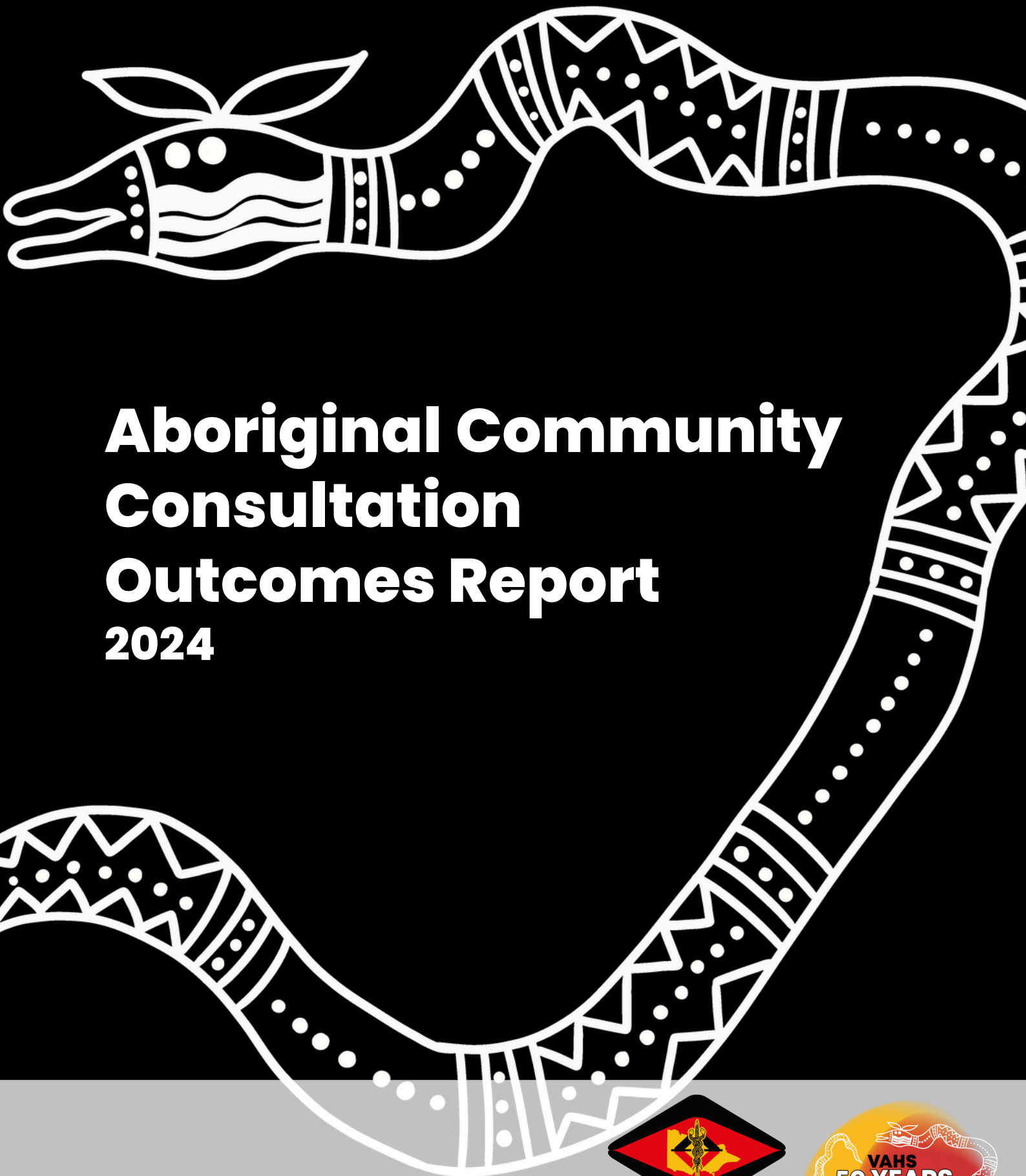


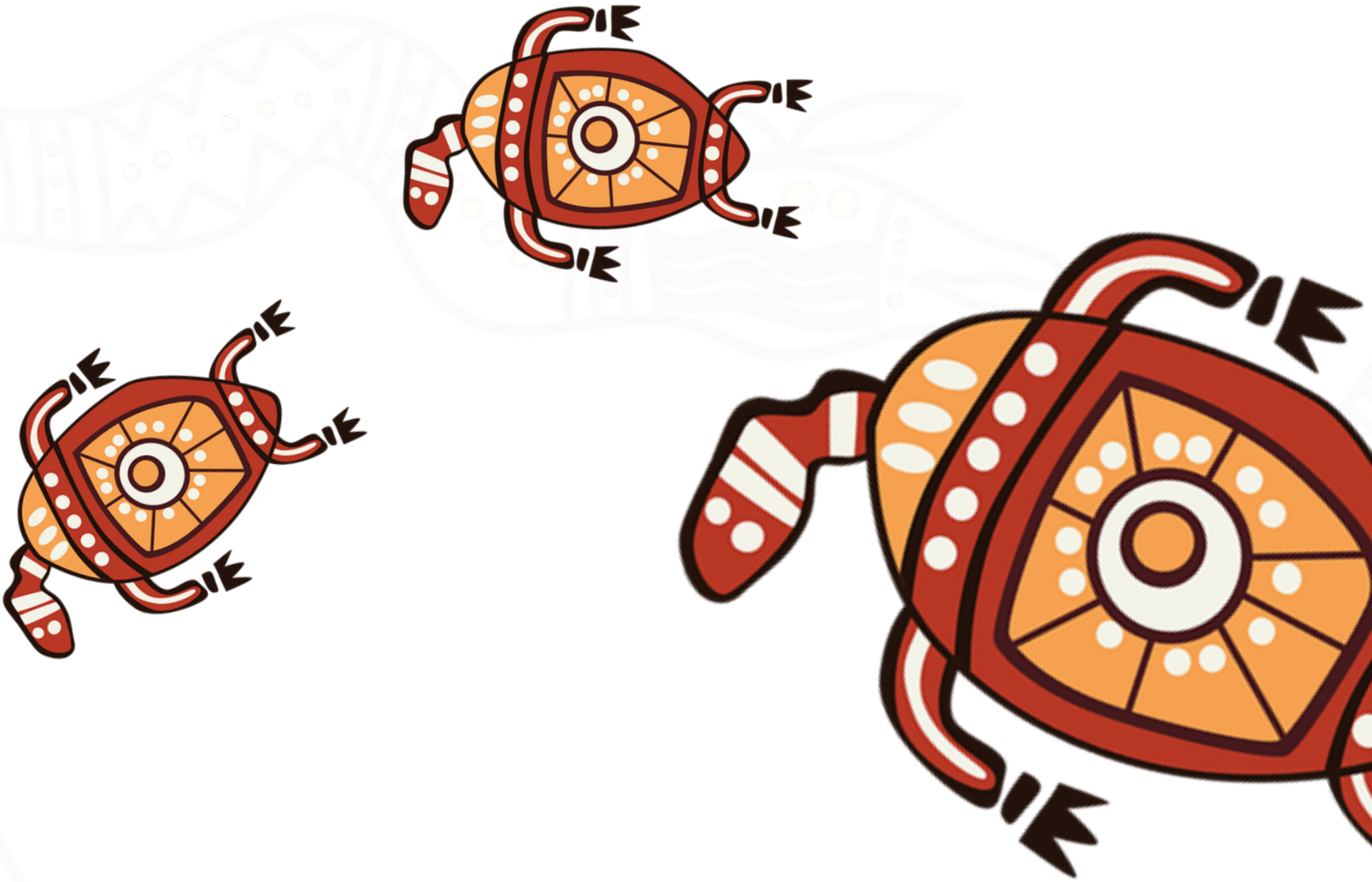
Aboriginal Community Consultation Outcomes Report

2024

VICTORIAN ABORIGINAL HEALTH SERVICE

Caring for the Community

VAHS 50 YEARS 1973-2023



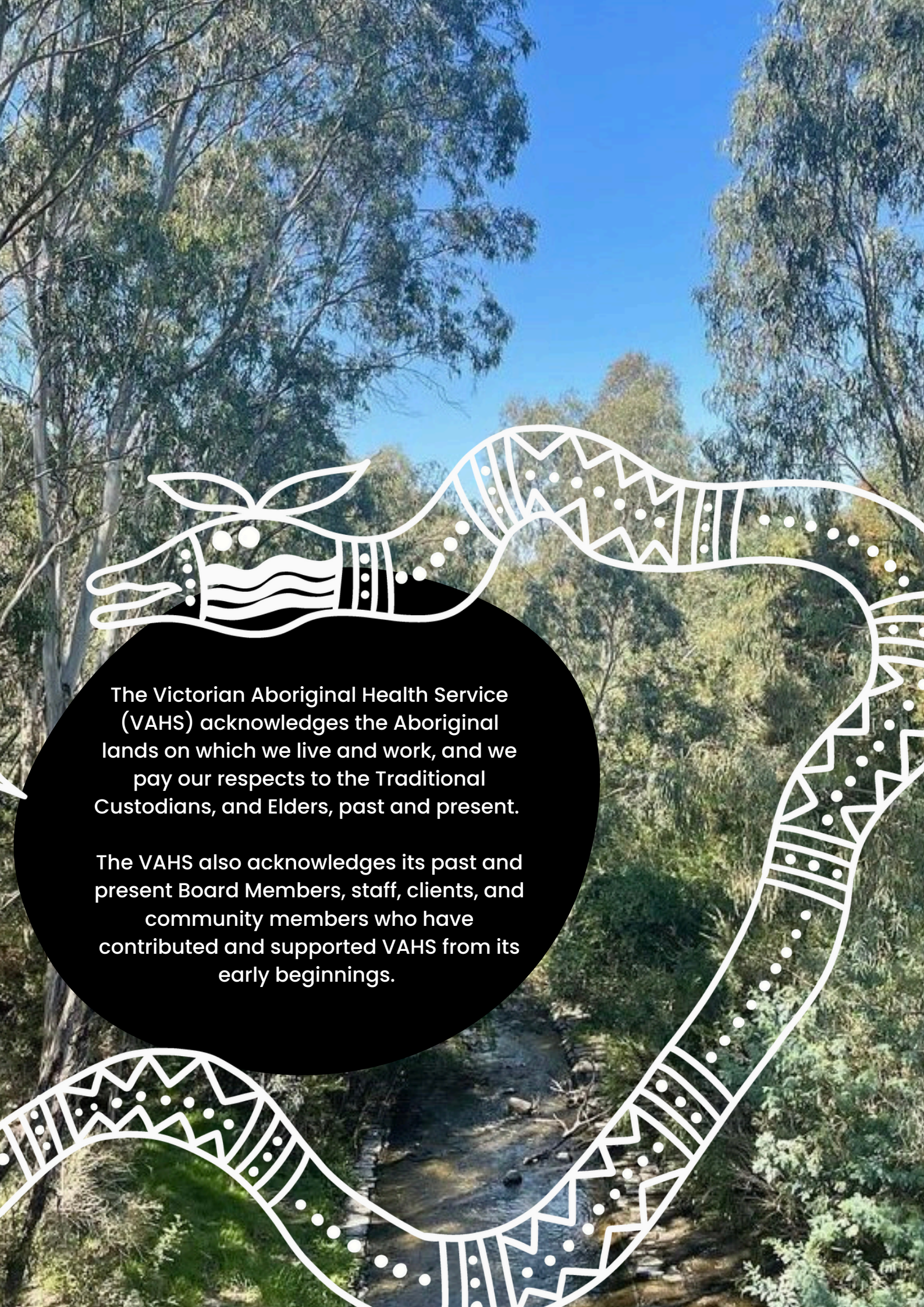
This report was authored by the Victorian Aboriginal Health Service as a commissioned work for the North Western Melbourne Primary Health Network.

DISCLAIMER

While all care has been taken to ensure that information contained in the Report is true and correct at the time of publication, changes in circumstances after the time of printing may impact of the accuracy of its information.

Aboriginal and Torres Strait Islander readers should be aware that this document may contain images and names of deceased persons.

VAHS is a Child Safe Organisation.



The Victorian Aboriginal Health Service (VAHS) acknowledges the Aboriginal lands on which we live and work, and we pay our respects to the Traditional Custodians, and Elders, past and present.

The VAHS also acknowledges its past and present Board Members, staff, clients, and community members who have contributed and supported VAHS from its early beginnings.

Aboriginal Community Control

"Community control means that each independent and autonomous health service is controlled by the Community it services, in order to provide that Community with health care delivery to meet its health needs, as defined by that community. The solution to each Community's health needs is in the hands of that Community."

- BRUCE MCGUINNESS

Contents

TERMINOLOGY

The term Aboriginal is used in this submission to embrace all Aboriginal and Torres Strait Islander peoples living in Victoria and Australia.

During consultations, Aboriginal community members who identified as LGBQTIA+ referred to their community as Rainbow Mob. This is the terminology we use in this report.

About VAHS

The Victorian Aboriginal Health Service (VAHS) was established in 1973 by a group of Aboriginal leaders in Fitzroy to address the poverty, injustices, high mortality rates, burden of disease and ill health of Aboriginal people as a direct result of government policies which restricted the access of Aboriginal people to essential health services. VAHS became the first Victorian incorporated Aboriginal Community Controlled Health Organisation (ACCHO) and over the last 50 years has evolved with a strong foundation of cultural knowledge and cultural competence in the delivery of comprehensive primary health and Social and Emotional Wellbeing (SEWB) care for Aboriginal peoples and communities across metropolitan Melbourne.

Over this time VAHS has expanded its service scope and operations and currently provides a comprehensive suite of medical, dental, mental health, preventative health, SEWB and community support programs. Our vision is to 'create and inspire healthy Aboriginal people and families through high quality and effective community health and wellbeing services, education and training. VAHS will achieve this with a flexible approach that is innovative, embraced by community and sets a standard as a Centre for Excellence for Aboriginal health internationally'.

VAHS Strategic Objectives are to:

- Build program and service excellence
- Extend our reach and improve access
- Invest in our workforce - making sure our staff are skilled and supported
- Ensure the future of VAHS is supported by first class systems

Recommendations

On the basis of the consultations, and taking into account the NWMPHN's scope, VAHS recommends the following:

Cultural safety

1. The NWMPHN develop quality improvement activities for General Practitioners relating to cultural safety, and 715 Aboriginal Health Checks, in partnership with Aboriginal experts.
2. The NWMPHN builds cultural safety into the NWMPHN Health Pathways, which should include specific details around asking if the patient is Aboriginal and if so, linking to additional information specific to culturally safe health service provision.
3. NWPHN commissioning includes specific mandatory criteria relating to cultural safety in health and community services. This should require tenderers to demonstrate:
    a. Understanding of local Aboriginal community and specific health needs.
    b. Ongoing internal auditing and an action plan for cultural safety, and demonstrable enactment of that plan.
    c. Partnerships with local Aboriginal Community Controlled Organisations and/or an Aboriginal workforce.
    d. Regular cultural safety training with an Aboriginal organisation(s).

Aboriginal Health Needs Assessment

4. The NWMPHN produces a separate annual Aboriginal Health Needs Assessment (AHNA) to supplement their annual Health Needs Assessment, which includes a strength-based approach and embeds community consultation into the development process. This separate AHNA should focus on priority populations within the Aboriginal community, such as women and men, youth, Elders, and Rainbow Mob.

Aboriginal Health Workforce

5. That the NWMPHN invests in capacity and capability building for the Aboriginal Health Workforce by:
    a. Conducting a mapping exercise to ascertain data about the Aboriginal Health Workforce, to ascertain roles and locations of those roles, as well as recruitment and retention information. This data should be shared with the Aboriginal Community Controlled Health sector in line with Indigenous Data Sovereignty.
    b. The NWMPHN facilitates an Aboriginal Community Controlled, self-determined approach to networking for the Aboriginal Health Workforce across the health and community services sector in the region, to enable peer-peer learning and capability building.
    c. The NWMPHN supports the professional development of the Aboriginal Health Workforce through resource development and partnerships with local ACCHOs.
    d. The NWMPHN supports health and community services to recruit and retain Aboriginal Health Workers by linking them up with local ACCHOs, and by providing relevant resources.

Background

Cultural determinants

Health is understood by Aboriginal people as holistic, including physical health, social and emotional wellbeing (SEWB), mental health and spiritual health. Aboriginal health includes both the health of the individual and that of the community (Dudgeon et al., 2017). The determinants of health for Aboriginal people include physical, social, historical and political and cultural (Lowitja Institute, 2021)[ii], which is why Aboriginal Community Controlled Health Organisations succeed using holistic models of care that include wrap around services and supports. The cultural determinants are vital to health and wellbeing and include,

- Family, kinship and community
- Indigenous beliefs and knowledges
- Cultural expression and continuity
- Indigenous language
- Self-determination and leadership
- Connection to Country (Lowitja Institute, 2021)[iii]

Findings from the Victorian Population Health Survey 2017 (Victorian Agency for Health Information, 2021), recognise, as well as the Aboriginal and Torres Strait Islander Health Performance Framework Summary report (Australian Institute of Health and Welfare, 2024) that the evidence shows that Aboriginal people who are connected with culture have better health.[iv v] Mainstream services that do not consider these determinants in service design and referral pathways, and that do not value cultural determinants as highly as physical and social determinants will not be effective in improving health outcomes. This was reflected in the community consultations summarised below.

Colonisation's impact on Aboriginal health

In order to better understand the health needs of Aboriginal community members and to understand how they might be met by all health and community services and programs funded by the North Western Melbourne Primary Health Network (NWMPHN) it is vital to understand the historical context that has led to a health gap for Aboriginal people in Victoria.

Colonisation wasn't a contained historical event; it continues to this day and impacts on all Aboriginal communities and families in different ways. The current health systems, services and policies that exist today were built on systems and policies established and imposed on Aboriginal peoples since colonisation. These systems still perpetuate the harms of colonisation and contemporary settings and have direct impacts on health and SEWB.

In Victoria, this has been well documented. As Graham Gee et al. note, "Historical records [8], ethnographic research [9], and the recorded stories of Koori people themselves [10, 11], show that colonisation for the Koori clan groups of Victoria involved systemic structural violence and oppression, the impacts of which are consistent with large scale collective trauma."(Gee et al., 2023)[vi] Evidence presented in the Yoorrook Justice Commission consistently speaks to these harms.

As VAHS CEO Michael Graham said when giving evidence at the Yoorrook Public Hearings,

"I just wanted to highlight that when we were colonised, invaded, whatever you want to call it and everybody calls it different things, our systems were taken away from us. Our language was taken away, we weren't allowed to speak our language. We weren't allowed to do song and dance. We weren't allowed, all of our systems they tried to take them away from us, they sent us off to missions and said, "Don't practise your culture, don't do this, don't do that." And the people who congregated to Fitzroy said, "If we don't do something, we're gonna die off. We've got to change something."

Mainstream colonial health systems are vastly different from Aboriginal health systems. Aboriginal people have a holistic framework for viewing health and social and emotional wellbeing (SEWB) that understands at social, cultural, political and physical determinants of health as connected and equally important to good health and wellbeing.(Thurber et al., 2022)[vii] Culture is a protective factor that keeps our people healthy and well. Preventing Aboriginal people from being connected to culture, Country, community, traditional ceremony and healing, lore – Aboriginal ways of being, knowing, and doing – was a deliberate application of racism, intended to reduce Aboriginal peoples' health outcomes.

Mainstream systems today still do not place the same level of importance on the cultural determinants of health and wellbeing that Aboriginal health systems did and do, as well as traditional healing and Aboriginal knowledge systems. This report will speak to the lived experiences of cultural safety or unsafety by Aboriginal people in the Northwest local government areas of metropolitan Melbourne (NW LGAs) below.

Further, in talking about cultural safety it is necessary to also talk about the legacy of racism that lives on in our health systems as both structural racism and interpersonal racism. This is a health crisis in and of itself. Racism against Aboriginal people, including in health settings, has been found to significantly impact on Aboriginal peoples' health and wellbeing. A recent study (Thurber et al., 2022) found that "up to 49·3% of the total burden of psychological distress among Aboriginal and Torres Strait Islander adults could be attributable to everyday discrimination." [viii]

Recently, racism has been increasing. For instance, ABC reported a spike in calls to the 13Yarn Crisis line last year around the time of the Referendum.[ix] In a 2017 survey it was found that the NW LGAs had the highest percentage of people who experienced racism out of all Melbourne LGAs (10.6%).[x] Note that this is likely an underreporting due to limitations with the survey method. [xi]

Within healthcare, high rates of racism has been found even amongst colleagues.

"The unacknowledged whiteness of health care results in a one size fits all model of care for all Australians that fails to recognise the needs of Aboriginal people and presents a challenge to non-white healthcare workers."

Aboriginal peoples have never been safe in mainstream systems, the levels of access to and quality of care has always been lower, which contributes to the gap in health outcomes. This is what has driven the establishment of Aboriginal Community Controlled Health Organisations (ACCHOs) like VAHS.

Mainstream health services and health providers do more harm than good when there is a lack of cultural safety. Devaluing and failing to recognise the cultural determinants of health perpetuates in a contemporary way what Michael Graham shared in the above quote.

During the community consultations, VAHS heard many stories of racism and a lack of cultural safety impacting on access to health services and health outcomes during our community yarns (detailed below).

Methodology and approach

VAHS was engaged by the North Western Melbourne Primary Health Network (NWMPHN) to undertake community consultations with Aboriginal people in Northwest Melbourne Metropolitan area to include community voices when identifying priority health needs for the purposes of their 2024 Health Needs Assessment (HNA). This is the first time that the NWMPHN has engaged an Aboriginal Community Controlled Organisation to collect qualitative data for the HNA.

Data collection

VAHS facilitated a series of seven group yarning sessions and additional individual yarns, conducted by Aboriginal facilitators with ties to the local Aboriginal community. These yarns were facilitated across six locations: St Albans, Melton, Wyndham Vale, Preston, Fitzroy and South Morang. A seventh yarning session was conducted with Aboriginal young men in Thornbury. VAHS also conducted 12 individual yarns to ensure that community members who did not feel comfortable in group settings were able to share, and to enable community members to share more deeply about their experiences in an environment in which they felt safe. Individual yarning also enabled community members choice about who they wanted to share their stories with, in line with cultural protocols around men's and women's business.

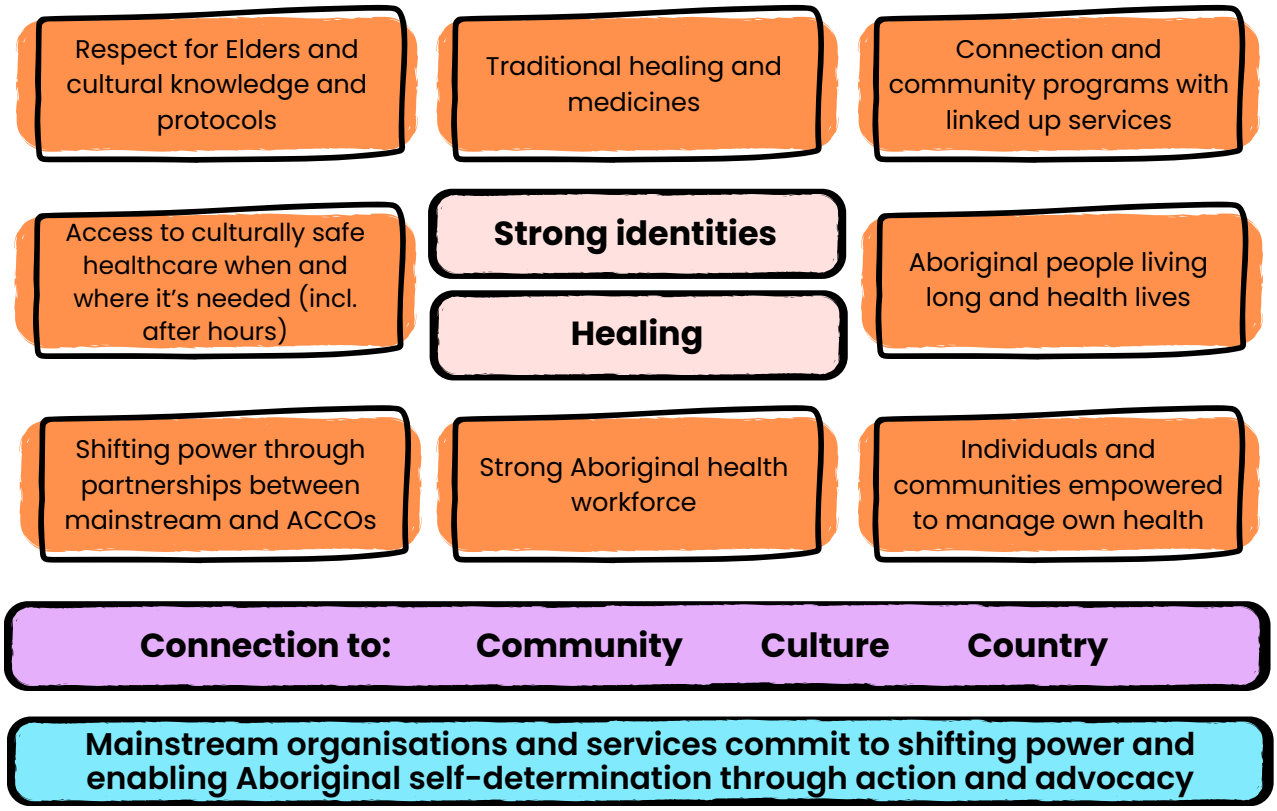
In addition to making space for community members to share their stories, two key questions guided the consultation sessions. The first was "What is the current health status of community?" The second was "What does good look like?" The positive framing of the second question was to ensure a strength-based approach was imbedded in the process. This is important to understand Aboriginal health needs and their relationship to desired outcomes and aspirations, and community members' input into how to meet those needs. We also asked for participants to share their positive and negative experiences within the health system, both in Aboriginal Community Controlled Organisations and in mainstream services.

VAHS spoke with a total of 62 community members, who all had unique stories and experiences to share. While all experiences were unique many themes were consistent across all groups.

Data analysis

The qualitative analysis of data received through these facilitated yarning circles is grounded in available public health data and VAHS internal data. The overall analysis employs a narrative analysis to determine key health needs identified in the stories of Aboriginal community members and a thematic analysis to determine the key thematic categories that are common across this region. The prioritisation of key themes identified in this section was achieved by determining the most frequently raised themes across consultations, while balancing this against the focus and emphasise placed on specific issues during the yarns.

Community aspirations and vision



As noted above, in determining the health needs of Aboriginal people, it is important to contextualise and understand those needs in relation to Aboriginal community members' aspirations and vision for the future. This aligns with a strengths-based approach that is vital when working with Aboriginal people. During each consultation session, community members were asked to describe 'What good looks like'. The aspirations and vision expressed was consistent across the groups, with strong identities and healing at the centre. Strong connections to community, culture and Country were the foundations upon which the elements rest.

Achieving this vision will take collaboration. It is a relational project that requires a genuine commitment to building trust, equitable partnerships and a willingness to support and respect Aboriginal leadership and self-determination. Community members want to see mainstream organisations and services sharing and supporting the vision that was shared. The Priority Reforms under the National Agreement on Closing the Gap are a good roadmap for this.

What does good look like?

When asked what good looked like community members shared many examples, including:

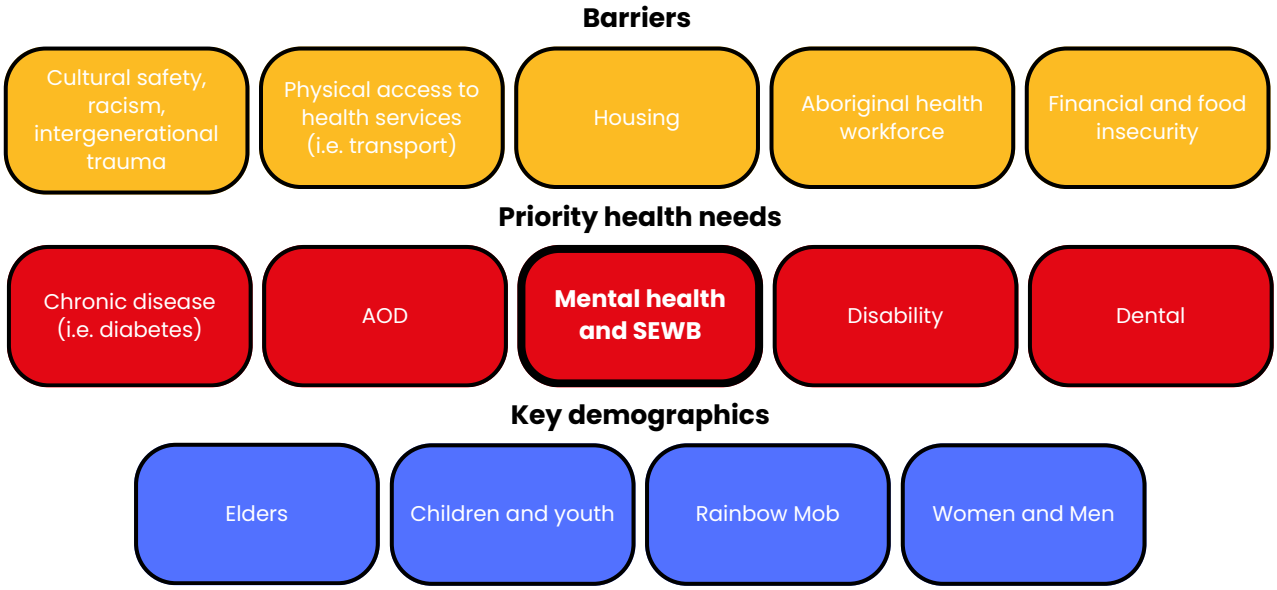
- Strong Aboriginal health workforce:
  - Includes recruiting the right people for the right roles, across all levels of service and career pathways for Aboriginal people.
- Holistic healthcare that considers both the individual and their family, to take into account hereditary concerns and involve family members when health issues might impact them.
- Offering gender specific services to enable men and women to see clinicians who are sensitive to their gender specific needs. This is culturally safe and allows for men's and women's business.
- GPs and other health professionals should aim to build trust and a strong relationship between themselves and the individual. This is key to good healthcare and improving outcomes.
  - GPs should take the time for deeper listening to understand broader life issues, such as family and work, creating a sense of care.
  - GPs should deliver results directly and with care, compassion, and respect. Transparency in the process and timing is important, as uncertainty can cause stress and anxiety. These approaches reduce stress and worry.
- Appropriate resourcing for programs and services to enable:
  - Timely appointments, with transparency about wait times and expectations.
  - Appointments that don't feel rushed.
- Freedom of choice:
  - GPs should avoid pressuring patients into decisions, like immunizations, ensuring individuals feel they have the freedom of choice.
  - Community members need to be able to have choice in their health provider, and whether they go to a mainstream service or ACCHO. This requires mainstream services to be culturally safe.
- Increase in preventative programs around:
  - Connection and identity.
  - Connecting family and healthy lifestyles, including access for Aboriginal families to gym and pool facilities.
  - Building capacity around life skills that include cooking, nutrition, budgeting, etc.
  - Men's and women's programs, youth programs, Elders' programs.
- Access to traditional medicine and healing.
- Inclusive healthcare that is safe for Rainbow Mob.
- Greater focus and investment in Aboriginal women's health, and pain management.
- Increased services and supports for Aboriginal men's mental health

Findings

Community members provided insight into the barriers that they experience in accessing health services, knowledge and broader supports.

The health needs expressed by Aboriginal people in the North West Metropolitan region of Melbourne track consistently with available public health data, VAHS' own internal data, and qualitative data from community consultations. Some of the specific gaps and challenges that were identified required localised solutions.

There were a number of consistent barriers and challenges raised in the community yarns, which speak to urgent needs. These were:



This tracks with what we see in the available population data and in VAHS internal data. Community members overwhelmingly emphasised mental health as a top concern; mental health is a crisis in community and it underpins most other access issues. It came up in every yarn and was often the first thing to be raised when asked about the health status and needs of the Aboriginal community in the NW LGAs.

While this report speaks to the above concerns separately, it is impossible to extract one from the other as health is holistic and underpinned by the physical, social, and cultural determinants. A sound understanding of the cultural determinants of health and SEWB will provide greater clarity around why service integration is so important for Aboriginal health.[xii]

While not listed above, we also note that both health in prisons, family/domestic violence, and child protection were raised as other key areas of concern for community. These are all important issues that connect to health and SEWB; are exacerbated by poor SEWB, and are barriers to health care and support services. Community members did note that SEWB programs, including men's and women's' yarning circles and early-intervention and prevention programs would be helpful in preventing and supporting those experiencing family violence.

VAHS clients and services in the NorthWest

The most populous LGA's for active Aboriginal and/or Torres Strait Islander clients are Darebin 14.7%, Whittlesea 11.7%, Hume 7.4% and Merri-bek 6.5% respectively.

The most common conditions/chronic diseases are asthma, mental health, arthritis, diabetes and epilepsy respectively.

86.2% of VAHS regular Aboriginal/Torres Strait Islander clients used Medical services, followed by Community Programs (Allied health, NDIS) 27.7%, FCS (SEWB) 25.4% and Women's and Children's 23.9%.

LGA	Community Programs	Family Counselling Service (FCS)	Women's & Children's (W&C)
Brimbank	36.9%	23.1%	20.0%
Darebin	30.1%	33.7%	20.9%
Hobsons Bay	46.2%	17.9%	10.3%
Hume	28.1%	21.9%	37.1%
Macedon Ranges	0.0%	16.7%	41.7%
Maribyrnong	30.4%	21.4%	0.0%
Melbourne	24.8%	29.3%	12.1%
Melton	30.5%	14.6%	24.4%
Merri-bek	28.7%	26.8%	23.9%
Moonee Valley	18.6%	32.6%	9.3%
Moorabool	40.0%	0.0%	20.0%
Wyndham	28.1%	22.9%	36.5%
Yarra	29.6%	31.2%	15.1%

*Community Programs, FCS and W&C is calculated from VAHS ATSI active patients with progress notes in the 23/24 FY in each LGA.

	# 1	# 2	# 3	# 4	# 5	
Brimbank	16.6% - Asthma	13% - Mental Health	9.1% - Diabetes	6.5% - Arthritis	5.2% - Epilepsy	
Darebin	22.1% - Asthma	17.8% - Mental Health	8% - Arthritis	5.1% - Diabetes	3.4% - Epilepsy	
Hobsons Bay	24.4% - Asthma	17.8% - Arthritis	15.6% - Mental Health	4.4% - Diabetes	2.2% - Epilepsy	
Hume	17% - Asthma	14.3% - Mental Health	5.1% - Diabetes	4.2% - Arthritis	3% - Epilepsy	
Macedon Ranges	21.4% - Asthma	21.4% - Mental Health	7.1% - Epilepsy	N/A	N/A	
Maribyrnong	26.5% - Mental Health	8.8% - Arthritis	8.8% - Asthma	4.4% - Diabetes	4.4% - Epilepsy	
Melbourne	22.7% - Mental Health	22.2% - Asthma	7% - Diabetes	4.9% - Arthritis	3.2% - Epilepsy	
Melton	24.2% - Asthma	10.5% - Mental Health	7.4% - Arthritis	5.3% - Diabetes	3.2% - Cancer	
Merri-bek	20.6% - Asthma	19.7% - Mental Health	5.7% - Arthritis	5.7% - Diabetes	4.8% - Epilepsy	
Moonee Valley	14.5% - Mental Health	7.3% - Asthma	3.6% - Arthritis	3.6% - Epilepsy	1.8% - Diabetes	1.8% - Cancer
Moorabool	14.3% - Kidney Disease	14.3% - Mental Health	N/A	N/A	N/A	
Wyndham	15.2% - Asthma	14.3% - Mental Health	5.4% - Arthritis	4.5% - Epilepsy	3.6% - Diabetes	
Yarra	20.1% - Mental Health	17.5% - Asthma	8.5% - Arthritis	7.3% - Diabetes	4.3% - Epilepsy	

*Chronic diseases and comorbidities is calculated from VAHS ATSI regular patients in each LGA within the NWMPHN catchment.

Cultural safety and racism

Cultural safety and anti-racism work is necessary to improving health outcomes for Aboriginal people. It improves healthcare access and increases the likelihood of a person coming back for follow up care. Importantly it removes the risk that in accessing a health service, an Aboriginal person may come away from that interaction less healthy and well than when they arrived due to racism.

There is an expanding evidence base that demonstrates that racism has significant impacts on mental health. The Victorian Wellbeing Survey found that 18.8% Aboriginal adults experienced racism, most often in public. However, this year's Closing the Gap Annual Data Complication Report reported that in Victoria 60% of Aboriginal people reported experiencing racism within the past twelve months in 2022. According to the survey, the second most common place to experience racism (47% of those who have experienced it) was in a healthcare setting by a member of staff such as a doctor or nurse. According to the Survey, experiences of racism were associated with poorer social and emotional wellbeing, and poorer physical health. 65.5% of those who experienced racism had been diagnosed with depression or anxiety.[2]

While the data seems to vary, the consultations showed that racism was widespread and a common experience. Not one community member disagreed that racism was a key issue; not one indicated that they had not experienced racism. There was a strong desire for mainstream organisations and systems to actively combat racism with education, which includes sharing information about Aboriginal people and culture with Australians from a young age, through schools. There was an understanding that some who work in the health system may have migrated to Australia and would therefore need to learn about Aboriginal people, and the history of colonisation through their professional training.

Community members expressed a strong desire to see mainstream services improve their ability to provide culturally safe health care for Aboriginal people, which includes service provision within mainstream organisations and a sound understanding of appropriate referrals. Aboriginal people in the Northwest should be able decide whether they want to use an ACCHO or whether they want to use a mainstream service.

"They base what you are off your skin colour. If you're not dark, then you're Australian."

One community member who works in the health sector shared that the push back from GPs is significant regarding cultural safety training. They don't see the need to do it and are time poor.

But for some health concerns, a mainstream service may be the only feasible option, either due to the nature of the health issue or because a local ACCHO does not have a close enough presence. If an Aboriginal person goes to a mainstream service they should be receiving a high level of care, as should anyone; this does not appear to be happening in practice.

Community members shared examples of racism from medical staff, including having their Aboriginality questioned and judgements made about Aboriginality based of skin colour. The assumption that skin colour defines Aboriginality remains a harmful stereotype that must be dismantled.

This causes anxiety for Aboriginal people; anxiety about making sure to behave in a way that avoids stereotypes, anxiety around being seen. It impacts on Aboriginal children and how safe they feel, and the pride that they feel in their identity, which has flow on effects across their lives. Young community members shared that they already feel judged before they even walk through the door of a mainstream service.

"Aboriginal mob [have] to live in today's society knowing that they have to have some trust in mainstream organisations, but they were the ones that perpetrated harms."

One community member, when asking about the closing the gap initiative at a medical clinic was asked by a receptionist, "What gap are you trying to close?".

Community members shared that they limited what they share with GPs or are sometimes worried to take their children to a GP because of concerns that the GP will not have a cultural understanding of Aboriginal kinship and family structures, and/or may improperly involve child protection. GPs need to take the time to build rapport and trust with Aboriginal people so that they feel safe to share. Having a non-judgemental approach is vital.

Aboriginal women in the community yarns shared experiences of medical gaslighting, GPs not listening, failing to investigate symptoms, and prescribing medication when the woman wants non-pharmacological options. Because of stigma and stereotyping, Aboriginal women avoid seeking treatment. Chronic pain is another significant issue for Aboriginal women but there is a lot of fear and shame around asking for pain medication. When pain medication is ineffective, there is a fear of returning to the GP to ask for an alternative medication.

Community members expressed that medicine is already a field that is predominantly based on men and has excluded women's health, so for Aboriginal women the bias and exclusion is even more acute.

Community members also shared examples where a lack of cultural understanding of men's and women's business has led to cultural unsafe and improper treatment. For example, being allocated a hospital bed in the same room as men, without proper privacy. This lack of understanding is evident across primary health services and hospital settings.

"[GPs] don't do the active listening. They tend to hear what they want to hear and give medication. Especially if you're a woman."

One community member spoke about accessing a counsellor through a mainstream service to help cope with grief after the loss of a family member. The counsellor was abrupt and rude and demonstrated an attitude that the community member should get over the family member's passing. The counsellor showed no understanding of Sorry Business[1] and the session was so uncomfortable and unhelpful that the community member did not want to go back. In consultations, they said that they would like to be able to access mental health support through an ACCHO if that were possible.

Community example

T, an Aboriginal man in the West, does not have access to a local Aboriginal health service, so he must attend a health service in his local area. There is not even basic cultural safety at this service; in the past they had brochures about 'Asking the Question' but don't even have these anymore. There are no Aboriginal staff there.

He has seen three different GPs across five appointments. He wants to get an assessment of the deterioration of an injury he sustained a while ago so that he can know what its status is and so he can get management and treatment. His injury prevents him from working and he wants to get back to work.

Each time he sees a GP, he is told to go see a different GP in the clinic; none seem to know what to do about his injury so he is passed around without any plan, attending appointments that don't result in anything. He has not had any referrals to any other services that would help. He knows that there are allied health services that would be helpful in managing his injury and getting him back to being able to work, but he has not been referred to any.

He has asked GPs to support him to get a prescription for medical marijuana to help with pain ad mobility, but they have been unhelpful; directing him to find a 'clinic in the city' but not giving him any other details. He has had to track down a clinic himself. Accessing a clinic in the city, or any other health service such as an ACCHO, is difficult as he does not have transport.

T has spent significant time and energy advocating for himself at this local health service. When asked what good looks like, the community member shared that he would like to have access to a local Aboriginal Community Controlled Health service so that when he and his children walk through the doors, he feels confident that he will be met by health workers who understand the specific health needs and culture of Aboriginal people.

1. There are multiple resources available online about Sory Business. One available resource is: https://www.evolves.com.au/national-reconciliation-week-tip-5-what-is-sorry-business/#:~:text=The%20Aboriginal%20concept%20of%20Sorry%20Business%20can%20cause

715 Health Checks and Aboriginality

An area of concern, raised by community members, which was also validated by VAHS clinical staff, was that 715 Aboriginal health checks[2] (715s) are being billed for by mainstream clinics but the Aboriginal person either does not know, or is told but does not receive a proper 715. These health checks are comprehensive and are supposed to take ~1-2hours to complete. 715's are key to holistic care and follow up.

Community members shared that they were unaware of what a 715 was supposed to involve and the time required, and had instead experienced GPs conducting health checks that take 10-15minutes and then billing for them. Alternatively, community members have found out afterwards that a 715 has been billed when they have come to VAHS to get one and VAHS then finds out that they are unable to bill for it. This means that either the community member cannot get a proper 715 for that year or the ACCHO does one anyway but is out of pocket for it.

This caused concern by community members that identifying as Aboriginal when they are being asked the question may lead to their Aboriginality being exploited by the clinics for profit. Community members were not confident that when identifying, this would lead to an improved and culturally safe service.

Experiences shared by community members showed that in some cases, identifying as Aboriginal did not in fact lead to culturally safe service provision, and some have had their Aboriginality questioned, causing distress. Any culturally safe service should understand why it is important to 'Ask the Question' and what to do when someone identifies as Aboriginal.

Some community members are fearful of answering and will prefer not to identify. For Aboriginal mothers, there is an additional fear of identifying at a health service because of the history and ongoing issue of high rates of child removal, in particular in Victoria.

Many community members felt that asking the question was a "tick a box" exercise.

For the Aboriginal young men that VAHS yarned with, most did not mind being asked about their Aboriginality, but preferred it be done privately, rather than at reception, where there were instances of disrespect, such as a receptionist rolling her eyes when someone identified as Aboriginal at a mainstream service.

2. See https://www.health.gov.au/topics/aboriginal-and-torres-strait-islander-health/primary-care/annual-health-checks#:~:text=Good%20health%20starts%20with%20the%20715%20health%20check

Resourcing for ACCHOs to expand geographic reach, specially in the West

Many community members spoke about the importance and unique value of ACCHOs.

There is a huge demand expressed by community for more local ACCHO services. Demand is particularly high in the western suburbs where there is limited ACCHO presence, and community members shared that they would like to see an expansion of VAHS into the outer regions of the West, such as Melton and Wyndham.

Community members in the West spoke about how this area is totally different from the North. There is a quickly growing Aboriginal population in the West, many of whom have moved from interstate or regionally. However, poor infrastructure in emerging communities impacts on service delivery.

"VAHS GPs don't just ask about me, they know my family and other things in my life impact how well I am travelling."

For the entire NWMPHN region, the average annual Aboriginal growth rate is 6.18%, with a prediction for the total Indigenous population to reach 20,864 by 2031.[3] For LGAs in the west of the NWMPHN only, the average annual Aboriginal growth rate is 6.91%, with a prediction for the total Indigenous population to reach 11885 by 2031.[4] For comparison, the average annual population growth of Aboriginal people in Victoria is 3.8%, more than twice the annual growth rate for the Victorian population (1.6%).[xiii]

Transport is difficult in the area and local health services are limited. Community members who accessed local GPs were rushed through their appointments and did not feel taken seriously or that they had received the level of care or interest required to receive proper health care.

Resourcing is required for ACCHOs to expand services and increase capacity in these areas.

Expanding and resourcing mainstream services only will not suffice as the reasons why community members wanted access to local ACCHOs specifically related to cultural and community factors, and programs and services that are unique to and can only be provided by ACCHOs.

3. NWMPHN includes the LGAs of Brimbank, Darebin, Hobsons Bay, Hume, Maribyrnong, Melbourne, Melton, Merri-Bek, Moonee Valley, Wyndham & Yarra and partially covers the LGAs of Macedon Ranges & Moorabool. For these predictions we included all of Moorabool and Macedon Ranges.
4. The Western LGAs that were included were Brimbank, Hobsons Bay, Maribyrnong, Melton, Moonee Valley & Wyndham.

Transport

Transport was an issue across the board as many community members found it difficult to access medical services. Even transport to VAHS as the local ACCHO was still time consuming for many, although community members often prefer to spend the time to go to VAHS instead of a mainstream service if that is an option.

	VAHS Fitzroy	VAHS St Albans	VAHS South Morang
Reservoir	41 mins	N/A	31 mins
Melton	71 mins	47 mins	N/A
Wallan	80 mins (52 mins)	N/A	92 mins (35 mins)
Whittlesea	86 mins	N/A	24 mins
Craigieburn	93 mins (44 mins)	N/A	71 mins (29 mins)
Taylors Hills	80 mins	29 mins	N/A

*Times are PTV travel times
*Times in brackets are car travel

However, public transportation is difficult for those in the West in particular, and for some it is not an option. For people with certain health issues or those on specific treatments, public transportation may not be safe, nor is driving. This means that Ubers or taxis are the only option, which is expensive, not culturally safe and a significant barrier to accessing health care.

Ubers and other ride sharing is only available for those with the technological ability to access them. While some community members wanted access to taxi vouchers, others have experienced racism from taxi drivers. Some, in particular Elders, will forego a medical care if a taxi is the only way to get there because of these harmful experiences.

Aboriginal Health Workforce

Aboriginal community members expressed that there is a need for an increased Aboriginal Health Workforce across the health system. For example, Aboriginal Health Liaison Officers (AHLOs) in hospitals were viewed positively. However, it was noted that they are so stretched, they are limited in how much time they can spend with Aboriginal people who require support. AHLOs and Aboriginal Health Workers were seen as vital to culturally safe and proper health care. It was acknowledged that for many in these roles the risk of burn out is high due, and turnover is high.

Aboriginal health workers bring their own lived experience and expertise to their role; they can relate to the person they are supporting and understand. Expertise and understanding about this is important in recruiting to select appropriate candidates for roles. Community members expressed frustration that in mainstream services they rarely saw Aboriginal staff.

There needs to be a greater commitment from funding bodies to building the Aboriginal health workforce. This includes resourcing for ACCHOs who actively invest in young staff and develop career and educational pathways for them.

Food insecurity and financial insecurity

Food insecurity was raised in multiple group yarns and came up indirectly in conversations around the affordability of healthcare, housing, and cost of living. Community members are struggling to afford rent, food, and other expenses, including health care. Some noted that there is a lot of reliance on food parcels in the West but that the parcels were sometimes too old to be safe to use or contained a random assortment of items that are difficult to cook with. This impacts directly on physical health as well as SEWB and mental health due to food stress.

In the 2024 Closing the Gap Annual Data Compilation Report it was reported that in Victoria smoking has decreased but alcohol consumption has increased, obesity has increased, and physical activity rates are low. Fruit and vegetable intake has decreased nationally. Community members want to stay healthy and fit but cannot afford to. Gym memberships and participating in organised sport is expensive and many cannot afford this.

This aligns with the Victorian Wellbeing Survey, which found that Aboriginal Victorians are more likely to experience food insecurity than Victorians generally.[xiv]

- 14.4% of Aboriginal adults in Victoria ran out of food and could not afford to buy more at least once in the 12 months preceding the survey interview (compared with 6.2%).
- 25.4% of Aboriginal parents sometimes or always relied on a restricted range of low-cost food for their children to avoid running out of money to buy food (compared with 14.5%).

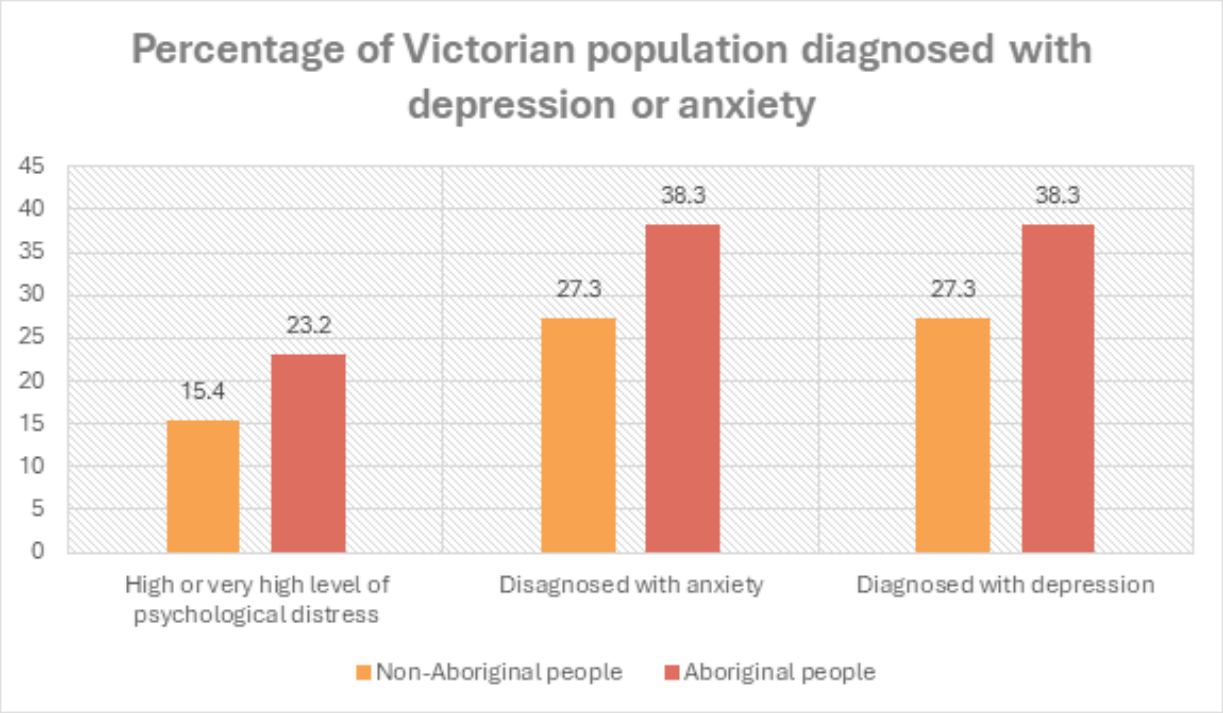
Further, community members were concerned about the risk that pathology may become decreasingly accessible due to policy changes that lead to less being covered by bulk billing. One community member shared that he was required to go get a test with pathology, but it was only when he arrived he was told he had to pay. He did not get the test done and travelled a great distance to VAHS in Preston instead, to get the test done there. Another young Aboriginal man shared that when he was prescribed insulin for the first time, he did not know that he had to pay for it. He had to steal his insulin as a result, which was not what he wanted to do. There is a need for better communication and transparency around the cost of health care, including medication.

Mental health, SEWB and AOD

SEWB and AOD are interconnected issues that were raised in conjunction during community consultations. Supports for mental health and AOD are in high demand and community members expressed frustration with long wait times for these services, across both mainstream and ACCHOs.

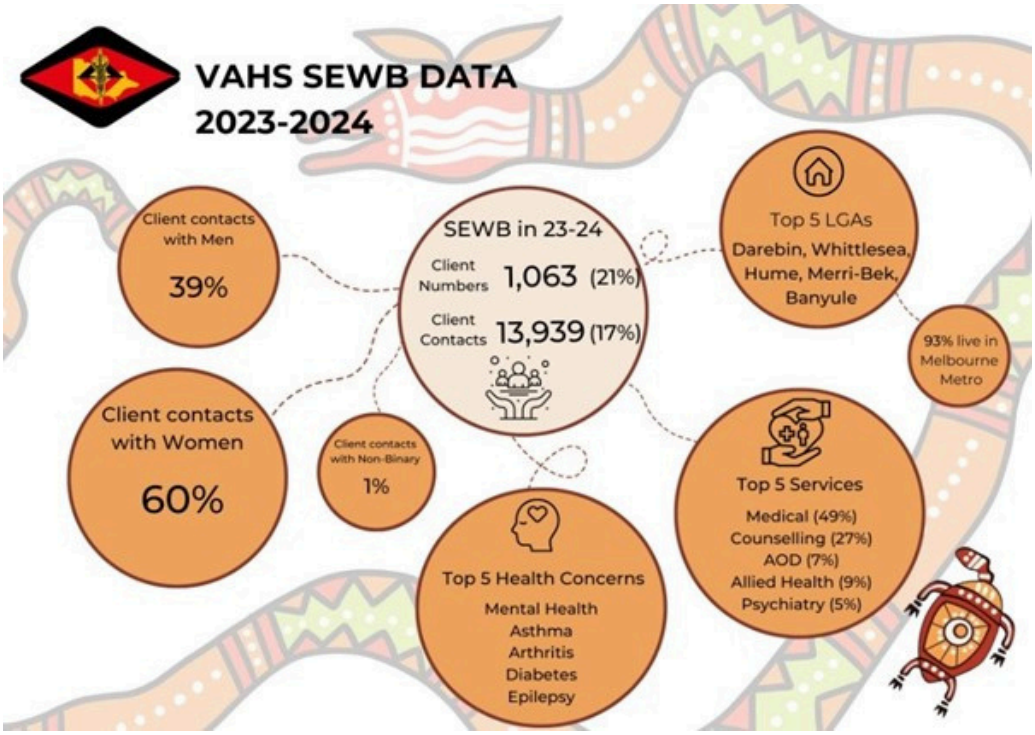
Mental Health

According to the Health Summary Performance Framework (ref), the burden of disease for Aboriginal people is 2.3 times that of non-Indigenous people, with mental ill health and substance use (AOD) as the leading contributors.[xv] According to the Victorian wellbeing survey, rates of anxiety and depression are far higher for Aboriginal adults in Victoria than for non-Aboriginal adults.[xvi]



For Aboriginal people diagnosed with depression, 49.8% of Aboriginal women and 29.5% of Aboriginal men are diagnosed. However, community members in consultation noted that Aboriginal men are far less likely to seek help or acknowledge their mental health needs. So diagnosis data likely does not give a full picture with the Aboriginal population in North West LGAs.

VAHS is seeing this increase as well. In 2023-2024, VAHS had 1063 clients, with 13,939 client contacts in SEWB services. The top LGAs that these clients were in were Darebin, Whittlesea, Hume, Merri-Bek, and Banyule. Since 2020, VAHS has had a 20% increase in SEWB internal referrals each year, with 820 referrals from 2023-2024. This shows the efficacy of the holistic ACCHO model where services are linked up. Mental health is one of the top 5 health concerns amongst VAHS clients. The top 5 VAHS services for 2023-2024 were medical (49%), counselling (27%), AOD (7%), Allied Health (9%) and psychiatry (5%). It is important to note here that VAHS has waitlists for counselling and AOD services and counsellors are stretched.



In the West in particular there are very few Aboriginal mental health practitioners and accessing culturally safe counselling is near impossible. VAHS does provide outreach and delivers services through a number of partnership arrangements, however this places additional burden on a workforce that is already at capacity.

In the North, community members also spoke about the huge demand for mental health services and long wait times for support. The waitlists put lives at risk as an Aboriginal person who does not get help when they seek it is unlikely to try again. Community members also spoke about the mental health service system as a revolving door with many people returning to emergency services in crisis because the system isn't working for them.

Community members shared that self-harm and suicide is a huge concern. There is a critical timeframe to get people support in this situation.

According to the Health Summary Performance Framework Report in 2015–2019 the suicide rate for First Nations people was 24 per 100,000 deaths and accounted for 5.5% of all deaths among First Nations people. This was an increase of 30% over that time period. Similarly, over the period from 2009–10 to 2018–19 the hospitalisation rate of First Nations people for intentional self-harm increased by 63%.

This year's Closing the Gap Data Compilation report showed that suicide/self-harm is now the leading cause of death for Aboriginal people nationally, in particular the age ranges of 15–19 years, 25–29 years and 35–39 years.[xvii] This was 3.3 times higher for Aboriginal men than women.

Many women community members expressed deep concern for Aboriginal men and mental health.

It is important to note that Victorian data on suicide and self-harm is not included in the Closing the Gap Annual Data Compilation Report. However, the community consults revealed that this is significant concern in Victoria also, reflecting the national data.

"I just heard numbers, numbers, numbers. It doesn't work, on disability you can't afford appointments."

One community member in the West spoke about her challenges in finding accessible affordable treatment. The medication prescribed by her GP had some unpleasant side effects so went back to get a different prescription. The GP could not do this and referred her to a psychiatrist, which was going to cost hundreds of dollars, including a significant sum to make the booking.

The consensus amongst the groups was that the system doesn't work; people with mental health issues who require medication and being left unmedicated due to cost and barriers to access. Community members shared how they sometimes have to decide between paying rent, buying food for the fortnight, or paying for medications. When they families to look after, medication is never the realistic choice.

Community members in the West wanted to be able to access a local ACCHO for mental health services but the travel required makes this impossible.

There has been almost constant Sorry Business during 2024, including the loss of several young people, and community members are suffering from the SEWB and mental health impacts of grief and loss.

Further, the mental health of Elders was flagged as a concern with community members noting that Elders are increasingly isolated and lonely. As Aboriginal people are living longer, we are seeing an increase in dementia, which creates mental health challenges for Elders and puts a lot of strain on family members who are often acting as carers with no extra supports.

AOD

Community members highlighted the need for more AOD treatment options, particularly culturally safe rehabilitation. The waitlists for inpatient rehab was seen a significant barrier to recovery. New drugs that have become recently available in Australia are a cause for concern, and community members are particularly worried for Aboriginal young people. There is a need to stay updated and informed about new drugs that are available and their effects.

When AOD came up in group yarns, there was consensus that when a person seeks help for AOD, they need help then and there. Otherwise, people slip through the cracks and do not get the support they need. But this is not happening. Waiting weeks to access treatment services is not feasible.

Community members felt that this issue gets handballed back to community. There are not enough resources or services such as psychologists and psychiatrists, and more aftercare is required. It was noted that there are too many hoops to jump through, especially for young people. Community members want to see more linked up services, and free services.

AOD use for Aboriginal people stems from trauma and not having the resources or support to resolve that trauma; the disconnection from culture, community and Country is a big part of this. There needs to be more education introduced at a young age on how to cope with stressful events and how to break the cycle and reach out for help.

Imprisoment

Community members also raised justice and health several times. There was concern that the health systems failure to provide culturally safe mental health and AOD supports to Aboriginal people, especially young people, was contributing to the overincarceration of Aboriginal people.

According to the 2024 Closing the Gap Annual Data Compilation Report, nationally in 2022, 42.6% of Aboriginal people entering prison had a mental health disorder, 71% used illicit substances, and 27.9% had had a family member in prison.

SEWB

SEWB programs and services were seen as important to both prevent and treat poor mental health and AOD, and to enable Aboriginal people to live healthy lives with good wellbeing.

In the group of Aboriginal young men, community members highlighted self-care and taking personal responsibility for one's own health as crucial to improving SEWB. Accessing healthcare and practicing moderation, particularly in areas like drinking and diet, were seen as important components of health and wellbeing. Culturally safe programs are needed to support and provide tools for Aboriginal people to do this. The more positive experiences Aboriginal people have in healthcare, the better they are able to take care of themselves and be proactive about health and wellbeing. ACCHOs need resourcing to be able to provide these.

Many community members raised the need for men's and women's programs for youth and adults that are culturally and socially connected, and that facilitate connection to Country. Access to traditional healers was a need expressed by community members.

Chronic disease

Diabetes was the predominant concern raised in group yarns. Community members spoke about the need to improve health literacy and for health promotion and education programs for topics including diabetes, smoking, diet and nutrition. Health education needs to start from a young age. For many, this includes education about and access to traditional medicine and healing.

Community members shared that the numbers of Aboriginal people aged 30-40 with severe chronic illness is increasing.

Respiratory issues are an area of concern, with community members noting that asthma is prevalent. It was observed that many Aboriginal people are in respiratory and endocrinology clinics. Many Aboriginal people smoke from an early age; especially for those who were put into homes and missions and began smoking as children.

This aligns with the Aboriginal and Torres Strait Islander Health Performance Framework that listed chronic diseases such as cardiovascular disease, cancer, musculoskeletal conditions and respiratory disease as common for Aboriginal people.[xviii]

Community members also shared how peoples' experiences with COVID have made them even more reluctant to seek medical care. For example, late diagnosis is a concern for community, and some in the groups shared examples of family members who did not seek treatment for so long that once they did they were found to be in the late stages of cancer. This issue was noted as especially impacting Aboriginal men, who are even less likely to seek help due to SEWB and a "tough it out" attitude.

A 715 Aboriginal health check is supposed to pick up on chronic illness and disease, and is supposed to involved follow up calls from a nurse to make sure that the person is accessing the services required to stay on top of their health. This makes the issue noted about with 715 health checks being done improperly even more impactful – Aboriginal community members have spoken about not having this important follow up care.

In the 2024 Close the Gap Annual Data Compilation Report, ischemic heart disease was the leading cause of death for ages 40–74 years in 2018–2022. Heart disease also came up as a clear need during consultations.

Disability

Disability was also flagged in community consultations as an area of significant need. This includes physical disability, chronic illness, and also SEWB and neurodiversity.

For Aboriginal people, family members often take on carer responsibilities, but there is little support available. This puts significant strain on families. NDIS is difficult to access and navigate.

Community members noted that there seems to be an increase in Aboriginal children and young people with autism and ADHD. The lack of supports and understanding impacts on their ability to engage with health services.

Because assessments can't be done on children until a certain age, certain conditions are not diagnosed early. Parents are often aware of neurodivergence and want to get diagnoses so that they can access support. Parents are struggling without supports until a diagnosis can be done. Diagnosis is also a complex process and Aboriginal community members found that these processes difficult to navigate and the language used by medical experts doing the diagnosis isn't accessible.

One community member spent six years trying to find an appropriate psychiatrist who could diagnose her with autism and ADHD. It was only through VAHS that she was finally able to access a psychiatrist.

Housing

Housing was raised as a significant issue across the consultations as poor-quality housing and poor maintenance is leading to or exacerbating preventable health issues for community members such as respiratory disease. This was a huge source of frustration for community members who know what they need to improve their health in terms of their housing, but who cannot afford to do so.

This is why it is important that primary health workers are aware of the social determinants of health and the importance of understanding a person's housing situation in order to have a clearer understanding of their health and health risks.

Dental

Community members raised concerns about dental care and noted that it is difficult to access dental, including long wait times. This issue is especially acute in the West. While dental was not mentioned much in consultations, this may be due to a lack of understanding about the link between dental health and other conditions and diseases. One of the benefits of a 715 is that the GP will discuss the importance of oral health in this check. There are also links between AOD and dental health, and this is an area to further explore.

In prisons, there is concern that Aboriginal people who are in pain often cannot see a dentist unless they are incarcerated for more than six months. This is too long to wait when someone has dental pain.

Elders and Youth

Community members also spoke about how barriers to accessing health services are even higher for young people and Elders; these are the critical point across peoples' lives where they are more vulnerable and tend to be more isolated.

Elders

There was a lot of concern for Elders who are isolated and who are unable to be with community and connect with culture and Country as a result. There is a need for more outreach, and services for Aboriginal Elders to socialise and stay connected. Health services should be mindful of this.

Further, there is a lot of distrust amongst the older population towards health services. Many Aboriginal Elders will refuse to access health care and seek treatment because they are worried that the service will harm them. This is because of historical experiences; many Aboriginal Elders experienced poor past treatment and have lived experience of injustice. As a result, Aboriginal Elders tend to view hospitals as placed you go to die.

There is a significant need for education around My Aged Care for Aboriginal old people, including around the age that Aboriginal people can access this support from. This requires paid roles for Aboriginal people to do this work. Aboriginal community expressed concerns around Elder abuse.

There was a strong preference in the groups for services and supports for Aboriginal Elders to be provided by ACCOs or ACCHOs to ensure cultural safety and connection to community and culture. This includes the assessment process, where non-Aboriginal assessors are not able to understand the cultural nuance of what is communicated during the assessment process.

In the 2024 Closing the Gap Annual Data Compilation Report, dementia was found to be the leading cause of death for ages 75 years and over. This aligns with concerns raised in the consultations, that there is a need for information for families and Elders about dementia, and for supports. Dementia is causing grief and stress for Elders and their families, who are unsure how to manage the condition and can feel distress at the symptoms.

Further, family members, often grandchildren are becoming supports for Elders, but there are no supports available for them.

Youth

Many community members in group yarns, as well as individual young people, expressed concern for Aboriginal children and young people and their ability to grow up with strong identities connected to culture and community. Having a strong identity is a key protective factor for young people as they move through life.

For Aboriginal children, the waitlists for speech therapists, paediatricians, and paediatric occupational therapists are long. VAHS own data can confirm this, with a current 3 month waitlist for paediatricians.

Child and youth mental health was also a significant concern, with community members noting that there are not enough specialist paediatric mental health practitioners. Community members also raised concerns about a rise in eating disorders among Aboriginal young people.

As noted above, child protection involvement and the removal of Aboriginal children is a significant concern for Aboriginal families. Child removal impacts on the health and wellbeing of Aboriginal children who often have significant and complex health needs that go unaddressed; a VAHS audit of 103 Aboriginal children in out of home care found:

- 66% mental health
- 46% developmental delay
- 37% hearing problems
- 40% dental caries (tooth decay/cavity)

Sexual health

Sexual health education is a big health need for Aboriginal young people. GPs rarely discuss sexual health with young people.

Community members have noticed an increase in Sexually Transmitted Infections (STIs) for Aboriginal young people and are concerned about an increase in unprotected sex. There has also been a noticeable increase in youth pregnancies, including those where the mother has an STI, risking the health of the baby. Aboriginal young women are nervous about getting treated for STIs and engaging them is difficult.

There is a need for more youth-specific sexual health education for young people and targeted promotional information about sexual health screenings that is done in a laid back and non-judgmental way. This is best done by ACCHOs who can communicate in culturally appropriate and clear language, and who need resourcing to do more of this work. ACCHOs have created some excellent sexual health resources in this past, such as Condom Man.

Community example

K, a young Aboriginal woman, neurodivergent and dealing with mental health issues, has a long struggle to access adequate healthcare. K also identifies as part of the Rainbow Mob. Despite numerous interactions with healthcare providers, her physical and mental health needs were often overlooked or dismissed, leading to delays in receiving appropriate care.

Throughout her like, K found it challenging to receive proper care for women's health issues and a lack of sexual health care. One significant experience occurred when she sought help for persistent stomach issues. A GP quickly dismissed her concerns, attributing them to premenstrual syndrome (PMS) without conducing a thorough investigation. This lead to K feeling invalidated, unheard and that her concerns were not treated as seriously.

A turning point for K in her healthcare journey came when she decided to undergo a comprehensive 715 Aboriginal health check at an ACCHO. This check was a critical intervention in linking her with the appropriate services she needed, particularly for mental health.

During the health check, a nurse raised concerns about her mental health after noticing sign of an eating disorder and potential depression. Although these issues had been present for some time, they had never been adequately addressed in previous consultations with healthcare providers.

The findings from the health check resulted in referrals to appropriate mental health services, including counselling and support for managing her neurodivergence (autism and ADHD). Prior to this, she had struggled for years to find a psychiatrist who understood the cultural context of her experiences, particularly the intergenerational trauma. The health check played a vital role in breaking down the barriers she had previously faced when trying to access mental health care.

This intervention empowered her to take control of her mental health and provided her with the necessary tools and support to manage both her physical and mental wellbeing. By addressing her mental health needs alongside her physical health concerns, the health check became a gateway to more comprehensive and appropriate care.

Rainbow Mob

The Rainbow Mob population was identified by community members as key population where there are some important health needs that should be addressed by health services and the health system. However, engagement with this population was challenging, and only two participants in the yarning circles identified as Rainbow Mob. VAHS spoke with an additional two Rainbow Mob in individual yarns.

This demonstrates the need for increased safety for Rainbow Mob across the board and resourcing to support Rainbow Mob people to engage, so that safe and meaningful engagement can be achieved. Further, VAHS encourages the NWMPHN to invest in targeted engagement led by an ACCHO, to have a dedicated focus on the health needs of LBTQIA+ Aboriginal people.

Mental health and AOD issues within the Rainbow Mob lead to risky sexual health behaviours. Sexual health is also an area of concern and there is a need for Rainbow Mob specific sexual heath promotion work, which needs to be culturally safe.

Unfortunately, both ACCHOs and mainstream services are not adequately addressing this space. While there are some efforts, these issues are not viewed as priorities. Engagement generally with Rainbow Mob is not done well.

There is a need for inclusive forms and processes, cultural safety for Rainbow Mob, and flexibility regarding choice of clinician and service. Token gestures, like waving the Rainbow flag, fall short of providing real inclusion. Rainbow Mob want to be visibly represented in policies and program designs. There is a distinct lack of preventative health programs and private, confidential spaces to access healthcare.

There is a need for specialised GPs who can work safely with Rainbow Mob.

Eating disorders were also increasing for Aboriginal young men in this cohort, from ages 14-19, which have been exacerbated by COVID19.

Family/Domestic violence is prevalent within this community, and greater education and awareness are desperately needed.

There's also a need for more Rainbow Mob in the workforce, alongside a clear commitment from leadership that shows genuine support and engagement with the community.

Conclusion

Overall, the issues discussed by community members in the group and individual yarns were complex and interconnected, requiring a holistic approach. The gaps and health needs that concerned communities require local solutions that need to be developed in partnership with the local communities, and ACCOs and ACCHOs. Further consultation is required to better understand the health needs of specific cohorts, including women and men, youth, Elders, and Rainbow Mob.

Three overarching issues rose to the top:

- Racism and cultural safety
- Mental health and SEWB
- Limited access to health services, in particular culturally safe services.

Mental health and SEWB were connected to the importance of culture and community as protective factors that nurture and support the development of strong identities. There is significant grief and loss currently felt by community members. As such, funders and services can achieve impact by:

- Immediately and urgently addressing racism and the lack of cultural safety in mainstream health services, in particular amongst GPs.
- Funding local ACCHOs to expand service delivery into the outer West, including Melton and Wyndham.
- Funding local ACCHOs to deliver SEWB programs for different cohorts, such as women and men, youth, and Elders.

Community members felt that the PHN was doing the right thing in engaging VAHS to facilitate community yarns. Community engagement should be established as an ongoing activity to inform the PHN Health Needs Assessment process and ensure that an Aboriginal community voice is embedded within it.

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