Central Coast Aboriginal Health Plan 2017 - 2020

NSW GOVERNMENT

YERIN
Eleanor Duncan Aboriginal Health Centre

phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

About the Artwork

The artwork for this plan is called ***where the bush meets the sea!*** It was created by Aboriginal artist Wendy Pawley

Acknowledgements

The partners would like to acknowledge Community Reference Group members Aunty Kay, Mick Pittman and Rebecca Curtis. The groups guidance was critical to the formation of this plan.

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Acknowledgement to Country

The partners would like to acknowledge the Darkinyung people, the Traditional Custodians of this land and pay our respect to our Aboriginal Elders, both past and present.

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Foreword from the Partners

Aboriginal Health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community. It is a whole of life view and includes the cyclical concept of life-death-life.

(National Aboriginal Health Strategy, 1989)

It is a great pleasure to be asked to write the Foreword to this, the second edition of the Central Coast Aboriginal Health Partnership Strategic Plan.

The first Strategic Plan set the scene for how the three Central Coast Health Partners would work together to bring about improvements in health outcomes for our local Aboriginal community and make a contribution to close-the-gap in our region.

Noticeable advances in collaboration between the Health Partners occurred during 2013 – 2017 with various programs implemented via 'cross-agency support'. For example, the well-funded Integrated Team Care and the Yadhaba (Well-Being) Team Programs to Yerin from Hunter, New England, Central Coast Primary Health Network, and installation of two dental chairs to Yerin from NSW Health. These are perfect examples of one of the objectives of the Collaborative Partnership Agreement which required "…. Yerin, CCNSWML and CCLHD to work collaboratively to connect care for the local Aboriginal community, with the right health services, in the right place, at the right time and with the right provider."

There were significant changes to all three Organisations during this period, but the relationship between the Chief Executive Officers and staff ensured a close relationship continued.

This relationship is so well-founded that many of our brothers and sisters can't tell where support from one Organisation finishes and support from the next Organisation starts.

This second edition takes collaboration and cooperation to another level.

As a consumer of the health services of all three Partner Organisations, I am very confident that I'm getting the best health services available and grateful they are here on the Central Coast.

Mick Pittman
Community Member
Central Coast Aboriginal Community

Executive summary

Area: the Plan covers the Central Coast Local Health District.

The Vision: The Plan represents a vision to see healthy people and healthy communities.

There are a number of values, goals and principles which will assist the partners and community to achieve the vision.

Co-Design: To improve the health and wellbeing of Aboriginal and Torres Strait Islander people, the partner organisations and community will work in partnership to deliver this health plan. The partners will work together to achieve the vision by working towards the goals. The partnership will be underpinned by the values and principles laid out in this plan. To assist in the implementation of the Plan, a number of committee/groups will be involved. These include:

- Aboriginal Health Partnership Committee
- Community Reference Group
- Working Groups per Priority Area

Figure 1 Health Plan Governance Structure

The Partners: Yerin Aboriginal Health Service Incorporated, Central Coast Local Health District (CCLHD) and Hunter New England Central Coast Primary Health Network (HNECCPHN).

Key Priority Areas: There are five Key Priority Areas in this plan. These include

1. Chronic Disease
2. Youth
3. Child and Maternal Infant Health
4. Drugs and Alcohol
5. Mental Health including prevention and early intervention

An implementation plan will be developed to ensure that the Plans vision is achieved.

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The Health Story of My Life by Aunty Kay

I was a part of the stolen generation and was taken from my family in the 1950's. I was placed with a family who took in both myself and my brother, but we were fortunate in that they always believed we should know where we came from.

I loved growing up with my little brother on the Central Coast and I was always made to feel special.

I started looking for my family when I was about 22. That's when I became insulin dependent and doctors kept asking me whether diabetes was '*in the family*' and of course I didn't know…I didn't know what I was passing on to my kids.

But life as a young mum got busy and I never really had much luck finding them. It wasn't until we thought my nephew might have been epileptic that I thought it was ridiculous not to know our story. And health was part of our story.

It was wonderful to discover that I was born into a close and loving family and am the ninth of eleven children. Finding my family helped me come to trust people again and restore that 'missing piece' of me.

It's important to that we continue to connect and take care of each other.

As someone who lives with six chronic diseases, I also feel that I live in a community that really takes care of me. I have excellent people I can talk to and they even help me with transport, so that I can get to appointments.

Because of this, I believe in giving back.

I have volunteered for the Heart Foundation, as well as cancer and diabetes foundations. I have seen family members struggle with health issues…my brother had a massive heart attack in his 40's and even today, there are a lot of our family and community who struggle with things like drug and alcohol issues. This motivates me to keep going and support our community to keep learning.

I think it's really important that community is a big part of developing and delivering this health plan. It's wonderful to see that the health partners are all working together on this too.

As a community, we need to make sure that we understand what people need, what they need to know and how we can reach everybody.

Even for me, through my own learning, I am also taking better care of myself through diet and exercise and am someone other community members can come and talk to.

The health plan in our community should be about helping people and supporting them to be well. That's one of the things I'm 'most loud' about and what's most important for everyone.

The Health Plan

The Partner organisations and community will work in partnership to deliver this health plan. The partners will work together to achieve the vision by working towards the goals. The partnership will be underpinned by the values and principles laid out in this plan.

The Vision

The Plan represents a vision to see healthy people and healthy communities

The scope of this plan is limited to guiding the delivery of health services to Aboriginal people through a partnership approach. However, all partners acknowledge that the environment in which the Plan will operate must be considered and responded to where possible.

There is strong intent and commitment from all, to deliver culturally appropriate services to our communities. The Plan will improve the health and wellbeing of Aboriginal people on the Central Coast in many ways. Overarching will be a robust and functional plan that is responsive to need and adaptive to change. This Plan considers and ensures that culturally appropriate preventative health care, early intervention and health promotion to play a significant role.

By providing accessible services, embedding cultural capability, upskilling and sharing our knowledge with non-Aboriginal organisations and their staff, the next three years will bring not just challenges but opportunities for all, leading to positive health outcomes. The partners are aware of the geographical landscape and the services that are spread across the region and will continue to find ways and means, to address and efficiently meet the growing needs.

The partners are aware that providing integrated and holistic health care across the community will be challenging; the changing face and landscape of the Central Coast region, the sprawling and transient population and the limited resources in a growing community will require consideration as the Plan evolves.

The partners also acknowledge and understand the challenges that are presented outside of the primary health care environment, significantly the connectivity to the social determinants of health including:

- a lack of affordable, safe and stable housing.
- a lack of access to personal and community transport across the region.
- a lack of access for all patients to all services.
- a lack of cultural competencies in non-Aboriginal staff within the work place.
- the historical lack of trust in institutions such as hospitals, including the feelings of ‘shame and fear’ for some Aboriginal people (who will then not visit a doctor and have health issues detected early enough).

“it sits in the subtle stuff, assumptions, transposed views, not making eye contact, not being aware of issues, that there is a diverse community, comes back to proactive approach to chronic disease, services deliveries are thrown out there”. Quote by co-design workshop participant

Cross Cultural Learnings

It is integral to the growing and changing Aboriginal population of the Central Coast that there is a commitment to the sharing of resources, data, skills, capacity and communities. For example, working together will enhance not only the physical health of our Aboriginal communities, but it will also improve the cultural learnings of non-Aboriginal practitioners by providing a deeper understanding of the historical context for Aboriginal people and how that has affected them.

Culture and cultural identity are critical to social and emotional wellbeing. Practising culture can involve a living relationship with ancestors, the spiritual dimension of existence, and connection to country and language.

"It is critical to ensure that any efforts to reduce the disproportionate harms experienced by Aboriginal and Torres Strait Islander people are culturally responsive and appropriately reflect the broader social, cultural and emotional wellbeing needs of Aboriginal and Torres Strait Islander people.

Planning and delivery of services should have strong community engagement including joint planning and evaluation of prevention programs and services provided to Aboriginal and Torres Strait Islander communities taking place at the regional level. Wherever possible, interventions should be based on evidence of what works specifically for Indigenous people."[1]

The three partner organisations are committed to providing a culturally safe and culturally responsive health system, to ensure access to services, and to improve health and wellbeing of their clients and community.

They endeavour to do this by;

- Providing a culturally responsive environment and services through training for all employees to imbed best practice behaviours, attitudes, policies and procedures.
- Ensuring all staff employed across the three agencies are culturally responsive by providing training and ongoing professional and cultural supervision.
- Ensuring all signage and instructional literature is in the local Aboriginal and Torres Strait Islander language (Darkinyung) and consistent with our local norms thus providing a culturally proficient health space.
- Ensuring all staff are culturally diverse to ensure the workforce reflects the Central Coast Aboriginal and Torres Strait Islander community's needs.
- Delivering trauma informed care and practices, directed through an understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences on the Central Coast Aboriginal and Torres Strait Islander community.

The partners are committed to sound community empowerment, based on our belief that:

[1] Zell Dodd and Joanne Badke (Ceduna Koonibba Aboriginal Health Service and Tullawon Health Service) submission to Standing Committee on Community Affairs 2017

- People in our communities should be involved in the decisions that affect them.
- People in our communities deserve high quality health services shaped around their needs and priorities.
- Our strategies and policies should reflect local Aboriginal and Torres Strait circumstances and aspirations.

The partners recognise the importance of community input in developing and delivering better health, social, emotional, spiritual and wellbeing services. The Plan also guides the involvement of the community, consumers of health care, health services and professionals, community-based organisations, non-government organisations and other tiers of government. The co-design approach means that decisions will be more likely to reflect a diverse range of concerns and interests, and provide well thought through solutions.

Social Determinants

The primary focus of this plan is primary health service delivery, but we must also acknowledge the role the social determinants of health play in Aboriginal and Torres Strait Islander people's health and wellbeing. The social determinants of health, such as justice, education and employment play a significant role in the health and wellbeing of Aboriginal and Torres Strait Islander people. A plan such as this cannot address all these issues. However, it is essential to recognise the role they play which is why it is crucial for partnership with organisations outside of the primary and tertiary health care sectors.

The Values

The Plan represents the values of its community, both practitioners and community members. It represents Integrity, Respect, Justice, Cultural Ability, Accountability, Collaboration, Recognition, Openness, Innovation and Empowerment.

The Goals

This plan hopes to achieve to following goals:

- To develop and resource sustainable and accessible programs for people and communities, leading to improved community engagement and access and long term, self-determined outcomes.
- To develop and educate a workforce across the region that is integrated and embeds the cultural needs of its clients and its peers in its day to day business in a systemic way.
- To build capacity including increasing the workforce's professional and personal development in both a practitioner and a cultural setting.
- To deliver a plan that speaks to all, with a whole of life approach, from birth to death, from babies to Elders and one that interconnects through the spectrum, connecting target groups to relevant support.

The Principles

The Plan sets out partnerships which underpin and empowers a healthy community. To communicate and consult with the community to ensure that there is an authentic community engagement process that enables community and gives a voice to them. In addition to creating a sustainable health plan with a focus on succession planning, which will 'bring young people' (community member) along on the journey.

The Plan has been developed building upon the following partnership tenets:

- The health of the Aboriginal community is a national priority;
- Improved health outcomes for the Aboriginal community will be achieved when they and their health services are empowered to act on their own behalf, and when access to relevant and culturally appropriate services are readily available;
- Recognition of Aboriginal self-determination and a collaborative approach are fundamental to the achievements of improved health outcomes;
- Individual health is closely related to the general wellbeing of communities, thus calling for a holistic approach;
- Mutual respect of each other's role, goals and culture internally and externally, partners and community; and
- The Plan serves to guide activities relating to Yerin, HNECCPHN and CCLHD in 'closing the gap' for health inequities for the local Aboriginal community.

The Partners

The partner organisations in this plan are Yerin Eleanor Duncan Aboriginal Health Service, Central Coast Local Health District and the Hunter New England and Central Coast Primary Health Care Network. The partner's roles and functions are varied and complementary.

Yerin Eleanor Duncan Aboriginal Health Service

For over 20 years our services and programs have been delivered in a culturally supportive and safe environment. Yerin Aboriginal Health Services Limited aims to provide high quality integrated primary healthcare services to the Aboriginal and Torres Strait Islander communities of the New South Wales Central Coast, Darkinjung country. To address the real and diverse health needs of our community by providing holistic, comprehensive and culturally able care to our patients and clients. This is underpinned by Aboriginal world views that health is not just the physical well-being of the individual, but the social, emotional, spiritual and cultural well-being of the whole community.

Central Coast Local Health District

Within the Central Coast Local Health District (CCLHD), Nunyara Aboriginal Health is the lead service in regards to Aboriginal health with a philosophy that Aboriginal health is everyone's business. This is consistent with the Aboriginal world view that health is not just the physical well-being of the individual, but the social, emotional, spiritual and cultural well-being of the whole community. Specific services provided by the CCLHD to the Aboriginal community include Child and Family Health (Ngiyang Mothers and Babies service which is inclusive of Nunyara Mothers and Babies team), Mental Health, Drug and Alcohol, Youth Health, including facilitation of the annual NAIDOC day celebration

Hunter New England and Central Coast Primary Health Care Network

Hunter New England and Central Coast Primary Health Care Network (HNECCPHN) is a not for profit organisation funded by the Commonwealth government. The PHN is not a direct provider of health services; instead it plans, develops, manages and supports a range of service agreements with organisations to deliver primary health care programs in areas of identified need. Program areas funded include mental health, Aboriginal health, drug and alcohol, GP after hours care and Rural Primary Health Services (RPHS). In Aboriginal Health, commissioned programs include the Integrated Team Care program, Indigenous Mental Health, and Drug and Alcohol programs.

Our Footprint

This plan covers Aboriginal and Torres Strait Islander people and organisations in the Central Coast Local Health District. The region is located between Sydney and the Hunter Valley and covers an area of 1, 680 km^2.

Figure 2 Central Coast Local Health District Region[3]

Aboriginal People on the Central Coast

The Australian population is over 23,000, 000 people. Aboriginal and Torres Strait Islander people make up 2.8% (650, 000) of the Australian population. The Central Coast region has a higher proportion of Aboriginal and Torres Strait Islander people than the national average, with 328, 000 Aboriginal and Torres Strait Islander residents representing 3.8% (12, 485) of the Central Coast population.[4]

The age structure of Aboriginal and Torres Strait Islander people on the Central Coast is different from that of non-Indigenous people living in the area. Over half the Aboriginal and Torres Strait Islander population on the Central Coast is 25 years of age or younger compared with 30.05%.[5] The difference between the Aboriginal and Torres Strait Islander people and other people was also noted in the 65 years and over age group. The proportion of Aboriginal people aged 65 years and over was considerably smaller than for non-Indigenous people (**4.8% compared to 16%**). [6]

Aboriginal and Torres Strait Islander people living on the Central Coast die younger and have a higher burden of disease than non-Indigenous peoples in the area. Aboriginal and Torres Strait

[3] http://www.health.nsw.gov.au/lhd/Pages/cclhd.aspx

[4] http://www.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/LGA11650?opendocumenthttp://www.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/LGA11650?opendocument

[5] http://www.cclhd.health.nsw.gov.au/ourservices/AboriginalHealth/Documents/AboriginalHealthReportCard.pdf

[6] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2071.0main+features102016

Islander people's lower life expectancy in 2014 was 57.7 years for men and 64.1 years for women compared to 79.00 years and 85.3 years for other men and women in the area. The disparity starts at birth with 9.9% of Aboriginal and Torres Strait Islander babies born with low birthweight (>2500 grams) in 2007-2011 compared to 4.7% babies born to other mothers in Australia. [7].

Episodes of care delivered through Aboriginal and Torres Strait Islander primary health care services have tripled (from 1.2 million in 1999-2000 to 3.5 million in 2014-15). [8]

Aboriginal and Torres Strait Islander hospitalisations have increased over time on the Central Coast, and Hunter New England area. Aboriginal and Torres Strait Islander people on Central Coast are more likely to be hospitalised for many preventable conditions [9] than other people living on the Central Coast, and are more likely than other people in the region to be hospitalised for infectious, circulatory and respiratory diseases, mental health conditions, injury and dialysis which is the leading cause of hospitalisation [10] *(Figure 1)*.

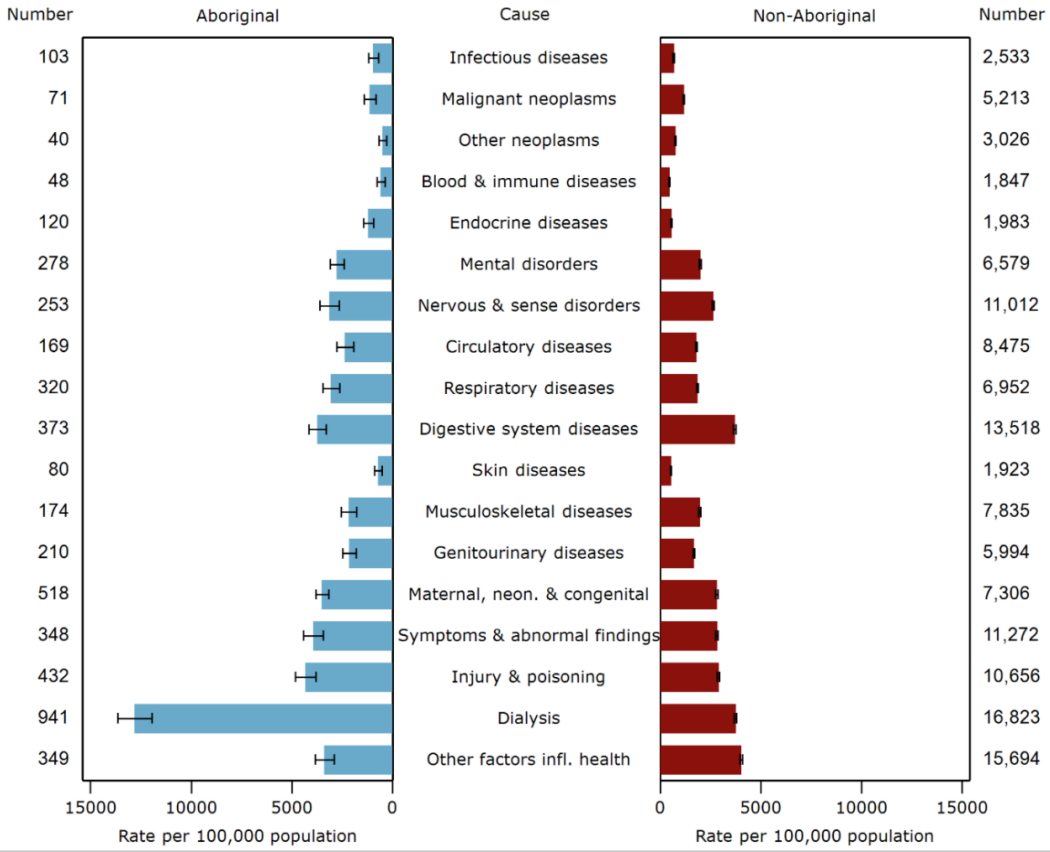

Figure 3 Hospitalisation by cause and Aboriginality Central Coast Local Health District, NSW[11]

Aboriginal and Torres Strait Islander people's poorer health outcomes can be attributed to the social determinants of health such as lower levels of education, lower employment rates, overcrowded households and racism.

This health plan seeks to address the morbidity and mortality rates for Aboriginal and Torres Strait Islander people on the Central Coast through partnership and improved service delivery. Morbidity

[7] https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier1/101.html
[8] https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/overview/Executive-summary.html
[9] http://www.healthstats.nsw.gov.au/Indicator/bod_acshos/atsi_acshos_lhn_trend
[10] http://www.healthstats.nsw.gov.au/Indicator/bod_hos_cat/atsi_hos_lhn_cat_comparison
[11] http://www.healthstats.nsw.gov.au/Indicator/bod_hos_cat/atsi_hos_lhn_cat

and mortality can only be addressed through partnership with relevant organisations and the Aboriginal and Torres Strait Islander community.

The Value of Community and Co-design

The partners, related organisations and Aboriginal stakeholders worked together to ensure the Plan was written in collaboration with and from an Aboriginal community perspective and that the Plan is inclusive of the values and views of Aboriginal people across the Central Coast, including executives, practitioners and community members.

For community to better inform and share their insights, the Plan reflects not just the view from a clinical perspective but from home, work, school perspective. The Plan represents the linkages of poor health and social, emotional wellbeing to housing, employment and education. By working in partnership, the co-design concept of the Plan will contribute to building sustainable, empowered communities, with opportunities to further strengthen alliances across the Central Coast.

The principles of the co-design process for the creation of the Plan was as follows:

1. The views of Aboriginal stakeholders informed the development of the Plan.
2. Aboriginal stakeholders were involved at all stages of the plan to ensure the Plan is applied in the spirit and intent of their conception.
3. The participation and engagement of Aboriginal stakeholders is essential to the authenticity of the project and the commitment that the partners have made to ensure the Plan is informed by Aboriginal people.
4. The co-designed plan was conducted with transparency and provides clear information and resources in plain English that are accessible to all. Through appropriate methods, stakeholder feedback will be shared and reported on and privacy respected.
5. The partners and any appointed contractors will report back on how community feedback has been used, included and reflected towards the Plan.
6. The co-design project is committed to the principle of including Aboriginal people, staff and community members.

Governance

To achieve the objectives of the Plan, a governance structure has been developed. The collaborative objectives and methods of this partnership agreement and subsequent plan is underpinned by the following guiding principles:

- People in our communities should be involved in the decisions that affect them;
- People in our communities deserve high quality health services shaped around their needs and priorities;
- Strategies and policies should reflect local Aboriginal and Torres Strait Islander circumstances and aspirations;
- Aboriginal world views that health is not just the physical wellbeing of the individual, but the social, spiritual, emotional and cultural wellbeing of the whole community;
- Aboriginal people empowering themselves by taking all appropriate and necessary powers and responsibility for our own lives and futures. Aboriginal people have the right to development of our economic, social and cultural life trajectory;
- Recognising the impact of history in trauma and loss;
- Universal access to health care across all areas; and
- Equitable funding for adequate and tailored health care provisions.

The embodiment of the Partnership agreement guiding principles are the Advisory Groups which will oversee the implementation and monitoring of this plan. Details of the Advisory Groups are below.

Advisory Groups

To assist in the implementation of the Plan, a number of committee/groups will be involved. These include:

- Aboriginal Health Partnership Committee
- Community Reference Group
- Working Groups per Priority Area

Figure 4 Health Plan Governance Structure

The committee/groups are outlined below:

Aboriginal Health Partnership Committee
The Aboriginal Health Partnership Committee has representatives from each of the three partner organisations; Yerin Aboriginal Health Services, Central Coast Local Health District and Hunter New England Primary Health Network. This committee has responsibility for the strategic decisions made to implement and monitor this health plan.

The Partnership agreement
The partnership agreement outlines the relationship of cooperation between Yerin Aboriginal Health Service Incorporated, Central Coast Local Health District (CCLHD) and Hunter New England Central Coast Primary Health Network (HNECCPHN).

The partnership aims to achieve the most efficient and effective use of health resources to ensure ongoing collaboration between primary, secondary and tertiary care services at a variety of organisations across the region.

The partnership aims to deliver holistic health care to the Aboriginal communities of the Central Coast. A healthcare concept that crosses borders, services, jurisdictions and organisations. The Central Coast Aboriginal Health Plan continues to promote the ongoing service collaboration which connects care and services for the local Aboriginal community.

This will involve pathways, communication strategies and networks that will connect the right people to the right services at the right time, across services and with the right provider, in a way that puts people at the centre of care.

For Aboriginal patients on the NSW Central Coast, this will mean better collaborative care arrangements which focus upon the identified needs of the community.

The partnership informs and underpins service level agreements across the region to ensure ongoing collaboration and cultural sensitivity in Aboriginal healthcare across the Central Coast. The values of the collaborative partnership are:

- Continued promotion of community wellbeing;
- Collaborative health care delivery across organisations;
- Better identification of health and social inequities (e.g. factors affecting access);
- Timely intervention to mitigate these inequities;
- Improved community engagement with and navigation of the health system;
- Better health outcomes.

Each party acknowledges and respects the role of other parties in the healthcare system. The partnership supports a genuine commitment to a holistic Central Coast Aboriginal Health Plan, one that shares a coordinated approach to assessing need and developing programs, to sharing research, networks and resources, across the informed priorities.

Community Reference Group

Aboriginal and Torres Strait Islander Central Coast Community are partners in this plan. Therefore, a Community Reference Group will be developed to support the implementation and monitoring of this Plan. Partners will include their community representatives in the Aboriginal Health Partnership Committee. The Community Reference Group will be developed in 2018.

Working Groups per Priority Area

In addition to the overarching governance framework, an additional working party per priority area has been convened to address issues such as complex case management panels, information and data sharing.

The unique and sometimes complex needs per area require a dedicated response across multiple organisations to manage response and find solutions, to ensure that quality health care and services are being provided to the many communities on the Central Coast.

A Working Group comprises of specialist staff representing each partner organisation for a specific priority and is responsible for resolving issues across the Plan or escalating them to the Central Coast Aboriginal Health Committee. The group reports to the Central Coast Aboriginal Health Committee. These Group feeds into the Aboriginal Health Partnership Committee and works alongside the Community Reference Group.

More details of the groups will be outlined in the Implementation Plan which is due to be finalised late 2018.

Communication Framework

A communication framework to support the implementation of this Plan will be developed in 2018 to ensure that the partner organisations, working groups, Community Reference Group, other community organisations and community members communication is effective.

The framework will ensure that there are dedicated pathways which will inform all end users, from executive to staff and community. With access and openness, the communication framework directs both internal and external communities to better address issues, source information or seek support.

The communication plan will set out key events, communication opportunities such as quarterly forums and community engagements and detail how to utilise the channels in providing a feedback loop for face-to-face workers and community members to ensure clarity of service delivery for each organisation. It will also outline communication strategies for engaging with non-health stakeholders.

Strategic Priorities

The Central Coast Aboriginal Health Plan sets outs Key Priority Areas that have been determined as part of a co-design experience and supported by the partner organisations. The areas identified will require action, dedicated and strategic thinking.

The Plan and the Key Priority Areas over the next five years will not be without challenges; however, with trust, dedication, communication and achievable goals, the partners intend to meet the targets while continually listening, reviewing and responding to the community's needs.

The Key Priority Areas complement the existing objectives in current national and state plans and frameworks.

State and Federal Aboriginal Health Policy Framework Landscape

Overarching the Central Coast Aboriginal Health Plan is the Council of Australian Governments (COAG), **Close the Gap** (CTG) goals. The Central Coast Aboriginal health plan and targets, are in place to decrease the gap between Aboriginal people and non-Aboriginal Australians living in contemporary Australia.

Closing the Gap has required a strategic and collective whole of health approach in addressing gaps in life expectancy, infant mortality, education and employment. As such the Central Coast plan embeds those key priority areas to ensure the Aboriginal population of the Central Coast benefit from a national approach with the partner organisations ensuring that they too are meeting their business objectives and obligations.

The Council of Australian Governments (COAG) Closing the Gap targets, are as follows with all governments committed to meeting the targets set:

- Closing the life expectancy gap within a generation by 2031
- Halving the gap in mortality rates for Indigenous children under five within a decade by 2018 (see measure 1.20)
- Ensuring 95% of all Indigenous four-year old's are enrolled in early childhood education by 2025
- Closing the gap between Indigenous and non-Indigenous school attendance within five years by 2018 (see measure 2.04)
- Halving the gap for Indigenous students in reading, writing and numeracy within a decade by 2018 (see measure 2.04)
- Halving the gap for Indigenous Australians in Year 12 attainment or equivalent attainment rates by 2020 (see measure 2.05)
- Halving the gap in employment outcomes between Indigenous[12]

Electronic access to the 2018 Prime Ministers Close the Gap Report can be found at: https://closingthegap.pmc.gov.au/sites/default/files/ctg-report-2017.pdf

[12] https://closingthegap.pmc.gov.au

It should be acknowledged that Closing the Gap is currently undergoing a refresh, with a new Closing the Gap framework, targets and performance indicators to be agreed by 31 October 2018.

Electronic access to the refresh can be found at: https://closingthegaprefresh.pmc.gov.au/about

In addition to the Closing the Gap framework, the Plan is shaped also by the learnings, directions and targets of the following:

The **Aboriginal and Torres Strait Islander Health Performance Framework** (HPF) was developed to support a comprehensive and coordinated effort across and beyond the health sector to address the complex and interrelated factors that contribute to Aboriginal and Torres Strait Islander health outcomes.

The HPF sets out a high-level summary of data and policy analysis for performance measures across three domains, as follows:

- Health status and outcomes
- Determinants of health including socio-economic and behavioural factors
- Health service performance.[13]

With a health plan that is embedded in Aboriginal community including social and emotional wellbeing, the HPF provides valuable information, guidance and performance data in understanding the broader landscape around addressing the social determinants of Aboriginal communities on the Central Coast.

More information can be found via: http://www.health.gov.au/indigenous-hpf

The **National Aboriginal and Torres Strait Islander Health Plan** framework is designed to guide policies and programmes to improve Aboriginal and Torres Strait Islander health over the next decade until 2023.

The Plan can be accessed via: http://www.health.gov.au/natsihp.

A **National Aboriginal and Torres Strait Islander Health Plan Implementation Plan** has been developed for the National Aboriginal and Torres Strait Islander Health Plan.

The implementation plan can be found via:
http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-implementation-plan

The **National Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016 – 2026** is a ten-year Framework directs delivery of culturally safe, responsive, and quality health care to Aboriginal and Torres Strait Islander people and communities. The Framework is a renewal of the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004 - 2009.

Access to the framework can be found:
http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-crf

[13] http://www.health.gov.au/indigenous-hpf

The **NSW Aboriginal Health Plan 2013 – 2023** includes six key strategic directions, is a framework to close the gap in health outcomes for Aboriginal people, across all NSW Health operations. The concept of which is the sharing of responsibility across all organisations to achieve equitable health outcomes for Aboriginal people in NSW.[14]

Access the Framework via http://www.health.nsw.gov.au/aboriginal/Publications/aboriginal-health-plan-2013-2023.pdf

Key Priorities Areas

To improve the health and wellbeing of Aboriginal and Torres Strait Islander people living in the Central Coast Local Health District, a number of Key Priorities Areas have been identified. The key Priority Areas include:

1. Chronic Disease
2. Youth
3. Child and Maternal Infant Health
4. Drugs and Alcohol
5. Mental Health including prevention and early intervention

Each of the priority areas are outlined below.

Key Priority Area 1: Chronic Disease

Aboriginal people will experience significantly higher rates of chronic diseases, including diabetes, cardiovascular diseases, kidney disease, liver diseases and respiratory disease. As the leading causes of illness, disability and death among Aboriginal people, it is estimated to be responsible for 70% of the health gap in disease burden between Aboriginal and non-Aboriginal Australians, (AIHW, 2016f).[15]

They will experience poorer health and have worse health outcomes than other Australians, with a burden of disease 2-3 times greater than the general Australian population. Also, they are more likely to:

- Die at a younger age (death rates are around 5 times that for non-Indigenous people in the 35-44yrs age group);
- Experience disability; and
- Report their health as fair[16]

Programs that promote preventative healthcare, early intervention and health promotion, are considered part of the overarching suite of tools available, to address the issues of chronic disease. Issues and access to services within Aboriginal communities may impact those healthy lifestyle choices, preventing, prevention.

[14] http://www.health.nsw.gov.au/aboriginal/Publications/aboriginal-health-plan-2013-2023.pdf
[15] https://www.aihw.gov.au/getmedia/e31976fc-adcc-4612-bd08-e54fd2f3303c/19667-bod7-atsi-2011.pdf.aspx?inline=true
[16] [3] Australian Institute of Health and Welfare 2014. Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

Behavioural risk factors play a key role in the prevention strategies and interventions of chronic disease conditions, smoking, poor diet and nutrition, harmful consumption of alcohol, physical inactivity and cognitive inactivity. Services, programs and staff that are culturally appropriate can address issues such as high-risk behaviours by providing a safe, supportive environment to seek assistance and or receive treatment, in turn, addressing the burden of chronic disease in Aboriginal communities.

"We must combat the vicious cycles of disadvantage that exacerbate mental and physical health issues. Poor mental health contributes to suicide risk and high rates of smoking, alcohol and substance abuse and obesity, that in turn progresses chronic disease: the biggest killer of Aboriginal and Torres Strait Islander peoples."[17]

Priority Area #1: Chronic Disease

Focus Area
• Diabetes • Cardiovascular disease • Respiratory • Renal • 715 Health Assessment (early detection) to ensure chronic disease and related illness are managed and coordinated efficiently. (Yerin)
Objectives
1. Reduce prevalence of diabetes 2. Increase management of diabetes 3. Reduce unnecessary diabetes related hospitalisations 4. Increase numbers of 715 Health Assessments undertaken and promote yearly check-up to community (Yerin)

[17] National Mental Health Commission (NHMC), 2012. A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention, Sydney: NMHC. <http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2012-report-card.aspx>; last accessed 19/04/2016.

Cancer

Cancer, as described by Cancer Australia is 'a disease of the cells, which are the body's basic building blocks. Cancer occurs when abnormal cells grow in an uncontrolled way. These abnormal cells can damage or invade the surrounding tissues, or spread to other parts of the body, causing further damage.' [18]

As at 2011, Cancer was responsible for 9% of the Indigenous burden of disease and 9% of the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians (AIHW, 2016f). Indigenous Australians experienced 1.7 times the burden due to cancer than non-Indigenous Australians. The biggest risk factor was for tobacco use (39%) and, 97% of the cancer burden was due to early death. Between 2003 and 2011 there was a 6% increase in burden due to cancer for Aboriginal and Torres Strait Islander peoples, mainly due to deaths from liver and lung cancer.[19]

Cancer death rates for Indigenous Australians have increased by 21% between 1998 and 2015, while rates for non-Indigenous Australians have declined (by 13%). [20]

Aboriginal and Torres Strait Islander people have a higher incidence of fatal, screen-detectable and preventable cancers and are diagnosed at more advanced stages, and often with more complex comorbidities (Cunningham et al., 2008). Compared with other Australians diagnosed with same cancer, Aboriginal and Torres Strait Islander people are doubly disadvantaged because they are usually diagnosed later with the more advanced disease, are less likely to have treatment, and often have to wait longer for surgery than non-Indigenous patients (Hall, SE et al, 2004; Valery et al, 2006).

In line with the National Aboriginal and Torres Strait Islander Cancer Framework (2015), the partnership seeks to contribute to the improved outcomes for the Aboriginal and Torres Strait Islander population of the Central Coast, about cancer and cancer care management.

The framework notes in the following:

- Is multidisciplinary and integrated across health sectors (primary, secondary and tertiary care) and into the community (including referral pathways to primary care, allied health and other relevant community services) [21]
- Incorporates quality improvement processes for ongoing assessment, review, evaluation and improvement of care [22,23]
- Includes strong involvement and leadership from Aboriginal and Torres Strait Islander people (including those affected by cancer) to ensure care is effective and appropriate to their needs and preferences [24]

[18] https://canceraustralia.gov.au/affected-cancer/what-cancer
[19] https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier1/108.html
[20] https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/overview/Executive-summary.html
[21] Cancer Australia and Menzies School of Health Research. 2015. Development of the Aboriginal and Torres Strait Islander Cancer Framework: Activity 1 and 2 Report. Unpublished.
[22] Institute of Medicine. 2013. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. National Academies Press, Washington.
[23] Cancer Australia. 2014. Review and collation of evidence on programs improving cancer outcomes in Aboriginal and Torres Strait Islander People Project. Health Outcomes Australia, Glynde, SA.
[24] Cancer Australia. 2014. Review and collation of evidence on programs improving cancer outcomes in Aboriginal and Torres Strait Islander People Project. Health Outcomes Australia,

- Occurs in a timely and equitable manner and delivers best practice care as close to home as (safely) possible is delivered by skilled and caring staff with effective cross-cultural communication skills, supported by organisations in which cultural competence is embedded as integral to quality and safety. [25]

As such the framework and the specific guidelines (see framework for further guidelines) will underpin a number of the activities as outlined in the focus area below.

The Plan will also reflect the patient journey, taking in to consideration the continuity of the client care experience, including the needs for a strong referral pathway for those clients requiring Palliative care, that is delivered in a culturally appropriate way.

Priority Area #1: Chronic Disease (Cancer Care)

Focus Area To ensure that services provided across the partners around cancer care, is multidisciplinary and integrated.
Objective 1. Patient continuity is ensured from GP to specialist across the service providers.

Relevant Documents
Palliative Care Review in October 2017
http://www.cclhd.health.nsw.gov.au/Publications/Documents/CCLHD_PalliativeCareEndofLifeCareReview2017.pdf

Key Priority Area 2: Young people

Aboriginal and Torres Strait Islander people under the age of 25 make up over 50% of the population in the Central Coast. This age bracket poses a significant opportunity for focusing on prevention. The Aboriginal and Torres Strait Islander child mortality rate is around twice that of other Australian children.[26] Aboriginal and Torres Strait Islander people are also at an increased risk of contracting a sexually transmitted disease[27]. In Australia, the average age of an Aboriginal and Torres Strait Islander mother is 25.1 years compared to 31 for all mothers. Aboriginal and Torres Strait Islander teenagers are more likely to give birth than other Australians (16.1% v 2.8% respectively).[28] Additionally, young Aboriginal and Torres Strait Islander people are more likely to have a mental health condition.[29]

Glynde, SA.
[25] https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier1/108.html
[26] https://www.aihw.gov.au/getmedia/b46de39b-eeb5-4a98-87e8-44dad29f99b9/ctgc-ip06.pdf.aspx?inline=true
[27] https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier1/112.html
[28] http://www.healthinfonet.ecu.edu.au/health-facts/overviews/births-and-pregnancy-outcomes
[29] https://blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/2017-youth-mental-health-report_mission-australia-and-black-dog-institute.pdf?sfvrsn=6

Priority Area #2: Young people

Focus Area
• Mental health (mental health plans indicator) • Sexual and reproductive health (Sexual health check indicator) • Prevention (715s indicator) (Yerin)
Objective: To improve the health outcomes for Aboriginal and Torres Strait Islander people 25 or under living on the Central Coast.

Key Priority Area 3 - Child and Maternal Infant Health

There were 18,537 births registered in Australia with one or both parents identified as Aboriginal and/or Torres Strait Islander (6.1% of all births registered) in 2015.[30] Aboriginal and Torres Strait Islander women had in 2015, on average, 2.3 births in their lifetime (compared with 1.8 births for all Australian women). [31]

About 16% of Aboriginal and Torres Strait Islander mothers were teenagers, compared with 2.8% of all mothers. The average birthweight of babies born to Aboriginal and Torres Strait Islander mothers in 2014 was 3,215 grams, 140 grams less than the average for babies born to non-Indigenous mothers (3,355 grams). [32]

Priority Area #3: Child and Maternal Infant Health

Focus Areas
• Smoking • Birthweight • Under registration of babies' births • Mothers access to Aboriginal Health Worker Collaboration with non-health organisations in areas of: • Child protection • Homelessness • Family/domestic violence
Objective: To improve the health outcomes for Aboriginal mothers, babies and children living on the Central Coast.

[30] Australian Bureau of Statistics (2016) *Births, Australia, 2015*. Retrieved 8 November 2016 from http://www.abs.gov.au/ausstats/abs@.nsf/mf/3301.0?OpenDocument
[31] Australian Bureau of Statistics (2016) *Births, Australia, 2015*. Retrieved 8 November 2016 from http://www.abs.gov.au/ausstats/abs@.nsf/mf/3301.0?OpenDocument
[32] Australian Institute of Health and Welfare (2016) *Australia's mothers and babies 2014: in brief*. Canberra: Australian Institute of Health and Welfare

Figure 5 Key Priority 3 priorities

Key Priority Area 4 - Drug and Alcohol

As at 30 June 2015, the estimated Australian Aboriginal and Torres Strait Islander population was 729,048 people of which it is estimated that NSW has the highest number of Indigenous people (225,349 people, 31% of the total Indigenous population). [33]

In 2013, 24.1% of Aboriginal people surveyed via the National Drug Strategy Household Survey reported use of an illicit drug in the 12 months prior compared to 15% of the general population. [34]

Aboriginal Australians were 1.6 times more likely to use methylamphetamine and 1.5 times more likely to misuse pharmaceutical drugs. [35]

Additionally, the survey notes that whilst there was a minimal increase in methamphetamine and amphetamine use, there was also significant change in the form of the drugs used. The use of crystal methamphetamine (Ice) doubled from 22% in 2010 to 50% in 2013 nationally as did the frequency of the usage. [36]

There is a recognition of the need to provide evidence-based practice responses is identified in the following national and state directions: National Drug Strategy 2017-2026 and NSW Drug and Alcohol Psychosocial Professional Practice Guidelines 2008 and reports from the National Indigenous Drug and Alcohol Committee (NIDAC).

The main drug types addressed by services include alcohol, cannabis, opioids and stimulants.

Broadly speaking young people will have higher rates of risky behaviours, with more susceptible patterns of behaviour than the wider population. Equally some drugs trends will attract the younger audience as opposed to the older population.

Additionally, alcohol and pregnancy can result in birth defects and behavioural and neurodevelopmental abnormalities, the symptoms of Fetal Alcohol Spectrum Disorder (FASD) can continue into adulthood.

250,000 Australians estimated to have been the victims of an alcohol-related physical assault in 2015-2016.[37]

33 Australian Indigenous HealthInfoNet: Overview of Australian Aboriginal and Torres Strait Islander Health Status 2015. http://www.healthinfonet.ecu.edu.au/health-facts/overviews

34 Australian Institute of Health and Welfare: National Drug Strategy Household Survey 2013. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549848 (page 14)

35 ibid (page 95)

36 ibid (page 7)

37 Australian Bureau of Statistics' (ABS) 2015–16 national Crime Victimisation Survey

Misuse of alcohol is a major risk factor for conditions such as liver disease, pancreatitis, diabetes, and some types of cancer. It also contributes to falls, burns, suicide and motor vehicle accidents and is associated with social and emotional harms such as family violence.

Priority Area #4: Drug and Alcohol

Focus Areas
• Pain medication addiction • Alcohol misuse • Dependency on methamphetamines
Objective: To assist in the reduction of the impact of drug and alcohol misuse among Aboriginal and Torres Strait Islander people on the Central Coast.

Key Priority Area 5 - Mental Health including prevention and early intervention

The Australian Burden of Disease Study 'Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011' (AIHW 2016f) notes that Mental health and substance use disorders combined, were the leading cause of total disease burden for Aboriginal Australians, representing 19% of the burden. Anxiety disorders, 23% of the total burden from mental and substance use disorders, alcohol use disorders (22%), depressive disorders (19%), schizophrenia (8%) and drug use disorders (6%). Non-fatal burden predominated for mental health and substance use (97%); burden was highest in younger age groups (44 years and under); and higher for males (56%) than for females (44%). Mental health related conditions accounted for 3% of deaths among Aboriginal Australians. [38]

Aboriginal Australians with a mental health condition were more likely to have experienced problems accessing health services (23%) than were people with other long-term health conditions (13%) or no long-term health conditions (10%). [39]

Good mental health and wellbeing is viewed as part of the holistic health that encapsulate Aboriginal people connecting protective factors such as strong home, work, community, connection to country and sense of self and spirit, all of which play a significant part in a person's wellbeing. Equally without those factors Aboriginal people may experience 'higher levels of morbidity and mortality from mental illness, psychological distress, self-harm and suicide than other Australians. [40]

Mental and spiritual health in the context of Aboriginal people (historical trauma, Stolen Generation, loss of lands) can be complex with complex case management and services required, referrals are also

[38] https://www.aihw.gov.au/getmedia/e31976fc-adcc-4612-bd08-e54fd2f3303c/19667-bod7-atsi-2011.pdf.aspx?inline=true
[39] https://www.pmc.gov.au/sites/default/files/publications/2017-health-performance-framework-report.pdf (p.77)
[40] https://www.pmc.gov.au/sites/default/files/publications/2017-health-performance-framework-report.pdf (p.76)

complex in nature requiring close work with other services providers such as Drug and Alcohol and Chronic Care.

"Co-morbidity, or the co-occurrence of an alcohol, tobacco and other drug use disorder with one or more mental health conditions, complicates treatment and services for both conditions. They can also co-occur with physical health conditions (e.g., cirrhosis, hepatitis, heart disease, and diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain.

Given the strong relationship between mental health and alcohol, tobacco and other drugs, it is imperative to improve the collaboration and coordination between services to ensure that the most appropriate treatment and supports is being made available to the individual." [41]

Priority Area #5: Mental Health

Focus Area • Prevention • Early detection • Management
Objective: Increase awareness – prevention and early intervention (Health promotion)

Implementation Plan

An implementation plan will be developed to assist in achieving the aims and objectives of this Plan.

The implementation plan will detail the Plan Governance, outline roles and responsibilities for each of the partner organisations, include a detailed communication plan and include strategies for achieving the objectives under each of the Key Priority Areas.

Measuring and Monitoring the Plan

It is important to monitor the success of the Plan, data relating to the Key Priority areas will be collected and analysed annually. Indicators will be developed to measure the success of the relationships and success of the Plan in meeting the objectives under each of the Key Priority Areas A measuring and Monitoring Plan will sit alongside the Implementation Plan which will be developed in 2018.

[41] https://www.hcasa.asn.au/documents/555-national-drug-strategy-2017-2026/file

Aboriginal Health and Community Services Directory

Services
Yerin Aboriginal Heath Services A primary healthcare service focusing on the physical, spiritual, social, emotional, and cultural well-being needs of the Aboriginal and Torres Strait Islander people on the Central Coast. An accredited practice and an Aboriginal Community Controlled Health Organisation. General practitioners (GPs) and registered nurses provide health care, advice and treatment for Aboriginal and Torres Strait Islander people, including health assessments linked to its Chronic Disease Management Program. The centre employs a psychologist, a family violence worker, a drug and alcohol worker, an Aboriginal outreach worker and an Aboriginal health promotions officer. There is access also to a range of specialist services for the local Aboriginal community including the psychiatry team, a paediatrician, an optometrist, a dietician, a diabetes educator, the Liver Clinic, a podiatrist, a physiotherapist, an endocrinologist and a speech pathologist. The Dhanggan Gudjagang team comprises of two Aboriginal Health Workers, an Aboriginal Family Violence worker, an Early Childhood Nurse and a Midwife. Providing antenatal care, postnatal care, advice on women's business, breastfeeding support, support for mothers and families when dealing with mainstream health services, advice on child development as well as support for clients and families who are at risk of or experiencing domestic and family violence. The Yadhaba Wellbeing team is made up of credentialed mental health and drug and alcohol workers, social worker, psychologist and credentialed mental health and drug and alcohol registered nurse team leader. The centre also has a ITC – Integrated Team Care and supplementary services, providing nurse care coordination for Chronic Disease clients, three Nurse Care coordinators, a transport assistant and an Aboriginal outreach worker. Yerin will be opening their own dental clinic in July 2018, all dental services will be provided from their own dental clinic on site. Yerin is also a registered NDIS provider, they have a Disability linking worker to support their clients navigate the NDIS.
Nunyara Aboriginal Health Unit (CCLHD) CCLHD provides a range of services specifically developed for the Aboriginal community in the community setting and promote the employment of Aboriginal people. The Nunyara Aboriginal Health Unit provides health services for Aboriginal people, Nunyara provides services through its Aboriginal Hospital Liaison Officer and the Aboriginal Chronic Care Team. Key services are shown below:

Chronic Care Team
Linking Aboriginal people who have been in hospital with services in the community.

Aboriginal Consultancy Team
Drug and Alcohol Service (D&A) – includes an Aboriginal consultant, Aboriginal Maternal and Infant Health Strategy (AMIHS) clinician and an AMIHS Aboriginal trainee.

Building Strong Foundations (BSF)
An Aboriginal Child and Family Health program that works with families with children from birth to school entry. Staffed by child and family health nurses, Aboriginal Health workers and a social worker, the team offers developmental and psychosocial screening, immunisation and referral to secondary services (Allied Health), internal and external to CCLHD. The AMIHS is co-located with BSF at Ngiyang, in Gosford providing a midwife and an Aboriginal Health worker who focus on antenatal care and family

Youth Health
Includes an Aboriginal Youth Health worker as part of the Primary Health team who works closely with the Homelessness Outreach Worker and Youth Health Nurses, psychologists and social workers.

The Aboriginal Mental Health Team
Provides specialist mental health services to the Aboriginal community via the Eleanor Duncan Aboriginal Health Centre. Senior mainstream mental health medical staff undertake clinical assessment, care planning and consultation in partnership with Aboriginal mental health staff.

The team also works in a liaison role with inpatient and community mental health services by providing cultural input and advice into mental health care planning. This collaboration assists in engaging and working more effectively with Aboriginal clients accessing mental health services.

Children and Young People's Mental Health
(CYPMH) and headspace Gosford provide a pathway of care that is accessible and culturally appropriate to young Aboriginal people.

CCLHD Aboriginal Maternal and Infant Health Service (AMIHS)
Provides Aboriginal families access to culturally sensitive pregnancy and postnatal care and support. This service aligns with the National Indigenous Early Childhood Development initiative to provide mental health and drug and alcohol programs to assist Aboriginal families. These programs also provide a mental health position to work with CYPMH and provide expert clinical support and supervision.

HNECC PHN
Hunter New England and Central Coast (HNECC) is a not for profit organisation funded by the Commonwealth government to improve the efficiency and effectiveness of the primary health care system.

Following changes introduced by the Commonwealth government in 2014 the PHN replaced the Central Coast, Hunter and New England Medicare Locals. It has however, been able to maintain and consolidate the existing business relationships built up by the three organisations over many years. These relationships include formal partnerships and health reform agreements, with the Central Coast and Hunter New England Local Health Districts (LHDs), formal partnerships and funding agreements with Aboriginal Health Services, Non-Government Organisations, Aged Care Organisations, Local Government and the private sector.

HNECC PHN is not a direct provider of health services. It plans, develops and manages a range of service agreements with organisations to deliver primary health care programs where they are needed. Program areas funded by HNECC PHN include mental health, Aboriginal health, drug and alcohol, suicide prevention, GP after hours care and Rural Primary Health Services (RPHS).

http://hneccphn.com.au/programs-resources

Bungree Aboriginal Association

Bungree provide a wide range of funded programs and services that assist vulnerable and isolated people and families such as our elderly and frail, people with a disability, people who are experiencing or are at risk of homelessness, children, youth and families. Services they provide include:

- Aboriginal Housing Program
- Respite Care Program
- Community Transport Program
- Community Options Program
- Podiatry Program
- Intensive Family Based Service
- Specialist Homelessness Services
- Community Aged Care Packages
- Social Support Program
- Registered NDIS provider

Mingaletta Aboriginal & Torres Strait Islander Corp.

Provides support through developing meaningful relationships with service providers supporting successful referral, advocacy and support. Services include:

- Provide information or advice about available resources and services
- Promote and protect land and culture
- Ensure that decision making is undertaken in a way that is culturally inclusive for Indigenous people
- Assist people find their independence through self-empowerment
- Refer Aboriginal people business who can assist
- Work closely with Aboriginal Services or Organisations to address issues
- Provide to the non-Aboriginal community knowledge of Aboriginal customs, culture and rights

Darkinjung Local Aboriginal Land Council

Darkinjung Local Aboriginal Land Council focuses on improving the health and wellbeing of the community. Darkinjung LALC shares its boundaries with neighbours Bahtabah LALC and Metropolitan LALC which were established around the traditional boundaries of the region.

The Darkinjung LALC is positioned within the Central Coast Council footprint. The following core operational functions of Darkinjung LALC are as below:

- Community Participation and Wellbeing
- Culture, Heritage and Environment
- Governance and Operations
- Business and Economic Development

Bara Barang Corporation Ltd

Bara Barang is a member of Empowered Communities.
Find out more HERE or download a copy of the report HERE.

Bara Barang is an Aboriginal Central Coast Corporation providing innovative programs, events, training and services to engage Aboriginal people and youth. We aim to create a self-determined and empowered community to improve school retention, build leadership and promote vocational learning and employment opportunities.

Cultural activities including performance, art, craft, visitation to significant Aboriginal sites are complimented by case management.

Aboriginal youth in need of additional support are linked with an Aboriginal mentor and are encouraged to participate in the variety of community activities that occur weekly throughout the region. Bara Barang has an Aboriginal Central Coast Youth Reference Group. Members of the group facilitate youth forums and are available as Master of Ceremonies.

Bara Barang promotes Aboriginal youth leadership through activities such as the 2011 Freedom Ride and links participants to disadvantaged Aboriginal communities throughout NSW. Participants work with these communities to bring about economic and social reform in the spirit of reconciliation.

Barang Regional Alliance

Barang is a uniting voice for Aboriginal communities on the Central Coast, a backbone organisation, speaking to government and other key stakeholders. We contribute to the retention of Aboriginal culture, create stronger community networks, develop local Indigenous leadership and optimise service delivery and investments for the Aboriginal community.

Through the Commonwealth **Empowered Communities** and NSW **Local Decision Making** initiatives, we seek structural reform to empower our community.

Gudjagang Ngara Li-dhi

Gudjagang Ngara Li-dhi is an early intervention service working with Aboriginal Children and families, providing Structured play group (based on Early Years Framework), cultural programs, support for parents, carers and foster carers by delivering culturally safe social activities, transition to school programs, advocacy and referral for natural parents and carers involved with community services Family and Community Services.

NAISDA

NAISDA Dance College offers professional expertise and word class training facilities to deliver accredited training programs that are rich in cultural learning and practice. Located on Darkinjung land just north of Sydney, we provide a creative learning space designed to inspire and equip Aboriginal & Torres Strait Islander young people for the future. Our dance performance program is delivered by qualified trainers comprised of former principal dancers, respected choreographers and cultural tutors from diverse Aboriginal & Torres Strait Islander communities.

NAISDA students are known as Developing Artists while they undertake training and learn aspects of artistic life in the world of dance. Many NAISDA graduates continue to play key roles both onstage and off at companies such as Bangara Dance Theatre and Descendance. The creative talents of developing artists are showcased each year at NAISDA Dance College's performances and stage productions. The productions express our commitment to honour the world's oldest living culture and share knowledge of Aboriginal and Torres Strait Island dance, music, art and history with audiences from around the world.