“The first thing is survival” – sexual health, blood borne virus and service delivery in the Long Grass in Darwin, Northern Territory Australia.

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Authenticity Note

August, 2013

I certify that this treatise, now submitted as a treatise for a Masters of Public Health, is entirely my own work and all references to ideas and work of other researchers have been specifically acknowledged. I also certify that the work embodied in this treatise has not already been accepted in substance for any degree, and is not being currently submitted in candidature for any other degree.

Verity Slee
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## Acronyms & key terms

### Acronyms

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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Virus</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Service</td>
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<td>AMS</td>
<td>Aboriginal Medical Service</td>
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<td>AOD</td>
<td>Alcohol and Other Drugs</td>
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<td>ART</td>
<td>Anti–retroviral Treatment</td>
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<td>ATSI</td>
<td>Aboriginal and Torres Strait Islander</td>
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<td>BBV</td>
<td>Blood borne virus</td>
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<td>CDU</td>
<td>Charles Darwin University</td>
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<td>DCC</td>
<td>Darwin City Council</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>FRP</td>
<td>First Response Patrol</td>
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<td>HEAL</td>
<td>Healthy Engagement and Assistance in the Long Grass</td>
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<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>Hepatitis C Virus</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>LG</td>
<td>Long Grass</td>
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<tr>
<td>LITS</td>
<td>Larrakia Intervention and Transport Service (service of LNAC)</td>
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<tr>
<td>LNAC</td>
<td>Larrakia Nation Aboriginal Corporation</td>
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<tr>
<td>MpH</td>
<td>Masters of Public Health</td>
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<td>MSHR</td>
<td>Menzies School of Health Research</td>
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<tr>
<td>NGO(s)</td>
<td>Non–Government Organisation (s)</td>
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<td>NP</td>
<td>Night Patrol (service of LNAC)</td>
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<td>NSP</td>
<td>Needle and Syringe Program</td>
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Key terms

BBVs  Viruses that live within the blood and are transmitted through blood to blood contact. Refer to Human Immunodeficiency Virus, Hepatitis C Virus and Hepatitis B Virus, for example.

Indigenous  First peoples of Australia. Also referred to as Aboriginal and Torres Strait Islander.

Intervention  Also referred to as the NTER

Living rough  A way of living, usually refers to people who are camping, staying in Long Grass

Long Grass  A place or places where people stay, sleep and/or live and conduct daily life where there is no conventional housing and few facilities with people camping, sleeping out, living rough, squatting or using some other improvised shelter in Darwin, Northern Territory.

Sexual health  Health including STIs, sexual behaviour, sexuality and sexual relationships

STIs  Infections that are transmitted through sexual fluids

Staff  Paid people working at HEAL

Volunteer  Person who is not paid, voluntarily working at HEAL
Abstract

This research project is a qualitative inquiry of the perspectives of outreach staff concerning sexual health (SH) and blood borne virus (BBV) related issues of people who spend time in the Long Grass in Darwin, Northern Territory, Australia. The staff are Aboriginal and non-Aboriginal employees and volunteers from Larrakia Nation Aboriginal Corporation’s (LNAC) Healthy Engagement and Assistance in the Long Grass (HEAL) Program. This treatise is part of the assessment requirements for the Masters of Public Health Postgraduate Course at the Menzies School of Health Research (MSHR), Institute of Advanced Studies, Charles Darwin University. The research project was initiated in consultation with the Northern Territory AIDS and Hepatitis Council (NTAHC), MSHR and LNAC. This treatise presents the main themes that emerged through an analysis of data collected through participant observation and interviews.

This research project is unique as it is the first to explore SH and BBV issues from the perspectives of staff who work in the Long Grass. While there is a small but growing body of literature that has focused attention on the lived experience of homelessness in Darwin from the perspective of the homeless person, the views and experiences of the service providers, working day to day with this population, have only received limited attention in the research literature. The findings of this research project aim to contribute to this evidence base.

There were a number of themes that emerged from the data. Through participant observation and interviews with HEAL staff the project identified: a multitude of competing primary health concerns for people in the Long Grass which are constantly negotiated with daily survival; complexities in SH and BBV health associated with shame and violence which largely go unspoken due to shame, lack of staff training, skills and
Confidence of staff, staff reluctance due to associated shame and a complex array of barriers to accessing mainstream services for people in the Long Grass. Further findings relate to the experiences and challenges faced by HEAL staff working in a hostile environment; and finally a reflection of service strengths and weaknesses within the Long Grass environment. Findings from this study suggest that although HEAL staff are well situated to deliver health initiatives based on rapport, a holistic approach and accessibility; a range of inhibiting factors such as shame, high demand, lack of training, competing health concerns and a hostile working environment all contribute to issues such as SH and BBV remaining unaddressed.
Chapter One – Introduction
Overview of this treatise

This treatise provides an ethnographical exploration of program staff and their interactions with people in the Long Grass in Darwin, Northern Territory, Australia (NT), in relation to sexual health (SH) and blood borne virus (BBV) service delivery.

The Long Grass refers to public spaces that have few or no facilities or amenities. For this project, a person or people who spend time in the Long Grass is used to refer to people in Darwin, NT who are homeless, itinerant and/or sleeping rough in public spaces. The program staff who are involved in this research project are staff members from Larrakia Nation Aboriginal Corporation’s (LNAC) Healthy Engagement and Assistance in the Long Grass program (HEAL), who provide outreach services to people in the Long Grass in Darwin.

Research aims

The research project aims to;

- explore the experiences and perspectives of HEAL staff and their interactions with people in the Long Grass, especially in relation to SH and BBV
- explore the challenges of service delivery to people in the Long Grass
- better understand the sexual health and blood borne virus context in the Long Grass and
- reflect upon the strengths and weaknesses of the HEAL program in addressing SH, BBV and general health within the Long Grass environment.
The term ‘Long Grass’ is commonly used to refer to people who are camping in permanent or temporary camps throughout public space in Darwin, particularly Aboriginal and Torres Strait Islander peoples. The Long Grass in Darwin is a result of historical and contemporary factors (Holmes 2007). Darwin was settled in 1869, during which time Aboriginal people were being ‘dispersed’ and ‘assimilated’ throughout Australia under government policy. Aboriginal people had lost their freedom, children were being removed from their families and people were forced from their traditional lands into towns and cities. Although Aboriginal people are traditionally mobile (Long & Memmott 2007), following European settlement they were forced to move towards towns such as Darwin as a result of displacement. By the 1970’s many Aboriginal people from communities across the NT, including Larrakia People from the Darwin region itself had lost access to their lands and were camping on the fringes of Darwin, areas of ‘long grass’ (Langton 2013). From here developed the term ‘Long Grassers’. The Long Grass is made up of a number of distinct camps and community groups. There are a number of more permanent camps with some basic infrastructure, such as Railway Dam and Sixteen Mile Camp. There are a number of other areas that are more transient such as beach camps, and various camps in the Long Grass surrounding the Royal Darwin Hospital for example. Although there is difference in opinion as to whether people in the Long Grass are actually ‘homeless’ (see Langton 2013), people in the Long Grass reside with inadequate shelter, facilities or safety measures (Taylor et al 2013) and fit the government definition of homeless (Australian Bureau of Statistics (ABS) 2012). According to Larrakia Nation there are approximately 2000 people camping in the Long Grass in Darwin each night (LNDC 2008).

As discussed in greater detail in Chapter Two, there have been a number of studies exploring how people come to be in the Long Grass. Darwin is
a major urban centre for the Top End of Australia, including many remote communities and homelands. People travel to Darwin to access services, such as the Royal Darwin Hospital, specialist services such as renal dialysis, Centrelink or simply to access supplies that are not available in remote regions. People also travel for social/cultural obligations (Long & Memmott 2007). People can become ‘stuck’ or ‘stranded’ in the Long Grass due to lack of accommodation options, and some people choose to stay there. It was not uncommon in my fieldwork for people to report they traveled to Darwin for a medical appointment and missed the returning flight back to community. Flights are often expensive back to remote communities and road travel is difficult, long and for some months of the year roads are inaccessible due to heavy rains. People are also forced to, or chose to leave communities for a range of reasons (discussed further in Chapter Two) and returning to community is not an option. There is some evidence to suggest that since the alcohol and other drug prohibitions were introduced as part of the Northern Territory Emergency response (NTER) without adequate treatment options, people were forced to move to Darwin to access alcohol and other drugs, leaving them in the Long Grass (Holmes et al 2007). Many people in the Long Grass have also lived there long-term, some for decades and it is considered ‘home’ (Taylor et al 2013).

Accommodation in Darwin is scarce and expensive. People can spend years on waiting lists for public housing, as many people were in the Long Grass from my discussions. Due to the tropical climate of Darwin, camping with no facilities or shelter can leave people exposed to harsh elements. The heat and lack of shelter and fresh water in the hotter months and the torrential tropical rain in the wet seasons ensure it is a harsh environment. Discussed in Chapter Four, the climate of the Long Grass is a significant determinant of people's health whilst staying in the Long Grass.

Although there are documented historical and contemporary accounts of functional and organised camps in the Long Grass (eg Day 1994 and
Taylor et al. 2013), people are targeted by the general community and the media, commonly deemed ‘drunks’ who engage in and perpetuate ‘antisocial behaviour’. People in the Long Grass commonly live in poverty and are faced with violence, racism, stigma, discrimination and trauma (Holmes and McRae Williams 2008; Taylor et al. 2013). People in the Long Grass generally face many complex barriers to accessing support and services, which is one of the foundations from which this research project was developed.

HEAL was established in 2008 in response to a request by the NT Department of Health and Families and other health providers, such as the Danila Dilba Health Service, to develop a model for health service delivery for people who spend time in the Long Grass. The model is based primarily on recommendations from Holmes (2007) who conducted a qualitative study into the experience of homelessness in the Long Grass in Darwin. The current research was conducted alongside the HEAL Program. The details of the HEAL program are discussed in more detail in Chapter Four. The development and delivery of the HEAL Program exists within an understanding of the daily-lived experience of staying in the Long Grass in Darwin. HEAL staff aim to develop good relationships with people who spend time in the Long Grass in order to be trusted conduits of information, education and support. Staff generally have some lived experience of being in the Long Grass and/or training to be Aboriginal Health Workers and try to have a good understanding of the effective and relevant ways to address health issues and service delivery for this population group. Gaining an understanding of staff perspectives is important to better inform effective service provision and gain an understanding of the SH and BBV context in the Long Grass.

This research project is part of the assessment requirements for the Masters of Public Health Postgraduate Course at the Menzies School of Health Research (MSHR), Institute of Advanced Studies, Charles Darwin University. The research project was initiated by myself in consultation
with the Northern Territory AIDS and Hepatitis Council (NTAHC), MSHR and Larrakia Nation Aboriginal Corporation (LNAC).

The main reason for undertaking this study was the knowledge that SH and BBV are significant health issues for Indigenous peoples in the NT (for example; Northern Territory Department of Health and Families 2009). Indigenous Australians, particularly in the NT, experience disproportionately high rates of some STIs and BBV when compared to other States and Territories in Australia (Australian Bureau of Statistics 2011). Considering the increased SH and BBV risks for Indigenous peoples in the NT, Indigenous people in the Long Grass are also confronted by diverse barriers to accessing services to assist in preventing and treating SH and BBV infections (Hermawan 2004).

In 2002, there were two new HIV notifications in the Long Grass, diagnosed as a result of a screening project conducted by the AIDS/STD Unit (now known as the Sexual Health and Blood Borne Virus Unit (SH&BBVU), Department of Health and Families). This highlighted the need for SH and BBV related services to be accessible to people spending time in the Long Grass. A screening project conducted in 2002 also concluded that people in the Long Grass did not access health services for sexual health testing and treatment and presented late when significant complications were present (AIDS/STD Unit 2003).

This treatise presents the main themes that emerged from an analysis of data collected through participant observation and interviews. The data was collected through my participation in the HEAL program, which included general outreach to all of the serviced Long Grass areas, and weekly participation in the Arts in the Grass project. Arts in the Grass is a HEAL project that aims to provide culturally appropriate art workshops within the Long Grass environment. Arts in the Grass aims to combat social exclusion and stigma experienced in the Long Grass.
I worked alongside HEAL staff and volunteers to gather qualitative data concerning their daily work, exploring their perspectives and experiences of service delivery in the Long Grass and the SH and BBV context. This research project does not aim to explore SH and BBV issues from the perspective of people in the Long Grass themselves. Although exploring SH and BBV issues for this population group is important, it was outside of the scope of this research project.

I also conducted open-ended interviews with HEAL staff and volunteers regarding their perspectives, and a number of themes emerged from the data. These include: the multitude of competing primary health concerns for people in the Long Grass which are constantly negotiated with daily survival; complexities in SH and BBV health associated with shame and violence which largely go unspoken due to; lack of training, skills and confidence of staff, staff reluctance due to associated shame and a complex array of barriers to accessing mainstream services for people in the Long Grass. Further findings relate to the experiences and challenges faced by HEAL staff working in a hostile environment; and finally from my own observations and considering broader literature I discuss some service strengths and weaknesses within the Long Grass environment. Findings from this research project suggest that although HEAL staff are well situated to deliver health initiatives based on rapport, a holistic approach and accessibility; a range of inhibiting factors such as shame, high demand, lack of training, competing health concerns and a hostile working environment all contribute to issues such as SH and BBV remaining unaddressed.
Chapter Two – Literature Review
“Some may not identify as being homeless if they have a spiritual connection to the land they live on, regardless of the type of shelter they live in”

(Homelessness Australia 2010;p.1).

Throughout the Literature Review I explore homelessness, stigma, high risk behaviour and health, good service provision and the role of the view of health workers on service provision. Although there is only a small amount of research to draw upon that is specific to the Long Grass, I explore some broader relevant literature.

**Indigenous homelessness, the Long Grass and stigma**

Concepts of home vary amongst people who spend time in the Long Grass. While the purpose of this treatise is not to explore concepts of home and homelessness amongst people who spend time in the Long Grass, it does intend to contextualise life in the Long Grass. The concept of home is socially and culturally constructed and can have many different meanings. In Australia, the term homeless is used in public policy and understood generally as a lack of house or shelter; However, it is commonly stated throughout the literature that homelessness requires more than one point of definition (Coleman 2001; Chamberlain and MacKenzie 2006; Holmes 2007; AHURI 2009; Heintjes 2005).

There is no principal definition of homelessness used in Australia; However, for the 2011 Census, the ABS adopted the following definition for application to the general Australian population:

“When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:

- is in a dwelling that is inadequate; or
- has no tenure, or if their initial tenure is short and not extendable; or

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does not allow them to have control of, and access to space for social relations"

(ABS 2011)

There is no definition developed that is used to adequately capture Aboriginal and Torres Strait Islander homelessness and as a result Indigenous Australians are drastically under enumerated in census data (ABS 2013). Despite the lack of formal definition by the ABS which adequately captures Indigenous homelessness, there are two common definitions used more widely in Australia which aim to capture Indigenous homelessness. Most commonly used, is the tripartite differentiation developed by Chamberlain and MacKenzie (1992) which has been adopted to some degree by the Australian Bureau of Statistics (ABS). This definition uses three identified categories of homelessness;

- Primary – living rough or in impoverished dwellings
- Secondary – staying with friends or family with no usual address or in homeless service
- Tertiary – living in a boarding house or caravan parks with no secure lease or private facilities.

This definition has been adapted for different purposes. For example, in the 2006 Census, the ABS adapted the above definition into two categories. These being Absolute homeless (primary homeless) and Relative homeless (secondary and tertiary homeless) (Birdsall-Jones & Shaw: AHURI 2008; p.9)

Despite the wide application of the above definitions (Heintjes 2005; Australian Bureau of Statistics 2006; Chamberlain & MacKenzie 1992: 2003; AIHW 2009), these categories are useful in enumerating homelessness but are criticised for failing to fully encompass the complexities and diversity of homelessness (AHURI 2009; AHURI 2004; AHURI 2010). They are also only temporarily representative as people continuously move in and out of various states of homelessness (Chamberlain & MacKenzie 2006). Furthermore, these definitions do not

To date, the available Australian literature on homelessness comprises of statistical data provided by the Australian Census, and a range of literature predominantly exploring prevention, alleviation and exit strategies. The 2011 Census found that the rate of homelessness in the NT was 730.7 per 10,000 people, by far the highest rate of homelessness in Australia (ABS 2012). Additionally in the 2006 census the population rate of homelessness in the NT was 248 per 10,000 in the NT compared to 67 per 10,000 in QLD (ABS 2006).

Although Indigenous Australians are traditionally mobile, the policies that followed colonisation have had a impact on mobility and the Long Grass context to date. Following European occupancy of Darwin, Land belonging to Aboriginal people was fenced off and farmed and people were forcibly moved onto communities, such as Bagot Community, having an impact on notions of home to date. Since White settlement in Darwin, there are recorded accounts of Aboriginal people camping in and around Darwin on public land, which is commonly referred to as the Long Grass (Day 1994).

According to LNAC, there are up to 2000 individuals living in Darwin’s Long Grass on any one night (LNAC 2008). Determined through statistical data gathered via service provision, LNAC predict that seventy five percent of these individuals identify as being Indigenous (LNDC 2008). It is difficult to gather accurate data on homelessness as people are highly mobile and will also hide for safety and anonymity.

There is a dearth of studies that explore the experience or perspectives of being in the Long Grass by people in the Long Grass themselves; However, there are a few local studies that have explored why people are
in the Long Grass, which can provide some important contextual background for this treatise. A study conducted by a group of Yalu Marngithinyaraw people explored why people were leaving Galiwin’ku on Elcho Island in North East Arnhem Land and staying in the Long Grass in Darwin. This study consisted of Yolngu researchers interviewing Yolngu people to explore why they had left their community and were residing in the Long Grass (Maypilama et al 2004). The main reasons that people provided for leaving home and moving into the Long Grass were:

“The consequence of a range of deeper problems which has not been addressed or resolved... the main reason for coming to Darwin was fear – fear of violence, including suicide, mental illness, aggressive behaviour and galka (sorcery)” (p3).

Other reasons outlined in the above study, which were also consistent with findings from Holmes (2007) and Memmott and Fantin (2001), were that people left their communities due to; grief and death; seeing elders being disrespected; to escape disputes and conflict; lack of employment opportunities; lack of housing and seasonal factors (such as moving to Darwin in the wet); and to seek out the freedom and lifestyle of living in the Long Grass (Maypilama et al 2004). Additionally, people are often ‘kicked out’ of communities due to breaking prohibition regulations such as drinking and causing conflict within community (Taylor et al 2013 & Holmes & McRae-Williams 2008). Maypilama et al (2004) and Holmes (2007) also found that people travel to Darwin from communities and homelands regularly in the NT. There are limited services available in communities and people visit Darwin to access specific services. Considering the disproportionately high rate of chronic disease, morbidity and mortality for Indigenous peoples, there is also the need to access specialist health services. It is common that people travel to Darwin with an escort or support person, particularly people who are ill or frail, do not speak English, have not been to Darwin previously, or for cultural reasons.
Once in Darwin, people often cannot find suitable accommodation. AHURI (2004) list the high cost of housing as one of the main contributors of homelessness Australia wide. In the NT, there is nowhere near the public housing stock to meet current demands. In Darwin, waiting lists for public housing averaged 4.75 years in 2010 (NT Shelter 2010). Indigenous peoples also occupy public housing stock in Darwin. Family travelling to Darwin from remote communities can place strain on small public housing units, which can lead to evictions perpetuating the homeless cycle. Consistent with Holmes and McRae Williams (2008), the housing shortage in Darwin and overcrowding in remote communities also contributed to people moving to the Long Grass.

These reasons why people report they move into the Long Grass are consistent with the below definition stated in a Keys Young (1998; p.45) report that considers the causes and contexts of Indigenous experience of homelessness:

- Spiritual homelessness – Arises from separation from traditional land or from family
- Overcrowding – A hidden form of homelessness
- Relocation and transient homelessness – temporary, intermittent and often cyclical patterns of homelessness arising out of lifestyle choices, but also the need to travel to obtain services
- Escaping from unsafe or unstable home – arises from threats to safety or survival. Especially affects women and young people
- Nowhere to go – Lack of access to any stable shelter, accommodation or housing.

The media reinforce the notion of homeless people as deviant, portraying affairs related to the Long Grass as anti-social, perpetuating associated negative stereotypes and reinforcing stigma. A major finding of Holmes (2007) and Holmes and McRae-Williams (2011) is that people in the Long
Grass are constantly stigmatised. Social science research broadly conceptualises stigma as a result of cognitive categories people place others in, based on stereotyped attributes of people and/or specific groups (Link & Phelan 2001). Goffman (1063; p.3) characterises stigma as an attribute that is socially defined as “deeply discrediting”. Homeless people and other marginalised populations have long been stigmatised by broader society and ‘blamed’ for their situation and state of homelessness. Holmes (2007) found that people in the Long Grass attracted and negotiated stigma in their daily lives, which had a significant impact upon their health and wellbeing. Similarly, a recent study that explored drinking patterns and behaviours in the Long Grass (Taylor et al 2013) found that people in the Long Grass identify that they are targeted in racially based policies and that they are stigmatised by the Darwin community. There is a broad literature base which explores the underlying causes of stigma (for example Goffman 1963; Link & Phelan 2001; Reece et al 2007) and the impact stigma can have on an individual’s health and health seeking behaviours (Goffman 1963; Newman et al 2007; Reece et al 2007), the health and well-being of stigmatised groups (Simmonds and Coomber 2009; Newman et al 2007) and how stigma can act as an inhibitor of service delivery, particularly for homeless people (Fitzgerald et al 2004; Daski 2007).

As outlined by Holmes, the stigma perpetuated by the media; “...masks the causes and consequences of being homeless and acts to prevent appropriate action in the creation of environments that are supportive of health and improved life quality” (Holmes 2007. p 4). Stereotypes and racism targeting people in the Long Grass are significantly damaging and “do not reflect the diversity of that population and its positive attributes and norms” (Taylor et al 2013. p.13).

Similarly, the Northern Territory Government (NTG) portrays the Long Grass as ‘problem’ areas. In July 2011, new laws regarding alcohol use were introduced as part of the NTG’s Enough is Enough campaign, which targets ‘problem drinkers’ (Taylor et al 2013). The focus has moved from
aiming to ‘return itinerants to country’ to ‘banning problem drinkers from accessing alcohol and mandating treatment programs’. Additionally, the NT Attorney General John Elferink recently stated that what people did in the Long Grass was their own lifestyle choice, that welfare response creates more vulnerability and that their best way to address lifestyle decay is to “get a job” (Toohey 2013).

**High risk behaviour, health and homelessness**

As supported by local, national and international literature people who are homeless generally suffer from multiple health issues, are more likely to engage in risky behaviours and experience higher rates of mortality (Martens 2001; Susser et al 1998; Brown et al 2011; Tucker et al 2011). Studies from the USA (for example Brown et al 2012) state that homeless men are at higher risk of contracting HIV due to increased likelihood of engaging in high risk sexual activities. Similarly, a study found with young people who are homeless increased risk of STIs and BBV due to high risk sexual and drug using behaviours (Tucker et al 2011). A local Darwin study (Taylor et al 2013) found that a large portion (48.7%) of people in the Long Grass included in their sample consumed alcohol on six or more days of the week. A report conducted by Holmes and McRae-Williams (2011) found that although the two are not commonly linked by women in the Long Grass, transactional sex and sexual assault and rape were common in the Long Grass. A study conducted by Daiski (2007) explored health concerns from the perspectives of homeless people themselves. They found that participants were concerned about their physical health but also discussed the stress, violence and emotional distress of negotiating survival within the homeless setting. They also found that people wanted to break the cycles of homelessness they were trapped in but were restricted by the stigma and discrimination they faced for being homeless (Daiski 2007).

There is a lack of SH and BBV academic research available in the NT
making it difficult to draw strong conclusions for specific population groups. The Northern Territory Government’s (NTGs) Department of Health and Families’ Sexual Health and Blood Borne Virus Unit (SH&BBVU) compile quarterly surveillance reports that provide epidemiological data on STIs and BBVs in the NT. This data reports that some STIs and BBVs are of high prevalence in the NT. For example in 2011, notification rates of chlamydia were three times as high as the Australian rate and gonorrhoea notifications were 16 times as high as the Australian rate (ABS 2012). Additionally, STIs rates are disproportionately prevalent within Indigenous Territorian populations and often go undetected for long periods of time (Merianos et al 2001; Plummer 2001). Higher rates of STIs and BBVs within Indigenous populations are consistent across Australia (Commonwealth of Australia, 2010; ABS 2012). For example, in 2010 more than a third of all gonorrhoea cases were among Aboriginal and Torres Strait Islander peoples (ABS 2012). There are similar higher rates of Chlamydia and infectious Syphilis in remote communities (NCHECR annual surveillance report, 2009). Further exacerbating the high infection rates is a lack of accessible STI and BBV service provision in remote communities (Commonwealth of Australia, 2010). Indigenous Territorians experience some of the highest STIs rates in Australia (Commonwealth of Australia 2010); However, there are no statistics available that specifically describe STI rates for people who spend time in the Long Grass.

A study conducted in 2013 found that ‘there are a significant number of moderate and non-drinkers residing in the Long Grass’ (Taylor et al 2013 p.13). There is published research which outlines the lifestyle factors of people who spend time in the Long Grass suggesting the likelihood of infection transmission among this population is higher given underlying risk factors such as alcohol misuse, loneliness, survival sex (transactional sex) to meet material needs and barriers to accessing health services (Taylor et al 2013; Holmes 2007). Furthermore, people who spend time in the Long Grass generally do not present to health services for STI and BBV testing and treatment (AIDS/STD Unit, Clinic 34 2003).
Australia has a relatively low prevalence of HIV compared to other developed countries (Commonwealth of Australia 2010). The NT has relatively low rates of HIV/AIDS (ABS 2011); However, there are risk factors that can increase the risk for the population. For example, the NT is in close proximity to and a gateway for travelers to high HIV prevalent regions such as South East Asia. Whilst on holidays, some people tend to partake in riskier activities, such as unprotected sex and alcohol and other drug binging, increasing their risk of HIV infection for themselves and partners once returning to Australia (Vivancos et al. 2010). There have been consistently similar rates of HIV infection amongst Indigenous and non-Indigenous populations in Australia (ABS 2012). For example, in 2010, the rate of HIV in Aboriginal and Torres Strait Islander people was 4.6 per 100,000, which was a similar rate to the non-Aboriginal population (4 per 100,000), excluding people born overseas in countries of high HIV prevalence (ABS 2012). From 2000 to 2009 there were 196 newly diagnosed cases of HIV amongst Indigenous peoples in Australia (Ward & Graham 2011).

Despite similar HIV prevalence rates between Indigenous and non-Indigenous populations, there are disparities in the modes of transmission. Modes of transmission within Indigenous populations are occurring within the broader Indigenous population whereas for non-Indigenous people transmissions are mainly with one demographic and therefore easier to target for prevention and treatment programs. For example, in non-Indigenous populations sexual contact between men (79 percent) is the most common mode of transmission for HIV, followed by heterosexual sex (13 percent) and IDU (three percent). For Indigenous populations, contact between men was still the most common mode of transmission (54 percent) but heterosexual transmission was a great deal higher (23 percent) as was IDU (22 percent) (Commonwealth of Australia, 2010; p.9). When viruses such as HIV are of high prevalence within the IDU community there is a higher risk of transmission across a range of demographics, such as through heterosexual transmission. There are also much greater rates of AIDS diagnosis in Indigenous than Non-Indigenous populations Australia wide. This is largely attributed to the decreased
access of services by Indigenous Australians until health conditions become severe (HealthInfoNet 2013).

Similar to the disparities in modes of transmission Australia wide, trends of HIV transmission are also unique in the NT particularly within the Indigenous population (NCHECR 2009). In 2009, it was estimated that there were 110 people living with HIV in the NT and 17 people living with AIDS (Minister for Health 2009). From January to June in 2009, 80 percent of new cases were transmitted through heterosexual contact (NT Department of Health and Families 2009). It is important to note that it is difficult to conclude trends as the low numbers mean small changes can easily skew the data. The Commonwealth of Australia states (2000:p.5); “Many people in Indigenous communities still fear and misunderstand HIV/AIDS. Consequently, some Indigenous people are leaving their communities to find care and support services in the larger cities”. NTAHC have also experienced additional challenges in supporting HIV positive people in medication compliance and related lifestyle support.

Other BBVs, such as Hepatitis C virus (HCV) are disproportionately prevalent amongst Indigenous peoples in Australia. For example, between 2005 and 2009 the rate of newly diagnosed HCV was between 120 to 131 per 100,000 for Indigenous Australians compared to 44 to 46 per 100,000 for Non-indigenous Australians (Ward & Graham 2011). Though Indigenous Hepatitis B virus (HBV) statistics are less accurate HBV is prevalent amongst Indigenous Australians. For example, in 2009 the rate of newly acquired HBV infection within Indigenous Australians was 3 per 100,000 compared to 1 per 100,000 for non-Indigenous peoples (Ward & Graham 2011).

STI’s and BBV are national health priorities as outlined in for example, Sixth National HIV/AIDS Strategy 2009 to 2013, the Second National Sexually Transmissible Infections Strategy 2010 to 2013 and the Third National Aboriginal and Torres Strait Islander Sexual Health and Blood
Borne Virus Strategy 2009 to 2013 (Commonwealth of Australia 2010a,b&c). All of these documents outline the need for Indigenous-specific tailored responses to SH and BBV health issues. STIs and BBVs remain health priorities for the Northern Territory Department of Health and Families who work in close partnership with NTAHC and other relevant stakeholders.

**Good service provision**

There are multiple barriers to accessing appropriate services for Indigenous Australians, with mainstream health services often being inappropriate or inaccessible (Baum 2008). There is a great deal of literature exploring these barriers. Additionally, there are a number of policy papers and literature documents referring to good service delivery for homeless populations in Australia. In 1973, The Homeless Persons’ Assistance Act 1973 (Commonwealth 1973) was passed and as stated by Coleman (2001; p. 6–7) it, “was the first official recognition of homelessness in Australia and the beginning of a coordinated government response to this long-standing social issue.” In 2008, the National White Paper on homelessness ‘The Road Home’ was released (Commonwealth of Australia 2008). The Mental Health Coordinating Council (MHCC) submitted a response to this, which outlines some gaps in service delivery responses. They outline the need for collaborative service response to people who are homeless and the need for a “dynamic strategy that adopts a holistic approach” (2008. p.13).

More recently in 2010, the Commonwealth, States and Territories developed a national quality framework (NQF), which aims to achieve better outcomes for people who are homeless or at risk of homelessness by improving the quality and integration of services. As part of this NQF development, Holmes (2010) consulted with a sample of 31 people in the Long Grass regarding service provision. Holmes (2010) found that Indigenous people in the Long Grass came into contact with a range of
government and non-government agencies. Holmes found that although people said that they were generally satisfied by the nature of services available, they faced various barriers in effectively accessing them and many barriers to accessing existing mainstream health services. Participants also mainly preferred outreach services. It is unclear if people surveyed in this study were even aware of possible alternatives to the services available and therefore this could not necessarily be a true indicator of service satisfaction. In this study, Holmes concluded that there was neither the adequate service provision nor adequate funding available to meet the needs of people in the Long Grass in Darwin (Holmes 2010).

Holmes and O’Donnell (2009) conducted an evaluation of the HEAL Program. As discussed further throughout this research project Holmes and O’Donnell (2009) found that the HEAL Program had achieved intended program outcomes but faced various challenges, such as retaining a high quality program coordinator and general continuity of program staff. The Evaluation Report further stated; “that the HEAL team have met or exceeded the set goals and have contributed to improved health and wellbeing of homeless people in Darwin” (p.32). Holmes and McRae Williams (2009) concluded another study with a number of recommendations which aim to support Indigenous people in the Long Grass to “attain an acceptable level of health and life quality and to be law abiding citizens” (p.69). These recommendations demonstrate a need for mainstream society to become more informed and understand the crucial need for services and interventions to be relevant and encompass the lived experiences of people who spend time in the Long Grass. For example, Recommendation 10 states (Holmes and McRae Williams 2009;p.70);

“Interventions and initiatives aimed at improving the health, life quality and citizenship of the population in the Long Grass are more likely to have success if they make sense to the target population, having relevance to their life worlds. They must be communicated by and
negotiated with agencies/individuals which have an established relationship of trust with this population.”

Although unpublished, NTAHC conducted a survey project on SH and BBV related issues in the Long Grass in 2004 (Hermawan 2004). The main findings referring to service provision are discussed in detail in the Discussion Section of this treatise. In summary, they outline the role for NTAHC to partner with pre existing services working in the Long Grass to ensure services are delivered effectively addressing the needs of people who spend time in the Long Grass. The effectiveness of adopting a holistic and integrated approach to specific health issues is supported across health literature (For example; Australian Indigenous HealthInfoNet 2005a; HIV/AIDS and Related Programs Unit 2007; Commonwealth of Australia 2001a,b and c). Additionally, outreach models are well supported in the literature as best practice when engaging with homeless populations (Fisk et al. 1999 for example).

There is a range of international literature that explores effective health service delivery for hard to reach populations from developing countries, some in particular reference to SH (WHO 2010). These summarise many of the same key program areas as explored in the treatise. These are for example; addressing stigma, shame and discrimination; vulnerability and power imbalances between clients and staff; the need for cultural appropriate resources; staff and messages; correct and up to date information; staff attitudes and respect for target group working within partnerships; and the need to name and address barriers such as cultural, social, economical and political factors (WHO 2010).

**View of health workers**

There is limited published literature that explores the experiences and perspectives of staff and the associated impact on good practice within
the SH and BBV fields. Additionally, there is limited literature that explores the value of the experiences of workers in outreach homeless projects. One study of relevance to this study is by Fisk et al (1999). This study explored the experience of outreach workers with homeless populations and concluded that the experiences of outreach workers with homeless populations are essential in “shaping and redefining work activities” (p.232).

There are various studies that explore the impact of attitudes and behaviours of staff on service accessibility, more generally, including those that engage with stigmatised health issues, such as sexual health and injecting drug use (World Health Organisation (WHO) 2010; Commonwealth of Australia 2010a.b&c; Hermawan 2004). WHO (2010) discusses health provider attitudes and practices as a determinant of sexual and reproductive health and effect access to services for marginalised populations (WHO 2010). Similarly, a study conducted by Thornton et al (2012) use staff views and experiences in informing the effectiveness of a specific HIV screening intervention. A study conducted by Simmonds and Coomber (2009), explored the impact of the discriminatory attitudes pharmacists have towards injecting drug users and the inhibiting impact this has on service accessibility. This study summarises that an increase in education and awareness of service providers as to basic health policies, such as harm reduction may increase service providers understandings, decreasing stigma and improving accessibility (Simmonds and Coomber 2009).

While there is a small but growing body of literature that has focussed on the lived experience of homelessness in Darwin from the perspective of the homeless person themselves, the views and experiences of the services providers working day to day with this population have only received limited attention by academics. Additionally, to date there is no literature available that explores the relevance of staff perspectives and experiences in relation to SH and BBV experiences of people in the Long Grass and how this could impact on and inform service provision. Service
providers tend to gather data as part of their service agreement, but their views and experiences tend not to be examined through any rigorous academic exercise. This research project and the findings discussed throughout this treatise aim to contribute to this knowledge base.
Chapter Three  – Methodology
Methodological Framework and Methods

The current research project is a qualitative inquiry, which utilises an ethnographic approach. Methods of participant observation and semi-structured interviews have been applied as they enable engagement and observation of staff perspectives and service delivery within the natural setting of the Long Grass. This section outlines; the methodological framework of the project, the methods used, data integrity and associated risks.

Methodological Framework

Scientific research has a long history associated with the outcomes and processes of colonisation and has perpetuated exploitation and disempowerment (Smith 1999; Denzil & Lincoln 2011). Considering this, I chose to employ a qualitative framework that enables sensitive and respectful inductive methods. The research project met the criteria for utilising a qualitative research as referred to by Babchuk and Badiee (2010. p.3) as they state;

“These criteria [for adopting a qualitative approach] include such factors as the research problem or question requires it, to better understand an area where little is known, to make sense of complex situations, contexts, and settings, to learn how participants construct their worlds, to gain deep, rich and detailed descriptions of cultural scenes, to help empower individuals to share their stories and enact meaningful social change, and to generate theory where little exists.”

A qualitative approach catered for the subjectivity of the research topic and the expectation of there being multiple and complex experiences and perspectives uncovered throughout the research process. The context of
this project, and the topics of research require a methodological approach which enables insight into how staff construct their daily lives within the HEAL program. It enabled exploration of the meaning in the experiences and perspectives of HEAL staff. The methodology needed to facilitate exploration of complex and personal experiences and perspectives, and needed to explore the observations of myself as the researcher in the field. A qualitative approach made this possible. As I was exploring a subjective topic, I was keen to observe and not draw hypothesis on staff experiences as a quantitative approach may have required. Additionally, the HEAL Program only has a small number of staff, therefore I knew I would require a methodology that allows for exploration of a small sample.

On adopting a qualitative approach, I then used the practices of ethnography to explore life in the Long Grass from the point of view of HEAL staff, and in turn explore the challenges to service delivery within the context of SH and BBV. Following an ethnographic approach, I ‘immersed’ myself through prolonged engagement and persistent observation, key aspects of studying groups within their natural settings (O’Leary 2010). I approached the service provision context within a social health model when considering the role of HEAL and the health and living context in the Long Grass. This considers the social, cultural and environmental determinants of health and illness (Germov 2005) that are paramount to health and wellbeing in the Long Grass in Darwin.

The approach to the development of the methodology for the treatise has been largely informed by the work of Zina O’Leary (2004; 2005; 2010). In her work, O’Leary emphasises the importance of the researcher being aware of their place within the research context and encourages constant reflection and flexibility. O’Leary states; “It is essential that researchers critically explore the dominant worldview; exploring your own perspectives; and exploring the range of perspectives held by various stakeholders” (2005; p.28). My own worldview is constructed and subjective. As an Anglo–Saxon non–Aboriginal woman working mainly
with Aboriginal people, my approach to this project is significantly influenced by my experiences, values, knowledge and worldviews to date. I have approached the design and conduct of this research project with ongoing critical reflection of the process, observations and findings. I believe in doing so, I have managed to effectively explore a small sample of experiences and perspectives of HEAL staff in relation to SH and BBV and critically compare these to the literature to further support and validate my findings.

Although the current study does not primarily engage with epidemiological methodologies, it is informed by epidemiological data of BBV and STI patterns and statistics. The motivation for this inquiry was informed by surveillance reports and feedback, which outlined the disproportionately high STI and BBV rates in the NT, particularly within Indigenous populations (CDC 2010). The epidemiological data does not however, explore the SH and BBV setting and the role of service delivery. This research aims to complement the epidemiological research into SH and BBV data in the NT by further understanding of the health context and challenges to service delivery.

**Methods**

The main methods that I utilised are;

- Participant observation, derived from ethnographic inquiry approaches and,
- Semi-structured informal interviews.

I also conducted a literature review to inform the research process, which is included as a chapter in itself. Within this research context, engaging in interviews allowed for gathering of in-depth views and perspectives. Participant observation provided an important context, which allowed me to compare what people said with what they actually did. I will now
outline these methods in more detail and justify why I have chosen to use them.

**Participatory observation**

Drawing from the principles of ethnographic research, the current study uses participatory observation. I adopted this method as it enabled a forum for the development of rapport and trust, whilst allowing me to observe the interactions between staff and people in the Long Grass. According to O’Leary (2010), ‘prolonged engagement’ is the “investment of time sufficient to learn the culture, understand context, and/or build trust and rapport” (O’Leary 2010, p.115). In addition, participatory observation enabled me to gain a sense of the social complexities between HEAL staff experiences, social interactions between staff and people in the Long Grass and better understand the sensitive topics of SH and BBV that are largely unspoken within the Long Grass context.

As a researcher working in a cultural setting very different to my own, I drew upon the principles of ethnography to inform my approach to observing people’s daily existence in the Long Grass and HEAL service provision. Although it was not the primary aim of my fieldwork, I learnt about life in the Long Grass through shared experiences with staff, volunteers and people who spent time in the Long Grass. This was imperative to building relationships and understanding the context of SH and BBV issues within the worldviews of HEAL staff and people in the Long Grass. Utilising this method also allowed me to develop and modify the research design throughout the process of observation. Baum (2008) refers to participant observation as an effective method to gather data about topics which people may be reluctant to share through other methods. Working with HEAL and participating in outreach gave me access to an environment which ordinarily would be difficult to access. It was also an effective method to engage with HEAL staff and people in the Long Grass in broaching sensitive topics such as SH and BBV. O’Leary (2010) discusses ‘persistent observation’ by stating it enables the researcher “to look for readings of a situation beyond an initial, possibly
superficial, level.” (p.115). As a result of the extended time I spent alongside the HEAL staff in fieldwork, I was privy to observing daily activities and interactions beyond a superficial level.

Participating in fieldwork from October 2009 through to June 2010, I attended 23 events alongside HEAL staff. These ‘events’ ranged from participating in general outreach alongside a HEAL staff member to regularly attending the Arts in the Grass project. Regular attendance of Arts in the Grass required me to be present each week from 9am to approximately 2pm. The program stopped from mid-December to February. I then engaged in general outreach alongside a HEAL staff member when Arts in the Grass was not running. Following each outreach trip, I documented field notes detailing where we went, what I did and the main health issues discussed and observed. While I was out in the field I avoided recording notes of observations or using any equipment as this can be seen as intrusive (O’Leary 2010), particularly in a context where I am entering people’s living space. Once I was in an appropriate space I would record my main observations. As driving between camps was often an effective opportunity to gather information from staff I recorded data of the fieldwork we were engaged in such as:

- Location/name of camp
- Observable health conditions and issues
- Type of service provided/reason for visit/themes of service delivery
- Main health issues discussed
- SH or BBV issues
- Relationship/role of HEAL staff
- Any other services present or discussed
- Any issues/perspectives raised by staff following the interactions with people in the Long Grass.

This data complemented the data gathered from the interviews.

Outreach consisted of responding to referrals or visiting specific areas of the Long Grass to respond to immediate needs. This was an effective
method of meeting a number of people in the Long Grass and spending extended periods of time with HEAL staff and volunteers working on building rapport and trust and gathering data.

Arts in the Grass pilot project:

Arts in the Grass is a project that aims to provide culturally appropriate art workshops within the Long Grass environment and is delivered by the HEAL team. Arts in the Grass aims to combat social exclusion and stigma experienced in the Long Grass. I began participating in weekly sessions. From various discussions with staff and some of the women in the Long Grass it was evident that Arts in the Grass provided a safe and appropriate space for health education and promotion, if delivered in a gender specific context. It was evident that Arts in the Grass was an appropriate forum to observe staff interacting with people in the Long Grass in a relaxed space.

Semi-structured Interviews

The other method that I applied was semi-structured interviews. The aim for using semi-structured interviews was to gather a rich understanding of staff members and volunteers experiences and perspectives of their daily work in the Long Grass. I decided to use semi-structured interviews as they allow in-depth exploration of complex topics, as directed by the interviewee. They allow rich data to be collected including verbal and non-verbal data and they enable both parties to explore tangents (O’Leary 2010). I used the questions to provide some structure, to guide the interview process and to facilitate the interviewee to discuss their experiences and perspectives.

These interviews were conducted one on one, with open-ended questions, which allowed the responses to be open and guided by the interviewee. Participating in HEAL outreach, I was able to conduct the interviews at times which did not hinder their work, for example as staff
were waiting for people to arrive at the Arts in the Grass Project. I also conducted interviews on outreach as the worker drove to the Long Grass camps. I found this effective as people were referencing events that were currently unfolding, so they were more contextualised. I conducted the interviews on an individual basis to ensure privacy and encourage people to feel more comfortable discussing sensitive topics. The interviews were also conducted face to face to ensure non verbal cues were not missed.

The interviews ranged from 30–80 minutes.

I interviewed six staff members and two volunteers, a total of eight people. I selected the staff to be interviewed by inviting every staff member to engage in an interview. Of the seven staff members, six agreed to interviews included in this research project. All staff agreed to have me conduct participatory observation whilst on fieldwork.

I conducted the interviews closer to the end of my time with the HEAL team, in order to develop relevant dialogue and questions based on my findings through my observations and insights from and having a better understanding of life in the Long Grass.

I interviewed three male staff members, two male volunteers and three female staff members. One male staff member declined to be interviewed. The interviews ranged from between 20 minutes to 80 minutes.

The HEAL staff that were interviewed ranged in experience and qualifications. For example, I interviewed the HEAL Coordinator who was a non-Indigenous woman qualified as a Social Worker with program management experience. The field staff were mainly of Aboriginal or Torres Strait Islander descent enrolled in Aboriginal Community Health Work, or who had some experience of living in the Long Grass themselves. I also interviewed two caucasian males who had worked with people in the Long Grass and had developed rapport with people in the Long Grass and the Aboriginal and Torres Strait Islander staff. The HEAL team was made up of a diverse range of Aboriginal and non-Aboriginal
staff and had developed rapport with their co-workers and many people in the Long Grass.

In conducting interviews with HEAL staff, it was also necessary to consider the impact that my relationship with staff may have on the interview process. For example, I had spent months developing relationships, rapport and trust with the staff and volunteers and this could have encouraged people to disclose more than they would otherwise consider. Gaining informed consent was an essential part of the research process. For each interview conducted, signed consent (Appendix B) was sought following on from presenting and reading a plain language statement (Appendix A). The information in the plain language statement outlined the purpose of the study, the purpose of the interview, the process, storage and use of the information once it is collected and how to make a complaint if necessary. The interviewee was also given a copy of the plain language statement to take away.

The interviews with staff members were recorded on Dictaphone, with permission of the interviewee. Following the interview, I transcribed the data into a word document and extracted relevant data. I analysed each interview, drawing upon relevant themes and common discussion points.

**Data accuracy, integrity and potential limitations**

Conducting a qualitative inquiry enabled the multiple perspectives, realities and experiences of HEAL staff to be explored. It enabled me to gain an understanding of the social complexities in the Long Grass environment such as staff and client interactions, service delivery and the SH and BBV context. As stated by O’Leary (2011.p114) “The goal is to gain an intimate understanding of people, places, cultures and situations through rich engagement and even immersion into the reality being studied”. As this project was initially focused on sensitive topics, such as SH and BBV with a service working with highly stigmatised people, developing rapport was essential. Although this was central to the
project, attempting to build rapport and become ‘immersed’ in the setting does not ensure the researcher has little impact on the researched, nor that it gives a true interpretation and understanding of events.

Potential risks associated with utilising participant observation include misinterpreted interactions and communications. In researching topics such as SH, observation can potentially be an inadequate method in isolation. A further problem included my inability to be with HEAL staff during their work hours, 7 days a week. The HEAL program exists within a responsive framework. In practice, this means that a lot of daily work is unpredictable and interchangeable. As I was only in the field for specific periods, I had limited access to these events. This was one motivating factor, which led me to engage additional methods, such as interviews. Engaging in both participant observation and interviews, I was able to strengthen the data validity by observing what occurred in the Long Grass in addition to relying on what people said occurred in the Long Grass.

In interviewing HEAL staff regarding their own experiences and attitudes, I was also aware of the potential imbalance of myself being considered as an ‘expert’ in SH and BBV by representing a specialist organisation such as NTAHC. I addressed this by outlining in the Plain Language statement and in discussion with staff and volunteers prior to the interviews that I was only gathering information from their own experience and perspectives and was not assessing their level of knowledge. I also conducted the interviews in an open-ended manner, so that the interviewee could direct the responses. This was also a potential limitation with participant observation as staff and people in the Long Grass were aware of my role and the study and people do not necessarily act ‘naturally’ or the same when they know that they are being observed (O’Leary 2011). Additionally, although trust and rapport were built to encourage people to be relaxed and open, the face to face interview process does not enable people to be anonymous in the process and it is possible some people felt ‘shamed’ in discussing SH and BBV topics,
particularly the men. I was able to sense non verbal cues and guide the interviews in a sensitive manner to avoid this as much as possible. It was evident through social cues when people appeared relaxed and open and we were able to discuss topics in some depth, for others the interview process was shorter and less personal. Having semi structured interviews enabled this process to be tailored to each individual interview process.

As I conducted some interviews in the Long Grass, I was aware of issues regarding privacy. I asked interviewees where they would feel most comfortable to conduct the interviews and offered to move away from group circles or common spaces. In conducting the interviews, I was aware of staff shortages and an extensive workload so I attempted to conduct the interviews in a manner that did not detract from people’s work commitments and from service availability to people in the Long Grass.

Critical analysis of the HEAL Program is itself challenging, particularly from observing how staff are received by people in the Long Grass. Staff were proud of the work they did and people in the Long Grass generally seemed to greatly appreciate the service. As is a finding of this study, there is a lack of adequate service provision for people in the Long Grass and HEAL is unique in this setting. People had little to compare it to and seemed to accept the service despite its limitations.

The study has undergone ethics approval from the Human Research Ethics Committee of the NT Department of Health and Families and Menzies School of Health Research (clearance number 09/36) and Larrakia Nation (2009).
Chapter Four – Results and Discussion
Healthy Engagement and Assistance in the Long Grass (HEAL)—An example of a service delivery model

In this section I will introduce Larrakia Nation Aboriginal Corporation (LNAC) and the HEAL program, exploring the guiding program objectives. I then explore the specific HEAL initiatives relevant to this research project and how the approach HEAL utilises, impacts on service delivery within the Long Grass. Although this treatise does not aim to simply endorse HEAL as a program, at the time of writing HEAL was the only consistent outreach program within the Long Grass so was an obvious choice of program to work alongside. The information about HEAL presented below is an accumulation of information as presented in HEAL program reports and my own experiences and observations throughout the duration of this research project.

LNAC is the peak representative body of the Larrakia People, the descendants of the original inhabitants of the greater Darwin region (LNAC 2010). LNAC provide a range of services to people while they are on Larrakia country and are one of the main service providers to people who spend time in the Long Grass. The current research was conducted alongside the HEAL Program, which is delivered by LNAC. HEAL was established in 2008 in response to a request by the NT Department of Health and Families and other health providers, such as the Danila Dilba Health Service, to develop a model for health service delivery for people who spend time in the Long Grass. The program model is based primarily on recommendations from Holmes (2007) who conducted a qualitative study into the experience of homelessness in the Long Grass in Darwin. Holmes and O’Donnell (2009; p.3) state that a medical or clinically based approach to service delivery was not appropriate or effective to respond to the “social and cultural nuances of health for marginalised populations, such as Aboriginal homeless/houseless people”. In Holmes’s study
(2007), she proposed that to understand health-seeking behaviours of people in the Long Grass, health promoters and promotion initiatives need to recognise the social and cultural worlds of people who stay in the Long Grass and the influence that these worlds have on conceptions of health (Holmes 2007). The findings from Holmes’ study (2007) led to the development and proposal of HEAL’s current service model that has the target population’s concept of wellbeing at the core of its approach.

The HEAL office is situated in Bagot Community, which is one of Darwin’s larger Town Camps housing approximately 400 residents. The HEAL office shares a space with LNAC’s Aged Care Program. The space consists of a small office alongside a bathroom and storage room. The rooms are surrounded by a community garden and outdoor areas, which are used for meetings and for work with service users. The space presents a welcoming, open and non-confrontational environment. HEAL has two vehicles, a transportable shower, trailer and BBQ.

The HEAL Program is directed by a project reference group, which meet monthly. HEAL is managed directly by the Program Coordinator who reports to the Chief Executive Officer (CEO) of LNAC. Staffing changed throughout the period of this research project but mainly consisted of:

- One full time female coordinator
- One full time female staff member
- One part time female staff member
- Two full time male staff members
- Two part time male staff members
- Varying numbers of volunteers and tertiary students.

Throughout my fieldwork, I observed a range of activities and strategies implemented to achieve the program objectives. There are two levels of activities within the program. These are the practical day-to-day activities which are primarily delivered by HEAL field staff, and the strategic responses which are coordinated and delivered at a strategic policy level.
On the practical day-to-day level, HEAL staff responded to incoming requests by people in the Long Grass and other services. This ranged from routine visits to some of the more permanent Long Grass camps, such as One Mile and Knuckeys Lagoon to the transient temporary camps along the beach where people camp but are regularly moved on from by Police and Council. This also involved the development of various SH strategies such as dispersing condoms and lubricant in hygiene packs.

HEAL uses a two-pronged approach to challenge stigma that people in the Long Grass often face. At one level, HEAL works alongside a number of government departments in an attempt to inform policy and affect strategic change. HEAL also engages with some non-government organisations by attending network meetings and events. One strategy I observed throughout my fieldwork that HEAL uses to challenge stigma is to deliver a range of activities such as education and in-services to organisations who work with people who spend time in the Long Grass. These services are for example; The Royal Darwin Hospital (RDH) Emergency Department (ED), Darwin City Council, and Parks and Wildlife and includes challenging stereotypes. HEAL provide daily outreach and response to individuals and groups in the Long Grass that range from providing lifts to appointments to assisting camps to relocate and negotiate with Council. Additionally they provide outreach shower and clothing facilities. HEAL also run specific projects such as Arts in the Grass, which is a HEAL activity that aims to provide culturally appropriate art and wellbeing workshops within the Long Grass environment. It aims to combat social exclusion and stigma experienced by people staying in the Long Grass. It is held weekly and set up in public space where people in the Long Grass can attend. It provides canvas and paints for people to work on and eventually exhibit if they chose and provides lunch and showers. Through the interviews and my discussions with people during fieldwork, Arts in the Grass was referred to as a unique and effective program model to connect people to services, culture and country; break cycles of everyday life and alcohol misuse; increase self-esteem; breakdown stigma; and improve health and wellbeing. One HEAL staff member stated that Arts in the Grass was a;
“Really successful way of engaging with people in the long grass because within that cultural safety that Larrakia Nation create and that the HEAL team create within their approach which comes in part from pre-existing relationships and connections that HEAL staff have with people in the Long Grass.”

In another interview, a staff member discussed the effectiveness of the Arts in the Grass Program as it provides a safe space outside of the daily existence of alcoholism. He stated;

“The painting, giving them a break from cycles of day-to-day life, and stuff that they go through like alcoholism and co-dependency issues that nearly all of the people we see have. It is a great package, it is a holistic approach and it says that healing doesn’t just come... That is why art therapy helps because it gets you back to culture and country because country is everything and that is where it becomes very important, it is a holistic view of trying to help people and you have a greater success rate. Having an art or cultural content rather than giving services singularly you’re going to have a much greater effect.”

Arts in the Grass provides an environment in which services can outreach health initiatives and build rapport and trusting relationships with people in the Long Grass. Staff focused on building relationships by being accessible and breaking down power imbalance. For example, staff at Arts in the Grass sat on the ground alongside people in the Long Grass. They were approachable and did not push agendas on them. I viewed Arts in the Grass as an effective forum to explore opportunities for SH and BBV initiatives as it provided a space away from alcohol, a relaxed environment and a consistent place and time that people in the Long Grass would gather. It also provided an opportunity for initiatives to recognise and incorporate cultural aspects such as art and country into healthful environments and discussions.
HEAL is an example of a service delivery model that aims to work within the worldview of people who spend time in the Long Grass by building relationships, understanding the daily lived experience of people in the Long Grass and providing practical supports relevant to their needs. In adopting a social justice approach to service provision, HEAL aims to address the health inequalities experienced by people in the Long Grass and address social health determinants. Additionally, HEAL staff immerse themselves within the Long Grass context, without pushing an external agenda. An observation from this study was that providing an outreach service not only created greater geographical accessibility, it also contributed to increased existential accessibility as related within the worldviews of people in the Long Grass.

HEAL aims to work within a wellbeing model but according to the Program Coordinator HEAL does not subscribe to any specific social or medical models of service delivery. This was identified as an inhibiting factor by a staff member who stated; “There is a little of the blind leading the blind here. We are not working within specific models like social work or health... I think it is a weakness that we haven’t had a model and that structure to follow.”

I observed the challenges that coexisted with this approach, as there were few clearly defined parameters of service delivery and staff strove to address the complex array of issues. As discussed throughout the coming sections of this treatise, the flexible approach is taxing to staff and it is resource intensive, by the nature of the outreach model. By developing an understanding of the SH and BBV situation in the Long Grass as perceived and experienced by HEAL staff, service provision can be better informed and targeted to meet the needs of people who spend time in the Long Grass and ideally improve health outcomes. This will be explored more throughout the coming sections of this treatise.
Multitude of health Issues, from the perspective of HEAL staff

“The first thing is survival. Just negotiating”

(HEAL staff member 2010)

The multitude of health issues faced by people in the Long Grass was a common theme raised by HEAL staff in the interviews, and observed throughout my fieldwork. Recognised as the biggest challenge to health and wellbeing, staff identified the complex negotiations of survival within a hostile environment, and the multitude of competing primary health concerns as the major daily challenges for people in the Long Grass. Primary health concerns of people who spend time in the Long Grass, from the perspectives of HEAL staff included; acute and untreated chronic illness, sexual and physical violence and assault, access to alcohol and food, loneliness, trauma, stigma, shame and disempowerment. These health concerns were further compounded by a range of barriers to service provision such as stigma and discrimination, lack of transport and mobility.

Throughout the interviews staff stated that for people in the Long Grass, activities focused on day-to-day survival took precedent over addressing longer term health needs. For example, when asked what the main health concerns for people who spend time in the Long Grass were, a staff member stated; “The first thing is survival. Just negotiating.” From the perspective of HEAL staff, survival was generally related to accessing food, water and for some people alcohol, accessing shelter and keeping safe from violence. The pressing ‘survival’ issue changed depending on the state of the individual and the group they were staying with and the safety the group provided.
I was overwhelmed by the level of visible acute health conditions that people were self managing on a daily basis. These for example, ranged from untreated injuries and infections to chronic illness, often resulting from violence and related alcohol use. In another interview, a staff member stated;

“I think after survival and depending on the state of chronic illness, as there is so much of that, respiratory problems”.

As reported by HEAL staff, injuries resulting from physical assaults were common and personal safety was an ongoing concern for people in the Long Grass. HEAL staff reported that violence, especially as a result of alcohol intoxication was common, and that it was occurring more frequently in the afternoons and was more common in specific camps. During outreach, I observed a number of untreated severe injuries. For example, a man’s hand and wrist were so swollen that he had no mobility in his arm. He had recurrently broken his hand and wrist three times and had each time let it heal without assistance. As stated by a HEAL staff member;

“Having an injury to manage is the biggest [health issue] and just not accessing any services and being in an environment with all of this violence in a life threatening capacity, an ongoing threatening place.”

People who spend time in the Long Grass were often victims of violent crime. They were targeted by other people in the Long Grass, but more commonly targeted by people who were not staying in the Long Grass. HEAL staff were aware of a number of incidents where people were beaten, and in some cases raped when they were camping in the Long Grass. One HEAL staff member, when asked what the main health concerns were, replied;

“Obviously the elements and harassment. People are being bashed by young fellas, more so white fellas just going into the Long Grass and bashing people who aren’t even doing anything, just sitting there”.
These incidents generally went unreported to Police and no medical assistance was sought. In some of the situations, staff believed that people’s reluctance to report the attacks resulted from their fear in, or lack of trust in the Police and the RDH. In a discussion with one staff member, he spoke of an incident he had responded to that day. He stated;

“Today we assisted two fellas. One was kicked five days ago in the ribs when he was asleep. So he has been coughing up blood for five days now and been in pain and really his priority is survival and choosing not to seek appropriate care.”

This particular staff member talked about the challenges he faced in trying to locate and assist people by encouraging them to seek medical care. In this particular case the person had been hiding in the Long Grass since he had been beaten and it was evident that he was suffering an internal injury. He did not want to seek any care nor contact the Police. This was not the only incident the staff member had experienced that week. He stated; “Then another guy, jaw is broken and he is refusing to see a doctor...”

Alcohol use and associated harms were regularly referenced throughout the interviews as a key challenge to people’s health and well-being. Often violence was related to alcohol use. One staff member stated; “we just see the edge of that... the reality of violence, the ugliness of alcoholism. I see people arguing, being really intoxicated.” Through my observations, there were some areas in the Long Grass known as ‘booze camps’ where people drank alcohol consistently throughout the day. Alcohol use was also often connected to episodes of sexual and domestic violence and abuse. Although these issues are discussed in more detail in the next section, sexual and domestic violence were constant issues raised in the interviews and evident in the fieldwork.
HEAL staff recognised the impact of loneliness and the emotional wellbeing of people in the Long Grass. Staff members were often familiar with the personal contexts of people in the Long Grass, especially people who had been there for a long time. As outlined in the Literature Review, many people moved to the Long Grass as a result of conflict in community and felt isolated from their community, country and culture. One staff member reported;

“The loneliness, feelings of being lost and not belonging anywhere... just drifting. Being far away from their own country, isolated from country. And anger and bitterness, injustice.”

Through observation and interview findings I found that although people may recognise the need to address health concerns, such as broken bones, competing concerns such as access to food and shelter generally took precedent. Starvation and restricted access to food, for example, were common themes of concern brought up in the interviews and also tasks, which were central to outreach response. One staff member stated;

“Cycles of starvation and not having access to good nutrition just effects your mental health so much. It must be a peak and trough existence. Feeling ok... to not feeling good... moodiness. I see that a lot.” “a mix between feeling a state of how they are feeling and what they need to be doing such as getting grog to medicate a feeling and hunger”.

HEAL staff also outlined the practical day to day issues such as material aid which impacted on peoples health and wellbeing such as access to linen, shoes, clothing for example. A HEAL staff member stated;

“Some of the main issues are people wanting sheets and blankets and food, medical things like hygiene packs, thongs and clothes etc. Transport is also popular with
people mainly needing ID, flights back home and sometimes trips to the hospital”.

Further, stigma and discrimination as experienced by people in the Long Grass was an evident theme throughout the interviews. The comprehensive health issues, environment and stigma and discrimination experienced by people in the Long Grass has a significant impact on health, health seeking behaviours and barriers to service accessibility. Although throughout the interviews I prompted specific discussions regarding SH and BBVs, these were not identified as the primary health concerns by staff and volunteers.

Although the impact of stigma is discussed throughout the later sections of this treatise, I will briefly discuss it here as a primary health concern identified by HEAL staff and through my own observations. Staff identified stigma as being a major contributor to poor health as people are more likely to take part in risky activities and not seek medical assistance when needed. For example when discussing opportunities for people in the Long Grass to engage in healthy activities a HEAL staff member stated; “I think if people feel better about themselves those things will happen earlier... we can be a measure to help people find a pathway to a more sustainable and happier existence and break unhealthy cycles”.

Similarly, another staff member stated;

“If people feel better about who they are they might be more likely to stop gap measures such as pain tablets, to address needs and might actually go and see a doctor... people say that they don’t mind being in the Long Grass but that the sense of social dignity that gets taken away because no personal hygiene like clean clothes so being able to supply that just builds a level of dignity and they can feel good about who they are”.
As reported by staff and from my own observations, people in the Long Grass were constantly faced with the complex negotiation of survival and a multitude of health concerns. As a result, people’s priorities changed day to day and evidently so did HEAL’s service response.
Sexual health, blood borne viruses and shame

“I just haven’t found the way to weave in conversations about sexual health and weave in discussions about rape and power because they are so disempowered already.”

(HEAL staff member 2010)

Although SH and BBV issues were not primarily raised in the interviews by HEAL staff, when prompted there were a number of consistent themes that emerged. As this section further explores, SH and BBV issues were integrated in a range of other complex concerns, and were not openly discussed in fieldwork or the interviews. From the experience of HEAL staff, SH was predominantly referenced in relation to sexual coercion and violence, which staff reported was common in the Long Grass. SH topics were perceived to cause shame and were challenging to address for staff. This was consistent with my observational findings. Activities in the Long Grass that caused risk of BBV transmission were for example, sharing of injecting equipment, fighting and blood exposure, sharing of razors and toothbrushes and sexual transmission. Despite trusting relationships with HEAL staff and volunteers, an ongoing challenge for staff to initiate dialogue regarding sexual coercion, violence, STIs and BBV transmission and treatment was evident, as well as the associated shame and stigma. These findings will be discussed in greater detail throughout this section.

Initially I aimed to explore the SH and BBV context in order to inform and develop health interventions. My initial observations and interviews with staff made it apparent that SH and BBV existed within a complex negotiation of health concerns and survival, and was not necessarily a health priority for people in the Long Grass. Discussions regarding SH were generally related to violence and survival. For example, when asked
“How does sexual health fit in with the survival and pressing health issues you deal with?”, a staff member responded;

“Sexual health is low. Health in general is low and sexual health even lower. I have had a few light discussions about condoms being in the hygiene packs and they’re recognised and useful things to have but most of the sex related stuff has been in the context of violence or even like the whole transactional sex.”

For example, a staff member stated;

“When the issues are so complex, there is a moral dilemma as workers as to what do we talk about and what don’t we talk about if we know that someone was raped four weeks ago and we’re seeing them today because they are hungry and they need transport to Centrelink because their payments have been cut off and they just got beaten up, why would we chose to talk about the survival issues from four weeks ago when there is a more recent survival issue? It is about prioritising what we know about people.”

This hierarchy of health concerns and the subsequent complexities of responding to them was exemplified in one particular discussion with a HEAL staff member. Throughout this interview, the HEAL staff member discussed a specific situation where a woman in the Long Grass could not return to her community because she had married against kinship protocols. The woman was targeted and harassed by people from her community, who were staying in the Long Grass, and was a victim of ongoing physical and sexual assaults. She was diagnosed with cancer and the RDH were regularly communicating with HEAL in an attempt to encourage her to commence treatment. Her husband had passed away in an interstate hospital. As understood by HEAL, her immediate concerns were in relation to grief and safety in the Long Grass now that she no longer had her husband to protect her. From the perspective of the HEAL worker her cancer and physical and sexual assaults were “lower down her list of priorities”. The HEAL staff member further stated; “she is an example of someone whose sexual health is so laid under all of the other complex issues. She is a highly traumatised person”.
In another interview, a HEAL worker discussed the incidence of sexual assault; “The other way we hear about it [sexual health] is violence again... knowing that women who have been bashed and expecting that they have been raped as well... there is so much shame.”

Staff reported that sexual violence, rape and transactional sex were all common in the Long Grass. Sexual violence and rape were believed to be perpetrated by men staying in the Long Grass and other men coming into the Long Grass regions. This was a consistent finding from Holmes and McRae-Williams (2011) whose study of transactional sex in the Long Grass found that;

“Perhaps the most significant finding to emerge through this study was the high prevalence of women who reported being raped and the extent to which sexual assault informed daily life patterns” (p. 55).

Two studies conducted by Holmes and McRae-Williams (2011 and 2012) found that many women feared for their safety and carried knives for protection and often avoided falling asleep at night. They found by interviewing 89 women in the Long Grass that women reported being raped by ‘their men’ regularly and that sex was frequently traded with white men for alcohol, cigarettes, marijuana and cash (Holmes and McRae-Williams 2013). They were also aware of the health implications of STIs in sexual assaults and transactional sex; However these were considered as ‘minor concerns’ (Holmes and McRae-Williams 2011).

In an interview, a HEAL staff member discussed a recent incident where a woman who lived in the Long Grass was raped in the public toilets of the Rapid Creek Shopping Village. HEAL staff were informed of the incident from a person staying in the Long Grass. A HEAL staff member approached the shop owners in the Rapid Creek Shopping Village to inquire about the incident. A shop owner responded that to their knowledge no one had contacted the Police or an ambulance, or checked to see if the victim was okay. They confirmed that they were aware of the
incident despite the fact they failed to respond at the time. This scenario had various implications for HEAL. As discussed in the interview, the staff member was emotionally confronted by this situation particularly the inaction and lack of response by the shop owners. They believed this was racially discriminatory and had the victim not been an Aboriginal person staying in the Long Grass, shop owners would have contacted Emergency Services immediately. Additionally, formulating an appropriate strategy to follow this up with the shop owners and with the victim in the Long Grass proved challenging. The frequency and lack of response to sexual violence and rape was also mentioned by another staff member who stated:

“We need to develop a way to talk to people about consensual sex and safety. We have to be prepared to find out if women have been raped. We need services like Ruby Gaea\(^1\) involved. We need to be prepared for sexual health first aid and let’s recognise that this is happening a lot... I have even heard some men say at an in–service session that they know of women getting raped in the Long Grass every night but that when it is reported to the Police there is very little response.”

This was consistent with one of my experiences in fieldwork. I contacted the Police, as a woman in the Long Grass was distressed and reported being repeatedly beaten by her partner who was present and yelling abuse at her. She requested I contact the Police. The Police arrived, they informed me they would ‘take him in’, but there wasn’t much point when ‘she’d just go running straight back to him’. They said this in front of the woman, which clearly heightened her distress and they failed to refer the woman to emergency services.

Throughout my fieldwork, I conducted some discussions with women in the Long Grass regarding condom use. I did this in some instances one

\(^1\) Ruby Gaea Darwin Centre Against Rape is an NGO in Darwin that provides counselling, education, advocacy and support for people who have been victims of rape and sexual assaults.
on one and in a group discussion. There were inconsistencies with what people in the Long Grass and staff believed in terms of condom use. The women said that they were aware the condoms were in the hygiene packs and they believed people did use them. A couple of the women however, said they would not use them and did not engage in further conversations. In some Long Grass areas I often found condom wrappers scattered throughout the bushes and occasionally found used injecting equipment. People were also frequently engaging in unprotected sex as perceived by staff.

Further discussions and observations raised the concern of BBV transmission through for example, products distributed into the Long Grass by the HEAL program such as razors and toothbrushes which were commonly shared. More specifically, in relation to BBVs staff felt strongly that these topics should be broached by specialist services, such as NTAHC. BBV health was generally viewed as a topic that the staff had minimal knowledge of, nor the confidence or capacity to discuss with people. For example in one interview a staff member stated;

“I feel like BBV is out of our scope. They are serious topics but to give the best advice you need someone with the knowledge. I don’t know what people’s awareness levels are. If there are the same cultural sensitivities attached to BBV, as with SH. I think communities have to play an active role. I think reasons why AIDS hasn’t spread into the communities is because it has been fairly isolated but hepatitis is fairly rife in communities.”

Findings from Hermawan (2004) found that people in the Long Grass had little to no knowledge of hepatitis C virus (HCV) and those that had heard of it did not know how it was transmitted or prevented. Additionally, through brief discussions with people in the Long Grass receiving hygiene packs, an overall lack of understanding about the potential risks in sharing products such as razors and toothbrushes was evident.

Considering the high prevalence of HCV amongst Indigenous populations
and the higher incidence of AIDS diagnosis, lack of understanding of transmission (HealthInfo Net 2013) is concerning.

Injecting drug use and the sharing of used injecting equipment occurs in the Long Grass (Pocock 2011; Holmes 2007) with limited access to sterile equipment. There are no published studies in the NT to date, which have explicitly explored IDU in the Long Grass. NTAHC conducts an annual survey of IDU who access the NSPs in the NT, titled ‘Snap Shot Survey Report of the Needle and Syringe Program’. The 2010 survey found that of the 93 people surveyed, 3.2 percent identified as residing in the Long Grass and 17.2 percent identified as being Aboriginal and zero percent identified as being Torres Strait Islander (Pocock 2011). This data supports my own observations confirming that injecting drug use does occur in the Long Grass. HEAL staff reported injecting drug use as a taboo topic, but did see evidence of it occurring. Although there is no local research to draw upon, international studies that have explored the diversity amongst IDUs have found that homeless people are some of the most stigmatised IDUs and experience discrimination amongst the broader IDU population, preventing them from accessing services such as Needle and Syringe Programs (NSPs) (Simmonds & Coomber 2009).

From the perspectives of the HEAL staff, SH and BBV were taboo topics that people did not openly discuss. When asked if SH is a topic that they discussed with people in the Long Grass, a HEAL staff member stated;

“No, not at all. There is a lot of stuff that we know goes on but that doesn’t get talked about. It’s hard because they are very personal things and there is a lot of culture caught up in those issues too and there can be abuse surrounding those issues, and violence. It is hard because sometimes we see the results of those things such as women getting beaten up and all those things”.

‘Shame’ was a concept that was often mentioned in the interviews and in relation to SH and BBV was used interchangeably with the concept of ‘taboo
topics’. For example, a staff member stated in reference to the barriers in discussing and addressing sexual health topics; “I think its shame job topics. It isn’t a topic that you can just start talking to people about.” The concept of shame for Aboriginal English speakers is somewhat broader than the concept in many non-Indigenous populations. Generally, shame is used in reference to someone feeling ashamed or embarrassed. For Aboriginal people shame can be an overwhelming sense of embarrassment, disempowerment (Leitner and Malcolm 2007) and can result in the individual being ostracised by others. Shame can also bring embarrassment onto family, friends and the broader community. People often refer to SH and BBV as ‘shame topics’ or ‘shame stories’. Similarly, ‘taboo’ is often used in reference to topics such as SH and BBV, which cause shame or have cultural connotations. Topics that are referred to as ‘taboo’ for Indigenous Australians often have cultural bans and avoidance rules placed upon them, conducting how people discuss and act accordingly. An example of this within the SH and BBV field is discussing men’s sexual health business with women. This is something HEAL staff are acutely aware of. The cultural taboos guide service delivery but as was evident in this program contribute to their reluctance to address any topics associated with shame or taboo. Staff did not feel comfortable encouraging people to discuss SH and BBV issues despite the fact that sexual violence, assault and coercion were evident. For example a staff member stated;

“It is personal to start enquiring about people’s relationships and we don’t often get to that level. People are naturally very hesitant to disclose. They will tease each other but not disclose their own relationships.”

HEAL staff reported that they often relied on ‘gossip’ to find out about SH issues, such as transactional sex and incidence of rape or abuse. As a staff member stated; “We only hear about this through other people gossiping and telling stories, it isn’t helpful”.

This was partly due to their reluctance to offend people by broaching taboo topics, and their own lack of confidence in how to respond to these issues once they have been disclosed. Staff reported that although they
recognised the importance in having these discussions, they identified not having the knowledge or skills to engage in conversations that may cause shame. For example, as a staff member stated; “I just haven’t found the way to weave in conversations about sexual health and weave in discussions about rape and power because they are so disempowered already.”

In another interview, a staff member stated;

“As far as those issues go, they don’t get discussed at all. I think there is a barrier because there have been so many white fellas intervening in the past and we want to help… We have a good relationship with mob but there are still many degrees of separation and I don’t know how to address that…”

HEAL staff also believed that not only did the shame and stigma associated with SH and BBV act as a barrier to their service delivery, they identified it as prohibiting people in seeking out support from each other and other services. Newman et al (2007) examined the barriers and incentives to HIV treatment uptake among Aboriginal people in Western Australia. They interviewed 20 people who were living with HIV and found that the fear of disclosure of HIV status and the associated stigma and discrimination was linked to shame and prevented Aboriginal people in their study from uptake of antiretroviral therapy (ARV) for HIV. They also found that people were concerned about bringing shame on their family or community. They stated;

“Maintaining social relationships, everyday routines and the respect of friends, family and community is a greater priority than individual health per se.” (2007:p.1).

The effects of stigma on individuals and groups are comprehensive. This is not only evident throughout the findings discussed here but thoroughly supported throughout the literature. For example, a study conducted by Daiski (2007) explored health concerns from the perspectives of homeless people themselves. They found that participants were concerned about their physical health but also discussed the stress,
violence and emotional distress of negotiating survival within the homeless setting. They also found that people wanted to break the cycles of homelessness they were trapped in but were restricted by the stigma and discrimination they faced for being homeless (Daiski 2007).

Erving Goffman (1963) was a prominent sociologist well known for his theorising on social stigma. Goffman’s theory described social stigma to be a result of an attribute, behaviour or reputation that is socially discrediting. The social discredit resulting from stigma, can be so severe that the stigmatised are ostracised, devalued and rejected by society and are viewed as ‘less human’ (Goffman 1963). There are a number of studies that suggest that the internalisation of stigma prevents people from accessing services (Fitzgerald et al 2004; Simmonds and Coomber 2009). A study conducted by Simmonds and Coomber (2009) explored barriers people faced in accessing safer injecting services in England. Stigma as a barrier to service accessibility was a common finding in the majority of interviews they conducted. They found that amongst the injecting drug users (IDU) within their samples, they experienced internalised stigma, with the most stigmatised of IDU groups being homeless people. They also concluded that experiencing stigma was a major barrier to accessing services despite people’s recognition that service access was important for their health. Stigma can decrease people’s motivation and sense of self worth decreasing the likelihood they will act on health needs (Simmonds and Coomber 2009; Holmes 2007). They also found that specific to HIV and HCV “the attribution of, and internalisation of stigma can reduce the effectiveness of prevention and harm reduction activities” (Simmonds and Coomber 2009; p121). Some respondents in their study actually attributed stigma to their own engagement in risky injecting practices (Simmonds and Coomber 2009).

The impact of stigma on health, health seeking behaviours and access to services was an issue identified in each interview, and frequently observed throughout fieldwork. From the perspectives of HEAL staff,
people in the Long Grass were stigmatised and discriminated against by mainstream society but also various factions within the Long Grass faced internal stigmatisation. There were three main elements of stigmatisation identified, these being: stigmatised in mainstream services for being Aboriginal, within Aboriginal services for being homeless and in the Long Grass as a result of behavioural or lifestyle choices, such as substance use. Holmes (2007) also found that stigma acts as a barrier to service response and responsibility taken by society. For example this; “makes the causes and consequences of being homeless and acts to prevent appropriate action in the creation of environments that are supportive of health and improved life quality” (Holmes 2007; p.4). As found in this research project, stigma was a barrier to service response as staff identified the challenges in addressing topics which stigmatise people. This is evident in Darwin’s Long Grass across a diverse range of issues. From an individual’s internalisation of stigma to views of service providers, stigma and discrimination acts as a significant barrier to service accessibility (Fitzgerald et al 2004; Simmonds and Coomber 2009; Holmes 2007). People in the Long Grass were often viewed by mainstream service providers as undesirable or less worthy of services and support, as supported by Holmes (2007) who found that people in the Long Grass were viewed by the mainstream population as being ‘ill’ and ‘undesirable’.

To summarise the perspectives of HEAL staff, although SH and BBV issues were evident in the Long Grass, staff did not have the confidence, nor view these topics as appropriate, to discuss. Further, amongst people in the Long Grass there was an overall lack of understanding of STIs and BBVs, which were a lower health priority. With the lack of confidence and perceived opportunity for staff to conduct discussions with people regarding SH and BBV, these issues were predominantly not addressed, despite being evident.
A challenging service delivery environment for staff

“What I am challenged with is separating myself, not getting personally involved but just trying to focus on being a fieldworker. Just being neutral I have a passion to see justice done, speaking as an Indigenous person I want to see people being treated fairly and equally.”

(HEAL staff member 2010)

This section examines the challenges that staff identified in relation to their work in the Long Grass in Darwin. The nature of outreach work itself compounded by the environment of the Long Grass, the diversity of varied skills and experience of HEAL staff and volunteers and the existing barriers to service provision, contribute to a hostile, confronting and challenging environment to work within.

The isolation experienced by staff extended more broadly within the social sector in Darwin due to the political and social environment that HEAL exists within. As outlined in Chapter Two, the political response to the Long Grass states the ‘need to eradicate anti-social behaviour’ (NTG 2008) and often portrays people in the Long Grass as ‘drunks’ (Media Release 2008) who are simply in the Long Grass due to choice (Toohey 2013). The general political approach perpetuates the stereotypes of people in the Long Grass and fails to recognise the diverse population living in the Long Grass. Additional to the feelings of frustration this causes, staff identified this as further isolating them as community workers. The HEAL evaluation report discusses the isolation of the program and staff by stating:

“Often the coordinator is a lone voice, with very little support in forums in which the coordinator has the least power, yet where policy and other changes have the potential to be
instigated. This is intellectually and emotionally exhausting and may eventually lead to burnout (Holmes & O'Donnell 2010. p.19).

Staff also had passionate views regarding the failure of government to positively assist and change the social inequality experienced by living in the Long Grass. For example, a HEAL staff member stated;

“Government thrown blanket policies are too extreme either put people off side or in prison... the longer we have people do these programs, it is crucial that it becomes a permanent workshop that continually has the support and it will slowly change people’s awareness and give people the better lifestyle.”

Staff reported finding the internal organisational environment that HEAL existed in sometimes challenging. From my observations and informal discussions with HEAL staff, I became aware of the conflicting views that exist within LNAC, regarding working with, and supporting people to stay on Larrakia land in the Long Grass. Not all LNAC staff agreed with supporting people to stay in the Long Grass, with some people strongly advocating to return people to their communities. As mentioned previously, people have often moved into the Long Grass to avoid issues in their community and returning is not always a safe or viable option. Advocating for the HEAL Program to support people whilst in the Long Grass was reported to be an isolating and challenging role. This was an observation from my fieldwork, and was also referred to in the interviews. As stated by a staff member, “The gains feel so small in a hostile environment.”

Evident from my observations and through the interviews, it was apparent that staff were experiencing varying levels of ‘burnout’. This was attributed to a range of issues that will be discussed throughout this

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2 Defined as physical and/or mental collapse caused by overwork or stress.
section but primarily this was attributed to the context and nature of the work itself. Burnout is more common in working environments with little control, clear guidelines and predictability (Maslach & Jackson 1982). This was also an issue further supported by the HEAL Program Evaluation Report which outlined the need for the program to; “re-examine what reasonable expectations can be placed on HEAL staff to achieve goals” (Holmes & O’Donnell 2009; p.32). Staff reported that due to the nature of the work, it is difficult to evaluate the service, impacting on staff ascertaining a sense of achievement, further contributing to burnout. This was an issue that I witnessed throughout my fieldwork and a common issue that participants discussed throughout the interviews. HEAL staff recognised the extent to which the daily duties often demanded skills beyond their training which consequently contributed to feelings of stress and burnout. An example often referred to was responding to and supporting people who have been significantly traumatised and staff not feeling they have the skills or training to respond appropriately. HEAL were often the first point of contact for people in the Long Grass for a multitude of issues, which sometimes made the work unpredictable and complex. Staff recognised they over relied on intuition in response to the complexities and unpredictability of situations they encountered throughout fieldwork. The harsh environmental factors were also identified by staff to contribute to daily challenges particularly working outdoors in extreme weather conditions such as heavy rain in the wet season and extreme heat and humidity in the build–up season.

The nature of the work and the HEAL model also relied on staff working autonomously. Relying significantly on your ‘own initiative’ within this work environment also created many challenges and resulted in some staff struggling with implementing professional boundaries. One staff member reflected on a recent incident by stating;

“This fella was pushing people around. I wanted to just say ‘you cant do that’ but he was too angry. As a field worker it can be really hard to separate yourself from it. You have to use your own initiative.”
In an interview, a staff member attributed this to inadequate support, clear guidelines or emotional responses and decisions being made by individual staff members. Another staff member took some people who were staying in the Long Grass to camp at his house. This was causing obvious distress for him and his family; however he could not find any other housing option or appropriate service for referral. The worker expressed great empathy and assisting them was the priority for him despite the personal costs. In this situation, the clients were too unwell to be camping in the Long Grass and were recently discharged from the RDH. They had no money and had been on a priority-housing waiting list for some time. Such situations were not uncommon from my observations. A similar finding of a study conducted by Fisk et al (1999) was that outreach workers struggled to implement professional boundaries as a result of their own emotional responses to ‘witnessing homelessness’ and wanting to do more to assist clients (Fisk et al 1999).

Evident from the fieldwork, the life experiences and values of staff and volunteers varied significantly, which had an impact on their attitudes towards service delivery and the challenges they identified. One staff member discussed his own personal experiences, which he said informed his approach and skills in working with people in the Long Grass. He stated;

“You just have to use your initiative. I have lived on the streets a fair bit myself actually so I know what it can be like... Doing this work I find it very challenging and that I have to use my initiative, I find it hard. I have grown up seeing a great deal of violence and have seen a lot of violence from police and I have grown up with a complete mistrust with police. So I can relate to some of the things they go through.”

In another example, in one interview a HEAL volunteer reflected on the time he had once spent living in the Long Grass. He referred to the Long Grass as a very challenging and violent place to live and had a good understanding of the worldviews of people residing there. He had a great
deal of knowledge about what occurred in the Long Grass and he was certain that people frequently engaged in high risk behaviours of STI and BBV transmission. This staff member identified feeling challenged by his own emotional responses to witnessing people living in the Long Grass. In contrast, another volunteer that I interviewed had grown up overseas and reported that he found the environment in the Long Grass quite challenging to understand and work within. He had grown up in a developing country and drew upon parallels from the attitudes and behaviours of impoverished people in comparison to people in the Long Grass in Darwin. Although he related to the lessons he had learnt and how his view had changed since starting his volunteer placement, he described his own cultural views from his country of origin and related this to people in the Long Grass as them being ‘dependent’ and ‘lazy’. He also stated that he did not think STIs were of concern as he believed people in the Long Grass were not sexually active as they were ‘too old’. The worldview of these two volunteers provides a stark contrast, which impacted upon their approach to service delivery. This was a good example of how the experiences of staff and volunteers can impact upon their perspectives and responses to the health context in the Long Grass.

There is a body of literature that suggests that workers develop better empathy and understanding when skills development training is supported by ‘humanising’ of the client group (for example Hillman et al 2012). Further, previous literature explores the effectiveness of peer-based models to service delivery when working with greatly stigmatised and vulnerable community groups (see for example Solomon 2004). The benefits of understanding the context that people in the Long Grass live within is effective in developing a relevant and responsive program. However, it can also create various challenges associated with staff ability to implement personal and professional boundaries. A finding of Fisk et al’s (1999) study as previously mentioned, was that staff struggled with boundaries as a result of witnessing homelessness. This caused staff feelings of ‘powerlessness, anger and sadness’ which they found “tempted staff to cross agency boundaries to assist clients” (p.233). This was evident in the current study. Staff were also clearly effected by
witnessing the constant barriers that people in the Long Grass faced in attempting to address health issues and make positive changes to their lives. Staff reported experiencing feelings of helplessness. They discussed being challenged daily by the multitude of health issues as discussed in Section Two of this chapter, the lack of appropriate services available for referral and the stigma that people in the Long grass constantly face. Despite the variance in personal views of staff members and the multiple challenges staff encountered, I consistently observed staff demonstrating respect and empathy towards people who spend time in the Long Grass. They were committed to providing a non-judgemental, respectful and appropriate service to people in the Long Grass. They showed accomplished empathy and compassion, which visibly broke down barriers and assisted in improving health outcomes.

Throughout the interviews HEAL staff outlined their experiences of mainstream health services discriminating against people in the Long Grass. The Royal Darwin Hospital (RDH) is the main public hospital in Darwin with the majority of public specialist services for the NT. As previously mentioned, people travel to Darwin to access specialist services and often end up staying in the Long Grass. In an attempt to address the stigma HEAL staff provide support to people in the Long Grass in accessing RDH’s Emergency Department (ED) but also provide education to hospital staff in an attempt to breakdown discrimination. A HEAL worker outlined the difficulties they faced in challenging stigma and discrimination through delivering in-services to health staff about working with people in the Long Grass. In reference to staff at the RDH’s ED a HEAL staff member said; “The relationship in ED is so short, it creates burn out in the nurses as opposed to empathy and understanding. They say oh here they are, drunk again. That really came out in our last in-service.” As stated by another staff member; “The bureaucracies of health institutions become too much of a barrier. Plus, they have to then fight off the stigma and attitudes attached to them for being homeless.” This is an ongoing daily challenge for staff, witnessing the stigma and discrimination and being limited in what they can do to address it.
Mainstream health staff also work within their own worldview and associated attitudes and biases to health (Baum 2008). This was further confirmed by my observational findings. For example, a HEAL worker and I transported someone from the RDH back to their Long Grass camp. In reflection of their experience being a patient of the RDH, the service user reported that they were happy that they had a bed and regular food but reported it was freezing cold in the room and they did not understand the medical care they were receiving. They felt that the staff had failed to communicate with them regarding their own health care. Although there are Aboriginal Liaison Officers and Interpreters employed at the RDH which aim to break down the cultural and communication barriers between Indigenous patients and the hospital staff, they are not always available or accessible. This finding is supported throughout the literature for example as stated by Baum (2008; p.3); “Health workers see health as central to their work and often assume that everyone sees their world revolving around the pursuit of health”. Such assumptions can create unrealistic expectations of the health priorities of patients. If patients do not meet these expectations, they can be unfairly judged which can then impact upon the care they receive.

In an environment where significant barriers to accessing Emergency Services are evident, HEAL may be the only access to health care. HEAL was often the first point of contact and people in the Long Grass often depended on outreach. People in the Long Grass reported being reluctant to inform police or Emergency Services of health concerns and would wait for HEAL staff to take them to a clinic, such as Danila Dilba Aboriginal Health Service or the Emergency Department (ED) at the Royal Darwin Hospital (RDH). In some cases if the worker has a strong relationship with the person in the Long Grass they can encourage and support them to access services. However, more often people would decline referral to other services, including emergency services and hospital care. As a result of people’s reluctance to access services, people will often remain in the Long Grass instead of, for example, seeking treatment in hospital.
This increases the burden of care and it is often beyond capacity of the HEAL team to meet the needs of people in the Long Grass. Staff reported facing many challenges in follow up care and referral, as people can be very difficult to locate and are constantly moved on by Police and Council, nor do they have the staff capacity or facilities to provide the required level of care.
Strengths and Weaknesses of the HEAL approach

“I like what HEAL stands for... as what I see is healthy engagement that works within the worldview of the person, that doesn’t force or push an agenda onto them and that doesn’t force the biomedical view of health on people and supports them in whatever their choices are for that moment.”

(HEAL staff member 2010)

In this section I will outline the effective aspects of HEAL service delivery as well as the areas requiring improvement, as identified by staff throughout the interviews. I will then critically discuss these aspects of service provision in relation to my own observations and the broader literature.

Encompassing a holistic approach to health and wellbeing that considers the lived experiences of people in the Long Grass was identified by staff as being a major strength of the HEAL approach. Staff believed that this approach allowed them to address a range of health issues within consideration of the relevant social determinants. In an interview, a staff member outlined some of the qualities of the HEAL model;

“We work within a wellbeing model. When you create a space that is ‘healthful’ like Arts in the Grass, that is peaceful, has safety and food et cetera and is an environment that you can be well in. There will still be illness but that can be attended to.”

This is well supported by the literature of BBV service provision. For example, a study conducted by Newman et al (2007) that explored HIV medication adherence with HIV positive Indigenous peoples in WA found that;
“Services that understand Aboriginal social and cultural values of social participation, family and collectivity are more likely to support people in managing HIV in the context of their everyday lives” (Newman et al. 2007; p.6).

I observed that whilst the HEAL holistic and flexible approach is effective in delivering a responsive and relevant service, it also had limitations. For example as people in the Long Grass were constantly faced with the complex negotiation of survival and a multitude of health concerns their priorities changed day to day and evidently so did HEAL’s service response. This made it evident that health concerns would be pushed down the list of priorities and effectively, issues such as SH and BBV not addressed. This was partly due to staff reluctance to offend people by broaching taboo topics, and their own lack of confidence in how to respond to these issues once they have been disclosed. There were few clearly defined parameters of service delivery and as staff strove to address the complex array of issues, topics such as SH and BBV went largely unaddressed. Additionally, challenging stigma and discrimination can further stigmatise people. There is a body of research in the SH and BBV field that explore this and outline the importance of challenging stigma but within a culturally considerate and appropriate way (For example Biradavolu et al 2012; Simmonds & Coomber 2009; Newman et al. 2007)

HEAL staff consistently referred to the effectiveness of having an outreach program model. This was perceived to address geographical isolation by breaking down the barriers of transport, mobility, the risks associated with leaving camps and to establish a level of control for people accessing the service. There is a great deal of evidence in supporting outreach models as effective engagement for homeless populations the world over (for example; Fisk et al 1999; Fisk et al 2006; Lam 1999). As found in Fisk et al’s (1999) study, an outreach model works best with vulnerable homeless populations and contributes to a power shift, enabling the client more control over their environment. Outreach models also assist in providing services to those most in need at least likely to
access services elsewhere (Lam & Rosenheck 1999). Although on one hand this was effective in providing a much needed accessible service, it had adverse effects on staff. People who spend time in the Long Grass are reluctant to access mainstream services and the burden of service provision resides with HEAL. As discussed in the previous section, staff found the demand on HEAL to be a constant challenge, particularly considering the multitude of health issues. Although effective in addressing barriers and increasing accessibility, the outreach model was observed to be taxing to staff and is resource intensive, by its nature.

An aspect of service provision for improvement, identified by HEAL staff was the need for increased outreach service collaboration with programs that fit within the health context and relevance of the Long Grass. For example, NTAHC’s Needle and Syringe Program (NSP) and Sex Worker Outreach Program (SWOP). Programs such as these could be adapted to be appropriate and accessible to people in the Long Grass by being developed within an outreach framework. For example, if we know that people are injecting drugs but experience significant barriers to accessing services such as NSPs or pharmacies to get sterile equipment, we should explore NSP outreach as an essential service. Hermawan (2004) found that there are some existing organisations who provided services to people in the Long Grass and that services such as NTAHC should take opportunities to partner and deliver SH and BBV services. She also concluded that education for all staff working with people in the Long Grass is essential. Services need to be educated on the worldviews of people who spend time in the Long Grass and should base their responses within the context of the Long Grass. As stated by a HEAL staff member; “It is different from community work, similarities but differences in the realities of what people’s lives are”.

Additional to providing an accessible service through outreach, HEAL provide projects which aim to be delivered in safe and accessible spaces. For example, Arts in the Grass was an effective form of service delivery. Arts in the Grass is an effective forum to talk to people in a non–
threatening environment. There was little alcohol present and people generally stayed sober throughout the event. Participants were focused on their art and there were many opportunities to build trust and rapport. This was also recognised by the HEAL staff as one staff member stated; “That is why art therapy works because it gets you back to country and culture. Having an art or cultural context rather than giving services singularly you’re going to have a much greater effect”.

One of the aspects of good service provision identified in the interviews was the importance of good relationships and rapport between staff and people in the Long Grass. HEAL staff spoke about positive and trusting relationships as enabling aspects of service accessibility. This was consistent throughout the Long Grass literature (Hermawan 2004; Holmes 2007; Holmes and Eldridge 2008; Holmes 2010; Maypilama et al. 2004). So in some ways, service providers such as HEAL who have developed trusting relationships with people in the Long Grass are well situated to deliver health initiatives. They do however, have limited capacity due to the diversity of health needs and as discussed previously, the demand creates a multitude of challenges for staff and a reluctance to discuss taboo topics. As outlined in the following statement by a HEAL staff member;

“HEAL Staff need to be trained on how to bring up awkward topics such as STIs and rape etc and know what advice to give or not. They have gained trust and are positioned better than any other provider to give advice”.

Additionally, as outlined in the previous section, staff reported the personal challenges they faced by relying on ‘your own intuition’. I observed this contributing to a lack of professional boundaries for some of the staff members.

Some of the limitations to service delivery identified by HEAL staff in this research project were their lack of knowledge and access to training of specific health issues, such as SH and BBV. Although this was not their core business, staff outlined the need to be able to refer to, or at least
gain support from specialist services. Engaging services such as NTAHC to provide ongoing support and mentoring to staff could increase their knowledge regarding SH and BBV so that people in the Long Grass can make more informed decisions regarding their health. Throughout this project, I organised the Nurse Educator at NTAHC to deliver training sessions on BBVs to HEAL staff. This was received with great enthusiasm and staff reported this to be useful and stated ongoing training would improve their knowledge and confidence in addressing ‘challenging’ issues such as SH and BBV. As stated by a staff member in reference to the in–service training that NTAHC conducted regarding BBVs; “I now know that I can encourage people not to share things”. There should be a two-way education and skills transfer between HEAL staff and services such as NTAHC. At the time of interviewing the team were commencing brief intervention and motivational interviewing training. As a core aspect of their daily service provision, undergoing training was imperative. As outlined by a HEAL staff member;

“There is a little of the blind leading the blind here.... I think that it is just as important that our staff are trained up to talk about these issues. We have so much time available to staff driving people in the car and there is so much opportunity for discussions and interventions... if each person can weave in a conversation about violence, sex and sexual health.”

HEAL staff would benefit from undergoing basic training, for example in responding to sexual violence disclosures. Considering the junction between violence and SH and staff reluctance to broach these topics, services that specialise in sexual assault and violence need to become involved and collaborate to address this. In Darwin, these services could be for example the Sexual Assault Referral Centre (SARC) and Ruby Gaea.

Consistency and accuracy of SH and BBV messages are essential in empowering people with the knowledge to make informed decisions regarding their health (Commonwealth of Australia 2010b). Within the context of the Long Grass it is also crucial to have consistent staff members and services present in order to build continuity and rapport. As
a HEAL staff member said when I asked what they thought the crucial element of SH and BBV programs in the Long Grass should look like; “Really important to have consistent people and messages for example, having you guys [NTAHC] here is a really good thing... regularity is so good”. In theory this is good, however given the nature of the work and the issue of staff experiencing burn out, there is generally a relatively high level of staff turnover and consistency is not always feasible.

The Long Grass is a hub to Aboriginal people of diverse language groups, dialects and cultures. English is often a second, third or fourth language and many people have limited English literacy. This poses further challenges in service provision, as a staff member stated that he experienced various; “Difficulties with so many different languages”. Messages are also lost due to low health literacy and the inadequacy of health promotion in being relevant and reaching people who spend time in the Long Grass. For example a HEAL staff member outlined; “I think we can safely assume that health literacy is not great and people have low literacy in a violent environment.”

Staff expressed the importance of health messages being relevant, real and accessible. For example, in an interview a staff member stressed the importance of SH initiatives being directly relevant to daily survival in the Long Grass. She stated;

“I think if we can house the sexual health information within the sexual assault context I think that we will be doing a really good job. Because with the violence the majority of it is also alcohol related, you can assume that the majority of sexual violence is also alcohol related. Women’s sexual health in the Long Grass might be best to be about self-defence rather than condom use. Maybe it should be geared more towards ‘how do I know when I have an STI?’ and accessing HEAL for treatment and that there actually is treatment. Taking a harm reduction approach. We might not be able to decrease the incident of
rape but we might be able to help women respond if it does happen.”

Additionally, creating gender specific spaces was identified as being crucial in order to discuss taboo topics, such as SH and BBV. This was further recognised by a staff member in an interview as they stated;

“You need to create the right spaces and I think the women’s space in the arts space is good and needs to happen, but still this is not a natural way for things to happen in the Long Grass, separating men and women... in the Long Grass open space and outreach is for both genders. For us to start separating won’t necessarily be a positive reaction.”

A group of women at Arts in the Grass assisted in painting a Women’s Business banner to encourage and invite women to sit away from the main area to discuss gender specific topics. For example, one woman stated; “Women’s space is good for us. Away from men we talk health”. The women also identified SH, safety and sex as important topics for health education and that condoms needed to be readily available.

By developing an understanding of the SH and BBV situation in the Long Grass as perceived and experienced by HEAL staff, service provision can be better informed to meet the needs of people who spend time in the Long Grass. Effective aspects of service provision that have been identified throughout this section are considered by staff as essential in the Long Grass. Considering the challenges discussed by staff in the previous section of this treatise, support regarding the work they do and the personal challenges that they encounter should also be considered in an effective service delivery model.
Chapter Five – Conclusion
Through participant observation and interviews with HEAL staff the following emerging themes have been identified: a multitude of competing primary health concerns for people in the Long Grass which are constantly negotiated with daily survival; complexities in SH and BBV health associated with violence exist, and are largely unspoken due to shame, lack of staff training, skills and confidence, staff reluctance due to associated shame and a complex array of barriers to accessing mainstream services for people in the Long Grass. Further findings relate to the experiences and challenges faced by HEAL staff working in a hostile environment; and a reflection of service strengths and weaknesses within the Long Grass environment.

From the perspectives of HEAL staff and my observations the multitude of health issues faced by people in the Long Grass was the most significant challenge to health and wellbeing. Throughout the interviews staff stated that for people in the Long Grass, activities focused on day-to-day survival took precedent over addressing longer term health needs. Primary health concerns were; acute and untreated chronic illness, sexual and physical violence and assault, access to alcohol and food, loneliness, trauma, stigma, shame and disempowerment. These health concerns were further compounded by a range of barriers to service provision such as stigma and discrimination, lack of transport and mobility.

Although SH and BBV issues were not primarily raised in the interviews by HEAL staff, when prompted there were a number of consistent themes that emerged. From the experience of HEAL staff, SH and BBV issues exist within a complex array of primary health concerns associated with negotiating safety, sexual coercion and violence and addressing immediate daily needs within the Long Grass environment. Understanding the centrality of violence and stigma is imperative to addressing any specific health issue.
Despite staff reporting they had developed trusting relationships with people who spend time in the Long Grass, they identified initiating dialogue and interventions regarding sexual coercion, violence, STIs and BBV transmission as an ongoing challenge. This was mainly a result of an overall lack of confidence in knowledge of the topics specifically, and the cultural sensitivities associated with broaching these topics, such as shame. Staff identified SH and BBV topics as ‘taboo’ topics that should be broached by ‘expert services’. People in the Long Grass engaged in activities that put them at risk of STI and BBV transmission, for example; sharing of injecting equipment, fighting and blood exposure, sharing of razors and toothbrushes and sexual transmission. These risks were further compounded by lack of access to testing and treatment. This finding was supported by other studies, which found an overall lack of access to testing and treatment for Indigenous peoples in the NT (Merianos et al 2001; Plummer 2001) and more specifically for people in the Long Grass (Hermawan 2004).

Staff reported a range of challenges within their daily work and these were further observed in my fieldwork. The Long Grass in Darwin is a difficult environment to work outdoors, within an outreach model. The weather is often extremely hot and wet and there is very little shelter in the Long Grass. Staff also reported feeling isolated within the sector and were, at times, experiencing high stress or ‘burnout’. Staff relied on working autonomously within the outreach model and some staff reported feeling they had to ‘rely on their own intuition’. Whilst there are a number of strengths of the HEAL model identified by HEAL, a range of program ‘weaknesses’ were evident. Staff reported the holistic, flexible and responsive model of HEAL was effective in providing a relevant and highly accessible service, though limitations were clearly reflected in the challenges staff outlined.
Exploring the attitudes and experiences of staff who work in delivering health care programs has proven an important component in understanding the health care context. In the nexus between patient and service providers, understanding both patients and health workers' attitudes and experiences in the health system itself is vital to service improvement (Fisk et al. 1999). Exploring HEAL staff experiences and perspectives within critical comparison of my own observations and the literature, has provided a good understanding of how SH and BBV service provision exists within the Long Grass in Darwin.

The findings from this research project suggest that HEAL staff would benefit from mentoring and support to build partnerships and capacity alongside services, such as NTAHC, Ruby Gaea, Danila Dilba Aboriginal Health Service. Greater service collaboration could result in building the capacity of HEAL staff and up skilling services to work more appropriately and effectively within the worldview of people in the Long Grass. Findings from this study suggest that although HEAL staff are well situated to deliver health initiatives based on rapport, a holistic approach and accessibility; a range of inhibiting factors such as shame, high demand, lack of training, competing health concerns and a hostile working environment all contribute to issues such as SH and BBV remaining unaddressed. Although this study does not explore ways to address this junction, HEAL staff would benefit from consistent support by other services to provide outreach, build rapport and focus on SH and BBV programs. These should be holistic and address other health issues and associated shame and stigma.
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Appendix A –

Handout for discussions with HEAL staff
Handout for discussions with HEAL staff

Thank you very much for participating in this interview. I am conducting a research project on sexual health and blood borne viruses and how related health outcomes for people in the long grass can be improved. This project is part of a Masters of Public Health that I am completing at Menzies School of Health Research.

You are invited to participate in an informal discussion regarding the work that you do with the HEAL program and your experiences of working in the long grass. By signing the attached form, you are consenting to this discussion however, your participation is voluntary. If you do not wish to participate, you can stop this discussion at any time.

I will be recording the discussion on a Dictaphone. I will be the only one listening to the recording and some of the information will be used to inform the research project. If I use any specific information from this discussion in the write up of the thesis I will ask your permission first. The discussion should take approximately 30 minutes. I will transcribe the information from this interview and an electronic copy kept in a protected folder on my computer, which abides by NTahc’s confidentiality protocols and is security password protected. This will be securely stored electronically for a period of five years as required by the Australian Code for the Responsible Conduct of Research.

HEAL staff and volunteers will receive a copy of the outcomes of the study but if you would also like a copy of the transcription of this discussion then please contact me. All of my details are on the business card attached to this letter.

If you have any questions or complaints about this project please do not hesitate to contact myself on the below details or either of my supervisors Richard Chenhall 03 8344 0826 or Catherine Holmes on 0419 441 021. If you would like to make a comment or complaint please contact the Human Research Ethics Committee on Human Research Ethics Committee of the NT Department of Health & Families and Menzies School of Health Research 08 89222792.

Thank you for your time and assistance. I hope that this study helps to contribute to improving health outcomes and assisting in some of the work that your great program does.

Verity Slee
p: 8944 7777 f: 8944 7700 m: 0488 553 232
Appendix B –
Handout for discussions with HEAL staff
Handout for discussions with HEAL staff

I am conducting a research project on sexually transmitted infections and blood borne viruses and how services such as NTAHC can better understand and support services such as HEAL to improve STI & BBV related health outcomes for people in the long grass.

Today you are invited to participate in an informal discussion regarding the work that you do with the HEAL program and your experiences of working in the long grass. By signing the bottom of the page you are consenting to this discussion however, your participation is voluntary. If you do not wish to participate, you can stop this discussion at any time.

I am recording the discussion on a Dictaphone so I don’t have to take notes. I will be the only one listening to the recording and some of the information will be used to inform the research project. If I use any specific information from this discussion in the write up of the thesis I will ask your permission first. The discussion should take approximately 30-50 minutes. Although the discussion will be recorded and I am documenting who the discussion is with, your name will not appear at any stage in the write up of this study.

HEAL staff and volunteers will receive a copy of the outcomes of the study but if you would also like a copy of this discussion or even if you would like a copy of this letter please let me know. All of my details are on the business card attached to this letter.

Thank you for your time and assistance. I hope that this study helps to contribute to improving health outcomes and assisting in some of the work that your great program does.

Verity Slee

Please sign: ___________________________ Date: ___________________________

And print your name: ___________________________
Appendix C –

Questions for HEAL staff
Questions for HEAL staff
Larrakia Nation

1. Can you please outline your role in the HEAL Program?

2. Who are the people in the long grass that HEAL mainly work with? Are there groups that you engage with more often than some? Or groups you struggle to engage with for various reasons?

3. What are the main approach/priorities you see for the program? (explore approach to ‘homelessness’ that HEAL take).

4. In relation to health- what has been your experience in the long grass?

5. Is the HEAL program guided by specific health priorities? If so what are they?

6. Are you aware of health priorities of people in the long grass? What are they? Do you record them? (explore differences in LG and programs health priorities and reasons why)

7. Is sexual health a topic that is discussed with people in the long grass? How is it discussed? What are the problems you encounter in discussing it?

8. Is BBV issues that are discussed in the long grass?

9. How do you see best interventions to improve the STI/BBV related health in the long grass? How have you learnt about what works best?

10. What are best opportunities for health promotion and education in LG?

11. Any recommendations for this project?

12. What would you like HEAL/people in the long grass to benefit from this project?

13. What access do you have to training? Are there areas you would like more training in?