

The Harmsworth Street Outreach Project

A Joint Project of:



Outreach Victoria



**Royal District Nursing
Service**



**North Yarra Community
Health**

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Abstract

The Harmsworth Street Outreach Project is a joint initiative of Outreach Victoria, North Yarra Community Health and the Royal District Nursing Service Homeless Persons program. The program commenced in August 2000 as a multidisciplinary outreach health and welfare program, and has thus been in progress for approximately twelve months.

The project targets a group of highly marginalised people who meet regularly in a park at the back of the public highrise estate in Collingwood. The vast majority of those present are Aboriginal males. This population has been widely recognised to have the worst health status of all Australian population subgroups, and to experience particular difficulty accessing mainstream health services.

These features of the target group were recognised, and consultation with Aboriginal agencies and the community themselves was identified as being of paramount importance to ensure relevance and culturally appropriate service delivery. As a consequence of this process of consultation, a holistic social model of health was adopted to underpin the planning of objectives and strategies for the program. Services such as nursing, physiotherapy, dietetics, podiatry, general practice, Centrelink outreach, recreation activities and assistance with housing are provided at point of contact. This ensures that not only are health needs being met, but some of the structural causes of ill-health are being redressed.

Commitment to this model, an ongoing process of community participation and consultation, and development of alliances with a number of other agencies has led to the program's success. While further evaluation is planned for the end of the first twelve months of the program, early evaluation through data collection and focus groups has indicated that there has been an increase in access to mainstream health and welfare services that are expected to lead to improved health status.

List of Abbreviations

RDNS HPP	Royal District Nursing Service Homeless Persons Program
NYCH	North Yarra Community Health
HACC	Home and Community Care
CAPPs	Consumer and Provider Partnerships in Health project
DHS	Department of Human Services
HIC	Health Issues Centre
CHP	Council to Homeless Persons

Overview of the Harmsworth Street Outreach Project

The Harmsworth Street Outreach Project is a joint initiative of Outreach Victoria, the Royal District Nursing Service Homeless Persons Program (RDNS HPP) and North Yarra Community Health (NYCH). The project officially commenced in August 2000 through an evolutionary process. It continues to expand as alliances are developed and strategies investigated to deal with issues as they present. Currently the program runs as a weekly collaborative outreach activity to a highly marginalised group of people who meet regularly in a sheltered barbeque area at the back of the Collingwood public highrise estate. A large proportion of the population attending the outreach session are Aboriginal men and women who typically have difficulty accessing mainstream health and welfare services.

An assertive outreach model has been employed which includes point of contact provision of health and welfare services, and provision of a nutritious meal. When clients need to access services, they are given choices as to the type of service they use – be that Aboriginal Health Service, hospitals, local general practitioner or community health service. They are then provided with practical assistance on entry to the service system through booking of appointments and provision of transportation to clinics. The specific services provided on location include nursing, dietetics, podiatry, physiotherapy, case work, recreational activities, housing assistance and Centrelink outreach services.

Leadership and strategic approach

The Harmsworth Street Project was initiated by workers from Outreach Victoria and the RDNS HPP Fitzroy Position in an attempt to build on their case management, support and referral work with a group of Aboriginal people who meet in a park. The project builds on existing relationships that these organisations had developed with the same population over a number

of years. Outreach Victoria had been providing long-term support to a number of members of the group who met regularly in the park on the Collingwood highrise estate. Primarily, individuals with high needs were targeted. However, Outreach had also been involved as a key player in the planning of a gazebo¹ shelter for the group in the park in 1999. They had also successfully submitted a proposal to the City of Yarra to fund the flexible provision of food to the group in 2000. Similarly, the Fitzroy based RDNS HPP worker had been engaging with a number of individuals who meet in the park through assertive outreach. From August 1999, this nurse had attended the park regularly to monitor the health status of those present, take self-referrals, case manage the many traumatic injuries, and to distribute vitamin supplements.

In 1999 and 2000, the NYCH allied health team was expanded through the addition of four 0.5EFT positions to target the homeless population. These positions included podiatry, physiotherapy, occupational therapy and dietetics. NYCH had also identified homelessness as a key health promotion area for the organisation to be targeted for a three-year cycle from 1999 to 2002.

During the development phase of the new NYCH positions, a reference group of local agencies targeting the same population of clients was established to provide direction to these new services and to increase awareness of the roles of these service providers. The agencies involved included the Department of Human Services, Brotherhood of St Lawrence, City of Yarra, Outreach Victoria, RDNS HPP, St Mary's House of Welcome, Clarendon Homeless Outreach Program and Yarra Community Housing. This process assisted in developing relationships with established agencies such as Outreach and RDNS HPP who saw an opportunity for a collaborative program of service provision to the collective, rather than individuals, in the park. NYCH's involvement, and the development of a project working group to plan this task, were thus facilitated.

¹ The gazebo was an initiative that has been fully funded and maintained by the Office of Housing.

Each of the agencies currently involved in the project therefore has a unique role in service provision to homeless² clients and those at risk of homelessness. The profiles of the three agencies involved in initiating the project and the services they provide to the homeless community are outlined in Appendices 1, 2 and 3. All agencies have demonstrated commitment to working collaboratively towards improving the health status of the group in the park.

The Harmsworth Street Outreach working group was thus a tri-agency working group. The working group agreed that the aim of the Harmsworth Street Outreach program was to:

improve the health and wellbeing of a highly marginalised group of people.

They also clearly articulated a number of core principles that would drive the program. These principles stated that the program would:

- Provide services in the belief that society should provide for the fundamental needs of all communities
- Operate in the belief that good health is a fundamental right and therefore the obligation of society to provide services that promote good health and well-being
- Respect the right of individuals to live according to personal choice
- Respect people's right to confidentiality
- View poor health as a systemic failure of society and therefore work to change people's circumstances, leading to better health choices.

Strategic partnerships and alliances

The working group recognised and acknowledged the largely Aboriginal composition of the client group, and the "mainstream" or primarily non-

²A major focus of the agencies involved in the development project is in targeting homeless clients. Where referred to in this document, a cultural definition of homelessness used by the Council to Homeless Persons defines this population: a homeless person is someone who "is without a conventional home and lacks the economic and social supports that a home normally affords. She/he is often cut off from the support of relatives and friends, she/he has few independent resources and often has no immediate means and, in some cases, little prospect of self-support." (Council to Homeless Persons, 1998) Within this population, the subgroups described by Chamberlain (1999) are recognised: primary, secondary, and tertiary homeless and marginally housed.

Aboriginal composition of the working group and service providers. While it had been identified that many members of the group were failing to access health services that they needed, it was also recognised that it was necessary to provide these services in a culturally acceptable manner. This led the working group to seek support and advice from a number of Aboriginal Health sources. These included the Victorian Aboriginal Health Service, Shirley Firebrace from the Department of Human Services, Aboriginal Community Elders Services (ACES), the Koorie Liaison officer at Darebin Community Health, and the George Wright Aboriginal Hostel. These agencies continue to be informed of the activities of the project. Outreach staff from the George Wright Hostel regularly attend the program, and provide reference to the program's service providers. ACES periodically bring elders to the program, and are involved in planning a separate complementary cultural program at the Collingwood highrise estate. The Darebin Community Liaison officer has also attended the park and maintains a keen interest in further involvement.

Two other large mainstream agencies have contributed significantly in providing support to the project. These are Centrelink and the City of Yarra. A Centrelink outreach worker attends the program to enhance access to Centrelink services and assist people with accessing the benefits for which they are eligible and follow-up enquiries. Providing the service in this outreach mode substantially alleviates the struggle marginalised groups have in navigating the welfare system, and fosters some independence from agencies such as Outreach who normally provide such assistance. This has freed Outreach workers to attend to other tasks, such as providing assistance in securing and maintaining housing, tenancy advice, and legal support at the program.

The City of Yarra HACC food program has similarly demonstrated flexibility and support for the outreach project. Through provision of \$50 - \$100 of funds per week, used to cover the costs of food provided at the BBQ, a large population of Meals-On-Wheels eligible clients (usually around 30 people) have been able to receive one free meal per week. Normally these clients do not receive the service, as due to their mobility and lifestyle, they are rarely at

home to have their meals delivered. For a number of those attending the program, this may be the only meal they eat for the week, with the remainder of their energy requirements coming from alcohol.

Use of an evidence based approach

Many of the participants at the program are Aboriginal. While most live in the City of Yarra, some participants travel to the program from Darebin and other areas. The numbers of Aboriginal and Torres Strait Islander people living in Yarra are estimated as 307 or 0.47% of the total Yarra population. (HIC, 2000) However, that some of the most relevant statistics about Aboriginal and Torres Strait Islander peoples are inadequately collected, or not collected at all is well documented. (HIC, 2000; ATSIHWIU³, 1997) Despite such under-reporting, the Aboriginal community is known to have the worst health status of all population subgroups in Australia. (ATSIHWIU, 1997; PHAA, 2000) Compared to non-Aboriginal Australians, Aborigines:

- live an average of 15 to 20 years less, with the life expectancy for Indigenous men in Victoria being 57.1-67.2 years and for Indigenous women the range being 62.9-72.5 years;
- are two to three times more likely to give birth to low birthweight infants
- are two to four times more likely to die at birth
- are two to three times more likely to be hospitalised – particularly for respiratory conditions and injury
- are 15 to 18 times more likely to die of infectious diseases; and
- experience significantly higher death rates at each age group, with the greatest differential being six to either times higher amongst adults aged 25 to 54 years. (ATSIHWIU, 1997; HIC, 2000)
- have much higher prevalence of cardiovascular and circulatory disease, diabetes, respiratory infections, injury, and eye problems (National Aboriginal and Torres Strait Islander Health Clearinghouse, 1998, Gracey, 1995, Hogg, 1992) to the point where these may be described as endemic.

³ Aboriginal and Torres Strait Islander Health and Welfare Information Unit

Unfortunately, no specific data for the City of Yarra on Aboriginal morbidity and mortality is available (HIC, 2000). The use of the above data, based on statistical means, as a proxy for the health status of the group meeting in the park at Harmsworth Street would over-estimate their well-being. As the population attending the Harmsworth Street program live in the public housing estates, rooming houses with insecurity of tenure, or are doubling up with friends or relatives and are therefore homeless by definition, the health problems within the group are expected to be more prevalent and complex than these figures would suggest.

Prior to commencement of the program, and confirmed through data collection over the initial months of the program, health service providers observed a number of health problems which were not being adequately addressed. This information is also used in planning services and identifying comparative need. These included a need for monitoring diabetics, poor dental and oral health, malnutrition, drug and alcohol issues, musculoskeletal injury and trauma, the need for assistance with medication-taking through filling of dosettes, family issues, and the need for assistance with linking into health services of any type.

The risk factors contributing the poor health status of Australian Aborigines are described by Hogg (1992). Among these are nutrition and lifestyle factors, and sources of chronic stress specific to the population such as “dispossession and institutionalisation, separation and loss; unemployment; alienation and inequity; and stigmatisation and assimilation.” (Hogg, 1992, p.343) Barriers to access of mainstream health services further contribute to poor health status. Anderson (1988) describes these barriers as being economic, geographical (in the case of remote communities) and sociocultural. Importantly, he outlines the sociocultural barriers as being:

- “The conflict between the dominant western philosophy of the service provider and the cultural background of the patient...”
- The failure to utilize... the strong kinship networks which are an important part of Aboriginal culture...

- The authoritarian nature of the doctor-patient relationship, which when compounded by previous bad experiences with other non-aboriginal professionals, serves to intimidate Aboriginal people... (and)
- The alienation which an Aboriginal person feels in an environment made up of people who have had little contact with Aboriginal people.” (Anderson, 1988, pp.108-109)

Thus, a biomedical model of service delivery was seen to be inappropriate for this target group. Furthermore, the finding that a large number of persons also live alone in the City of Yarra (34% of Yarra's population), contributes to a risk of social isolation which can in turn lead to ill-health (HIC, 2000), highlighted a need for a collective activity. The need for a social model of health, incorporating primary health care principles, was therefore accepted. Along with the key strategy areas outlined in The Ottawa Charter for Health Promotion (1986), evidence gathered on the health status of the Aboriginal population and on the nature of the barriers presented to them by health services, were used to guide the development of the project's objectives and strategies.

Relevance and applicability

In the early stages of program delivery, a focus group was undertaken with a small group of people who regularly attended the program as part of the process evaluation. This was done informally and not recorded to encourage participation. The aims of the focus group were two-fold: to gain an appreciation of the felt need within the group and their perception of their health status, and to seek input on future directions and activities of the program. The information gained was to be used to ensure the relevance of the program to the community.

The findings of the focus group were interesting. In response to a question “What do you think are the main health problems that people in the group have?”, the participants responded that they had pains all over and woke up

hungry, and that they needed a first-aid kit for emergencies (the nature of these emergencies was not specified). However, they also felt that most people did not have any real problems and had reasonable health. Similar self-reporting of health status was found in the 1994 National Aboriginal and Torres Strait Islander Survey, where 88% of the 15,700 participants reported having excellent, very good, or good health; despite evidence to the contrary. (National Aboriginal and Torres Strait Islander Clearinghouse, 1998)

The focus group participants also felt that they did not require health information on topics such as diabetes, heart disease, nutrition, parenting etc., as these were not felt to be particularly relevant to the members of the group. The group reported that the feature they liked most about the program was the opportunity to socialise and people getting together to communicate. They indicated that they liked having the service providers attending their park, and that it would be good to also have a doctor attend periodically. As a result of this request, a general practitioner from NYCH now attends the program regularly.

That social connectedness was strongly identified as an important part of the program by the group, confirmed the need to utilise a social model of health. It was decided that health service provision and dissemination of health information needed to continue to be provided within a social context to increase relevance of the program to the community. The importance of community and culturally relevant activity also emphasised the value of the role of the recreation worker from Outreach Victoria. A number of activities suggested by participants in the focus group (including having a fishing trip, going to the new museum, and having a trip to an Aboriginal national park) have been successfully undertaken by the worker, and are happening with regularity. Members of the group have also been taken abseiling and camping, and a fishing group is being established. Further information on the recreation worker's program is detailed in Appendix 1.

Suggestions were also made for having a special Christmas event, and culturally appropriate foods were recommended, food hampers and having

Santa Claus attend for the children were requested. The Christmas event was well attended, and those present were provided with food hampers containing non-perishable foods that would last over the Christmas period and did not require refrigeration, oral hygiene items such as toothbrushes and toothpaste, and socks and underwear. Santa Claus distributed donated toys to children, and food served included kangaroo, shark, and emu sausages.

More recently, in response to a request for a family day, the group were involved in planning of a funding request to the DHS. Individuals were invited to assist in drafting a letter that explained the reasons for wanting to run a family day. When the draft was typed and approved by the group, the members signed the request, which was forwarded to the department with covering letter from service providers that included approximate costings of the events for the day. The funding has been received, which is of significance in empowering this group as a collective and encouraging the group's involvement in the planning and running of the project.

Concurrent to the development of the project, NYCH received funding from the Department of Health and Aged Care, for participation in the Consumer and Provider Partnerships in Health (CAPPs) project. This project paid nominated consumer liaison persons from various communities, to act as a link between their relevant communities and service providers. The Aboriginal CAPPs consumer representative has also become an invaluable source of advice and guidance to service providers. She has agreed to becoming involved in facilitating program participants to feedback to service providers on project direction and planning.

Originality and innovation

A number of aspects of the program demonstrate originality and innovation. While the concept of service delivery and entry at point of contact is recognised as a keystone to effective outreach, few projects provide this in a collaborative manner. In particular, the combination of provision of health and

welfare services at point of contact ensures a holistic approach to promotion of well-being. While provision of health services to those who need them, but cannot receive them due to barriers of the service system is important, without the concurrent provision of welfare services to address the fundamental conditions for health such as shelter, income and education, no sustainable progress or prevention is likely to be made. As noted by Anderson (1988): “Given that health is determined by a whole range of factors such as housing, employment and educational opportunities, it is necessary that these should be taken into account when developing services for the Aboriginal community.” (p.109) Without this holistic approach, provision of health services becomes a band-aid for the structural causes of ill-health.

An additional innovative aspect of the project is its location in an open space such as occurs with use of the park. The adjacent community hall is used to provide some treatment services such as physiotherapy, medical assessment and podiatry treatments. Some treatments, including vaccinations for the flu, have occurred in the park on the request of members of the group. Practical food preparation and hygiene skills are imparted to participants and supervised by a dietitian. The Australian Dietary Guidelines and HACCC Food Services handling guidelines are adhered to in meal planning and preparation. The use of HACCC food program funds to provide food option using an outreach model is another unique feature of the program that has increased access to meals. The cost effectiveness and ability of this project to reach a group of people who would otherwise not utilise traditional Meals-On-Wheels services has subsequently lead to City of Yarra’s support for other innovative food programs.

Importantly, the project has worked towards demystifying health professionals and the mainstream services that they represent, for this most vulnerable and marginalised group of consumers. The consistent attendance of the same service providers who respond rapidly to clients’ requests and promptly address problems presented has helped to foster trust and build strong relationships between providers and consumers. This can only lead to greater opportunities for access to health services.

Quality and peer review processes

The project aims and objectives are clearly detailed in the Evaluation Plan below. These are frequently referred to, both to ensure process evaluation progresses as planned and to enhance the quality of the program. This process of quality and peer review occurs in two ongoing forums: a monthly meeting of service providers whose term of reference is to address problems as they present and plan future program events, and a tri-monthly meeting of the original steering committee where the program is reviewed. Efforts to have consumers involved in a peer review process at the monthly service provider meetings have been problematic. Occasionally a representative from the group will attend one of these meetings, but not regularly. It is felt among providers that the forum may be intimidating for clients as it is held in a meeting room and is too highly structured. In order to address the problem of consumer participation, the CAPPs Koorie representative and a representative from George Wright hostel attends these meetings where possible to provide feedback from the group in this formal setting, and steer service providers to deliver services in culturally appropriate ways. Feedback and input from the group is encouraged in other less formal settings. Key community members are approached for advice on program activities and their relevance to the group, and for feedback on activities held.

Each of the key agencies also demonstrates commitment to quality service delivery at an organisational level. All agencies respect client confidentiality, recognise their duty of care to their clients and work within the DHS guidelines on privacy principles and health records. All agencies are accredited services, and NYCH utilises a quality improvement officer for ongoing organisational improvement.

Evaluation Plan

While process and impact evaluation have taken place in the forms of focus groups and data collected on the day, summative evaluation of the project

Table 1: Evaluation Plan

Objectives	Strategies	Evaluation
1. Identify health and welfare needs in the target group	<ul style="list-style-type: none"> • Conduct focus group interviews with the target group (or representative of the group, chosen by the group) • Service providers initially involved in the program to record needs that were initially identified • Collect ongoing data of needs as identified throughout the program • Utilise established health data on homelessness and Aboriginal health 	<ul style="list-style-type: none"> • Focus group occurred • Data collected
2. Increase utilisation of health and welfare services by the target group	<ul style="list-style-type: none"> • Develop trust between the client group and local services by having service providers engage with them in the environment in which they live and frequent • Provide a weekly outreach clinic providing health and welfare services at the gazebo in Harmsworth St • Utilise the adjacent community centre to provide health and welfare services as required • Provide relevant health and welfare services in a holistic, culturally appropriate and flexible manner that responds to the needs of the client • Facilitate referral of individuals to mainstream health and welfare services as required • Advocate for clients upon entry into mainstream services 	<ul style="list-style-type: none"> • Baseline data collected • Weekly data collection to include demographics and numbers of new and ongoing clients accessing outreach health and welfare services, food and recreation programs. It shall also document any referrals made to other programs or services, and any new health needs identified by clients or workers. Evaluation shall include collation and analysis of data collected and comparison of this data with that collected initially. • Second focus group of participants after program has been running for 12 months
3. Impart personal skills and knowledge to enable the client group to make choices that lead to better health	<ul style="list-style-type: none"> • Incorporate health promotion advice in client contacts • Provide information in a culturally appropriate manner 	<ul style="list-style-type: none"> • Focus group of participants after program has been running for 12 months

4. Promote ownership of the program by the target group	<ul style="list-style-type: none"> • Involve the target group in the planning, implementation and evaluation of the program • Respond to self identified needs 	<ul style="list-style-type: none"> • Participation of target group in the planning, implementation and evaluation of the program • Focus group of participants after program has been running for 12 months
5. Improve coordination of care of individuals with complex needs within the group	<ul style="list-style-type: none"> • Convene monthly meetings of service providers to coordinate service provision to individuals • Nominate case managers for individuals as appropriate 	<ul style="list-style-type: none"> • Meetings occurred regularly
6. Increase participation by the client group in sustainable healthy recreational activities	<ul style="list-style-type: none"> • Provide regular access to culturally appropriate healthy recreational opportunities 	<ul style="list-style-type: none"> • Data on number of people participating in the recreation program collected and collated • Focus group of participants after program has been running for 12 months
7. Increase access to and consumption of safe and nutritious food	<ul style="list-style-type: none"> • Provide a once weekly culturally appropriate lunch program utilising the barbecue at the Gazebo in Harmsworth St • Provide food which complies with HACCC National Guidelines and the Australian Dietary Guidelines • Promote safe food handling and preparation practices • Develop guidelines on safe food handling for the program • Impart skills and knowledge to enable and encourage the target group to prepare and cook health meals on a barbecue • Contain costs of food provision to \$50 - \$100 per week 	<ul style="list-style-type: none"> • Collect and collate data on number of people accessing the meals program • Analyse nutritional contribution of food provided • Have food handling requirements been met? • Involvement of participants in food preparation, cooking and cleaning to be recorded • Analyse costs of the food program • Focus group of participants after program has been running for 12 months
8. Promote awareness of the social justice needs of the client group	<ul style="list-style-type: none"> • The program to operate within the philosophy outlined in this document • Workers to advocate for the client group on social justice issues as relevant 	<ul style="list-style-type: none"> • Advocacy occurred

and of any long-term health outcomes from the project have not yet been evaluated. The plan for evaluation of the program is given in Table 1.

Achievement of objectives and/or health outcomes

Data on the first three months of the program was collated in January 2001 to review progress of the program. The planned collation of the remaining data from the 12 month period is underway, and a second focus group is to be run in August. Since this initial period of data collation, numbers of participants attending have increased and more services have become available, including regular attendance of a doctor. Despite the short period of time the program has been underway, a number of objectives have been achieved, and the longer-term objectives continue to be worked towards.

Objective 1: Identify the health and welfare needs in the target group

- Felt need has been determined through the use of a focus group, and noting comments may by those attending the program.
- Comparative need has been identified through data collection by service providers.
- Expressed need is witnessed in the utilisation of services at the program.
- Documented data on Aboriginal health status has been collected to identify the specific health problems that are most prevalent in Aboriginal communities.

Objective 2: Increase utilisation of health and welfare services by the target group

- As data collection commenced some time after the program was initiated, the data does not extend back to the very early stages of the program when attendance was less. At times other than when the program is run, there is usually less than 6 males present at the gazebo. Data collected on attendances and gender breakdown of the group are presented in Charts 1 and 2 respectively.

- The group regularly seeks services from those present who promptly attend to those needs and link to other providers where necessary. Service utilisation data is presented in Chart 3.

Chart 1: Total Participants by Time

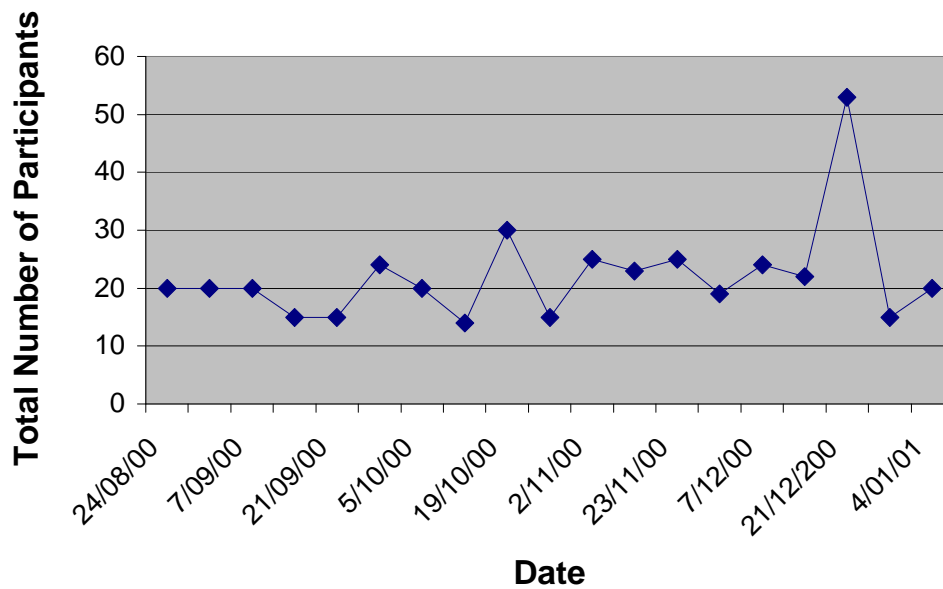
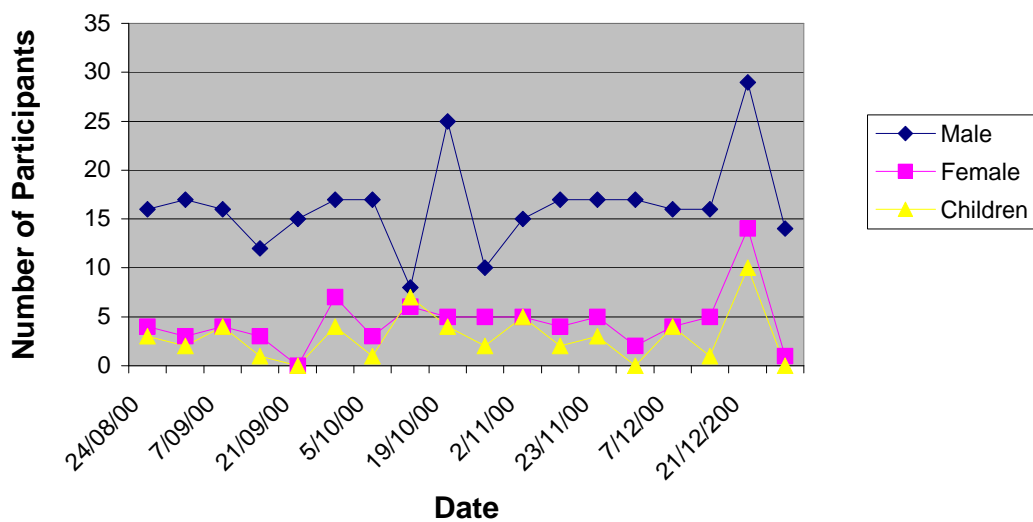
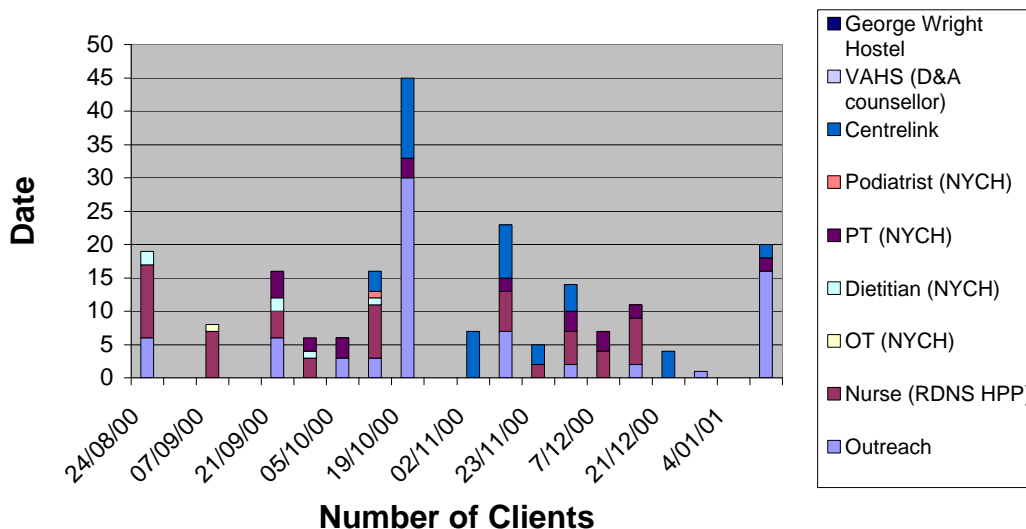


Chart 2: Breakdown of Group by Participants Gender



- Aside from the uptake of services at point of contact, there is strong anecdotal evidence of increased access to mainstream health services as a result of the project. All agencies involved report a large volume of follow-up work arising from service provision at the program. Clients receiving services at the park, or who have appointments made, will now often attend the community health service for follow-up treatment.
- Follow-up outreach services from all agencies involved are also arranged for many clients.
- In advocating for the client group in mainstream services, NYCH has made efforts in a number of areas to make clinic services accessible. These include flexible appointment structures for allied health and nursing clinics, a dental clinic for homeless clients and for those with drug and alcohol dependence, and priority of access to emergency appointments. This has helped eliminate one of the significant barriers to mainstream services – waiting lists. Another barrier that is also removed is a co-payment fee or services. These fees are waived for this group of clients.
- To evaluate the extent of the increased utilisation of mainstream services, a review of individual provider’s centre-based statistics and file audit will need to be conducted.

Chart 3: Services Provided to Client Group



- Clients are also given practical assistance to access services at healthcare agencies of their choice other than those represented at the outreach program. This occurs through booking of appointments and provision of transport.

Objective 3: Impart personal skills and knowledge to enable the client group to make choices that lead to better health

- Clients regularly prepare and clean the BBQ prior to cooking of food. Many have also assisted in cooking of food and preparation. Those assisting have been taught in a practical manner food hygiene and handling skills under the observation of the dietitian.
- Health promotion advice and information on relevant services and how to access these is provided to clients as part of direct client contacts.

Objective 4: Promote ownership of the program by the target group

- The target group has been involved in the planning implementation and evaluation of the program.
- As previously noted, participation has also included involvement in focus groups and assisting with funding submission for family day.
- Individuals health and welfare needs have been responded to promptly by service providers at point of contact.

Objective 5: Improve coordination of care of individuals with complex needs within the group

- Meetings of service providers have occurred on a monthly basis and have been used to coordinate service provision for individuals where this has been appropriate.

Objective 6: Increase participation by the group in sustainable healthy recreational activities

- The recreation worker employed by Outreach Victoria has arranged a number of recreational activities for program participants. These have been outlined in the section “Relevance and Applicability”.

- The activities arranged for clients have been responsive to the needs of the group and their requests.

Objective 7: Increase access to and consumption of safe and nutritious food

- From the collation of data from the program, an estimated 90% of those present at the program access a meal
- The food safety and nutrition guidelines outlined under Specific Requirements for HACCC Food Services (HACC, 1998) have been met.
- Food provided has included a variety of nutritious vegetarian and non-vegetarian meals, fruit and cheese. Due to the limitations of funds for purchasing the ingredients of food, it has been difficult to provide culturally appropriate food such as kangaroo, fish etc. on a regular basis. This been provided for special events, but “bush tucker” is something that is frequently requested but unfortunately rarely possible to provide.

Objective 8: Promote awareness of the social justice needs of the group

- Providers involved in the project remain committed to the program principles outlined
- Advocacy on behalf of the client group has taken place in a number of forums, including advocacy to reorient mainstream services to be responsive to the needs of the client group, advocating for the client on entry into the service system, and through actively seeking ongoing funding for the current program and for introduction and expansion of activities relevant to the group.

The timeframe for achieving the aim of improved health of the target group has not been determined. Without the removal of the structural causes of ill-health such as “compromised access to work, to education, to secure and acceptable housing, to a living income and to needed services” (HIC, 2000,

p.47), it is something that may never be realised. “The World Health Organisation lists the structural social determinant of health as being about the:

- ‘social gradient of health’; where people’s social and economic circumstances strongly affect their health throughout life leading to issues about...
- stress,
- early life, social exclusion,
- social support,
- work,
- unemployment,
- addiction,
- food,
- transport.” (HIC, 2000, p.47)

These issues overwhelmingly feature in the profile of the target group. It is therefore expected that such a marginalised group will continue to experience ill-health at a much greater prevalence than the remainder of the community, but that with increased service access, the years of life lost due to disability or morbidity will be reduced.

Communication and Dissemination of findings

In the initial stages of the program’s development, the NYCH Allied Health Homeless reference group was a forum where progress on the project was reported. Subsequently, the project has been presented at a number of larger forums. The Koorie consumer representative for the CAPPS project, Debbie Learhinan, presented information on the Harmsworth Street project at a CAPPs conference in Sydney in April 2001. The project has also been discussed at a number of other forums by Stephen Nash, the manager of Outreach Victoria, including the Housing Week Conference 2001 and the Council to Homeless Persons Workshop, Homeless Outreach Forum in 2000. Word of mouth between service providers has also lead to widespread interest in the project. A number of representatives from other agencies

targeting similar populations but in other regions have attended to observe model of health service delivery and assess transferability to their local area.

Capacity to enhance public health practice

A number of features of this program may be taken in part or in combination to enhance public health practice. Firstly, the assertive multi-disciplinary outreach model where services are provided at point of contact, and simultaneous entry to the service system occurs, is vital for access to the health and welfare system for marginalised groups. However, to be successful, such projects need to be adequately resourced. This includes the resourcing, and expansion, of flexibility in funding of food services to be able to generate real improvements in nutritional status. This is especially so for the Aboriginal community who is the most disadvantaged of the Australian population subgroups, and whose health risks largely revolve around malnutrition.

Secondly, the importance of flexible funding strategies to enable such methods of service delivery is crucial. Without the additional targeted funding to provide outreach services to marginalised groups and develop flexibility in service provision, the many barriers that exist in the mainstream health and welfare systems will remain. Furthermore, in recognition of the primary health care concept, funding frameworks need to recognise the value of health promotion and community development by skilled service providers. Where increasing emphasis is placed on direct service provision, important development of relationships with clients and between service providers, participation of communities and fostering of practical health management skills are neglected. Community participation and ownership have been an integral part of this program, and have driven its success. A number of strategies have been employed to achieve participation. These have included use of focus groups; recording of, and responding to, individuals' comments and suggestions; joint consumer and provider submissions for funding of program activities; and use of community representatives for peer review.

Finally, the primary health concept employed here also recognises that health status reflects broader social and economic development. (Baum, 1998)

That truly holistic health care programs need a welfare component for prevention of ill-health to become a reality is illustrated here. This requires, however, not only collaboration between health and welfare services, but whole of government commitment to resourcing of public health programs for disadvantaged groups.

These features of the Harmsworth Street project are important for developing an equitable health and welfare system, which is otherwise a myth to populations such as a group of Aboriginals who gather in a local park.

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Appendix 1: Outreach Victoria

Outreach Victoria is a community based organisation working in the areas of housing and homelessness. It was established in 1991 as George Street Outreach Services, then subsequently became Bedford Street Outreach Services and then Outreach Victoria. The organisation was established to provide assistance to people with complex needs who were homeless or at risk of homelessness in the inner Melbourne suburbs of Collingwood, Richmond and Fitzroy. In 1997 the organisation began providing Tenancy Services for people in public housing across Melbourne Northern Metropolitan Region. Outreach aims to empower and improve the circumstances for people who are homeless or live in public housing. The service outreaches into the community and makes contact with people who require outreach services as they are isolated or unlikely to approach services for assistance. The service provides practical assistance and advocacy for homeless people in a number of areas including: obtaining and maintaining housing; linking people into legal, health, home and community care, material aid and tenancy services; providing tailored practical assistance such as completing forms, assisting with cleaning and taking people to appointments. The service also provides a shopfront service for clients to use resources and facilities to conduct their own business and solve problems. (Outreach Victoria, 2001)

Outreach Victoria is currently funded by the Victorian Health Promotion Foundation to deliver a pilot recreation program to its client group. The program funds a recreation worker for one day per week for one year. The recreation worker has recently received an additional three years funding for drug harm prevention activities under the community strengthening initiative. These funds are to be used to establish a fishing group and expand recreational activities. The project will also involve training and skill development of participants with the aim of community members being able to organise and run their own recreation activities in the future. This will enable members of the Harmsworth Street group, as well as other disadvantaged members of the wider community, to regularly participate in an activity they enjoy.

Appendix 2: Royal District Nursing Service Homeless Persons Program

The Royal District Nursing Service (RDNS) is the largest and oldest provider of home nursing and healthcare services in Australia. (RDNS, 2001) The Royal District Nursing Service Homeless Persons Program uses assertive outreach as a key strategy for engaging clients and improving access to the service system. Central to the RDNS HPP assertive outreach model is providing an immediate response to address the health care needs of homeless people in their own environment. In addition to clinical and assessment activities, this approach includes elements of personal interaction, advocacy, community organising and political action. A key feature is that the service is offered in a respectful and empowering way.” (RDNS HPP, 1999, p.A47)

The aims of the Homeless Persons Program are to provide holistic health care to homeless people and to help homeless people gain access to other community services. (RDNS 2001)

Appendix 3: North Yarra Community Health

North Yarra Community Health consists of three centres of Collingwood, Carlton and Fitzroy. All three Centres are funded by State and Federal governments to address the health and social problems of large numbers of socially and economically disadvantaged residents. These multi-purpose centres provide a range of medical, allied health, casework and community development services to the local communities. (North Yarra Community Health, 2001)

Following successful submissions for funding under the Home and Community Care Flexible Service Response program in 1999 and 2000, the allied health team was expanded to incorporate outreach services to homeless clients and those at risk of homelessness. These positions include podiatry, physiotherapy, occupational therapy and a dietician. All are 0.5EFT and all are based at the Fitzroy site, covering clients throughout the City of Yarra region.