eight-week course ('Caring for Kids') with structured learning and support on a range of issues related to parenting.

The 'action research' based process enables the CYP network to remain flexible and responsive to local needs, prioritising evolving concerns as they come up, and taking advantage of opportunities that arise.

What did it achieve?

'Caring for Kids' has had a 64 per cent enrolment rate, with 59 per cent of enrolees attending over half the course. Over 40 per cent of participants had successfully re-engaged with education and/or employment at the conclusion of the course. Evaluation also showed that the course increased social connectedness, satisfaction with life factors and self-perception of parenting competence.

Who was involved?

The network responsible for CYP now includes over fifty agencies (youth, health, education, family services, homelessness, Indigenous and others).

Learning points

A well-designed yet simple program can deliver multiple outcomes simultaneously, and respond to young parents' wishes and needs by combining the expertise and support of multiple agencies.

Connect Central

Education and training are highly correlated with social, economic and health outcomes. Marginalised and vulnerable youth often experience barriers to education and/or training. Connect Central targets youth who are disengaged from education and employment.

The integrated assessment and referral (IAR) model was developed to make the education and training sector easier to negotiate for the at-risk cohort of young people, in the 15 to 19 year age group. Extensive case management support is provided for at risk young people with an aim of preventing these young people becoming early school leavers.

The model includes a primary assessment of the young person's needs, and a case management approach to ensure that after assessment occurs the young person can be supported over an extended period (at least six months). The options identified must be realistic, and offer opportunities for success, rather than continuing to create a revolving door where the young person simply moves from organisation to organisation for short periods of time without gaining any meaningful outcomes.

In September 2006, the Connect Central Consortium was formed to put in place the IAR model across three communities which included the Mount Alexander and Central Goldfields Shire and the City of Greater Bendigo.

Contact

Coral Hogan
Team Leader
Phone: (03) **5441 1444**
Email: **c.hogan@saintlukes.org.au**

Aim

To reduce the numbers of young people who are disengaged from education, employment and training.

Target group

Predominantly disengaged 15 to 19 year olds in the local government areas of City of Greater Bendigo, Central Goldfields and Mount Alexander Shires.

Inequalities dimension

Education: The initiative addresses the social, health and financial inequalities suffered by early school leavers. The initiative recognises the lack of societal opportunities experienced by early school leavers and the poor outcomes associated with lower levels of educational attainment.

How did it work?

Structure:

The consortium has a committee of management made up of representatives from each consortium member, as well as additional invited members. A leadership group of sector practitioners meets regularly throughout the year and provides advice regarding on the ground issues back to the consortium. The case management service is delivered through St Luke's Anglicare on behalf of the consortium and includes four staff. The service is supported in sector relationship management by staff from Goldfields Local Learning and Employment Network.

Resources/Funding:

Funding of approximately $200,000 per year is derived from Youth Transition Support Initiative funding. A further amount of in-kind staffing support equivalent to 0.5 FTE was derived from the Goldfields Local Learning and Employment Network (GLLEN). Administration and other support has been provided by consortium members, as well as contributions of time towards governance.

Process:

A typical young person's interaction with Connect Central is loosely divided into three interconnected phases. The first two phases cover Connect Central's assessment and assistance process. Although the partner providers assume more responsibility during the ongoing support phase, Connect Central maintains a strong interest in each client's progress to ensure a sustainable, positive outcome.

What did it achieve?

The program has been evaluated as part of the Victorian Government Youth Transition Support Initiative review and evaluation. 145 young people intensively case managed, with over 60 per cent sustained within education, employment and training, 20 per cent awaiting courses to commence and less than 20 per cent deemed to be not appropriate at the time for re-engagement with education, employment and training due to the nature of barriers they were experiencing. 119 young people at risk of dropping out, along with their families or other carers were provided with consultations to assist navigating the education, training, employment, health and welfare systems.

Who was involved?

Consortium members include: Bendigo Regional Institute of TAFE, Continuing Education Bendigo Inc, Bendigo Senior Secondary College, Catholic College Bendigo, St. Luke's Anglicare, Castlemaine Secondary College, Maryborough Education Centre, Future Employment Opportunities, and Bendigo Community Health. The establishment of this consortium has been facilitated by the GLLEN.

Learning points

The importance of a shared sector-wide response to the issue, for example sector governance.

WayOut

Homophobia is a form of discrimination known to have profound negative health impacts. The Victorian Government Youth Suicide Task Force identified that same sex attracted young people, particularly those in rural areas, were at a high risk of suicide.

In response, and recognising that around eight to eleven per cent of young people are same sex attracted, the WayOut project was developed to support young people.

> ***'Being from such an isolated hometown … the general opinion I am forced to live with daily … is that homosexuality is something that should be feared and hated … The atmosphere that I encountered upon the forum starting was incredible. Never before have I felt such an openness … everything is so totally comfortable … It is so far from anything that I have experienced and so far from anything I would ever begin to image to expect…'***
>
> *Young person, aged 16.*

Contact

Sue Hackney
Coordinator –Wayout
Phone: (03) **5421 1619**
Email: **sue.hackney@cobaw.vic.gov.au**
www.wayout.org.au

Aim

To raise awareness about the needs of same sex attracted young people and the nature and effects of homophobia in rural Victoria.

Target group

Young people in rural Victoria aged 15 to 24 years who are or think they might be attracted to people of the same sex. In addition, the peer group of these young people, staff in organisations and schools who work with these young people and the rural communities they live in.

Inequalities dimension

Discrimination: Studies have shown that same sex attracted young people are more likely to experience family conflict, encounter difficulties at school, experience abuse, become homeless, report high rates of drug and alcohol abuse and be at higher risk of suicide.

How did it work?

Structure:

The WayOut project commenced in January 2002 as a three year youth suicide prevention pilot project targetting same sex attracted young people in four shires in Central Victoria. A reference group was formed and consisted of workers from across the region.

The project team was committed to youth participation in the design and delivery of services and at the earliest possible point we sought to engage local young people. Following initial consultations with same sex attracted young people in Macedon Ranges Shire, the first local working committee of young people was established. The group members stated that they didn't want to have a group exclusively for same sex attracted young people, rather they wished to involve their 'straight' (ie. heterosexual) friends. Consequently membership was open to all young people who shared the project's aim.

Resources/Funding:

The project was funded $255,000 by the Department of Human Services over three years and this provided for the employment of a project coordinator four days per week, an external evaluation and the establishment of a brokerage fund. The project continues to be auspiced by Cobaw Community Health (Kyneton) and since 2006, has operated as a partnership between Cobaw and Gay & Lesbian Health Victoria. Over the past two years, the project has received one-off grants from VicHealth, The Reichstein Foundation and the Myer Foundation.

Process:

The project has involved a diverse range of activities aimed at providing a community of support to young people and building awareness of homophobia. Action has included the production of material (t-shirts, stickers, posters etc), public advocacy (articles in the local newspaper, a forum for young people on how to reduce homophobia in their community) and service education (partnerships with rural services).

What did it achieve?

The WayOut project has had spectacular success in raising awareness of discrimination, homophobia and its health impact in rural areas of central Victoria. The project has supported a significant number of people in these communities to take action for change in their professional and personal lives.

Learning points

Young people are the experts on how to best make change for the benefit of themselves or other young people.

Bridging the Digital Divide

Social connections, inclusion and feeling a sense of control over your life are important pre-conditions for health and wellbeing.

Bridging the Digital Divide uses information and communication technology (ICT) to promote civic participation and social connectedness among young people aged 16 to 25 who experience or are at risk of experiencing social, economic or cultural marginalisation.

The program partners with youth-serving organisations to deliver 'Youth Action Workshops'. The workshops utilise multimedia technology as an engagement tool. They also act as a mechanism for marginalised young people to take action on issues that concern them and to generate diverse content for the ActNow website (www.actnow.com.au).

The project was piloted in Victoria by the Inspire Foundation (www.inspire.org.au) with support from VicHealth and the Westpac Foundation. The model is now delivered across Australia.

Contact

Ms Philippa Collin
Inspire Foundation
Phone: (02) **8585 9300**
Email: **pippa@inspire.org.au**
www.actnow.com.au; www.inspire.org.au

Aim

To promote civic participation and social connectedness via ICT.

Target group

Young people aged 16 to 25 who experience or at risk of experiencing social, economic or cultural marginalisation.

Inequalities dimension

Civic participation and social connectedness: ICT is now an important source of social connection for young people. ICTs also provide an important avenue for civic participation. Inability to use or access ICT creates a digital divide.

How did it work?

Structure:

In the first phase of the project, community consultations and research involving 16 focus groups were held at 12 organisations and 97 young Victorians participated. The young people were from diverse backgrounds and each were identified as currently experiencing, or at risk of experiencing social, cultural or economic inequality and/or disadvantage. This research was conducted with the support of the Orygen Youth Health Research Centre at University of Melbourne.

The key themes examined included the impact of ICT on young people's social relationships; the role of ICT in skill development as well as information provision and communications; the use of ICT by young people to exercise citizenship and civic engagement; the digital divide created by lack of access to ICT; and organisational capacity of youth and related services to utilise ICT to promote social connectedness and civic engagement.

Resources/Funding:

Funded by VicHealth and the Westpac Foundation. Research supported by Orygen Youth Health Research Centre at the University of Melbourne.

Process:

Youth Action Workshops were piloted in youth services in Victoria. These aim to motivate, inspire and assist young people to identify what they are passionate about changing in their world and provide them with the tools, skills and opportunities to get started. Participants in the workshops took action on issues ranging from local pedestrian safety through to climate change and human rights. The workshops are also an opportunity for young people to meet new people, and share stories and experiences about taking action and their visions for their world. These stories are being collected for publication on the ActNow website, which also serves a platform for getting the messages of marginalised young people out to the wider community.

What did it achieve?

In the initial 12 months of the project, seven pilot workshops were implemented in a range of settings, engaging a total of 114 young people. The young people generated 33 individual actions, four group/collective action plans and 35 vision stories.

Seventy-nine per cent of workshop participants reported they now feel like they can make a positive difference. Eighty per cent of workshop participants reported feeling confident to apply skills learned in the workshop in the future.

Eighty-seven per cent said the workshops made them more aware of how they could take action.

Who was involved?

The project was led by the Inspire Foundation and involved numerous community partners.

Learning points

Participatory action research facilitated involvement of young people in the project design and delivery and ensured that the practical aspects of this project (such as the workshops and the research) were relevant to participants.

Adds Up

For young people, difficulties at home often co-exist with difficulties at school, behavioural problems, health and other issues.

Sometimes support for these young people requires an individual response where services can come together and work with the young person to ensure their needs are met.

The Adds Up program was initiated by St Luke's in response to the high number of young people (15 and under) in Out of Home Care in the Bendigo area who were disengaged from mainstream education and/or denied access to education due to behavioural issues. The program creates an individualised education plan with each young person and supports their achievement of agreed goals.

Contact

John Bonnice
General Manager
Children, Youth and Family Services
St Luke's Anglicare
Phone: (03) **5440 1100**
Email: **j.bonnice@stlukes.org.au**

Aim

To improve the educational and social outcomes for young people aged 15 and under who have become disengaged from school.

Target group

The target group for the program is young people aged 15 and under who are in Out of Home Care and/or linked to youth/family support services in the Bendigo sub-region. The program is for young people who are disengaged from school and there is little likelihood that they can easily be placed back in school without the support of an educational bridging program.

Inequalities dimension

Education: Vulnerable young people require adaptable service models that can support their access to education.

How did it work?

Structure:

The program is managed by St Luke's youth resource team in partnership with the local office of the Department of Education and Early Childhood Development. These two organisations meet regularly to review the program. St Luke's also reports to the school principals on the progress of each student and the overall program. The enrolment program is coordinated by St Luke's youth resource team leader and managed on a day-to-day basis by four secondary school teachers employed in the program.

Resources/Funding:

Funding is generated by the enrolment of the young person at a local school ($5,800 per participant). The school isolates these funds and allocates them to be spent on the individual in the program. Some additional funds are generated through individual brokerage funds from the Department of Human Services. In 2008 an additional $20,000 was granted by the Department of Human Services to the program. Schools also provide educational resources for the program. Funding has been received by the Department of Education and Early Childhood Development to conduct an evaluation of the program during 2008.

Process:

An education team is formed to support the young person's education. Included in the team are the young person, their family, a St Luke's or Department of Human Services caseworker, school representative and a staff member from the program. An education plan is developed with the young person and how this can be achieved is identified. The plan is based on a young person's interests and learning goals. St Luke's, in conjunction with the caseworker, develops educational programs and options for the young person to consider. Programs are identified and put in place to meet the young person's educational goals. The education team meets regularly with the young person and family to review the plan and progress and to celebrate successes.

What did it achieve?

Of the 18 participants in 2007, eight returned to mainstream education, one started a pre-apprenticeship course, seven maintained participation in the program for the full year and two did not did not fully engage in the program.

Learning points

Use the interests, strengths and capacities of young people to build an individual educational program.

Transport Connections – Southern Mallee and Wimmera

The Victorian Government established the Transport Connections Program in 2003 to address the access and mobility needs of transport disadvantaged communities and individuals in rural and regional Victoria.

The Transport Connections Program is a joint initiative of the Department of Human Services, Department of Infrastructure (DOI), Department for Planning and Community Development (DPCD) and Department of Education and Early Childhood Development (DEECD).

> ***'Improving transport connections between communities will give Victorians access to jobs and services, as well as their family and friends.'***
>
> *Meeting our Transport Challenges*

Contact

Margo Northey
Senior Program Officer
Department of Planning and Community Development
Phone: (03) **9208 3229**
Email: **Transport.connections@dpcd.vic.gov.au**

Aim

To improve existing transport options.

Target group

Transport Connections is delivered throughout Victorian rural, regional and interface municipalities. This profile is based on the Southern Mallee and Wimmera program.

Inequalities dimension

Transport: Accessible and affordable transport is crucial for enabling people to participate in social networks, in employment and in education. Provision of transport is particularly important in rural settings where there are substantial distances between places.

How did it work?

Structure:

Funding is provided to help communities set up working groups, employ a coordinator and develop a range of transport initiatives.

In the Southern Mallee and Wimmera region, working with the Government, Tyrell College, Sea Lake District Hospital and the community, the Transport Connections groups brokered a partnership to develop an innovative transport solution, using existing assets.

Resources/Funding:

Transport Connections is an $18.3 million Victorian Government investment.

Process:

Through local partnerships and the use of existing assets and services such as taxis, school buses, community buses and volunteers, communities are able to develop innovative approaches that can make participation in community life easier for people with limited access to transport.

The Southern Mallee Transport Connections project allows senior citizens on a school bus route to use the spare seats to travel to Sea Lake. Additionally, a low-cost weekly service for the general public to travel between Sea Lake and Swan Hill has commenced.

What did it achieve?

The external evaluation reported that Transport Connections has empowered the community to develop solutions to transport issues. Access to transport in most areas has increased. Where accessibility has improved, the independence of individuals had also improved.

Koori Courts

Koori people are greatly over-represented in the criminal justice system and are 12 times more likely than non-indigenous people to be placed in an adult prison. Koori contact with police has increased by 31.5 per cent over the last five years.

The Koori Court, a division of the Magistrates' Court, sentences Indigenous defendants who plead guilty. All offences that can be heard in the Magistrates' Court, except family violence and sexual offences, can be heard in the Koori Court. A Koori Elder or Respected Person, a Koori Court Officer, the defendant and their family can contribute during the Court hearing.

The Koori Court provides an informal atmosphere and allows greater participation by the Aboriginal community in the court process. The magistrate sits at a table with the participants, not at the bench. The defendant, the defendant's family, and the magistrate then discuss the matter in plain English, not in legal language. The Court reduces perceptions of cultural alienation and tailors sentencing orders to the cultural needs of Koori offenders.

The success of the pilot program has seen the expansion of the Koori Courts, and Victoria currently has seven adult Koori Courts (Shepparton, Broadmeadows, Warrnambool, Mildura, Moe/Latrobe Valley, Swan Hill, and Bairnsdale). There are also two Children's Koori Courts, located at the Melbourne Children's Court and in Mildura.

Contact

Mason Atkinson
Manager, Koori Courts
Magistrates' Court of Victoria
Phone: (03) **9603 9415**
Email: **mason.atkinson@justice.vic.gov.au**

Aim

The aim of the Magistrates' Koori Court initiative is to improve Indigenous criminal justice outcomes and increase Indigenous confidence and positive participation in the law.

Target group

Koori offenders who have pleaded guilty to crimes within the jurisdiction of the Magistrates' Court.

Inequalities dimension

Justice: Over-representation of Indigenous people in the Victorian justice system. The Koori Courts are a part of the Victorian Government's approach to working in partnership with the Koori community to reduce the high level of disadvantage and inequality.

How did it work?

Structure:

The Criminal Law Policy section of the Department of Justice (DoJ) employed an Indigenous Project Manager in 2001 and a Statewide Working Group was formed to facilitate the development of the Court. The Statewide Working Group consulted extensively with the Aboriginal Justice Forum (comprising representatives from a range of Aboriginal community organisations and also key government departments) during this phase.

In April 2002 the Aboriginal Justice Forum decided that the first Koori Court would be located at Shepparton and it was also determined that a metropolitan Court would be established at Broadmeadows. With the expansion of the Koori Courts, the Koori Programs & Initiatives Unit was established within DoJ to oversee the establishment of new Koori Courts, and in 2006 the Koori Court Unit in the Magistrates' Court of Victoria was established to oversee the operations of the Koori Courts.

Resources/Funding:

DOJ internally reprioritised a small amount of its base funding to pilot the implementation of the Magistrates' Koori Court in 2002. This pilot was successful and the department has been able to obtain significant specific funding to secure the continuing operation of the program.

Process:

Specialised Koori Court Officer positions were created for each Koori Court. They build relationships with stakeholders, liaise with the defendant and their family before and after the case is heard, assist the defendant in accessing support services or provide more information about the court processes. The Koori Court Officer is also able to assist Indigenous defendants who are not appearing in the Koori Court.

The role of the Aboriginal Elder and Respected Person is to provide cultural advice and background information about the defendant (and if appropriate, the victim) that may assist the Magistrate to understand the reasons for the offending behaviour.

What did it achieve?

An independent evaluation of the Magistrates' Koori Courts found they have achieved significant outcomes targeting the disproportionate representation of Kooris in the justice system.

The evaluation found that Koori Courts had reduced the levels of recidivism amongst Koori defendants, achieved reductions in the breach rates for community corrections orders and the rates of Koori defendants failing to appear for their court dates, and increased the level of Koori community participation in, and ownership of, the administration of law. The Koori Courts have also reinforced the status and authority of Elders and Respected Persons, thereby strengthening the Koori community.

Learning points

Working in partnership with the Koori community to develop, establish and implement justice responses is effective.

The Bridge Project – supporting young people in the justice system

The YMCA has been in partnership with Victorian Youth Justice since 1993. For 15 years, the YMCA has been the only non-statutory agency to have contact with every young person in custody across Victoria on a daily basis, delivering recreation, lifestyle and personal support programs to build meaningful long-term relationships.

The Bridge Project combines the expertise of the YMCA with leaders of the business, corporate and community sectors to provide support and meaningful employment opportunities for young people involved in youth justice.

The Bridge Project facilitates a cross-sector partnership approach to deliver on its vision of '*a safer, more supportive society where all young offenders seeking to improve their life outcomes are accessing meaningful opportunities to do so, and are successful in becoming valued members of the community.*'

After the success of the 2007-08 pilot program, the Bridge Project seeks funding for expansion into the future.

Contact

Sherilyn Hanson
The Bridge Project Manager
Phone: **0421 177 569**
Email: **sherilyn.hanson@ymca.org.au**
www.bridgeproject@ymca.org.au

Aim

To provide meaningful education, training and employment opportunities to young offenders, with the aim of empowering young people to become valued members of the community.

Target group

Young people involved with Youth Justice in Victoria aged 16 to 21.

Inequalities dimension

Justice: Young people with a significant history of involvement in the criminal justice system are often stigmatised as a result of this involvement. Fifty-seven per cent of individuals with a criminal record report having trouble finding employment post-release due to their criminal record.

How did it work?

Structure:

The Bridge Project is a program of the Victorian YMCA run in partnership with Youth Justice Victoria. The Bridge Project is also supported by a Community Council that provides advice and assistance on developing the program. There are a range of other stakeholders and partners involved in the delivery of support.

Resources/Funding:

The YMCA received $480,000 funding over two years from the Victorian Government's Workforce Participation Partnerships (WPP) program to help fund the Bridge Project's initiatives in the area of training and employment for 45 young people (supplemented with significant funding from YMCA Victoria and other sources).

Process:

Opportunities are provided to the young people in custody in the areas of healthy choices, personal support, certified training and economic and social participation of the young person upon release back to community through workforce engagement.

The Bridge Project knows that meaningful work opportunities are a key to solving the re-offending puzzle. Work placements within the community attract the participation of the young offender; they offer a supported environment for developing workplace skills, and serve as a vehicle for constructive social engagement and skill building.

What did it achieve?

By 2007–08 the impact of The Bridge Project resulted in:

- Safer communities – zero per cent re-offending rate amongst the fifty participants;
- Strong partnerships – fifty-five empathetic employers providing work opportunities for young offenders;
- Supportive work environments – forty young offenders successfully completing their work placement and remaining in ongoing work;
- Increased awareness - five hundred people from the Government, corporate and philanthropic sectors in attendance at Bridge Project Breakfast;
- Reduced Recidivism - The Bridge Project employment support model has achieved unprecedented and significant result in Victorian Youth Justice given the current rate of recidivism is 67 per cent.

Learning points

Provision of financial subsidies and individual support options is essential to encourage participation and offset costs of potential employers.

Evaluation of effectiveness requires funding.

3. Promoting health for all

This dimension supports action to enable health promotion and disease prevention opportunities to reach all Victorians. Exposure to disease risk factors such as smoking, unhealthy eating and health damaging environments is socially patterned and unequal. The growing burden of chronic disease and its concentration among the disadvantaged heightens the significance of health promotion and prevention activities being more effective in reaching all Victorians.

The case studies in this section reflect the different approaches that can be adopted by health promotion practitioners. These case studies also reflect the seven Victorian health promotion priorities. The overarching aim of these priorities is to improve overall health and reduce health inequalities. The seven priorities are:

1. Promoting physical activity and active communities
2. Promoting accessible and nutritious food
3. Promoting mental health and wellbeing
4. Reducing tobacco-related harm
5. Reducing and minimising harm from alcohol and other drugs
6. Creating safe environments to prevent unintentional injury
7. Promoting sexual and reproductive health

Where you can find out more about this dimension:

Victorian health promotion home

www.health.vic.gov.au/healthpromotion/index.htm

People, places, processes: a comprehensive guide to health promotion processes to reduce inequality

www.vichealth.vic.gov.au/Resource-Centre/Publications-and-Resources/Health-Inequalities.aspx

Best Practice Portal for Health Promotion (Canada)

cbpp-pcpe.phac-aspc.gc.ca/

Health Nexus (Canada)

www.healthnexus.ca/services/resources.htm

Four steps towards equity: a tool for health promotion practice (NSW)

www.health.nsw.gov.au/pubs/2003/pdf/4stepstowardsequi.pdf

Darebin Alcohol Strategy

The number of alcohol outlets in an area is associated with increases in alcohol consumption, which in turn leads to an increase in alcohol-related harms. These harms include impacts on individuals through assaults, accidents and injury, as well as through social harms such as drink driving offences, noise disturbances and vandalism.

A review of available data on alcohol-related harms in the Darebin area, alongside a community health planning consultation with local stakeholders and service providers, identified alcohol as a key issue of concern to be addressed by Darebin City Council. Using seeding funds from the Department of Human Services and Council resources, an alcohol management strategic plan was developed. This plan introduced more stringent planning controls and assessment of new liquor licences and was developed within the overarching Community Health and Safety Planning Framework which had identified health inequalities as a key priority.

The strategy is now a national model for how local government can manage alcohol problems through planning and regulation controls, and resulted in the first successful case of objecting to a liquor licence on the grounds that it would substantially contribute to local alcohol-related harms.

Contact

Mark Boyd
Director - Cities for Safe and Healthy Communities
ICLEI
Email: **mark.boyd@iclei.org**

Aim

To reduce alcohol-related health inequalities in Darebin.

Target group

Planning processes within Council.

Inequalities dimension

Alcohol: Residents in areas of higher disadvantage in the Darebin community experience greater alcohol-related harm. There is also a concentration of alcohol outlets in these areas.

How did it work?

Structure:

The plan was developed as part of the Darebin Community Health and Safety Policy Framework which had identified four key priorities, the first being to reduce health inequalities in Darebin. The stakeholders overwhelmingly endorsed alcohol as a key issue to respond to through Darebin Council's available policy levers.

Resources/Funding:

Financial support of $60,000 was provided by the Department of Human Services to assist in planning processes. This funding contributed to the employment of a policy coordinator to manage the development of the plan. Funding from Darebin City Council was also contributed.

Process:

Following consultation, a data snapshot of local harms was created, based on available evidence on the link between outlet density and community health and wellbeing harms. Policy levers available to local government were reviewed to ensure that Council operated within its sphere of influence and focused on its potential to act effectively. The policy coordinator worked across Council to build support for changes in planning and regulatory processes across the organisation to assess liquor licences based on a harm prevention model. Partnerships with the Police – particularly the District Inspector – were enhanced to ensure a collaborative approach was taken. Councillors were briefed on the strategic plan before it was endorsed at a Council meeting.

What did it achieve?

The strategy resulted in changed processes within Council in the assessment of new liquor licences in areas of high disadvantage where there was already high liquor outlet density and high levels of community harm. A test case in the Liquor Licensing Tribunal successfully objected to a new bottle shop from starting business in a low socio-economic area with existing high levels of alcohol harm. This model has now been used to highlight deficiencies in the current system and to encourage other local governments across Australia to minimise alcohol-related harms, particularly in areas of high disadvantage.

Who was involved?

Consultation with local stakeholders gave the Council a mandate to take action. The key relationships were within Council, particularly across other departments such as planning and economic development to support use of land use powers. The Police were central to demonstrating the exponential increase in new liquor licences in the area and the corresponding increase in assaults and other social harms.

Learning points

An overarching policy platform that prioritises health inequalities allowed the alcohol plan to have a clear goal.

Availability of local data proved the need for Council to act.

NEAMI Smoke-free psychosocial services

As the rates of smoking in the general Australian population over the past 20 years have steadily decreased, there is evidence to suggest that the rate of smoking for those experiencing serious mental illness has remained relatively steady. Research indicates up to 60 per cent of people with a mental illness smoke (compared to 17 per cent for the overall population). Tobacco use is acknowledged as the leading preventable cause of early death. In addition, smoking costs individuals financially, socially and contributes to the impacts of poverty amongst people on low incomes.

Neami is a psychosocial rehabilitation support provider that works with and on behalf of people with serious mental illness. Neami identified smoking as a key occupational health and safety issue for consumers of their services as well as for staff. Following an education campaign with staff and consumers, Neami instituted an organisational policy to ban smoking on all Neami premises from 1 September 2008.

In support of the complex issues surrounding smoking within a community mental health service, Neami has introduced a comprehensive Smoke Free program for all consumers and staff of its services. This includes the development of smoking policies, education and training programs, access to behavioural intervention programs and resources through an organisational change management process.

Neami has provided an important example for all community mental health service providers and supported important research on best practice. As a result the New South Wales Mental Health Co-ordinating Council has established the 'Breatheasy' project which has developed models to reduce smoking among clients of mental health services.

Contact

Neami Service Delivery Team
Angela Caruso
Senior Policy & Project Officer
Phone: (03) **9481 3277**
Email: **angela.caruso@neami.org.au**

Aim

To provide a non-smoking environment for people with a serous mental illness who access psychosocial rehabilitation services.

Target group

People with serious mental illness engaged in Neami's services.

Inequalities dimension

Smoking: Smoking rates are much higher among people with a psychiatric disability than for the general community. There is often an implicit acceptance of smoking within mental health services and amongst this population. Research indicates those with a serious mental illness have the same motivations and levels of interest in quitting smoking as the general population.

How did it work?

Structure:

Following consultation with Neami consumers, a smoke free program was developed to support people with a serious mental illness to reduce and/or quit smoking. During the delivery of the Quit program, it was found participants of the program were required to pass a common area in which a larger number of consumers would congregate to smoke. This created an inconsistent approach, and as a result Neami focused on the environment they were creating and instituted a service-wide smokefree policy. Quit programs have become a regular aspect of service delivery and are delivered on a regular basis. Evaluation researchers were contracted to monitor the impacts of the smokefree policy on consumers' smoking rates.

Resources/Funding:

Neami resourced the quit groups. Neami provided $50,000 to do follow-up evaluation and research.

Process:

The program included trained support workers to deliver the Quit programs, and organisational policies to institute a smoke-free environment. The process required strong leadership as this was a significant cultural change that met with some resistance, particularly from consumer advocacy organisations who feared that consumers would be 'forced to stand in the rain' to have a cigarette and that this was a pleasure consumers should not be denied.

What did it achieve?

Twelve per cent of service users who were smokers have successfully quit smoking so far. Overall rates of anxiety amongst consumers dropped as there was less 'protecting' of cigarettes and a stronger social engagement process as consumers stopped leaving the service individually to smoke and instead talked more in groups. Consumers reported delaying smoking and thus smoking less due to the 'hassle' of going outside to smoke. Admission to a psychiatric unit is a key opportunity to encourage smoking cessation amongst this population group, particularly when there is an environmental context of a smokefree policy. As an unexpected outcome, staff smoking rates also dropped.

Who was involved?

Staff and clients of Neami services. The SANE Quit program was used to run the Quit programs.

Learning points

Leadership is required to maintain significant policy changes at the organisational level. Education of staff and consumers assists in maintaining momentum in a change agenda.

‘Go for your life’ Be Active, Eat Well

While obesity is a community-wide problem, solutions have not always been tailored to reach children from low socio-economic backgrounds. The ‘Go for your life’ Colac Be Active, Eat Well program has reduced unhealthy weight-gain among children from a low socio-economic area.

The township of Colac was identified as a suitable location to pilot the *Be Active Eat Well* approach due to its small population size, relative degree of social disadvantage and community strengths such as existing networks, leadership and skills. The program has worked by supporting behaviour change plus acting on the whole community environment known to influence obesity. For example, the program has seen the local council improve maintenance of footpaths used by Walking School Buses, introduced by local primary schools to encourage more children to walk to and from school.

The initial success of the pilot program in Colac resulted in additional funding for community-based projects targeting primary school aged children (*Fun ‘n’ Healthy in Moreland*) and adolescents in secondary schools (*It’s Your Move*). This has since seen the expansion of the initiative to six new sites in metropolitan and regional Victoria. One works with an Indigenous community and uses the *Be Active Eat Well* whole-of-community based approach to promote healthy eating and physical activity with Indigenous Victorians.

‘Promoting healthy eating and physical activity policies and activities in children’s settings such as schools, encourages families in greatest need to make healthy changes.’

Project Coordinator, Ruth Cuttler.

Contact

Department of Human Services
Phone: (03) **9096 0400**
www.goforyourlife.vic.gov.au

Aim

To improve the health and wellbeing of individuals and strengthen the Colac community through healthy eating and physical activity promotion.

Target group

Children aged four to twelve years old and their families in the rural Victorian town of Colac.

Inequalities dimension

Obesity: In Colac, as in most of Victoria, obesity levels rise with each greater degree of socio-economic disadvantage. The obesity prevention strategies developed through the program aimed to reach children in disadvantaged families.

How did it work?

Structure:

A project coordinator worked with a Reference Committee and a Local Steering Committee. The Reference Committee provided strategic input and its membership included the Department of Human Services, Deakin University, Colac Area Health and Colac Otway Shire. Membership of the Local Steering Committee reflected key partners for program implementation including the local health service, shire council, sports assembly, Neighbourhood Renewal program, primary schools, childcare services, parents, and Deakin University.

Resources/Funding:

The Department of Human Services provided core funding of $400,000 from 2002–06 (one year of preparation, three years of intervention). Deakin University provided the support, training and evaluation for the project and this was funded by the Department of Human Services, the Australian Department of Health and Ageing and VicHealth.

Process:

Community stakeholders participated in a planning forum to determine the target group and settings, identify and prioritise the interventions and develop a social marketing campaign. The action plan outlined a multi-setting, multi-strategy approach to obesity prevention addressing behavioural and environmental influences. The action included policy development, environmental change, parent education, community programs, social marketing, and curriculum changes. Action focused mainly on the primary schools but also through other settings (kindergartens, schools, sport and recreation facilities, fast food outlets, health services and neighbourhoods).

What did it achieve?

Children in Colac had significantly lower weight gain (by an average of one kilogram), and waist growth (by three centimetres) than children in a control group.

Be Active Eat Well is the first obesity prevention program to show significant reductions in the difference in weight gain across different socio-economic groups. At the completion of the program, the relationship between weight and socio-economic status identified prior to commencement no longer existed in Colac, but remained for children elsewhere in the region.

Who was involved?

The Department of Human Services engaged Deakin University as program partners with a role in evaluation, training and support. Key local stakeholders involved were Colac Area Health, Neighbourhood Renewal, the Colac Otway Shire and local community.

Learning points

Engaging the community in re-shaping environments that support healthy eating and physical activity is essential to deliver benefits to those most in need.

Braybrook Maidstone Healthy Canteen

Making healthy eating the easy option for children can also help boost local employment and support the life skills of participants.

The Braybrook Maidstone Healthy Canteen Enterprise is an example of an Employment Support Initiative implemented in a Neighbourhood Renewal site. Eleven Braybrook Maidstone residents were recruited to participate in a project which included a combination of training in Victoria University's Certificate II in Hospitality (Kitchen Operations) and work in Footscray City Primary School (FCPS) canteen to deliver healthy, culturally appropriate lunches to students.

Contact

Frances Newell
Victoria University
Phone: (03) **9919 8741**
Email: **Frances.Newell@vu.edu.au**

Aim

To support unemployed Braybrook Maidstone residents to enter the workforce, and to provide a healthy multicultural canteen service for Footscray City Primary School.

Target group

Residents of Braybrook Maidstone Neighbourhood Renewal.

Inequalities dimension

Healthy eating and unemployment: The program aimed to address barriers to unemployment while also providing education and understanding about healthy food options.

How did it work?

Structure:

FCPS and Victoria University signed a memorandum of understanding to collaboratively deliver this project. The school agreed to be the host employer for the participants. The University managed the project including participant recruitment and support, liaison with partners, business planning, and post-placement support. Victoria University provided hospitality training. The Council facilitated resident participation by ensuring the hospitality training could be delivered locally at the Maidstone Community Centre. Adult Multicultural Education Services provided advice on operating a school canteen as a social enterprise.

Resources/Funding:

Funding by Victoria University, Maribyrnong Council and Neighbourhood Renewal Funds totalled $85,366 and was used for program support (project manager, police checks, materials and equipment, administration and coordination), hospitality training (Certificate I and II), Maribyrnong Council kitchen equipment and a Canteen kitchen upgrade.

Process:

The project included Certificate I in Hospitality (Kitchen Operations) for 32 residents who expressed interest in participating in the Healthy Canteen Project. From this group, 11 Braybrook Maidstone residents were enrolled in Certificate II in Hospitality Project group (included two sole parents and nine African women, not previously in work or training).

All 11 participants worked in the FCPS Canteen one day per week from July to December 2007. In addition, each participant was rostered for additional work including food service for catering jobs and customer service for the after school market.

What did it achieve?

The program gave participants the opportunity to build on their life skills and experience a realistic introduction to the workplace. There has been 100 per cent student retention with 85 per cent achieving competency at Certificate II level. Eleven of these participants had employment outcomes in 2007 with six commencing work in 2008.

The income from the canteen has ensured the canteen remains sustainable, students are choosing healthier eating options and improving their capacity to learn.

Who was involved?

Victorian University, Neighbourhood Renewal, FCPS, Maribyrnong City Council, and AMES.

Learning points

The success of the project relies on the provision of tailored personal support to participants relevant to their specific cultural, health and training needs.

Residents Making A Difference - Whitehorse

People living in public housing are likely to experience higher levels of illness and chronic disease related to the social, environmental and economic conditions in which they live.

A consultation with community members in three public housing estates in the Whitehouse area identified lack of access to opportunities for physical activity as a key health issue. A number of barriers against participation were also identified, including: lack of knowledge of appropriate physical activity options for their age and states of health; lack of local and accessible opportunities for physical activity, poor access to public transport making it difficult to travel outside the estate and lack of 'control' over the estate environment, in particular the development and maintenance of gardens and access to an adjoining council parkland reserve.

A partnership between some key local agencies, such as the tenancy and housing support agency, the Council and local Community House now works with the community on improving neighbourhood and living environments to create a healthier, active community.

Contact

Olive Aumann
Health Development Manager
Whitehorse Community Health Service
Phone: (03) **8843 2233**
Email: **oaumann@wchs.org.au**

Aim

To create a neighbourhood environment that supports active community opportunities for residents at Eastbridge estate.

Target group

A group of 54 older residents in a clustered public housing estate in the City of Whitehorse (age range 55 to 93 years).

Inequalities dimension

Physical Activity: The overall picture of health and wealth in the City of Whitehorse masks considerable variation. The 2004 Whitehorse Population Health Survey demonstrated high levels of chronic disease among public housing tenants. Lack of physical activity is a key risk factor for these diseases.

How did it work?

Structure:

A Whitehorse Community Health Service (WCHS) physiotherapist and dietitian have been working in partnership with community members and other key stakeholders. Key engagement strategies include weekly outreach on the estate, a community newsletter, monthly resident and partnership luncheon meetings, health education workshops and a number of community wide events and celebrations. Residents also formed small working groups to work on their priorities together.

Resources/Funding:

Funding has been allocated each year as part of the WCHS Health Promotion Plan budgets.

Process:

WCHS and partner agencies work within a participatory action research framework so that community concerns are identified and addressed along the way and the process of residents working in small groups together means that solutions are generated, owned and where possible implemented by them. For example, residents mapped their preferred walking routes then undertook neighbourhood walkability audits using the National Heart Foundation 'Healthy by Design' audit tool.

What did it achieve?

Neighbourhood environment & safety improvements: footpath repairs, parkland access path redevelopment, park bench installation, ramp installation at community hall, housing safety upgrades, improved estate signage and road intersection improvements. A weekly exercise program in the local hall, provided by Council's Leisure Centre staff and WCHS fitness instructor. Improved access to public transport (such as a new Sunday bus service and improvements to bus stops at Mitcham station). Empowered residents who are now more able to advocate to agencies and departments on their own behalf. Advocacy and significant consultation with council departments in the partnership recently culminated in the development of a ten-year Council plan for the neighbourhood and upgrading of local amenities.

Who was involved?

In addition to WCHC, partners have included the Council, Wesley Harrison Information Support & Housing and Mitcham Community House and the residents.

Learning points

Developing trust and rapport between and among community members and partner agencies is critical to success.

Rumbalara Healthy Lifestyles Program

Rumbalara Football and Netball Club (Rumba) is a positive and safe place for players and supporters to meet and enjoy sport. As well as providing the opportunity for club members to participate in a local competition, Rumba is a focal point for supporting improved health, education, cultural and social outcomes.

The Club has operated its Healthy Lifestyles program in partnership with the University of Melbourne and the Rumbalara Aboriginal Cooperative since the Club commenced in league competitions. The program includes a range of activities such as preventing and/or managing smoking and alcohol consumption, gym programs for over 45s to build muscle mass (in partnership with the International Diabetes Institute), information and advice on a healthy diet and nutrition, and the provision of fresh fruit for all players at training and on game day.

A holistic model of wellbeing is used to demonstrate how many elements of an individual's life contribute to their sense of wellbeing. The model incorporates a sense of control, managing threats, connectedness, history and relationship with the mainstream.

Whilst it is referred to as a 'program', Rumbalara Healthy Lifestyles is a fundamental element of the Club's whole operations.

Contact

Michael Bissell
CEO
Shepparton VIC
Phone: **0413 016 073**
Email: **michaelb@kric.org.au**

Aim

To improve the health, wellbeing and social connection of the Koori community in the Goulburn Valley, Victoria by leveraging the Indigenous community's passion for sport and using the resources and goodwill associated with the Rumbalara Football and Netball Club.

Target group

All players and members of the Club. This includes elders, supporters and 'non-playing' community members.

Inequalities dimension

Health promotion: The program enables Aboriginal and Torres Strait Islander people to access health promotion initiatives focused on healthy lifestyles (including diet, nutrition, physical activity, smoking and alcohol).

How did it work?

Structure:

Healthy Lifestyles is a core element of the Club's function, it is fundamental to the operation of the Club. The Club has had a healthy lifestyle coordinators role for five years that is responsible for managing all aspects of the program. Two of the major requirements of the role are to report all activities and outcomes to the Board and to organise the activities for the substantial number of volunteers, who are critical to the success of the program.

Resources/Funding:

The program is funded from a range of Rumba sponsors and supported by expertise from Rumba's specialist staff. The program uses Club equipment and facilities and connects with other regional organisations, such as the YMCA Gymnasium and Njernda Aboriginal Cooperative in Echuca, the Viney Morgan AMS and the Rumbalara Aboriginal Cooperative.

Process:

The planning cycle for the program is built into the strategic planning and budgeting of the RFNC with specific project plans being required of the coordinator. The RFNC budget plays a large role in guiding the resources available to the program.

What did it achieve?

Evaluation undertaken by the University of Melbourne, School of Rural Health found:

- Increased consumption of healthy foods, particularly fruit
- Increased self esteem and awareness of health issues by young people that were taken into the home and influenced the purchasing behaviour of parents
- Increased skill and capacity of all participants in a number of areas including providing employment and training opportunities to community members
- Encouragement and opportunities to improve fitness, including opportunity for those on low incomes to play sport

Outcomes can be measured in terms of participation with the Club now fielding eight netball and four football teams. Approximately 150 to 180 participants attend the Club twice a week and on game days.

Learning points

In Indigenous communities, programs need to respectfully incorporate cultural dimensions. In particular, health must be viewed as a part of and influenced by all aspects of a person's life.

Paying Attention To Self

Young people with a parent who has mental health issues are considered to be at increased risk of developing a mental illness. Often young people who have a parent with a mental illness may have a decreased support network, and experience stigma.

The Paying Attention To Self program aims to overcome these barriers by increasing understanding of mental health issues, empowering young people to seek help, and providing a peer support network. A key aspect of the program is the utilisation of peer leaders (young people who have a parent with a mental illness) as co leaders in the program.

> ***'PATS has opened up so many doors to me that I've realised just how much getting involved and making a contribution can kick the misery out the window, and lead you through a multitude of open doors which can give you the opportunity to go anywhere.'***
>
> *PATS participant*

> ***'The reduction in levels of depression and risk of homelessness after completing the PATS program… show promising indications that the PATS program can impact favourably on risk factors known to be experienced by this group of young people.'***
>
> *Centre for Adolescent Health, final report*

Contact

Sharon Patton
Coordinator Mental Health & Counselling Services
Youth Services - Shire of Yarra Ranges
Phone: (03) **9294 6716**
Email: **youthservices@yarraranges.vic.gov.au**

Aim

To reduce the risk of developing mental illness for young people who have a parent with a mental health issue.

Target group

Young people (12 to 18 years) with a parent experiencing mental health issues.

Inequalities dimension

Mental Health: Risk factors that contribute to mental illness are often present early in life. Young people who have parents with a mental illness often have reduced access to social support and experience considerable stigma that prevents health seeking behaviour.

How did it work?

Structure:

Funding was used to provide 0.4 EFT and program costs.

Resources/Funding:

The pilot program was initially funded by the Department of Human Services, Beyond Blue–National Depression Initiative and VicHealth. Currently the ongoing PATS program is funded by UnitingCare Community Options. The Shire of Yarra Ranges is funded $35,000 annually to provide the PATS program. The Shire of Yarra Ranges has contributed additional funding and resources to support the PATS program such as oncosts, administration, management support, additional support staff, reference group and social activities for young people, and Mental Health Week activities.

Process:

PATS is an eight-week peer support program facilitated by a health professional and a peer leader who provide groups with ongoing support through social, emotional and education based components. The PATS program offers peer support, recreational activities and linkages to appropriate respite services. The program was implemented across five project sites that involve both a rural and an urban interface. Transport is available to young people to access the group.

What did it achieve?

Results from the evaluation of the pilot programs revealed that 60 per cent of participants reported depressive symptoms pre-involvement with PATS with a reduction to 38 per cent 12 months later. Forty-four per cent of young people reported to be at risk of homelessness pre-involvement with PATS with a reduction to 15 per cent 12 months later. Thirty per cent of young people reported a high level of associated stigma pre-involvement with PATS with a reduction to 15 per cent 12 months later. Current groups are replicating these results.

Who was involved?

The Department of Human Services, Beyond Blue, VicHealth and the Shire of Yarra Ranges were all involved in the establishment of the program. A partnership between UnitingCare Community Options and the Shire of Yarra Ranges Youth Services ensures that the program continues.

Smiles 4 Miles

Oral disease is largely preventable although many children still suffer unnecessarily from the pain and complications of this disease. Victorian school dental service data from 2007 found 54 per cent of five year old children accessing the service had experienced dental caries, of which 74 per cent had not been treated. Some children are more prone to experience poor oral health, particularly those from lower socio-economic backgrounds, culturally and linguistically diverse communities and rural communities. *Smiles 4 Miles* seeks to address this need among disadvantaged communities.

Smiles 4 Miles is an initiative of Dental Health Services Victoria (DHSV) which works in partnership with local agencies to improve the oral health of young children in the community. *Smiles 4 Miles* primarily targets children and families at high risk of developing oral disease, and complements programs that work with disadvantaged communities, such as Neighbourhood Renewal and Best Start.

Smiles 4 Miles began in 2004 as a pilot program, and was trialled at three sites in Victoria. The program now operates at thirty four sites state-wide.

Contact

Seona Powell
Dental Health Services Victoria
Phone: (03) **9341 1197**
Email: **powells@dhsv.org.au**

Aim

To provide a sustainable and comprehensive oral health promotion program that targets high risk communities across Victoria.

Target group

Preschool aged children (zero to five years of age) who are at high risk of oral disease.

Inequalities dimension

Oral health: Good oral health is an essential part of general health and wellbeing. Primary teeth affect the eating ability, speech patterns and appearance of children, and guide permanent teeth. Poor oral health is associated with socio-economic disadvantage. Those at greatest risk often have limited access to necessary services and support.

How did it work?

Structure:

Smiles 4 Miles aims to promote life-long oral and general health across all sectors of the community. This is achieved by encouraging healthy eating, drinking and oral hygiene habits in children and their families by:

- communicating simple messages such as eat well, drink well, clean well
- increasing community knowledge of oral health
- educating early childhood educators

- engaging parents and staff
- creating environments that support healthy choices
- embedding oral health messages into the early childhood curriculum
- developing sustainable partnerships that foster healthy communities.

Resources/Funding:

DHSV provides training, resources, ongoing support and funding to all *Smiles 4 Miles* sites. The sites receive funding over a three to four year period based on an agreement that establishes project sustainability. The sites are also provided with specific resources and support to assist in achieving a *Smiles 4 Miles* award. The *Smiles 4 Miles* award indicates a site's ongoing commitment to the program.

Process:

DHSV supports coordinators from local organisations to implement the *Smiles 4 Miles* program in high risk communities in the local area. Each local *Smiles 4 Miles* coordinator is responsible for engaging early childhood settings, for example, kindergartens, child care centres and playgroups, and assisting the settings to build the capacity to implement the program and to achieve the *Smiles 4 Miles* award.

What did it achieve?

The *Smiles 4 Miles* program has established mutually beneficial partnerships with local organisations and services. The program has been coordinated with thirty four local agencies (including councils and community health services) and has been implemented in over 350 early childhood settings.

An independent evaluation undertaken in 2006 identified local ownership and engagement as strengths of the program. Further evaluation focusing on program impacts will commence in 2009.

Who was involved?

DHSV continues to work with community health organisations, local government and primary care partnerships to ensure a local approach to the implementation of *Smiles 4 Miles*.

Learning points

The flexibility of *Smiles 4 Miles* allows local networks to adopt and adapt the program to suit the local community's needs.


Asthma First Aid
Asthma attacks can occur anywhere, at any time.
If someone has an asthma attack you should follow this 4 STEP Asthma First Aid Plan.
If their condition suddenly deteriorates or if at any time you are concerned – call an ambulance immediately.
1
Sit the person down and remain calm to reassure them. Do not leave the person alone.
2
Without delay shake a blue reliever puffer* (inhaler) and give 4 separate puffs through a spacer.** Give one puff at a time and ask the person to take 4 breaths from the spacer after each puff.
3
Wait 4 minutes. If there is no improvement repeat step 2.
4
AMBULANCE
One of these people could have an asthma attack
Would you know what to do?

4. Ensuring Quality, Affordable and Accessible Services

This dimension supports action to limit the compounding impact of illness on disadvantage by ensuring that health and human services are accessible, appropriate, based on the best available evidence and responsive to human need. Despite having a world class health system, service availability, use and results vary for particular population groups. Access and quality initiatives make direct and immediate contributions to reducing inequalities in health.

The case studies in this chapter have a strong emphasis on innovation in primary and tertiary health services. They demonstrate the substantial difference that can be made by providing a welcoming atmosphere or by rethinking the inadvertent barriers placed before vulnerable Victorians.

Where you can find out more about this dimension:

Primary Health Branch (Victoria)

www.health.vic.gov.au/pchtopics/index.htm

The Health Issues Centre

www.healthissuescentre.org.au/

Centre for Primary Health Care and Equity

www.cphce.unsw.edu.au/

Royal Australasian College of Physicians, Inequity and Health: a call to action

www.racp.edu.au/page/health-policy-and-advocacy/public-health-and-social-policy

Royal Australasian College of GPs, Guidelines for Preventative Activities in General Practice

www.racgp.org.au/guidelines/redbook

Health Departments Take Action: A compendium of state and local models addressing racial and ethnic disparities in Health (US)

www.astho.org/pubs/nabookfull.pdf

The Comprehensive Health Assessment Program

People with an intellectual disability have poorer health than the rest of the population. The annual health review with a General Practitioner has been a long-standing practice in Victorian disability accommodation services. However, barriers including communication difficulties, lack of familiarity between support staff and the person or their medical history, and the time pressures on general practice have existed.

The Comprehensive Health Assessment Program is a health assessment, advocacy and education process that has been shown to improve health promotion, disease prevention, case-finding and management activities for people with an intellectual disability in the general practice setting.

The initial pilot was conducted in one region of Victoria, Barwon-South Western, but has since expanded to the rest of the State.

> ***'Approximately 2 per cent of all people live with intellectual disability. They die prematurely, and adults may have five or more unrecognised or poorly managed medical conditions of a diverse nature. Inadequate attention to disease prevention is also common, with, for example, cervical screening rates one quarter of that in the general population.'***
>
> *Lennox et al, International Journal of Epidemiology, 2007*

Contact

Helen Matters
Department of Human Services
Phone: (03) **9096 7188**
Email: **helen.matters@dhs.vic.gov.au**

Aim

To strengthen the annual health review of people with an intellectual disability with General Practitioners in Victorian Government-funded and managed disability accommodation services.

Target group

People with an intellectual disability living in approximately 500 government-funded and managed disability accommodation services in Victoria.

Inequalities dimension

People with an intellectual disability have many barriers to managing their health, such as access and communication. The Comprehensive Health Assessment Program (CHAP) aims to overcome some of these barriers, highlighting the health needs of people with an intellectual disability to ensure an effective health review.

How did it work?

Structure:

CHAP was developed by Dr Nicholas Lennox, the Director of the Queensland Centre for Intellectual and Developmental Disability after extensive research into the health management needs of adults with intellectual disability.

A steering group oversaw the pilot of CHAP in the Barwon-South Western Region of the Department of Human Services, with participation from disability services staff and GPs. Disability Services purchased the licence to use CHAP in Government funded and managed shared supported accommodation from December 2007. A communication strategy was developed in conjunction with General Practice Victoria.

Resources/Funding:

An electronic version of CHAP was developed. Information for staff and GPs was developed as part of the communication strategy.

Process:

CHAP will be used in 500 community residential units in Victoria each year.

What did it achieve?

The number of Medicare rebates for health assessments more than doubled in Victoria after the introduction of CHAP in December 2007. CHAP is a validated tool which has been proven to be effective in a cluster randomised controlled trial of 453 clients in matched pairs conducted in the primary care setting in Queensland. The rigorous evaluation of CHAP by Dr Nick Lennox has been published. A pilot of CHAP was undertaken in Barwon South West Region to identify barriers and practical solution to the introduction of CHAP in Victoria.

Learning points

The tool has a strong evidence foundation.

Use of CHAP was made a requirement of practice.

Refugee Health Nurse Program - Greater Dandenong

People from a refugee background are known to have poorer health outcomes than those who are born in Australia and those who have migrated to Australia. Refugees have witnessed and survived violation of human rights and persecution. All have come from countries of war and unrest.

The Victorian Refugee Health and Wellbeing Action Plan 2005–08, developed in partnership with the Victorian Foundation for Survivors of Torture, recommended that newly arrived refugees needed increased access to timely primary health care to assist in re-establishing good health as soon as possible. Good health enables more successful settlement.

Employing nurses within the community health services in areas of Victoria with high refugee settlement was seen as the best way of being able to deliver such a service. One of the areas provided with a nurse was Greater Dandenong, which has the highest number of refugees settling in the area per annum (approximately 600–900 people each year) in Australia. The Greater Dandenong Community Health Service has employed a Refugee Health Nurse since March 2006. In 2008, the community health centre received funding for a second nurse.

Victoria is now a recognised leader in the provision of refugee health and wellbeing services.

Contact

Sue Willey
Refugee Health Nurse
Greater Dandenong Community Health Service
Phone: (03) **8558 9133**
Email: **Suzanne.willey@southernhealth.org.au**

Aim

To improve refugee access to primary health services and enable individuals, families and refugee communities to improve their health and wellbeing.

Target group

Newly arrived refugees (usually less than three years in Australia as a guide) and asylum seekers.

Inequalities dimension

The RHN program enables better access and co-ordination of health needs for newly arrived refugees, with a focus that includes assisting refugees to navigate the health system and to establish and maintain good health practices.

How did it work?

Structure:

The RHN is based within a community health setting but has developed networks with a variety of external organisations. The nurses' role is to provide a bridge between the acute and community sectors. A project coordinator worked with a statewide Reference Committee and a Local Steering Committee. Membership of the Local Steering Committee reflected key partners for program implementation including the local health service, the local council, sports assembly, the Neighbourhood Renewal program, primary schools, childcare services, parents, and Deakin University.

Resources/Funding:

The Department of Human Services provided ongoing funding of $100,000 per annum per EFT. In addition to this, $25,000 is available for interpreting and translating costs. The position at Greater Dandenong CHS is a Div 1 Nurse Grade 3B.

Process:

- Initially networking within the communities and with organisations that provide services to refugees to raise awareness of the RHN role and services the community health centre is able to provide.
- Attending meetings to develop and establish clinics.
- Ensuring the most appropriate people were involved in the process and that ongoing communication with these people took place (i.e Program Manager, GPs, medical staff at Dandenong Hospital, AMES case coordinators).
- Ongoing evaluation and discussion to adjust the clinics and program as needed.

What did it achieve?

At the Greater Dandenong CHS there has been an increase in people from a refugee background accessing the service.

Raising awareness of refugee health issues has been an integral component of the role and has enabled the health service to respond more appropriately to the health needs of refugees and asylum seekers.

Who was involved?

Through the Refugee Health Research Centre at La Trobe University an evaluation of the program at a state-wide level was conducted in the first 12 months. In 2008, a descriptive report about the role of the refugee health nurse in the Greater Dandenong area was prepared.

Learning points

Outreach has been vital. Instead of expecting the communities to come to the health service, the nurse has gone to the communities.

Dandenong Asylum Seekers General Practice Clinic - General Practitioner Support to Asylum Seekers

Asylum seekers who apply for protection once in Australia often suffer from many unique health issues related to fleeing persecution overseas, and stresses related to the often prolonged asylum seeking process in Australia. Asylum seekers in Australia generally have limited or no access to Government support including Centrelink benefits, the right to work, Medicare and the Pharmaceutical Benefits Scheme.

Until early 2009, Dandenong Asylum Seekers GP Clinic provided Medicare-ineligible asylum seekers with GP and other referred services without charge. Acute and chronic health conditions were treated with improvements in health status.

In partnership with the Dandenong Asylum Seeker GP Clinic, the Dandenong Hospital Refugee Health Clinic, established in 2007, extended its support to Medicare-ineligible asylum seekers in early 2009. This new hospital-based service ensures that asylum seekers can now access a range of onsite GP and other referred services such as diagnostic tests, medications, specialist and allied health clinics within the Southern Health Network. The Dandenong Asylum Seeker Clinic has now consolidated operations in the new hospital clinic.

> ***'The Asylum Seekers Clinic established in collaboration with other local health services put the Division at the cutting edge of service provision to vulnerable CALD consumers.'***
>
> *– commendation from QICSA (Quality Improvement and Community Services Accreditation Inc)*

Contact

Dr. I-Hao Cheng
Refugee Health Program Coordinator
Dandenong Casey General Practice Association
Phone: (03) **8792 1900**
Email: **i.cheng@dcgpa.com.au**

Aim

To provide GP consultations and other referred health services to Medicare-ineligible asylum seekers in the community, without cost through the Dandenong Asylum Seekers General Practice Clinic.

Target group

Medicare-ineligible asylum seekers on Bridging visa E.

Inequalities dimension

The combination of unique health issues and a lack of access to the full range of health care result in gross inequalities of health status for the asylum seeker population.

How did it work?

Structure:

One GP was employed to provide services in the main clinic for four hours each fortnight. Other selected GPs in existing private clinics linked into the network and were reimbursed for consultations.

GPs provided services and referred to funded referral partners including dental, optometry, pharmacy, pathology, radiology, specialist doctors, emergency departments and hospital clinics

Resources/Funding:

Program administration provided by a Program Coordinator at the Dandenong District Division of General Practice (now called the Dandenong Casey General Practice Association). Guidance and finance provided through the then Refugee and Asylum Seeker Health Network (RASHN).

Process:

Patients referred to the clinic by asylum seeker support organisations (for example Red Cross, Hotham Mission, Asylum Seekers Resource Centre) and members of the public. Patients were assessed for general eligibility to health services and provided with free formal GP consultations and free referred services.

What did it achieve?

There were 184 GP consultations provided from June 2005 to February 2008. Other health related and advocacy services were also provided. Health outcomes for patients for both acute and chronic conditions improved.

Who was involved?

The clinic was initiated by Dr Tim Lightfoot of the Refugee and Asylum Seeker Network in partnership with the Dandenong District Division of General Practice (now the Dandenong Casey General Practice Association).

Learning points

Continuous access to GP care was important, hence the expansion and transition of GP services from a fortnightly clinic into existing private GP clinics which provide 24 hour assistance.

General Practice Innovations Program

People who are homeless or transient often experience difficulty accessing mainstream health services. These include sex workers, people who use illicit drugs, people with a mental illness, young people who have been involved with the justice system and people recently released from correctional facilities. These sub-populations experience serious health problems, including diabetes, chronic infections, hepatitis C, cancer, heart disease and physical injuries. These conditions are often undiagnosed or untreated.

To meet their needs, Inner South Community Health Services (ISCHS) provides an outreach clinical service staffed by a GP and a practice nurse at a number of community locations. Clinic locations include welfare, housing and other support agencies so that people can be offered the opportunity for their health to be supported along with the other issues in their lives.

Sessions focus on opportunistic engagement with the existing populations accessing the community agencies. For example, Sacred Heart Mission in St Kilda provides a daily meals program to 400 people a day. A GP and Nurse team are located at Sacred Heart Mission during meal times twice a week. When people come to the centre for lunch, the opportunity is taken to assess their health needs. The service also co-locates at Hanover Welfare Services and at an Indigenous meeting place.

The model does not use an appointment system but seeks out and establishes relationships with people traditionally difficult to reach. In addition, the Practice Nurse and GP will work collaboratively with outreach support workers, allied health, dental and other staff to access clients and support follow up.

'They treat me with respect, even my mental problem. When I use his surgery office I feel safe.'

'I like what they do, they sit and talk to us.'

Two participants

Contact

Robyn Mitchell
GP Innovations Program Coordinator
Phone: (03) **9690 9144**
Email: **rmitchell@ischs.org.au**

Aim

Provide an integrated primary health service system for disadvantaged clients with chronic and complex conditions.

Target group

People who are marginalised by issues of homelessness or transience and who experience difficulty accessing mainstream general practice.

Inequalities dimension

The need for an alternate approach to engaging marginalised client groups is clearly demonstrated by poor heath status and heath outcomes, low levels of engagement in traditional primary clinical services and the number of preventable presentation levels at inner city hospital emergency departments.

How did it work?

Structure:

A Coordinator is allocated to manage the program and the equivalent of a full-time Practice Nurse is employed with GPs to cover each session. The GP Innovations team work in equal partnership with staff on the ground at each location. There is a key contact person at each site with whom they collaborate. For example at Our Rainbow Place Indigenous Access Program the team work directly with an Indigenous Access Worker to access and build relationships with the target community.

Resources:

The program was funded through the GPs In Community Health Strategy 2004 with an establishment grant of $128,000, plus operational funding of $256,000 over three years. GP Innovations also utilises Medicare bulk billing as a source of income. The program is supplemented with funding from other sources.

Process:

In addition to the outreach clinics at community agencies, GP Innovations uses alternate models of engagement and health promotion including:

home visits to public housing and rooming houses;

assertive outreach to local parks and other environments where the Indigenous community and the homeless communities congregate; and

use of the Inner South Community Health Service Health Bus – a fitted out mobile clinic space.

What did it achieve?

Key outcomes to date include: i) successful provision of bulk billed GP services to the hardest to reach and disadvantaged populations, ii) 1,130 new patients reached since project began in 2005 (43 per cent females and 57 per cent males from a range of age groups), iii) delivery of targeted health promotion initiatives to a high need and hard to reach population, and iv) prevention of low-level triage presentations from emergency departments achieved by targeting those with high preventable presentation rates.

Who was involved?

The program is overseen by the GP Innovations Steering Committee consisting of representatives of each partner agency: ISCHS in collaboration with a partnership of local agencies; Sacred Heart Mission; Hanover Welfare Services and Prahran Mission.

Learning points

Utilise existing environments and established target community networks to access difficult to reach populations

Working from a partnership model in an area of service delivery new to each agency was a significant challenge. GP practice development required a commitment to learning and a flexibility from ISCHS lead staff and partners.

More Allied Health Services – Eastern Ranges

The More Allied Health Services (MAHS) program aims to provide general practice patients with access to allied health professionals. Due to the rural and remote area where these practices are located, allied health services are often sparse and expensive for patients from low socio-economic backgrounds. If a service can be accessed, the waiting period before the initial consultation is often lengthy, whether it be for private or community health patients.

The MAHS initiative was first rolled out to rural Divisions of General Practice throughout Australia in 2000–01 by the Department of Health and Ageing (DoHA). Funding for the Program is managed by eligible rural Divisions.

Eastern Ranges GP Association (ERGPA) was previously not eligible for MAHS funding due to its rating as a metropolitan area. In October 2004, the classification of part of the Division, which covered the areas of Healesville to Marysville, and Woori Yallock to Warburton, was changed. This change made the Eastern Ranges GP Association eligible for MAHS funding, which was granted in late 2004.

'The MAHS program has enabled me to provide my patients with timely and accessible allied health treatment that they would not otherwise be able to access.'

Eligible GP

Contact

Mark Caldwell
Manager, Patient Services
Eastern Ranges General Practice Association
Phone: (03) **9739 7651**
Email: **mark.caldwell@ergpa.com.au**

Aim

To improve the health of people living in rural areas through allied health care, with linkages between allied health care and general practice.

Target group

General practice patients in rural areas in Healesville, Warburton, Woori Yallock and Yarra Junction.

Inequalities dimension

Rural and interface areas: Many people living in areas on the borders of the city face barriers to accessing appropriate allied health care. Distance between services and availability of professions are key issues influencing the use of allied health for prevention and management of disease.

How did it work?

Structure:

A project officer at ERGPA carried out a needs assessment with each of the GPs in order to assess what gaps in service delivery they believed were the most prevalent. This data was triangulated with population health data, population statistics and local health service data.

In the first year services were contracted through Yarra Valley Community Health Service. The following year's program changed its structure and private allied health professionals were contracted to ERGPA and received payment on a session basis. In some cases allied health professionals were contracted to provide services within general practices in a 'clinic' model. This linked the allied health professional and the general practice team (GP, practice nurse, patient) in coordinating care.

Resources/Funding:

DoHA provides the funding for the program to be implemented each year. The program receives $170,000 per annum to purchase services in the RRMA 5 area.

Process:

The program's processes are simple yet effective. The referring GP completes the MAHS referral form. The GP sends ERGPA the referral and data is recoded in a MAHS database. The referral is then processed to the most appropriate allied health professional based on discipline and geographic location. The allied health professional then contacts the patient and makes a time for the first appointment. The allied health professional feeds back to the GP at the completion of the treatment.

Patients are entitled to three treatment sessions and a re-referral of a further three if deemed necessary by the allied health professional and referring GP.

What did it achieve?

The MAHS program provided allied health services to over 1,100 clients in rural and remote areas. Patient surveys show high level of satisfaction with services received, timeliness, accessibility and cost.

Learning points

Interface areas on the border of rural and metropolitan regions often have similar service access and availability issues to those faced by rural regions.

The Ballarat Maternity Unit Indigenous Antenatal Program

The infant mortality rate among Indigenous people is three times higher than the national average, or 15.2 deaths per 1,000 births compared to five per 1,000. Low birth weight is associated with an increased risk of neonatal death and various diseases in later life, including diabetes and cardiovascular disease.

The Ballarat Health Services (BHS) Maternity Unit Indigenous Antenatal program is designed to inform Aboriginal women of birthing, breast-feeding and parenting issues. When booking into the maternity unit, Aboriginal women are offered the services of a midwife who provides information and support in a culturally appropriate environment.

The Ballarat Maternity Unit Indigenous Antenatal Program is one successful result arising from the Partnership Agreement for the Improvement of Koori Health Status in the Grampians region between Ballarat and District Aboriginal Co-operative and Ballarat Health Services.

Contact

Tracey Wilson
Manager of Population Health and Strategic Planning
Ballarat Health Services
Phone: (03) **5320 4267**
Email: **traceyw@bhs.org.au**

Aim

To facilitate improved health outcomes for Aboriginal people within the Grampians Region, by improving the birth weight of Indigenous children.

Target group

Indigenous women who are pregnant or have young babies.

Inequalities dimension

Service provision is only accessible when it is delivered in a culturally safe and appropriate way.

How did it work?

Structure:

The Ballarat Maternity Unit Indigenous Antenatal program commenced in 2006. A position was provided by the Department of Human Services, employed through Ballarat Hospital. The midwife works in conjunction with the Aboriginal Maternal and Child Health Nurse out in the community.

The Partnership Agreement for the Improvement of Koori Health Status in the Grampians region aimed to facilitate improved health outcomes for Aboriginal people within the Grampians Region. The parties agreed to work together to assess the health needs within the Aboriginal community, plan services and provide resources.

Resources:

Funding for the position came from the Department of Human Services. The Co-op made space and resources available.

Process:

Weekly information sessions at the Ballarat and District Aboriginal Co-operative have been embraced by women with participants saying the programs have 'removed fear' and in one case, 'helped me get over post natal depression'. The same midwife attends the Co-op regularly to develop the trust of the community. The midwife runs both the antenatal clinic, as well as the mums and bubs clinic in conjunction with the Aboriginal Maternal and Child Health Nurse. This program has developed into a playgroup for mums to talk to other mums, and get advice and guidance from other mums or the nurses if required.

The midwife works in the hospital, and tries to be available for any Indigenous births. She provides the familiar face that mums know from the antenatal clinic.

What did it achieve?

Aboriginal mothers now average ten antenatal visits per pregnancy at the centre, with the average birth weight of babies increasing from 3,000 to 3,600 grams since the program's inception. All sessions are well attended with increase of participants from four clients to an average of 10 to 15 mothers presenting each week.

Learning points

The development of trust between organisations and individuals within each organisation has been a key achievement and learning of the Agreement.

It really takes time to build and establish trust with community and it is important to let trust develop at its own pace.

Adolescent Antenatal Care and Education Program

Antenatal care has significant positive health impacts on improving and maximising maternal health and improving the health and survival rate of infants. Participation rates of young women under the age of 21 in mainstream antenatal programs in the Goulburn Valley (GV) was, prior to the commencement of this program, around six per cent.

The Adolescent Antenatal Care and Education program was initiated out of a research project indicating that in the GV there are a high number of teenage births (more than twice the State average), low participation rates in antenatal programs by young women, and a critical need for youth specific antenatal services.

In response, the Bridge Youth Service piloted an on-site, youth-focussed Antenatal Care and Education Program. This was supported by GV Health Midwifery who provided a midwife to undertake individual healthcare consultations with participating young women.

> ***'The group at The Bridge is the only thing I have to look forward to each week. It makes the rest of the week bearable.'***
>
> *21 year old participant*

> ***'The program plays a pivotal role in engaging young women at the earliest point in their pregnancy and providing antenatal care, parenting education, information, support and healthcare while ensuring they reconnect with their community and with the mainstream healthcare system.'***
>
> *Managing Director, Graeme Parish.*

Contact

Graeme Parish
Managing Director
The Bridge Youth Service
Phone: (03) **5831 2390**
Email: **gparish@thebridge.org.au**

Aim

To improve health and wellbeing outcomes for pregnant adolescents and their children in the GV.

Target group

Young pregnant women aged 21 and under and their partners (or support people) in Shepparton.

Inequalities dimension

Young women's participation in antenatal education and support in a rural area.

How did it work?

Structure:

The program is overseen by a steering group which includes: the Chief Executive Officer of The Bridge Youth Service; Midwifery Unit Manager (GV Health); Senior Social Worker (Centrelink); Manager of Children and Family Services (City of Greater Shepparton); Manager Parent Child Program (GV Family Care); Counsellor (GV Pregnancy Support); and a number of other key stakeholders.

The steering group has been in place from the beginning, and initially the research project workers reported to the steering group. With the completion of the research project, the steering group jointly developed the program model and the program staff now report to this group which meets bi-monthly.

The program is dependent on effective partnerships, particularly between The Bridge Youth Service and GV Health Midwifery Unit.

Resources/Funding:

Current Government funding is $30,000 per annum of the Department of Human Services Family Services Funding with additional operating costs met by The Bridge Youth Service's own fundraising.

Process:

The program is facilitated by experienced youth workers, one of whom is also a Community Health Nurse and the other a Social Worker. The on-site support of a midwife from GV Health with a separate room provided for individual consultations for young women attending is an important part of the program.

What did it achieve?

The Melbourne University School of Rural Health evaluation indicated a dramatic increase in participation rates of pregnant young people in antenatal care and education. It also indicated increases for participants in self-perceived knowledge of pregnancy, labour and parenting.

Learning points

Youth-focussed antenatal care and education programs are more effective when delivered as part of a suite of services.

Access to education opportunities can play a key role in assisting young parents to remain focussed and to retain future plans, particularly when their child reaches preschool age.

Integrated Humanitarian Settlement Strategy Community Guides

For newly-arrived refugees and humanitarian migrants, navigating the health system poses considerable challenges. To achieve the best health outcomes from available health and support services, newly-arrived migrants and refugees need to understand the role of, and systems for accessing GPs, hospitals, specialists, pharmacies and dentists, as well as understanding the need for referrals and appointments.

This is a complex system for newcomers who frequently miss appointments, do not know where to go for various kinds of medical assistance, or feel unable to manage the system with poor English skills. Without support to access health services many families are at risk of remaining outside the health system or not receiving the ongoing care and medical interventions required.

Adult Multicultural Education Services (AMES) started the Community Guides program in October 2005 as part of the Integrated Humanitarian Settlement Strategy contract with the Department of Immigration and Citizenship (then DIMIA). Community Guides are former refugees who provide practical assistance in the first language of clients. AMES has extended the program by providing an employment pathway for Community Guides to become Settlement Information Officers. These officers provide valuable settlement information including health education in the first language of clients.

> *'Being a Community Guide is one of the most positive experiences of my life. It is very rewarding being able to help new arrivals find their feet and find a place in their community.'*
>
> *Mary Doul, AMES Community Guide.*

Contact

Ramesh Kumar
Manager Settlement Services
AMES
Phone: (03) **9926 4604**
Email: **kumarr@ames.net.au**

Aim

To assist newly-arrived refugees to Victoria link to broader community and mainstream networks and services. In addition, to provide an employment opportunity for refugee community members who become Community Guides – often their first job in Australia.

Target group

Newly-arrived refugees in their first year of settlement.

Inequalities dimension

The program aims to prevent refugee families having chronic, long term health issues due to lack of access to and knowledge about the health services and systems.

How did it work?

Structure:

Case coordinators manage and monitor service delivery to each refugee family. Community Guides are an integral part of this service delivery model and are matched with families based on language and cultural backgrounds. Community Guides have first language skills of current refugee arrivals, an understanding of, or shared experience with refugees, sound community networks and the ability to communicate with people who are in the very early stages of settlement in Melbourne.

Resources/Funding:

AMES recruited and trained 185 Community Guides and draws on their services on a case by case basis. They were recruited from newly arrived communities using AMES existing community networks.

AMES employs a Manager, Settlement Partnerships who manages the Community Guides.

Process:

Community Guides provide practical assistance to refugees by accompanying refugees or refugee families to Medicare, assisting refugees and their families to understand and make general and specialist medical appointments and demonstrating how refugees can manage their own health care.

What did it achieve?

The Community Guides program has improved access and effectiveness of health services for newly arrived refugees. To date, 185 Community Guides have been trained. It has reduced the number of 'no shows' at medical appointments.

Who was involved?

The program also worked closely with the Victorian Government's Refugee Health Nurse (RHN) Program. The Guides assist the RHNs reach and establish relationships with their intended service recipients.

Learning points

Support and information delivered face to face in the refugee's first language enables them to access the health system effectively.

5. Supporting sustained action: data, awareness and tools

This section profiles a small number of programs that have worked to strengthen the infrastructure that supports successful equity-focused initiatives. Improvements in health are not the primary objective of these programs, as they aim to improve understanding and practice. This section illustrates that innovation in the development of systems and support mechanisms is also required to build health equity.

Data and visibility

Clear and precise data is a prerequisite to understanding different experiences of health across socio-economic groups. Although much is already known about the health status of Victorians, more detailed information regarding equity is a critical foundation for developing effective interventions.

A project funded by the Disability Services Division of the Department of Human Services provides an excellent example of building on existing data collection mechanisms to identify the needs of small population subgroups that may be experiencing poor health relative to the general population.

Since 2001, the Department of Human Services has been collecting information on the health of the population through the Victorian Population Health Survey. This survey is one of the largest in the country. Nevertheless, because of the telephone based data collection method, certain groups are likely to miss out on being surveyed. The Disability Services Division developed a survey tool to ensure that a representative sample of the two per cent of Victorians who live with an intellectual disability will be able to complete a parallel survey. The impact of this innovation is that we know much more about the health and wellbeing of people with an intellectual disability. We will also be able to accurately compare their health with the rest of the Victorian population to identify where priorities for action to address inequalities lie.

For further details contact the Disability Services Division of the Department of Human Services
(03) **9096 6927**.

Awareness and advocacy

The impetus for action on equity is often driven by greater awareness of the impact that inequality has on individuals, services and the wider community. Sustained action requires strong awareness among decision makers, practitioners and the community. The three case studies featured here were successful in changing levels of awareness and creating the opportunity for action.

In the *Action on Inequalities through General Practice* project, a cultural change program was initiated among primary care practitioners. The project, run over several years, focused on raising awareness among GPs and the Divisions of GPs. Steps taken included the publishing of evidence resources, research documenting barriers to equity in general practice and the review of training and quality assurance mechanisms to include equity aspects. The project built increased awareness of equity and led to new approaches in general practice. As one participant remarked 'we are now really starting to make some inroads into providing new evidence in many Divisions of General Practice … and therefore contributing to improved quality of health outcomes…'.

For further details contact John Furler, Senior Research Fellow, Department of General Practice, Melbourne University
(03) **8344 4747**
j.furler@unimelb.edu.au

In the *Making Two Worlds Work* project the emphasis was on awareness through dialogue. The project brought together the Aboriginal community in Wangaratta (the Mungabeena community members) with health and community workers in northeast Victoria. In addition to developing a range of resources, the impact of this dialogue has been observed in shifting attitudes of health workers leading to altered practice and also greater community use of generalist health services. One community member commented on the approach: 'If you haven't got the community on board then you've got nothing. The rest of the stuff will fall into place when there is good consultation, good communication and networks with the Indigenous community.' The project has been a partnership between Mungabeena Aboriginal Corporation and Women's Health Goulburn North East.

For further details contact Kylie Stephens
(03) **5722 3009**
k.stephens@whealth.com.au

Sometimes building awareness takes the form of direct advocacy. The *Port Phillip Community Group* led a project to present the impact on health of the 2005 Welfare to Work policies of the former Commonwealth Government. This project worked with those who were receiving or had received welfare benefits to document the impact of the policies. With stories collected, the project then presented this material to local organisations, the local media and also elected representatives. The project generated awareness through the telling of personal stories.

For further details contact Valerie Kay
(03) **9209 6394**
vkay@portphillip.vic.gov.au

Equity tools

Simple tools can assist practitioners to develop and deliver effective approaches to increasing health equity and social inclusion. An array of tools to support good practice are presented in the links section of this publication. The following case studies outline the development of two useful tools in Victoria. Both tools aim to support the systemic inclusion of diverse groups in practice and policy.

The *gender and diversity lens* was developed to assist the Department of Human Services programs and funded services better respond to the interactions between gender, diversity and disadvantage. To develop the tool, the project team worked with a mix of potential users, consumers and also academic experts. In addition, after the tool was finalised, a series of training workshops were organised to demonstrate the tool and guide practitioners in its use.

The gender and diversity lens is available online at:
www.health.vic.gov.au/vwhp/publications/genderdiversity.htm

For further details contact (03) **9096 7244**

The *VicHealth* equity lens tool was developed to introduce discussion of equity issues into program and service planning, delivery and evaluation. The working group developed a checklist to assist health promotion initiatives embed equity considerations into their work and to encourage projects to plan creatively and practically when addressing the wider socio-economic influences on health. Initial evaluation of the tool suggests it is useful in improving equity-based health promotion planning. A second trial seeks to identify the key actions within the comprehensive checklist that have the greatest potential to reduce inequity.

The tool is available online.

For further details contact: (03) **9667 1333**





PLANNER
OfficeMax

6. About this guide, about good practice

What do we mean by fairer health?

This guide has sought out case studies that have demonstrated their impact on creating a fairer distribution of health in Victoria. Fairer health means reduced inequalities. The most marked health inequalities in Victoria are experienced by:

- Indigenous Victorians
- Socially and economically disadvantaged Victorians
- Victorians in rural areas
- Refugees

Health inequalities are differences in health status that result from social, economic and geographic influences that are systemic, avoidable and unfair. This means:

- Measurable differences in health status between social groups do not occur at random, but in a systematic manner. For example, level of income and life expectancy are tied regardless of how high your income might be.
- The size of health inequalities varies between similar countries and states and over time. This indicates that they are not biologically fixed, but are socially produced and so avoidable. For example, there is no law of nature that says children born to poor parents should die younger.
- Fairness reflects a value-based assessment. For example, it is not now commonly viewed as fair that the cost of care or your ethnic background should shape health status.

Recognition of the unfair distribution of health and access to health services drove the development of universal health insurance through Medicare, as well as long standing preventative programs such as maternal and child health nurses. Since then, much has been learnt about the causes of inequalities in health.

Good or bad health is the consequence of several intersecting causes acting along a pathway. Action to reduce inequalities in health can be divided into three critical dimensions. These dimensions reflect the mechanisms that drive inequalities and each one has been briefly explained in the opening of the chapters in this guide. The three dimensions are:

- Reducing the disadvantage and discrimination that leads to ill-health and exclusion
- Promote health for all: health promotion opportunities reach all Victorians
- Provide quality, affordable and accessible services

Many existing policies and services already make major contributions to tackling health inequalities by acting on these dimensions.

What do we mean by good practice?

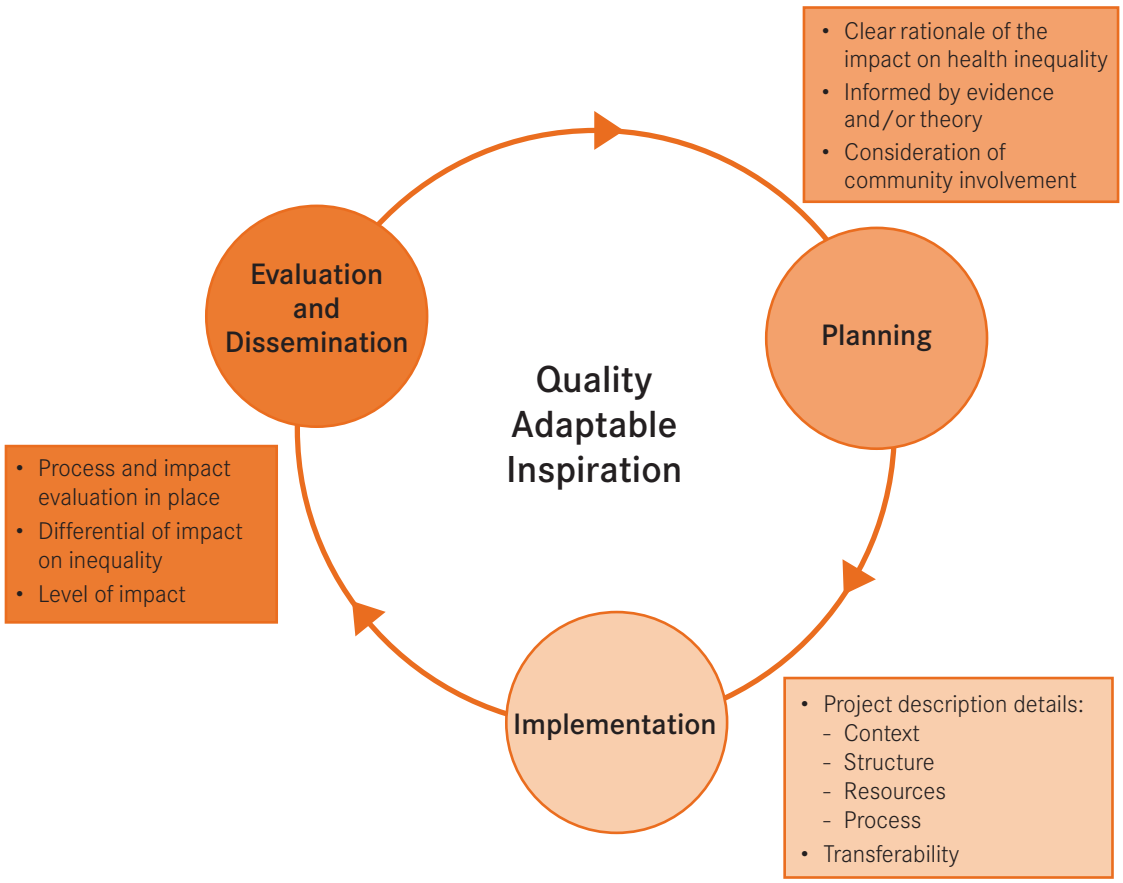
The understanding of good practice in this guide emphasises impact: action that produces a demonstrable benefit for people. To guide the identification of good practice and the selection of case studies, the project panel developed criteria of good practice.

The project panel reviewed a range of academic and practice oriented literature and tools to prepare the following simple diagram that identifies eight essential elements of good practice (or best, promising or model practice) in equity-focused initiatives. This diagram represents the selection criteria used to determine the projects included in this publication.

The model for selection used means that each of the included case studies:

- has been informed by evidence and/or theory;
- includes a clear rationale of the impact on health inequality; and
- put in place a process and/or impact evaluation.

Criteria for inclusion in compendium of health equality initiatives*



** initiatives may be policies, programs or projects. Examples include direct interventions, environmental change, development of legislation, partnership and system development.*

Other collections of good practice in health equity, both internationally and inter-state, have commented on the difficulty in finding programs with evidence of success in reducing health inequalities. We think the tide has turned and good practice to build health equity is now becoming more common.

Impact and evaluation remains critical. Many programs submitted for inclusion in this Victorian guide appeared to be effective programs, but were unable to demonstrate the impact they were making. Evaluation, quantitative or qualitative, is essential to ensure that a program is not only targeting inequality, but reducing it. There is no guarantee that a project targeting a group identified as experiencing disadvantage will decrease inequalities or reduce the health gap. In some cases, the intervention itself might be too modest to counter other factors that affect the health of some individuals.

Finally, there is extensive literature regarding evidence and evidence-based practice. The standards set and assumptions made often bear little relationship to practical programs or lived experience in the community. The case studies featured in this guide are examples of good practice, but this is not an 'evidence review'.

Selection of case studies

To select case studies a rigorous collection and selection process was established. This process was led by a project panel and reviewed by a stakeholder advisory group (to ensure independent review of selections).

A widely distributed call for case studies was issued at the start of the project in 2008. In addition, a number of known programs were invited to submit.

Over 100 potential case studies were submitted as examples of good practice. Each submission was sorted into one of the three strategic dimensions or identified as a process oriented program. The submitted case studies were predominantly from the health promotion field, as the following table illustrates.

Strategic dimension	% of submitted cases
1. Reduce disadvantage that leads to illness	26%
2. Promote health for all	43%
3. Provide quality and accessible services	31%

Each submitted program was reviewed by the project panel (using the criteria outlined above). After this initial screening, a short-list of possible good practice case studies was established and these programs were invited to submit further program information.

A more detailed review of these short-listed programs was then conducted by the project panel. The question of impact was crucial at this stage and a number of very good projects were omitted because of a lack of evaluation results. After this final selection process, case studies were written into a consistent format for final review.

The intention in compiling the case studies was to inspire and inform new practice. Some innovative state-wide programs were not included because there can only be one such program in Victoria. Effort was made to include component parts of state-wide programs or local innovations that could be adapted and implemented elsewhere.

Each published case study has been approved by the appropriate project owner.

Good Practice Resources

Other Victorian Resources

Child Protection Good Practice Guide

www.office-for-children.vic.gov.au/every-child-every-chance/library/publications/good_practice_guide

Fair Health Facts: report on inequalities in health

www.health.vic.gov.au/healthstatus/inequalities.htm

Women's Health Victoria, Gender Impact Assessments

www.whv.org.au/

Australian Resources

NSW Health Promotion Director's Network, Four Steps Towards Equity: A Tool for Health Promotion Practice, 2003.

www.health.nsw.gov.au/pubs/2003/4stepstowardsequi.html

SA Dept of Health, Towards a Fairer Society: community case studies, 2006.

www.dh.sa.gov.au/pehs/branches/health-promotion/fairer-society-vol2-06.pdf

International Resources

EuroHealthNet 2004, 'Promoting Social Inclusion and Tackling Health Inequalities in Europe: An Overview of Good Practices from the Health Field' (Europe).

www.eurohealthnet.eu/images/publications/pu_3.pdf

National Institute for Health and Clinical Excellence, Behaviour Change Guidance, 2007 (UK).

www.nice.org.uk/Guidance/PH6

Applied Research Centre, Closing the Gap: solutions to race-based health disparities, 2005 (US).

www.thepraxisproject.org/tools/ClosingGap.pdf

NZ Ministry of Health, Social inequalities in health–New Zealand, 2000 (NZ).

www.moh.govt.nz/notebook/nbbooks.nsf

State Government Victoria
Department of Human Services