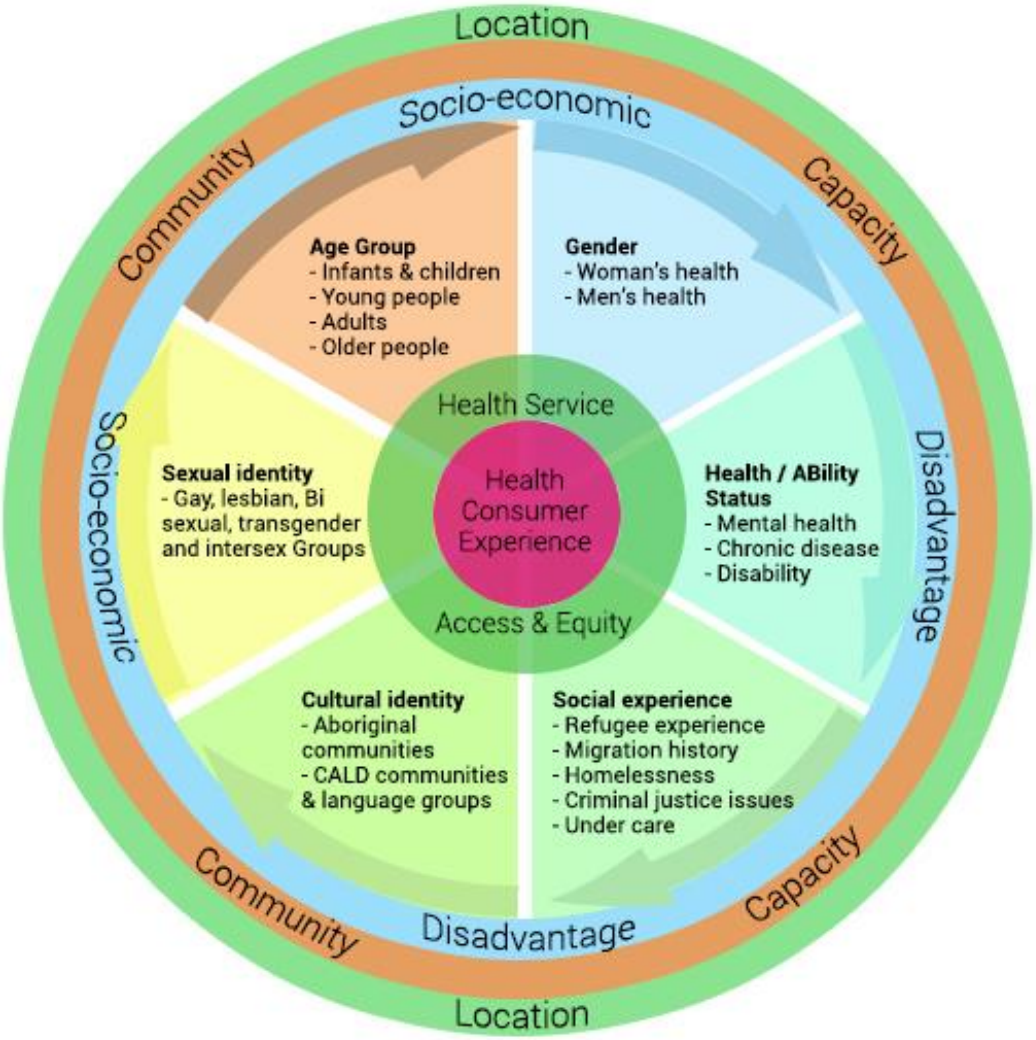
Health Consumers Alliance of SA Inc.

Consumers at the heart of health care

A Framework of Engagement Practice with Vulnerable South Australian Communities



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A Framework of engagement practice with vulnerable South Australian communities

1 Introduction

Health Consumers Alliance (HCA) Strategic Directions 2012-16 and SA Health Service Agreement 2013-16 identify the need for our organisation to develop a processes for the effective engagement of members of vulnerable communities in its representative and consultative functions.

From April to August 2014, HCA undertook a planning process to identify a range of community groups who faced poor health outcomes as a result of disadvantage, as well as strategies for effective engagement and representation.

The approach taken to research this project was to summarise SA Health's population health plans, public health reports and Medicare local analysis to identified vulnerable community groups and document health needs, key social determinants, exposure to risk factors and associated service access issues.

The work of developing engagement strategies was based on a number of considerations and sources of information. These included:

- Identifying existing strategies of engagement achieved by HCA with vulnerable groups.
- Using the IAP2 participation spectrum to consider possible strategies of advocacy engagement.
- Considering the commitments to engagement made within HCA' s 2012-2016 strategic plan.
- Ensuring the framework reflects and compliments the directions of the HCA, and builds on HCA's existing strengths, networks and activities.

HCA also consulted with a number of community peak bodies for advice on key health policy issues, possibilities for advocacy collaboration, perspectives on effective engagement and networking opportunities. The document has also been developed in consultation with SA Health, through our funding and contract representatives. HCA is thankful for the time and advice provided by:

- Aboriginal Health Council of SA

- Council of the Ageing
- Multicultural Communities Council of SA
- SA Council for the Care of Children.
- SA Health
- Youth Affairs Council of SA

Purpose of the framework

The aim of the Vulnerable Communities Engagement Framework is to inform and guide HCA practice for effectively engaging members of vulnerable health consumer groups into advocacy activities and health policy development. The framework achieves this aim by:

- Identifying a range of community groups who face poor health outcomes due to the combined impact of social determinants of ill health, and who face challenges in health service access and engagement in decision making.
- Promoting a 'diversity lens' to encourage engagement activities which are inclusive of community groups experiencing marginal social experience and low socioeconomic status.
- Describing a range of strategies and processes which will strengthen HCA's capacity to engage disadvantaged groups in our policy advice and advocacy work.
- Enabling HCA to establish priorities for more intensive engagement with specific community groups.

HCA commits to utilising the framework to inform practice within its 2012-2016 Strategic Plan and 2013-2016 Service Agreement with SA Health.

2 Identifying vulnerable communities and health priorities

The development of the framework has presented a number of challenges to HCA. One of these challenges is to adequately understand and describe the various community groups who experience social disadvantage and are vulnerable to developing poor health as a result. A traditional approach in public health has been to identify the relationship between poor health status and a range of indicators of social economic status and disadvantage.

Locality has also been a strong feature of public health analysis. Another approach is to identify groups via ascribed aspects of social identity and background. This is an important process as the literature of social determinants of health does not fully identify particular social groups who may experience social disadvantage and marginalisation. An example may be to consider the health status and vulnerability of people engaged with the criminal justice system or asylum seekers. Data of this level is often found in specific research projects, published articles and consultation reports. With limited resources, HCA felt the best way to achieve this understanding was to utilise and extend the work already produced by SA Health and other states in identifying priority groups and issues. The table provided in Appendix A summarises this information using the lifespan approach taken under the SA Health Primary Prevention Plan 2011-2016 (Govt. of South Australia, 2011).

Below is a list of community groups identified in this literature:

Table 1: Vulnerable community groups across the lifespan

Children	**Young people**
➢ From low income families ➢ Under guardianship ➢ Who have parents with mental illness, ➢ With young parents ➢ Living with disability ➢ Who come from Aboriginal backgrounds ➢ From refugee backgrounds	➢ In contact with the criminal justice system ➢ Experiencing mental health issues, substance use disorders and unsafe alcohol use. ➢ Of Aboriginal background ➢ Of LGBTI identity ➢ From refugee backgrounds
Adult	**Older people**
➢ Of Gay, Lesbian, Bi sexual, Transgender, or Intersex identity ➢ Women experiencing family violence. ➢ Women who are carers of people with a disability	➢ With chronic disease and co morbidity ➢ Living in rural areas ➢ Of Aboriginal background ➢ Living with mental health issues

➢ Men with chronic disease ➢ With Aboriginal identities ➢ Suffering mental health issues and substance abuse disorders. ➢ Who are homeless ➢ From a refugee backgrounds	➢ From culturally diverse background communities

2.1 Socio economic disadvantage, health outcomes and locality

Public health research suggests that the poor health outcomes and risk factors associated with all vulnerable population groups are related to socio economic disadvantage. It is important that HCA planning and resource utilisation are able to respond to the social gradient in health and have literacy on the various social determinants involved. A summary of these is as follows.

Nationally, it has been demonstrated that "Australia suffers the effects of a major differential in the prevalence of long-term health conditions''. Those who are most socio-economically disadvantaged are twice as likely to have a long-term health conditions, than those who are less disadvantaged. Put another way, the poorest people are twice as likely to suffer chronic illness[1] and will die on average three years earlier than the most affluent" (Brown, Thresh and Nepal, 2012 p.vii).

Regional location tends to be a primary focus of public health research. In a recent report the SA Chief of Public Health summarises: "Those living in more disadvantaged areas report poorer outcomes for almost all risk factors with the exception of alcohol consumption" (Government of South Australia 2012, p.34). SA public health data indicates that the regional areas of Barossa-Yorke, Midnorth, Adelaide West and Adelaide North had higher levels of

[1] The SA Primary Care and Prevention Plan (Govt. of South Australia, 2011) summarises that chronic disease attributed to lifestyle and social determinants are the major cause of death and disability among South Australians. The following chronic disease account for 42% of the total burden of disease: cardiovascular disease (17.5%), diabetes (6.1%), chronic obstructive pulmonary disease (3.7%), musculoskeletal disease (4.0%), lung cancer (3.3%), asthma (2.4%), breast and colorectal cancers (each 2.3%). Anxiety and depression (6.1%). The plan suggests that whilst life expectancy increases, more people are living with chronic disease that affects quality of life and productivity. "Around 46% of South Australian adults have been diagnosed with at least one chronic disease and an estimated 15% suffer two or more chronic diseases".

people experiencing this level of disadvantage compared to other SA regions[2] (Govt of South Australia 2012).

The Health Performance Council (HPC) (2012) reports that the prevalence of "people living with multiple risk factors was statistically significantly higher in Country SA than metropolitan Adelaide in 2011. Trend data indicates that the gap between Country SA and metropolitan Adelaide is widening" (p 160). Reporting data and studies on psychological distress[3], the Council summarizes that " Almost 10% of South Australians aged 16 years or more reported recently experiencing high, or very high levels of psychological distress" (p 103). Whilst the extent of the population experiencing distress has reduced since 2002, "prevalence remains particularly pronounced in areas of lowest socioeconomic status and the rate in metropolitan Adelaide is statistically significantly higher than Country SA" (p. 103). The HPC reports that approximately one third of Aboriginal people report high to very high rates of psychological distress. The rate of 33.4 % is second highest out of all Australian states.

3 Diversity planning and intersectionality

Diversity analysis and planning is an area of practice which aims to meet policy commitments in achieving access and equity outcomes in education, childcare, aged health and other areas of human services. Diversity planning can have a broad focus to include groups based on multiple social identities (E.g. Dept. of Health 2011), or be narrowed to explore cultural diversity (NSW Health, 2012) or gender diversity (Western Australian Peak of Women's Health Services, 2011).

[2] Other common social determinants considered in public health include employment levels, levels of annual income, experience of disability and exposure to multiple risk factors. For employment status, Adelaide North had the greatest proportion of people experiencing unemployment, with SA outback, and Adelaide West, SA South East and Adelaide South following. In respect to annual income levels, the report highlights that people with low incomes are vulnerable to affording basic life supports and services are likely to have worse housing, educational and employment outcomes, and interconnected with these, poorer health outcomes. Adelaide west had the highest proportion of residents with annual incomes under 50,000.

[3] The Council reports also that the rate of people 16 years or more reporting feelings of suicidal ideation was "more than double in areas of lowest socio-economic status compared to highest" (p. 103). Public health data identifies the regions with the highest reporting of psychological distress as Adelaide North, Adelaide West, SA Outback, Adelaide South and SA South East (Govt. of South Australia 2012).

A commonly used metaphor involves the use of a 'diversity lens' to identify the health equity concerns for particular disadvantaged groups and make planning commitments that identify the specific characteristics and circumstance of members of these groups. It often involves a focus away from the one size fits all approach to service planning, to develop a set of particular plans which also recognise barriers to access and use of services.

The diversity framework used by Home and Community Care Victoria provides a useful example for the current project. The framework requires planning which uses the 'diversity lens' to identify vulnerable populations and map the geographic distribution of these groups and the local services (Dept. of Health 2011).

The diversity lens also encourages exploration of the various social identity characteristics of service consumers. This has been adapted (see figure 1) to HCA context by emphasising the social identities of gender and sexual identity, age, health status, cultural background and profound social experiences which shape health outcomes (eg. refugee status, offender status, being homeless). The lens also emphasizes the factors of socioeconomic disadvantage, community capacity[4], location, accessibility and equity of health services and consumer experience, so that these become centred as considerations for HCA planning and activities.

The diversity lens highlights that community members may experience multiple or overlapping disadvantage where many aspects of social disadvantage are experienced together, to produce either shared or unique outcomes for community members. This theme is called intersectionality in public health analysis (see e.g., Hankivsky, 2012). It refers to a sociological understanding about how specific community groups experience disadvantage and exclusion as an 'intersection' of multiple social structures and processes (the various social determinants of health). For instance, looking at Figure 1, the characteristics of poor English literacy, low income, unemployment, the experience of depression, gender and family member disability, would be social experiences impacting simultaneously on many women and men from refugee backgrounds in South Australia. The

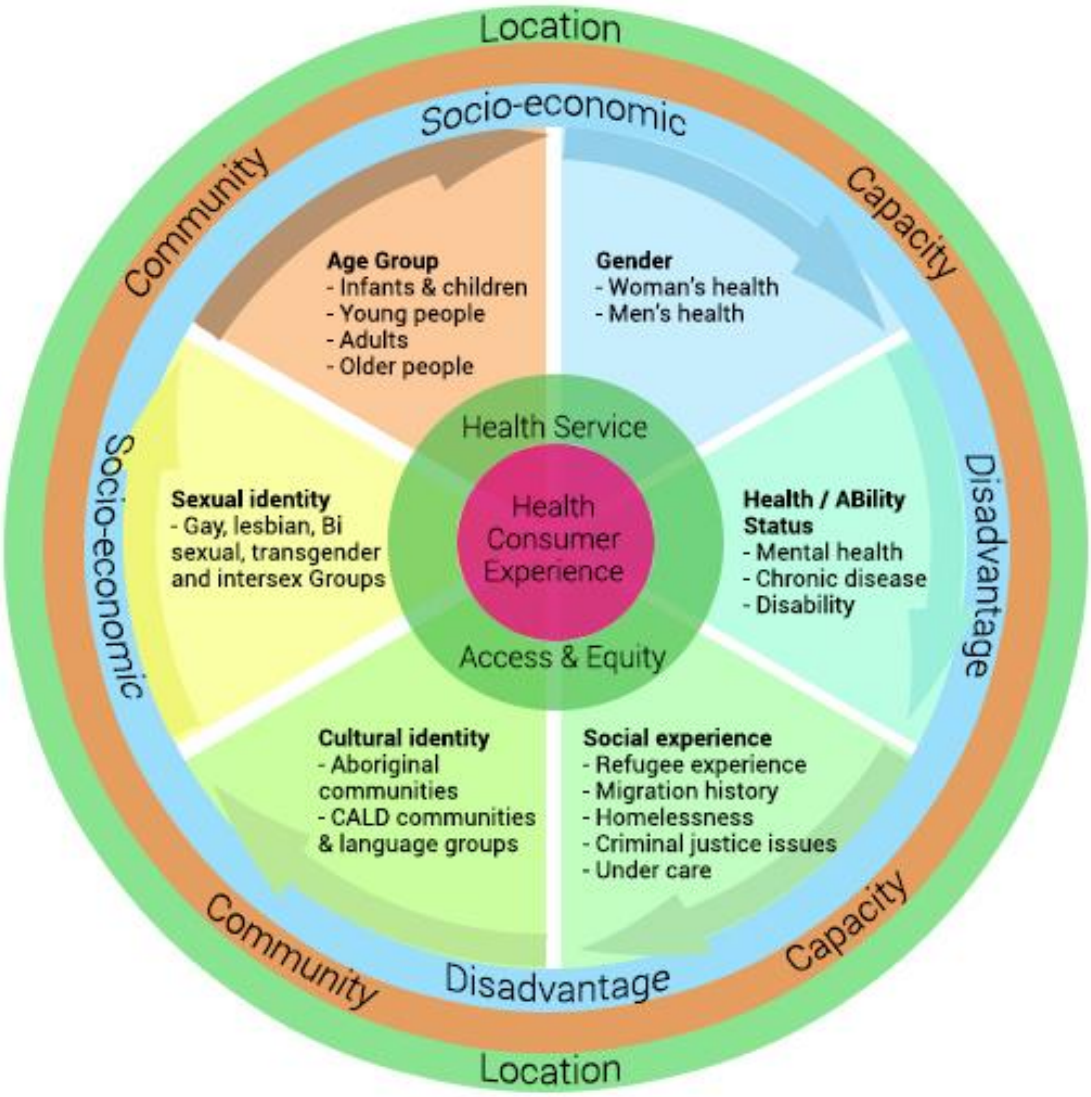
[4] Community Capacity refers to the concept used in health promotion to guide activities that build upon the strength's and assets of individuals and groups, taking account of social processes of belonging, cohesion, connectedness and support networks. As an approach Community Capacity Building is associated with themes of empowerment, self-determination and participation and the values of equality and health equity. As such it is often used in approaches for working with marginalised and disadvantaged communities (Raeburn et al, 2006).

concept helps us to understand that analysis and action in approaching vulnerable groups needs to take into account their specific experience, and be mindful of potential advocacy action in a variety of policy contexts[5]. When we categorise a person as belonging to a vulnerable group, we should also maintain awareness that they may have experience/ memberships to other areas of disadvantage (Dept. for Communities and Social Inclusion, 2014).

Intersectionality offers various strengths for informing both the analytical and planning tasks of the HCA framework. It is guided by principles of social justice and equity and helps promote the understanding that vulnerable group agencies have specific ways of knowing and in responding to marginal experience. It draws attention to power dynamics and the role that local culture can play in engagement (Hankivsky et al, 2012). These are important aspects for eventual engagement strategies to consider and respect when building our networks.

[5] From our example above, HCA activity in connecting with refugee groups could require action in terms of promoting recognition as health priority groups, advocacy for better levels of translated health/illness information and income support measures, encouraging better access and engagement with local health services, liaison with chronic disease/ disability foundations and capability building projects in responding to health issues.

Figure 1. Diversity Planning Lens: Vulnerability and Health Consumer Experience



(Source: Adapted from Dept. of Health, 2011 p 8)

4 Strategies for effective engagement

Diversity planning documents, as well as literature on increasing participation with specific communities, offer a range of strategies for engagement practice. These cover areas such as communications and branding, information and education, partnerships and direct engagement.

There are some priorities areas indicated in the public health data which affirm long term HCA activity. These include HCA member networks and connections with consumer networks and groups focused on the chronic health issues of cancer, asthma and respiratory diseases, cardio vascular illness and diabetes, as well as our work in supporting mental health advocacy and improved service provision. The focus on low socioeconomic status and locality suggests that HCA can strengthen its awareness on key areas of disadvantage, such as the Northern, Western and Southern Metropolitan regions, and country areas such as Barossa/ Mid North/ Yorke region.

The following tables describe a range of engagement strategies which are arranged according to the five goals of the IAP2 participation spectrum (International Association for Public Participation, 2004).

The strategies have been developed by reviewing the common methods of engagement as outlined under the IAP2, and considering these in light of both existing HCA practices and the diversity planning literature (e.g., Govt. of Victoria, 2011)

Specific consideration has been given to:

- HCA's existing representative links and activities with member organisations and community groups. It is important that the framework builds on HCA's existing strengths, networks and activities undertaken by representative and consumer advocates.
- Ensuring the strategies reflect and compliment the directions of the HCA 2012-2016 strategic plan, and its long term advocacy targets including ensuring consumer centred care, partnerships with consumers, improved mental health services etc.

- HCA's specific relationships with Local Health Networks, where we can encourage recognition by the health system of the need for improved levels of service to vulnerable communities.
- Ensuring that strategies are feasible given resource limitations.

As described, the strategies are general in nature and express a diversity focus. However, each can be further specified and detailed as HCA establishes priority population groups for engagement. In this way, the framework becomes applied when planning our partnerships and engagement and we can draw on methods which are known to be effective locally and within the literature[6].

In addition HCA can draw on the Diversity Planning Lens to consider how specific issues are experienced by consumers belonging to various social identity memberships, and work to build more inclusive engagement.

[6] As definitive plans for population groups are developed, HCA should consider an integrated approach to risk management planning. This is especially the case where activities are proposed which are not established practices of the organisation and where risks in a range of areas (e.g., in financial, public/ staff safety and legal terms) need to be identified, assessed and managed (Victorian Managed Insurance Authority, 2010).

Table 2: Strategies for informing vulnerable communities

IAP2 Participation Goal	Strategy	Community groups and organisations to engage	HCA Strategic directions and current activities
Inform	Increase communications links to peak / consumer organisations who represent vulnerable community groups.	Community Centres SA, AHCSA, MCCSA COTA, YACSA, MYSA, SACOSS	Strategic Engagement and Partnerships
	Utilise stronger diversity focus in HCA communications to broaden promotion of issues facing specific groups – connect universal interests – e.g. patient centred care with specific groups interests for the audiences e.g., young people with mental health issues. Identify and share stories and articles.	Broader Membership and Networks	Strategic Engagement and Partnerships
	Within the review of membership forms and processes- identify vulnerable group interests to new members	New Members	Strategic Engagement and Partnerships
	Utilise diversity imagery on online content and surveys, and in the physical environment of HCA.	Various representative organisations	Strategic Engagement and Partnerships

Table 3: Strategies for consulting with vulnerable communities

IAP2 Participation Goal	Strategy	Community groups and organisations to engage	HCA Strategic directions and current activities
Consult	Utilise online communication – e.g. e-News, Facebook, Twitter to publicise issues associated with key groups – link articles, stories and projects etc. Seek comment.	Community Centres SA, AHCSA, MCCSA COTA, YACSA, MYSA, SACOSS	Health Equity and Rights
	Develop and implement a health literacy program with a diversity focus and delivered in low socio economic areas. Program required to meet accessibility, literacy, cultural and language needs of participants and utilise a health based conversation approach. Focus on charter rights, self advocacy, getting best outcomes in primary care, finding support.	Develop in consultation with representative organisations. Deliver in partnership with Community Centres SA and representative organisations	Health Equity and Rights
	Ensure HCA consumer advocacy training programs reflect diversity content and issues of discussion.	Member and representative organisations	Strategic Engagement and Partnerships

Table 4: Strategies for involving vulnerable communities

IAP2 Participation Goal	Strategy	Community groups and organisations to engage	HCA Strategic directions and current activities
Involve	Develop and strengthen working links with organisations via HCA activities with specific diversity focus. Hold a 'diversity in health policy forum/ event'	Member and representative organisations	Health Equity and Rights
	Increase participation of representative organisations with HCA Policy Council and Community Relations Committee.	Member and representative organisations	Policy Leadership and Systemic Advocacy
	Directly invite organisations to attend key events, forums and consultations occurring the SA public health system – to input their experience and perspectives.	Member and representative organisations	Policy Leadership and Systemic Advocacy

Table 5: Strategies for collaborating with vulnerable communities

IAP2 Participation Goal	Strategy	Community groups and organisations to engage	HCA Strategic directions and current activities
Collaborate	Activate advocacy partnerships with organisations/ members to support and help consolidate specific health advocacy agenda's, and mutually inform with HCA's more generalist policy directions. Reinforce that HCA policy positions reflect diverse member input	Community Centres SA, AHCSA, MCCSA COTA, YACSA, MYSA, SACOSS	Policy Leadership and Systemic Advocacy Strategic Engagement and Partnerships
	Develop portfolio positions for HCA staff/board to build partnerships with key groups. Foster information exchange and encourage conversations across diverse/ common health experience	HCA staff/board members in collaboration with members	Strategic Engagement and Partnerships
	Build partnerships- attend group forums and events, publicise, support in our media, celebrate outcomes publically. Strategically devote time to disadvantaged community groups that are being engaged within LHN's, achieving partnerships on multiple levels.	Stakeholder groups CALHN CHSALHN NALHN SALHN WCLHN	Strategic Engagement and Partnerships
	Encourage HCA consumer advocates further learning and engagement with diversity and health equity issues:	Members, active consumer advocates & LHNs	Strategic Engagement and Partnerships
	Utilise communication and learning within the Consumer Advocates Network to build skills and knowledge, and networks.	Consumer Advocates Network Representative Groups	
	Encourage advocates to continue their interest in raising diversity and	Consumer Advocates Network, LHNs	

	health equity issues in their committee work.	
	Raise expectations that LHN committees and groups identify and respond to the needs of groups	Consumer Advocates Network, LHNs

Table 6: Strategies for empowering vulnerable communities

IAP2 Participation Goal	Strategy	Community groups and organisations to engage	HCA Strategic directions and current activities
Empower	Encourage representatives of community groups to nominate for HCA Board as general members or sector representatives	Members and representative organisations	Policy Leadership and Systemic Advocacy

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Appendix A: Summary of Vulnerable Community Groups and Health Issues

Table No 7 Vulnerable population groups – Children

Age Group	Populations	Significant health issues	Sources
Children[7]	Children from low income families, Children under guardianship Children with parents with mental illness Children of young people Children with disability	Poor health outcomes with children in range of areas associated with socioeconomic disadvantage, and experience of trauma and dislocation These include increased admissions to hospitals, higher use of CAMHS, poor oral health, higher rates of abuse and neglect, more profound disability.	Council for the Care of Children, (2013) Govt. of SA (2011)
	Children from Aboriginal communities	Neo natal health issues and adequate access to care and follow up. Rurally located children have higher rates of respiratory and ear infections and eye care needs, poor dental health	Govt. of SA (2011) Govt. of SA (2010) Australian Institute of Health and Welfare (2013)

[7] These priorities are supported by the Snapshot of Young South Australians, (The Council for the Care of Children, 2013)" Children and young people who have special needs and who live with disability, those who identify as Aboriginal, those who have experienced deprivation and trauma, and those with existing long-term illnesses are among young South Australians most likely to experience the poorest health and wellbeing."(p5) Further: "Children and young people who are more vulnerable to injury, abuse, neglect or trauma include those who have special needs or a disability; those who are disadvantaged by poverty, poor parental health and education, or social isolation; and those who have already experienced trauma and dislocation from kin and country (such as some Aboriginal, refugee and homeless children and young people)" (p10).

Age Group	Populations	Significant health issues	Sources
	Children from refugee backgrounds	Higher rates of psychological distress and uncertainty, disruption to developmental needs. Poor dental health. Exposure to trauma and discrimination. At risk of poor nutrition	Govt. of SA (2011) NSW Dept. of Health (2012)

Table No 8 Vulnerable population groups – Young People

Age Group	Populations	Significant health issues	Sources
Young People	Young people in contact with criminal justice system Young people with mental health issues Young people with unsafe alcohol use.	Mental health a critical concern: higher rates of self-harming, anxiety and depression, psychological distress. Coping with stress a leading concern expressed by young people. Suicide a leading cause of death for age group, but low users of mental health services. High rates of some STi's (Chlamydia, gonococci infections) Higher rates of smoking, and unsafe use of alcohol and drugs, associated with high rates of injuries and road trauma. 15-19 year olds have highest rate of hospitalisation for acute alcohol intoxication[8]. Nearly 1 in 4 young people are overweight or obese.	Govt. of SA (2010) Govt. of SA (2011) SA Department of Health and Ageing (2012) Aust. Mental Health Commission (2013) Aust. National Council on Drugs (2013). Mission Australia (2013) Office for Youth (2009)

[8] National level data indicate continuing trends of binge drinking among young people, including high rates of 'drinking to get drunk'. Additionally, up to 22% of hospital admissions and 13% of deaths of young people can be attributed to alcohol, whilst 52% of alcohol-related road injuries and 32% of alcohol-related injuries requiring hospital admission are from violence involving 15–24 year olds (Australian National Council on Drugs, 2013 p.12).

Age Group	Populations	Significant health issues	Sources
		Concerns on rates of eating disorders amongst young people 75 per cent of all cases of mental illness will occur by the time Australians reach 25 years-old. Transition periods are a key issue.	
	Young people of LGBTI identity	Young gay men traditionally experience higher levels of distress associated with marginalisation and discrimination. At risk also of higher rates of STi's	Govt. of SA (2012b)
	Young people of refugee background	Sexual and reproductive health issues (experience of sexual assault, FGM, STI's) and experience of discrimination, social disruption and trauma.	NSW Department of Health (2011) Govt. of Victoria (2012) Office for Youth (2009)
	Young people from Aboriginal communities	At risk from cluster of issues including substance misuse, poverty and poor housing, poor diet, offending. Higher rates of sexually transmitted disease Higher rates of psychological distress, self harming behaviour	Govt. of SA (2010, 2011, 2012b) Office for Youth (2009)

Table No 9.1 Vulnerable population groups – Adults

Age Group	Populations	Significant health issues	Sources
Adults	Adults with Gay, Lesbian, Bi sexual, Transgender, or Intersex identity	A national survey study revealed that the most common health conditions among these groups were depression and anxiety/nervous disorders. Higher levels of psychological distress. Rates of drug use for non-medical purposes higher than national averages. A significant number act to avoid heterosexist discrimination by hiding identity/ sexuality.	Govt. of SA (2014) Leonard et al (2012)
	Women experiencing family violence. Women who are carers of people with disability Men with Chronic Disease	Women experiencing family violence - linked to higher rates of depression and anxiety. Carers can also have poorer mental health. Men – unsafe alcohol use, smoking in disadvantages areas and country, less use of health services, but after age 65 are high end users (chronic disease). Male rates for diabetes, heart, stroke, vascular disease are higher, lack of social support and stress compounds risk of disease.	Govt. of SA (2011)
	Adults with mental health issues and substance use disorders	People who have mental health issues and a substance use disorder are twice as likely to be homeless as those who had one of these problems, and twice as likely to have been in prison or a correction facility. People with mental health issues have higher drug use, including smoking up to 2 times general rate. People with psychosis more likely to be affected with problematic drug use, including long term cannabis use. Strong association with methamphetamine use and psychosis. Further association between completed suicide and alcohol consumption.	Aust. Mental Health Commission, (2013) Govt. of South Australia (2011b)

Age Group	Populations	Significant health issues	Sources
		Higher rates of smoking and alcohol use heighten risk of Cardio Vascular disease and other chronic illness. Adult substance misuse impacts negatively on dependent children and other family. People with severe mental illness die between 10 and 32 years earlier than the general population.	

Table No 9.2 Vulnerable population groups – Adults

Age Group	Populations	Significant health issues	Sources
Adults	Adults from Aboriginal Communities	Higher prevalence of chronic diseases, including diabetes, cancer, kidney, cardiovascular and respiratory diseases. Diabetes is four times more prevalent; kidney disease is 12 times more prevalent. Co-morbidities and risk factors including smoking, high cholesterol, obesity, unsafe alcohol, lack of physical activity. Higher rates of psychological distress and mental health needs due to discrimination, ongoing life stresses, dislocation, and marginalisation. Oral, eye and ear health relatively poor. Less access of primary MH care, higher use of emergency MH care Aboriginal people are exposed to discrimination and higher rates of accidents requiring hospitalisation (19 times higher), self intended injury (4 times higher).	Govt. of SA (2010) Australian Institute of Health and Welfare (2013). Govt. of South Australia (2011b) Vass, A. Mitchell, A and Dhurrkay, Y.(2011)

Age Group	Populations	Significant health issues	Sources
		Poorer access to dental care and GPs, higher rates of hospital discharge against medical advice. Breast cancer screening and ante natal care lower rates of access Generally poor health literacy in western terms.	
	Adults from refugee backgrounds	High mental needs relating to long term stress and trauma, uncertainty, as well as separation from networks and traditions Higher level of post-traumatic stress, depression and anxiety Asylum seeker detainees face high rates of psychological distress and suicidal ideation Also, higher rates of dental disease, under immunisation, effects of poor nutrition, the experience of infectious disease, and poorly managed chronic disease. Sexual and reproductive health issues affecting adults (experience of sexual assault, FGM, STI's) and young people are commonly cited in the literature Poor health literacy	NSW Dept. of Health (2011) Australian Medical Association, (2011) Public Health Association of Australia (2012) St Vincent's Health Australia, (2012) Govt. of Victoria (2012) Ethnic Communities Council of Victoria (2012)

Table No 10 Vulnerable population groups – Older People

Age Group	Populations	Significant health issues	Sources
Older people	Older people with chronic disease and co morbidity	Issues include social isolation, lack of physical activity, poor dental health and low health literacy. Older people more likely to have chronic diseases such as diabetes, cardiovascular disease, cancer, with often increased co-morbidities affecting neurological functions. Injury from falls also at a higher rate. Poly-pharmacy also affects wellbeing. Dementia rates continue to rise.	Govt. of South Australia (2011) Govt. of South Australia (2009)
	Older people in rural areas	Issues include isolation, lack of transport, challenging service pathways, and access to specialist services. High needs for care, stress from caring roles	Govt. of South Australia (2011) Govt. of South Australia (2009)
	Older people as carers	Many older people provide a carer role to their parents, spouse, children, grandchildren and others. Issues of carer stress, financial issues and need for respite are important, also time for attending to own health	Govt. of South Australia (2011)
	Older people with mental health issues	Older people often have co morbidity of mental illness and chronic disease, high rates of depression, isolation an issue for older women.	Govt. of South Australia (2011)
	Older people from CALD background	Make up 20% of population – issues of culturally competent medical and aged care service provision, meeting language needs.	Govt. of South Australia (2011)
	Older people of Aboriginal background	Aboriginal people become elders earlier, due to shorter life expectancy (high rates of chronic disease and life stress). Elders play	Australian Institute of Health and Welfare (2013).

Age Group	Populations	Significant health issues	Sources
		extremely significant role for communities and cultural maintenance. Appropriate service provision remains an issue	

Appendix B: Summary of Priority Groups from SA Medicare Locals

Medicare Local	Health/ Service Priorities	Vulnerable Communities
Country South SAML CSSAML (2014) Comprehensive Needs Assessment – Full Report	• Early Childhood Development and wellbeing • Type 2 Diabetes • Cardio Vascular disease and secondary prevention • Chronic Disease risk factors (obesity hypertension, smoking, alcohol) • Unintentional accidents –road traffic trauma • Immunisation rates	• Aboriginal groups • Culturally and Linguistically Diverse Communities – Humanitarian entrants
Country North SAML CNSAML (2014) Comprehensive Needs Assessment Report	• Mental Health – expanding service provision, person centred care, service partnerships • Aboriginal Health - High ED presentations and acute care service needs – expand service provision and improve cultural safety of services in mainstream context • Chronic Disease, encompassing overweight and obesity. Expand, realign preventive services • Health System Access and Integration, increase effective referral pathways, access to medical and allied health. Other issues of concern • Women's Health, Cancer, Child Development, Dental Health	• Aged Population, promote service access and pathways to aged care, and respite services • Aboriginal and Torres Strait Islander Population-
Northern Adelaide ML NAML (2013) Stakeholder Report 2013-2014 Comprehensive Needs Assessment	• Mental health (access to services, lack of knowledge, stigma) • Accessibility of health (internet access, transport, education and employment) • Perinatal Care (antenatal visits, smoking during pregnancy, low birth weight babies) • Healthy lifestyles (good nutrition, physical activity, smoking, smoking during pregnancy, obesity) • Chronic disease (respiratory conditions, diabetes, high cholesterol, heart disease, musculoskeletal) • Families (housing stress income, childhood development needs)	• Yet to be determined – Profiling of population groups still being completed.
Central Adelaide and Hills ML	Integrative approach: • Mental Health (service development and access, comorbidities)	• Young people with mental health issues

Medicare Local	Health/ Service Priorities	Vulnerable Communities
CAHML (2012) Population Health Profiling, Needs Assessment and Commissioning- an Overview	• Complex comorbidities (incl. COPD) • Positive and healthy ageing Health Promotion and prevention: • Immunisation • Healthy weight • Cancer Screening Health literacy	• Older people • Aboriginal Groups
Southern Adelaide, Fleurieu and Kangaroo Island ML SAFKIML (2014) Comprehensive Needs Assessment. 2014 Report	Aboriginal Communities • Cultural competence of health workers for engaging Aboriginal community members • Improved services and access for Aboriginal children and youth, including immunisation services • Improved health service and support service access for Aboriginal communities • Improved sexual health service access for Aboriginal young people. Ageing • Increased demand for services for ageing populations, including dementia support and respite, primary health care services • Address gaps in services for ageing populations Mental Health • Access to Psychologist – raise availability • Improved after hours mental health service access for young people • Suicide prevention for young people • Anxiety and depression – high rates for adults and young people • Increased support for new parents • Better access to mental health support for LGBTI community members • Improved access to MH community based specialists • Young carers of parent with mental illness • Address gaps in mental health support identified by different populations	• Aboriginal and Torres Strait Islander (ATSI) Health and Wellbeing • Ageing Population • Mental Health • Primary Health Care Workforce Support & Wellbeing

Medicare Local	Health/ Service Priorities	Vulnerable Communities
	Primary health Care • Access to GP's – reduce waiting times – raise availability – increase after hours care • Address various gaps in community health service availability. • Access to accurate, timely health information and resources • Improve health literacy • Improve health service coordination	

Appendix C: Representative Organisations for Vulnerable groups in SA

Population	Name of Organisation	Type
ATSI Groups		
	Aboriginal Elders Village	Service
	Aboriginal Health Council of SA Inc	Peak
	Aboriginal Health Teams within LHNs	Service
	Aboriginal Prisoners and Offenders Support Service	Service
	Aboriginal Sobriety Group	Service
	Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation	Service
	Kalparrin Community	Service
	Kaurna Aboriginal Community and Heritage Assoc.	Community
	Kaurna Warra Pintyanthi – Uni Adelaide	Community
	Nganampa Health Council	Service
	Nunkuwarrin Yunti of SA Inc	Service
	Nunyara Aboriginal Health Service Inc	Service
	Oak Valley Health Service	Service
	Pangula Mannamurna Inc	Service

Population	Name of Organisation	Type
	Pika Wiya Health Service Aboriginal Corporation	Service
	Port Lincoln Aboriginal Health Service	Service
	Tullawon Health Service	Service
	Umoona Tjutagku Health Service Aboriginal Corporation	Service
Asylum Seeker, Refugee, CALD		
	Migrant Communities Council of SA	Peak
	Migrant Health Service	Service
	Migrant Resource Centre of SA	Service
	Multicultural Youth SA	Service
	Red Cross – Refugee program	Service
	Shine SA – Multicultural Programs	Service
	Statewide CALD Domestic Violence Service	Service
Children/ Young People		
	COPMI – Children of Parents with Mental Illness	Service
	Council for the Care of Children	Statutory
	Create – Young People in Care (National)	Service
	Headspace – Youth Mental Health Programs	Service
	Parents helping Parents – Children with disability	Consumer
	Re-engage Programs (DSS funded)	Service
	Second Story Youth Health Service	Service
	Shopfront Youth Health and Information Service	Service
	Youth Affairs Council of SA and Sector Networks	Peak
People living with Chronic Disease or comorbidities		

Population	Name of Organisation	Type
	Alzheimers Australia SA Inc	Service
	Arthritis SA	Service
	Asthma Foundation SA	Service
	Australian Pain Management Association Inc	Service
	Bridges & Pathways Institute Inc	Service
	Cancer Council South Australia	Service
	Cancer Voices SA Inc	Consumer
	Diabetes South Australia	Service
	Hampstead Rehab Consumer Council	CAG
	Health Advisory Councils within CHSALHN	Community
	Hepatitis Council of SA	Service
	Kidney Health Australia	Service
	Lyell McEwin- Modbury Consumer Council	CAG
	Men's Health SA	Service
	Parkinson's South Australia Inc	Service
	Polio Awareness SA Inc	Service
	QEH Consumer Council	CAG
	RAH Consumer Council	CAG
	SALHN – various site groups (in formation)	CAG
	Southern Cancer Club	Community
	Type One Voice	Consumer
	Women's Health Statewide	Service
Disability Groups		
	Brain Injury Network of South Australia (BINSA)	Service

Population	Name of Organisation	Type
	Disability Advocacy and Complaints SA	Service
	Disability Information and Resource Centre	Service
	Disability Rights Advocacy Service (Malssa)	Service
	Royal Society for the Blind	Service
GLBTI Groups		
	Gays Men's Health , Relationships Australia SA	Community
	Rainbow Advisory Group, DCSI	Community
Homelessness		
	Aboriginal Transitional Housing Outreach	Service
	Aboriginal Youth Early Intervention Program	Service
	Aged Homeless Assistance Program	Service
	Shelter SA	Peak
	Together for Kids – Child focused support	Service
Low Income Groups		
	Community Centres SA	Peak
	SA Council of Social Services	Peak
	Uniting Communities	Service
	Welfare Rights Centre SA	Service
Maternity		
	Beautiful Birth Inc	Consumer
	CAFHS -WCLHN	Service
	Maternity Choices Australian (National)	Consumer
Mental Health Groups		
	AMSA – Men's Sheds	Peak

Population	Name of Organisation	Type
	Carer Statewide Reference Group	CAG
	Carers SA Mental Health Task Group	Consumer
	Community Mental Health Programs UCWPA	Service
	Consumer Statewide Reference Group	CAG
	DASSA	Service
	Eastern Lived Experience Liaison Group	CAG
	Grow SA (Community Mental Health	Service
	Inner Southern Consumer Carer Advisory Group	CAG
	Life Without Barriers	Service
	Mallee Mental Health Community Liaison Program	Service
	Mental Health Coalition SA	Peak
	Mental Health Focus Group – Barossa Council	Community
	Mental Illness Fellowship of SA Inc	Service
	Mind Australia SA	Service
	Murray Mallee Consumer Advisory Group	Consumer
	Noarlunga Consumer Carer Advisory Group	CAG
	Older Persons Consumer Carer Advisory Group	CAG
	One Voice Network Inc	Consumer
	Ramsey Health (Private) Consumer Group	CAG
	SA Network of Drug and Alcohol Services	Peak
	Veterans Consumer Carer Advisory Group	CAG
	Western Lived Experience Liaison Group	CAG
	Youthink CAMHS Consumer Group	CAG
Older People		

Population	Name of Organisation	Type
	Aged Rights Advocacy Service Inc	Service
	Carers SA	Peak
	COTA	Peak
	Seniors Information Service	Service