

# Jesuit Social Services Unequal in Health

*Standing in solidarity  
with those in need*



## OUR PURPOSE

*"To challenge the world to act justly,  
to deal respectfully with one another"*



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October 2001



## Preface

Access to comprehensive health services is one of the most important needs of Australians who experience social disadvantage.

This study by Emeritus Professor Tony Vinson maps how effectively it is occurring in the populations of the most disadvantaged postcodes in New South Wales and Victoria.

In 1999, the policy and research arm of Jesuit Social Services, *The Ignatius Centre*, mapped the distribution of social disadvantage in New South Wales and Victoria, on a postcode basis, using a range of medico-social indicators, in its paper *“Unequal In Life”*.

*“Unequal In Health”* compares the 50 most disadvantaged postcode areas in each state with the 50 postcodes that fell in the middle range from most to least disadvantaged, in relation to their access to comprehensive health provision.

The study assesses this level of health service by measuring the delivery of the Enhanced Primary Care Package in these areas, including the provision of Multidisciplinary Care Plans, Case Conferences and Health Assessments.

Socially and economically disadvantaged Australians generally exhibit more health problems and it is expected that General Practitioners would spend more time in consultation with such persons as a consequence.

This study, following up our earlier research on the distribution of social disadvantage, suggests that this is not occurring in many of the most socially disadvantaged areas, especially in Victoria. In particular, it found that extended standard consultations and case conferences were not being provided proportionate to social disadvantage in many of the most needy postcode areas.

Monitoring the provision of health care services to those who are the most socially disadvantaged in Australia is one of the most effective ways of assessing how, as a community, we respond to those in special need.

This study *“Unequal In Health”* identifies specific ways in which the health needs of socially disadvantaged Australians could be better addressed.

We present this report to health professionals, policy makers and the Federal and State Governments, at a time when many Australians are concerned about the growing gap between the rich and the poor. We need to address such issues, before serious social disadvantage becomes entrenched in Australian society.

*Father Peter Norden, S.J.*  
*Director, Jesuit Social Services*



## CONSULT THE REPORT “UNEQUAL IN LIFE”

- the landmark study which maps by postcode the distribution of social disadvantage in Victoria and New South Wales

<http://www.jss.org.au> (under publications)

*“Unequal in Life”* and *“Unequal in Health”* have been produced by **The Ignatius Centre**, the policy and research arm of Jesuit Social Services.

Situated in the inner-city Melbourne suburb of Richmond, **The Ignatius Centre** complements the community service programs of Jesuit Social Services with social action, advocacy and research, as a means of standing in solidarity with those in need.

Emeritus Professor Tony Vinson has had a long and distinguished career in education, government services, social research and community development. He was the Foundation Director of the New South Wales Bureau of Crime Statistics and Research (1971-76), the Foundation Professor of Behavioural Science in Medicine at the University of Newcastle (1976-79), the Chairman of the New South Wales Corrective Services Commission (1979-81) and Head of School and Dean of the Department of Social Work at the University of New South Wales, until his resignation from the University in 1997.

Professor Vinson was the author of the study by The Ignatius Centre, the policy and research arm of Jesuit Social Services, on the distribution of social disadvantage in Victoria and New South Wales (*Unequal in Life*, 1999: <http://www.jss.org.au>)

He is currently the Chair of the Public Education Inquiry in New South Wales.

# UNEQUAL IN HEALTH

Gorin (2001) has summarised the connection between health and social position in the following way:

*Regardless of the organ system or disease, how we measure socio-economic position, or when and where the study is conducted, there is an inverse relationship between socio-economic position and health.*

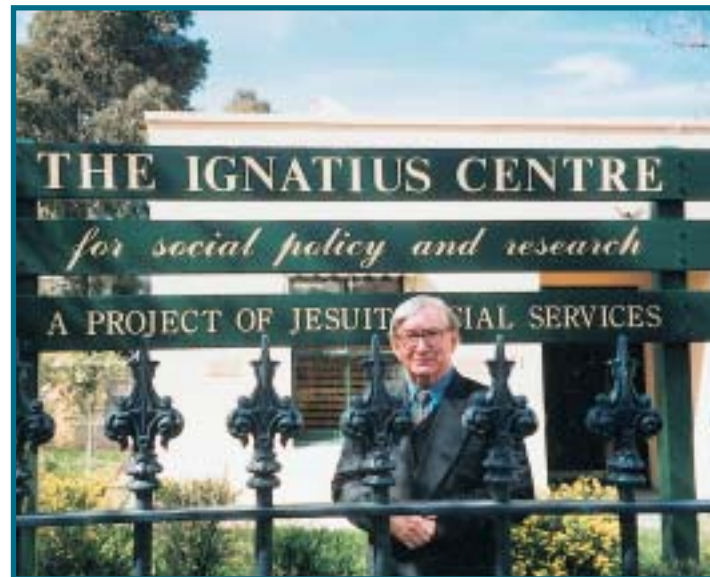
The World Health Organization's recent authoritative pronouncements concerning the *Social Determinants of Health* (1998) have been followed by similar Australian declarations. A report, *Action on health Inequalities Through General Practice II* (Centre for Health Equity Training Research and Evaluation, 2000), states that "There is now overwhelming evidence that social and economic factors are associated with poor health and that the gap between the most advantaged and disadvantaged groups in Australian society is widening. GPs are aware of the effects of social and economic disadvantage on health and are well placed to link their patients to other health and welfare services".<sup>1</sup>

The increasing recognition of the role played by socio-economic status (SES) in the occurrence of ill health opens the possibility of promoting greater social equity by means of targeted, preventative GP services. That possibility recently has been strengthened by the introduction in November 1999, of a range of new Medicare services as part of an Enhanced Primary Care (EPC) Package. The purpose of the change was to allow general practitioners to focus on preventative care for older people and to better coordinate care for people with chronic illness and multidisciplinary care needs "through a more flexible, efficient and responsive match between care recipients needs and services" (Royal Australian College of General Practitioners, Enhanced Primary Care: Fact Sheet, 2000). Three new Medicare items were introduced – *health assessments* (of people aged 75 years and older, 55 years in the case of Aboriginal and Torres Strait Islander people), *multidisciplinary care plans* and also *case conferences* (for people with chronic conditions and multidisciplinary care needs).

The new items were stated to represent a considerable change in the application of the Medicare scheme in clinical practice because they:

- "Provide the opportunity for the GP, in partnership with the patient, to focus on longitudinal, whole person care, including health promotion,
- Provide the opportunity for the GP, in partnership with the patient, to focus on care that is integrated with other health and community care providers,
- Allow for aspects of the health assessment items to be carried out by other health professionals supervised by the GP, and
- Allow for aspects of the care planning and case conferencing items to take place in the absence of the patient" (Enhanced Primary Care: Standards and guidelines for the enhanced Primary Care Medicare Benefits Schedule Items – hereafter referred to as EPC, 2000, – p. 1-2).

Apart from undertaking these activities in community settings, the new items were expected to encourage GPs



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to involve themselves more fully in the delivery of care in residential aged care services by contributing to a multidisciplinary care plan and participating in multidisciplinary case conferences. A publication of the Royal Australian College of General Practitioners, *Enhanced primary Care: Standards and Guidelines*, 2000, contains illustrative case studies of each of the three relevant services. These illustrations are reproduced in summary form in the appendix to this report.

From the point of view of promoting social equity via subsidised health services, the Enhanced Primary Care program has considerable potential if applied on a needs basis to areas of concentrated social disadvantage. The *health assessment* provides "A structured way of identifying problems and conditions that are potentially preventable or amenable to intervention in order to improve health and/or quality of life" (EPC, p.29). The assessment is to be made in the context of the patient's social and physical environment. There are no age restrictions on *care planning*, patients being required to have at least one chronic medical condition and multidisciplinary care needs involving at least two other health or community care providers. *Case conferences* usually involve immediate management plans and require the participation of a GP and at least two other health professionals or care providers. The aim is to identify and discuss the care goals of a patient with multidisciplinary care needs and to enable the GP to shift from short term, episodic, fragmented care to whole person care that is integrated with other health care providers (EPC, p.7). The provision of health assessments, care planning and case conferences attracts special fees.

Is the equity-promoting potential of the Enhanced Primary Care package being realised? It is necessary to pose that question because an existing body of research suggests that formidable attitudinal and other barriers might stand in the way of low SES groups benefiting from the new services. Recent Australian research indicates that while GPs are more likely to discuss preventative care topics with socio-economically disadvantaged patients than advantaged patients, they spend less time in consultation with the former even though they exhibit more health problems (Wiggins and Sanson-Fisher, 1997 (a) and (b)).

A 1996 meeting of Divisions of General Practice in New South Wales identified financial issues, such as the cost of consultations to address broader aspects of disadvantage, as a barrier to more adequate treatment of low SES patients (Lee, Harris, Powell Davies and Harris, 1996). *Action on Health Inequalities Through General Practice II* (2000) argues that it would be advantageous if patient histories routinely included societal risk factors but notes that this is seldom done in Australia, a practice attributed by Spencer (1996) to the perception of Australia as a classless society. According to Mathers (1994), low income Australians may make more frequent use of health services but are less likely to use preventative services, a finding that parallels the outcome of research conducted 25 years ago in Newcastle (Vinson, Homel and Bonney, 1976).

Patients' orientation to 'here and now' problems, and doctors' limited ability in the past to respond to the comprehensive medico-social needs of disadvantaged patients, indicates the advisability of monitoring the social reach of the new package of enhanced primary care services. That is the aim of the present study.

#### Method

In 1999, Jesuit Social Services undertook a study of the distribution of cumulative social disadvantage throughout Victoria and New South Wales (*Unequal in Life*, Vinson). The study was based on a range of medico-social indicators, some of which were derived from departmental and organisational records (for example, child abuse, court convictions, low birth weight, emergency assistance and child injuries), and others were derived from census data (for example, unemployment, long-term unemployment, early termination of schooling, low income and unskilled workers). The unit of counting was postcode area – there were approximately 600 in each state – with rates for each indicator being calculated using the appropriate population base. Finally, each postcode was assigned a general disadvantage score based on the results of a principal components analysis of the data. This meant that the postcodes could be ordered in an array, ranging from the least to the most disadvantaged.

The present study is based on comparisons between the 30 most disadvantaged postcode areas in each state and the 30 postcodes that occurred in the middle of the range from most to least disadvantaged.<sup>1</sup> The rates of provision of the three services that comprise the Enhanced Primary Care Package (*Multidisciplinary Care Plans, Case Conferences and Health Assessments*) were compared during an eighteen months period (November, 1999 to April, 2001). In addition, lest focusing on the pattern of provision of these services failed to take account of detailed attention provided to residents of the disadvantaged and 'middling' disadvantaged areas by way of extended standard GP consultations, information concerning the latter was included. Data on all four comparisons, obtained from the Health Insurance Commission, appears in the Results section, below. The number of instances of each type of service is expressed as a rate per 10,000 of population, the base population for each of the comparison groups being as follows:

#### Population totals

	Total	Non-Aboriginal 75 years +	Aboriginal 55 years +
NSW – 30 most disadvantaged postcodes	61,319	3,650	392
NSW – 30 'middling' postcodes	395,085	16,300	414
Vic – 30 most disadvantaged postcodes	239,104	11,449	169
Vic – 30 'middling' postcodes	168,296	7,993	57

The base populations for the *Health Assessment* comparisons were comparatively smaller because of the age and Aboriginality requirements.

## RESULTS

#### Multidisciplinary Care Plans

The pattern of provision of Multidisciplinary Care Plans within the most disadvantaged and 'middling' disadvantaged areas was similar in both states. In New South Wales the rate of provision per 10,000 of population was 1.4 times that of the comparison areas and the difference was statistically significant ( $p < .001$ , Chi-square *goodness-of-fit* test). In Victoria, the ratio was slightly higher (1.7:1,  $p < .001$ ):#

Table 1: Multidisciplinary care plans x comparison groups

	Total	Rate per 10,000
NSW disadvantaged postcodes	145	23.65
NSW 'middling' postcodes	647	16.38
Vic disadvantaged postcodes	270	11.29
Vic 'middling' postcodes	115	6.83

#### Case Conferences

The pattern of provision of case conferences within disadvantaged and 'middling' disadvantaged areas was different in the two states. In New South Wales the concentration of these services within disadvantaged areas was most striking, the rate being four times higher than in 'middling' areas ( $p < .001$ ). The pattern was reversed in Victoria where the rate of service in the 'middling' areas was 1.5 times that provided within the most disadvantaged locations ( $p < .01$ ):

Table 2: Case Conferences x comparison groups

	Total	Rate per 10,000
NSW disadvantaged postcodes	59	9.62
NSW 'middling' postcodes	96	2.43
Vic disadvantaged postcodes	70	2.93
Vic 'middling' postcodes	78	4.63

#### Standard Consultations (extended)

There was the possibility that higher rate of case conferences within the 'middling' disadvantage postcodes noted immediately above, was offset by the disadvantaged areas receiving more extended standard consultations (of 40 minutes

duration or longer). Unfortunately, the opposite proved to be the case: people living in the 'middling' areas were 1.2 times more likely to benefit from extended consultations ( $p < .001$ ). In New South Wales the previously noted pattern of less well off residents receiving higher levels of care was sustained. People living in the disadvantaged areas were 1.6 times more likely to receive extended consultations ( $p < .001$ ):

Table 3: Extended standard consultations x comparison groups

	Total	Rate per 10,000
NSW disadvantaged postcodes	5,488	894.99
NSW 'middling' postcodes	22,218	562.36
Vic disadvantaged postcodes	14,604	610.78
Vic 'middling' postcodes	11,772	699.48

### Health Assessments

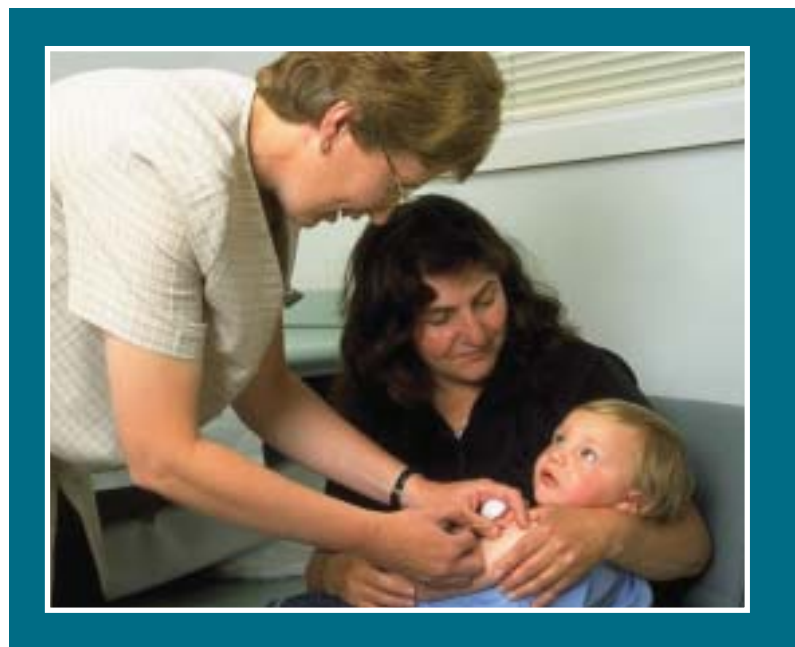
Two groups of people are eligible for Health Assessments, non-Indigenous members of the community aged seventy-five years and over, and Aboriginal and Torres Strait Islanders (ATSI) aged fifty-five years and over. In order to calculate the extent to which these groups have benefited from the health assessment package, it was necessary to extract the relevant population counts from census data. The most recent data available for calculating the number of aging ATSI and non-Indigenous residents in the 30 disadvantaged and 'middling' disadvantaged postcode areas in New South Wales and Victoria is now dated so that the figures used for our calculations are estimates. However, given our intention of comparing the take-up rates for the enhanced primary care package at two broadly contrasting points along the continuum of social disadvantage, the available population data is adequate for our purposes. It must, however, be noted that the figures for the ATSI group are quite small so that the results must be interpreted cautiously.

Given the susceptibility to health problems of the two age groups concerned, and the relatively small numbers of people involved, it is not surprising that the overall health assessment take-up rates were high compared with the other components of the enhanced primary care package. The focal interest in this instance remains the comparison of results for the disadvantaged and 'middling' disadvantaged localities in both states. In New South Wales the rate with respect to older non-Indigenous people in the 30 most disadvantaged postcode areas was 1.7 times greater than in the 30 comparison areas ( $p < .001$ ). In Victoria the rate within the most disadvantaged localities was 1.25 times higher than in the comparison areas ( $p < .001$ ):

Table 4: Older non-Indigenous health assessments x comparison groups

	Total	Rate per 10,000
NSW disadvantaged postcodes	529	1449.32
NSW 'middling' postcodes	1389	852.15
Vic disadvantaged postcodes	1226	1070.84
Vic 'middling' postcodes	686	858.25

With respect to health assessments among ATSI people over 55 years of age, the pattern was less clear-cut, at least in Victoria. On the evidence of the small numbers involved in



that state, there was virtually no difference between the take up rate in the disadvantaged and 'middling' disadvantaged localities. However, the rate of health assessments within the disadvantaged postcodes of New South Wales was 1.8 times that of the comparison localities ( $p < .05$ ):

### COMMENT

Three Enhanced Primary Care services, Multidisciplinary Care Plans, Case Conferences, and Health Assessments, have been examined from the point of view of their availability to people living in locations in Victoria and New South Wales that have been shown to be highly socially disadvantaged. To put the findings in perspective, a comparison has been made between the number of times that each of the recently introduced services was made available to residents in disadvantaged areas and the residents of areas standing mid-way along the disadvantage/social advantage continuum.

If one of the purposes of the Enhanced Primary Care package is to increase the availability of health services to vulnerable communities, then the scheme is enjoying some success in New South Wales but its performance in Victoria is patchy. In both states there is a higher rate of Multidisciplinary Care Planning and those Health Assessments made of aging non-Indigenous people living in disadvantaged areas. On the other hand, among residents of Victoria's most disadvantaged postcodes the rates for Case Conferences and Extended Standard Consultations were significantly below those of the residents of comparison areas, and Health Assessments for Aboriginal and Torres Strait Islander people were at the same level as the comparison areas. In all of the above comparisons in New South Wales, the rates for residents of disadvantaged areas were higher than their counterparts in areas of 'middling' disadvantage.

Data published by the Commonwealth Department of Health and Aged Care (2001) provides estimated take-up rates for Enhanced Primary Care for Divisions of General Practice (DGPs) during the period 1 July, 2000-30 June, 2001. This information provides a rough check on the reasonableness of the foregoing analysis of the data provided by the Health Insurance Commission.

In making comparisons between the two sets of information it must be remembered that we have defined the disadvantage score of different postcode areas in a particular way and have accepted the fact that poverty, so defined, is differently distributed in Victoria and New South Wales.

One third of the 'top 30' disadvantaged areas in NSW are in the Hunter Valley and many are on the upper North Coast and Northern Rivers areas (embracing the Hunter Urban and Hunter Rural, Tweed Valley, Mid North Coast and Northern Rivers Divisions of General Practice), as well as the DGP of Barwon. Thirteen of the 38 DGPs in NSW had a relatively high *take-up* score of 50+. Both Hunter areas were in the list of thirteen, Hunter Urban (with five postcodes within the top ranking 17 disadvantaged areas in the state, including ranks 1, 8, 13 and 14) having the fourth highest take-up score, Barwon had five of the most disadvantaged areas, the Tweed Valley (with two top ranking areas of disadvantage) had the third highest take-up score, Mid North Coast (with three top ranking areas of disadvantage) the sixth highest, and Northern Rivers (two areas of concentrated disadvantage) also appearing among the 13 DGPs with the highest take-up scores.

The New England DGP (which had the second highest take-up rate) included another of the top 30 disadvantaged areas, as also did the Wagga Wagga DGP. Within the Sydney Metropolitan Area, unlike the situation in Melbourne, there were just two highly disadvantaged areas and these are located within DGPs with relatively low take-up scores.

The foregoing comparisons take us to this point: of the 38 New South Wales Divisions of General Practice, the 13 with take-up rates in excess of 50 accounted for five out of six of the top 30 disadvantaged areas in that state. A majority of the postcode areas with high cumulative disadvantage scores within New South Wales lie outside of the major metropolitan areas of Sydney, Newcastle and Wollongong. On the evidence presented in this report, and the supplementary evidence of take-up rates within DGPs, these areas are attracting a relatively higher *per capita* share of services provided under the Enhanced Primary Care package than areas of *moderate* disadvantage, consistent with an equitable distribution of these services.



In the case of Victoria, 18 of the 31 DGPs have take-up scores in excess of 50. Six of the 18 have scores of 60+ and apart from Central Bayside (66) the remaining five lie well outside the Melbourne Metropolitan Area. The non-metropolitan divisions had uniformly higher take-up rates, only three of 17 DGPs having rates below 50, compared with ten of the 14 metropolitan DGPs. Take-up scores were comparatively low in the west, north and inner southeast of Melbourne (ranging from 32 to 40).

How did this distribution of take-up rates compare with the distribution of socially disadvantaged postcodes? It is true that seven of the 30 most disadvantaged locations were within Metropolitan Melbourne and six were within the band of low scoring western, northern and inner southeastern DGPs. The remaining 23 were spread throughout non-metropolitan areas where, as noted, take-up scores were generally higher but selectively less so for the more disadvantaged areas. For example, one non-metropolitan DGP with a relatively low take-up rate of 48 was Central West Gippsland and this region contained seven of the 30 disadvantaged postcodes.

## CONCLUSION

Consideration of the data for the distribution of Enhanced Primary Care across Divisions of General Practice generally supports the conclusions drawn from our analysis of the information provided by the Health Insurance Commission. Enhanced Primary Care measures and Extended Standard Consultations appear to be more successfully directed to poorer communities in New South Wales than in Victoria. It is possible that the level of service extended to the disadvantaged in New South Wales should be even greater but a first step is to at least ensure that equity-promoting health services in Victoria more readily reach those with the greatest need of them.

## APPENDIX

### ILLUSTRATIVE CASE STUDIES

*Summarised from: The Royal Australian College of General Practitioners, 2000, Enhanced Primary Care, South Melbourne)*

#### Case Conferencing

Mrs Barbara M is a 68 year-old patient with type II diabetes who presents to Dr Sellars for a routine review. Dr Sellars last saw Barbara six months ago. Last week he arranged for follow up blood tests and today he reviews these with Barbara. Dr Sellars is aware that Barbara is the sole carer for her husband, Ron, who has dementia. Barbara tells Dr Sellars that Ron has recently become more dependent on her for his day-to-day needs, such as personal hygiene, showering, toileting and assistance with feeding. This has meant that she has been unable to leave the house as often as she would like. She has been unable to take part in her walking group, and has not been able to purchase more glucose monitoring strips for her meter. She admits that the home situation has created more stress for her, especially as her two children live two hours away. Barbara has been buying food from the corner shop for convenience, rather than cooking her own meals. Dr Sellars recommends to Barbara that he convene a case conference with a diabetes educator and a social worker to discuss her needs and work out the best way to help her. He tells Barbara that she would be welcome to attend. Among the other measures taken, the social worker refers Barbara to the Carer Respite Centre to arrange home-based respite care for Ron, so that Barbara can have time to do her shopping, banking and walking...

### Health Assessment

Mrs Joan P. is a 78 year-old widow with hypertension who comes to see her GP, Dr Lau, for her regular blood pressure check. She has been attending Dr Lau for the past two years, since she moved into the area to be nearer her son and grandchildren. She does not suffer from any other illnesses but is cautious about her blood pressure as her husband died from a stroke three years ago. She lives independently, about 3km from her son and his family.

When Dr Lau sees her on this occasion, she suggests that it would be valuable to conduct a health assessment with Joan. She explains that the purpose of a health assessment is to conduct an annual in-depth assessment, covering not only medical and physical health, but also psychological and social aspects of health. Dr Lau explains that her practice nurse will perform some parts of the health assessment. Dr Lau explains that she will be bulkbilling Joan for this service. She also informs Joan that at the end of the assessment she will explain her findings and recommendations to her.

Joan reports that her health is generally very good. Dr Lau checks for alcohol and smoking, and finds that Joan is drinking 2-3 standard drinks per day, and currently smokes 15 cigarettes /day but wishes to quit. Joan does not engage in regular exercise. Joan scores poorly on a nutrition scale. Dr Lau asks about social support and finds that Joan does not have as much social support as she would like. Joan feels out of touch with her family and friends and is dissatisfied with her relationships. Joan indicates that she has been moderately bothered by feeling downhearted.

Dr Lau also visits Joan's home, partly to assess safety around the house, but also to complete the medication review. Dr Lau outlines the results of the health assessment to Joan and suggests an action plan...

### Care planning

Jack N is a 39 year-old man of Aboriginal descent, and an infrequent attender, who visits Dr Johnson at the Aboriginal Community Controlled Health Service (ACCHS) for a repeat prescription for his anti-hypertensive medication. She notes that his medical problems include:

- Non-insulin dependent diabetes;
- Obesity;
- Hypertension; and
- Chronic renal failure.

She checks Jack's blood pressure and weight before arranging for some blood tests and renewing his prescription. She recognises that Jack requires multidisciplinary care for his chronic medical conditions and considers he would benefit from having his care coordinated through a care plan. Jack agrees to the care plan and wants to take advantage of his visit to start the care plan straight away. Together, Jack and Dr Johnson identify lack of reliable transport to the ACCHS and other health providers as a major factor preventing him from attending the health service and having regular medical checks and repeat prescriptions. Dr Johnson performs a biopsychosocial assessment. She finds that Jack feels that his family and community support him, but that he has dependent children and financial problems, with little money left for healthy foods. Dr Johnson and Jack identify Jack's health care needs and goals. Dr Johnson contacts the other contributors to the care plan and discusses their willingness and availability to provide the services...

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<sup>1</sup> The use of middle range postcodes was considered to be more realistic than comparisons involving the most advantaged areas.

## Jesuit Social Services: Program Centres

### CONNEXIONS

4 Derby Street, Collingwood  
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An innovative and unique program for young people with mental health and problematic drug use issues ... engaging alienated young people in a relationship of trust and understanding.

### THE BROSAN CENTRE

10 Dawson Street, Brunswick  
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16 The Vacluse, Richmond  
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Preventing truancy and the onset of drug use in vulnerable young people by providing specially selected, trained and supervised mentors who maintain a relationship of trust and support, and an important stabilising influence during a critical period of a young person's life.

### COMMUNITIES TOGETHER

P.O. Box 468, Richmond  
Telephone: 03 9427 9899

Building stronger neighbourhood networks and resident associations within the high rise housing estates of North Richmond, Collingwood and Fitzroy. Supporting vulnerable families from a range of different ethnic backgrounds in local neighbourhoods that have been heavily influenced by the drug culture.

### VIETNAMESE WELFARE RESOURCE CENTRE

58 Holland Court, Flemington  
Telephone: 03 9376 2033

A multi service agency, located within the Flemington high rise housing commission estate, providing assistance to Vietnamese families in the northern and western region of Melbourne, focusing particularly on domestic violence, and problems associated with gambling and drug use.

### THE OUTDOOR EXPERIENCE

4 Derby Street, Collingwood  
Telephone: 03 9415 7121

A therapeutic outdoor program for young people at risk of, or experiencing, drug and alcohol related difficulties. Highly trained and experienced staff involve young people on extended journeys in wilderness areas, combining support workers and a multi-disciplinary team who help facilitate lasting change in young people's lives.

### THE YOUTH GROW GARDEN

22 Bellevue Street, Richmond  
Telephone: 03 9427 1305

A horticultural and landscape gardening program providing workplace training to long-term unemployed young people affected by multiple disabilities, including drug misuse. The community living skills program provides a range of educational, vocational and recreational strategies to improve the quality of life of the participants.

### PARENTING AUSTRALIA

4 Derby Street, Collingwood  
Telephone: 03 9415 7186

A training and consultancy service for parents, professionals and service providers, raising self-esteem skills and building hope and resilience within families across Australia. Parenting Australia has conducted four national conferences on parenting issues, and has recently completed a national parent training program under the National Youth Suicide Prevention Strategy.

### THE IGNATIUS CENTRE

371 Church Street, Richmond  
Telephone: 03 9427 7388

The centre for social policy, public advocacy and social research for Jesuit Social Services, addressing issues of wider community concern emanating from our direct service provision. Our recent initiatives have included a study of the geographical distribution of social disadvantage, and work towards a more just policy in relation to drug misuse, mental illness and the criminal justice system.

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