



# **PHV First Progress Report to the Minister for Health and Wellbeing 2023**

## **Supporting System Listening**

## Background

Access to inclusive, high-quality health services is critical to the wellbeing of all South Australians. The participation of health system users in policy and practice improvement is central to ensuring this access, allowing community perspectives to guide responsive, patient-centred health reform.

The closure of the Health Consumers' Alliance of South Australia in 2020 left South Australia without an independent platform for health consumer advocacy. Since this time, SA has been the only Australian state without a structured, independent mechanism for including community concerns and priorities in health system improvement processes.

In 2022, the Malinauskas Labor government provided an \$800,000 grant over four years to the South Australian Council of Social Service (SACOSS) to establish a People's Health Voice with a view to addressing this gap in community-driven health system participation. The government announced the initiative as an important opportunity to ensure that measures aimed at improving the safety and quality of healthcare systems and services are guided by lived experience and oriented to the provision of patient-centred care.

Along with SACOSS, the government emphasised the importance of including the voices of diverse and marginalised communities in the design of the People's Health Voice mechanism. It was agreed that the new platform should place a central focus on health equity, and be co-designed with community interest groups whose members have lived experience of what works well and of the barriers to health access and inclusion, and who are best-placed to contribute informed suggestions about how the health system might better meet the needs of all sectors of our society.

## Launch

The People's Health Voice project was launched at SACOSS on the 3<sup>rd</sup> of March 2023 by Health Minister Chris Picton. In his launch address, the Minister outlined the important role of community participation in improving the safety, quality and responsiveness of healthcare systems, and the opportunity afforded by the People's Health Voice project to amplify the needs and perspectives of marginalised South Australians in processes of health system reform.

Introducing the project, Dr Toby Freeman presented findings of research, supported by SACOSS, that formed the basis of the People's Health Voice initiative. He explained that the 2020 closure of the Health Consumers' Alliance left gaps in terms of state-wide



Health Minister Chris Picton at the People's Health Voice launch with speakers Dr Toby Freeman (Stretton Institute), Ellie Hodges (LELAN), Jala Burton (disability advocate) and A/Prof. Natasha Howard (SAHMRI) and SACOSS staff

health advocacy, and that a new mechanism is needed to identify and communicate community perspectives on the quality, inclusivity and responsiveness of South Australian health provision.

Launch attendees from across the health, community and advocacy sectors engaged in thoughtful discussion around their aspirations for the People’s Health Voice, understanding its establishment to represent an important opportunity to embed and sustain a systematic focus on equity and participation in South Australian health system improvement processes.

## Project management and governance

An internal project management group for the People’s Health Voice (PHV) was established at SACOSS in line with the project launch. This group, comprising Director of Policy and Advocacy Dr Rebecca Tooher, Senior Policy Officer Sue Tilley and Senior Project Officer Dr Katherine Hodgetts, will manage day-to-day project operations and lead a community co-design process to develop a proposed structure and function for the People’s Health Voice.

A Co-Design Methodology Group comprising experts in co-design and the social determinants of health has also been established to provide guidance around engagement methodology.

### Co-Design Methodology Expert Group

#### Panel of health equity and codesign experts including:

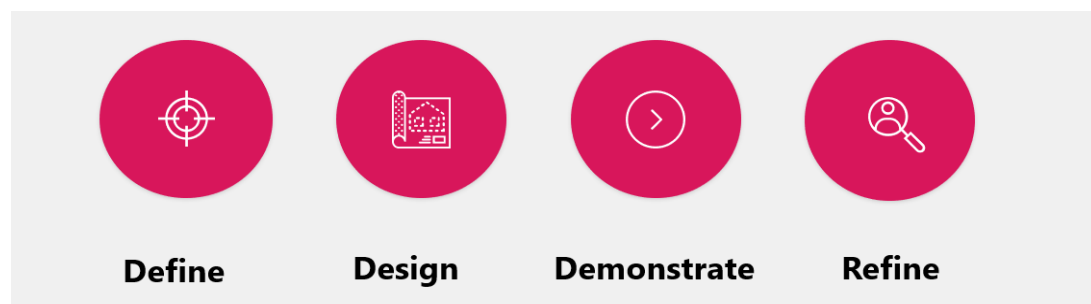
**Prof. Jennie Popay** (Professor of Sociology, Lancaster University and Chief Investigator on ‘Communities in Control’ place-based health equity program)

**Dr Toby Freeman** (Stretton Health Equity, University of Adelaide)

**Dr Jackie Street** (University of Adelaide, deliberative community engagement specialist)

## Co-design approach to developing a People’s Health Voice

To scaffold an inclusive, collaborative and effective process for the establishment of the PHV, the SACOSS project management team drew upon the principles of co-design. Co-design methodology actively works to involve ‘the people who are closest to the solutions’, providing a structured process in which lived experience can guide community responses to complex issues. The co-design framework for the development of a PHV will move systematically through the following phases:



Structured around this co-design process, this next section of the report sets out the phases of the PHV project over the four years.

### **PHASE ONE (YEAR ONE: October 2022 - October 2023)**

#### **'DEFINE'**

In this phase of the project, the project team will engage with members of 13 focus communities including First Nations groups, people living with disability, LGBTIQ+ communities, people with experience of family violence, people who have been incarcerated, carers, young people, seniors, people living in poverty, culturally and linguistically diverse communities, regional/rural communities, people living with mental distress, and experienced health consumer representatives.

In engaging with each community we will seek to:

- map current and emerging health concerns
- identify issues affecting health system accessibility and responsiveness
- define engagement principles and preferred mode/rhythms of working to guide the subsequent co-design process for the People's Health Voice

### **PHASE TWO (YEAR TWO: October 2023 - October 2024)**

#### **'DESIGN'**

This phase will begin with a combined community forum, in which members of focus communities will be invited to discuss and reflect upon the outcomes of Phase 1. Particular attention will be paid to shared accessibility/inclusion issues, as well as distinct impacts of the social determinants of health. At this forum, focus community members will also be asked to decide how they wish to be represented on the co-design group (a smaller group of participants responsible for drafting a proposed structure and function for the People's Health Voice).

The co-design group will then enter a facilitated process in which they will be asked to consider a range of existing models of health participation and to design the structure and function of a People's Health Voice mechanism for South Australia

### **PHASE THREE (YEAR THREE: October 2024 - October 2025)**

#### **'DEMONSTRATE'**

This phase will involve (at least) two community participation events in which the People's Health Voice mechanism proposed by the co-design group will be demonstrated. After each demonstration, a review process will be undertaken in which participants will be asked to provide feedback on both outcomes and process.

### **PHASE FOUR (YEAR FOUR: October 2025 – June 2026)**

#### **'REFINE'**

In the final project phase, SACOSS will facilitate combined consultations between focus communities and SA Health personnel to design an approach to ensuring the People's Health Voice is sustainable, embedded into health system decision-points, and an inclusive means of translating community participation into improvements in equitable health outcomes.

## Phase 1 Activity: Community Engagement

Overview of engagement undertaken since project launch (March – June 2023)

Focus community	Perspectives included	Engagement mode	No. of participants
LGBTIQA+ communities	Trans Femme community (young people, parents, allied health provider)	Focus group	9
	Trans Masc community (young people and peer mentors)	Focus group	10
	Trans-specialising mental health professionals	Interview	2
	LGBTIQA+ advocacy organisations	Discussion with leadership representatives	3
			(24)
Culturally and linguistically diverse communities	Members of SA CALD communities, including current/former translators, health workforce members)	Workshop	19
	Peak body leader	Interview	1
			(20)
Seniors	SA branch leaders of national advocacy group	Meeting	12
	Community development personnel across 3 Local Government Areas	Meeting	5
	Rural aged care provider representative	Interview	1
			(18)
Experienced health consumer representatives	Members of health consumer network (HCAN SA)	Workshop	18
	Health consumer leaders (other)	Interview	2
			(20)
Aboriginal and Torres Strait Islander communities	First Nations Health Advocacy Leaders	Meeting	2
<b>TOTAL</b>			<b>84</b>

## Further engagement scheduled for July/August 2023

Focus community	Perspectives included	Engagement mode
Carers	Unpaid carers connected through Carers SA	Focus group
People with lived experience of mental health distress	Initial discussions have been undertaken with the Rural Expert by Experience team, with a view to setting up rural engagement processes	Focus groups, interviews
People living with disability	Planned engagement with groups of young and older people living with intellectual disability	Workshops
People living in poverty	Anti-Poverty network representatives	Interview
Young people	Women's and Children's Hospital Network Director Consumer and Community Engagement	Meeting
LGBTIQ+ seniors	Council on the Ageing SA (COTA) Rainbow Hub	Focus group

### Other engagement planned

Engagement opportunities will be pursued to seek a range of additional perspectives across all 13 focus communities including those not mentioned above, such as, people with experience of family violence; people who have been incarcerated; people living in rural and regional SA.

## Community reflections on current – and potential – mechanisms for health system participation

Phase 1 engagement to date has involved discussion with focus communities (most extensively with members of culturally and linguistically diverse communities, trans and gender diverse communities, seniors and experienced health consumer representatives). Insights drawn from these engagements are outlined below, foregrounding

- the development of principles to underpin meaningful, effective and inclusive community health participation (which, when consensus is reached across focus communities, will guide the co-design process for the People's Health Voice) and,
- the identification of issues affecting health system accessibility and responsiveness for each community (which will inform potential focus issues for the demonstration of the proposed People's Health Voice mechanism generated via co-design).

### Setting the terms of engagement with health consumer representatives

Experienced health consumer representatives from the Health CAN SA network indicated that they deeply value opportunities to participate in SA Health processes as members of advisory groups, on health consumer panels and in roles within governance structures. They noted a preference for health system engagement in which collaboration is welcomed at all levels, including in decision-making around:

- the areas of practice and policy in which consumer participation is deemed to be relevant

- the manner in which participants are invited to contribute
- available modes and timeframes for participation
- the use to which participation outcomes are put, and the weight these are given in guiding decisions around system reform and improvement.

Consumer representatives suggested that the impact of their contributions can be constrained when their participation is limited to specific forms of consultation or feedback on system-determined processes and priorities. Indeed, representatives communicated the desire for involvement in higher-level decision-making around the focus, prioritisation, design and evaluation of health initiatives and reform. They indicated that involvement at each of these junctures would support health systems to be both responsive and accountable to community-raised concerns.

Likewise, representatives suggested that involvement in deciding *how* community members might voice health concerns could enhance inclusive, meaningful and effective engagement in system improvement. For example, we heard that current participation options often emphasise online registration, in-person meeting attendance, pre-reading requirements, continual communication and a considerable commitment of time – all of which can be barriers to those with limited English proficiency, digital access and literacy, transport options and flexible daytime hours. Options to contribute to the design of accessible health participation *modes* could support a broader range of community members to contribute more equitably and more fruitfully.

### **Meeting people where they are (understanding community-preferred health-seeking/help-seeking information channels)**

Beyond experienced health consumers, members of our focus communities indicated low levels of awareness of existing mechanisms for health system participation and/or the management of feedback and complaints.

When example mechanisms were raised and discussed, community members noted an assumption within them that those wishing to support reform or express a grievance will seek out system-provided channels to raise their concerns. However, they suggested that this expectation may not always be appropriate. In some contexts, it may be unrealistic to expect individuals to approach a system by which they feel intimidated or excluded. In others, raising an individual, formal complaint may be at odds with preferred collaborative, community-based approaches to health service navigation and help-seeking. Consultation with trans and gender diverse communities also raised the pervasive experience of feeling “constantly responsible for educating health providers about our issues” – and the notion that a health system committed to understanding and addressing their needs would approach *them* in a “spirit of support” rather than placing on them the weight of additional instructive responsibility.

The emerging notion that participation processes should ‘meet people where they are’ highlights the importance of engaging proactively and supportively with communities – and community organisations – to scaffold the accessibility of health participation avenues.

### **Assumed interpersonal and bureaucratic ‘know how’**

Discussion with our focus communities identified concern that existing avenues for health participation rely upon assumed interpersonal and bureaucratic skills. The perception that engagement with SA Health requires a) understanding of health system hierarchies, conventions and

terminology, and b) capacity to engage in conventional or online meeting arrangements (perceived to provide little scope for differentials in communication skills/preferences, literacy, attention, and interpersonal confidence) were identified as significant barriers.

### **Commitment of time and emotional labour**

Community participation in health system improvement generally involves reflecting upon, and sharing, lived experience of health system interactions. Throughout our consultations we heard that this can involve a significant emotional burden and acceptance of vulnerability, particularly for those experiencing additional layers of disadvantage.

Experienced consumer representatives reported appreciation that they are acknowledged and remunerated via sitting fees when they are engaged to provide expertise to SA Health. Nonetheless, they suggested that additional supports are often required to ensure all potential participant groups feel safe, confident that they will remain the authors of their own experience (trusting their stories will not be disseminated out of context or put to unanticipated uses), and convinced that the burden of sharing their experience will contribute to visible and meaningful change.

The fact that health system participation takes considerable time and energy – which people facing complex health issues often have in short supply – was identified as a significant barrier to engagement. Indeed, we heard that perceptions of SA Health processes as onerous and bureaucratic can lead motivated health advocates to direct their personal resources to activities outside the system that they believe will more directly and meaningfully improve the wellbeing of their communities.

*“I wouldn’t understand [SA Health] committees. But we share our experiences at our branch, and that way we can help each other” (senior)*

### **Sensitivities involved in providing critique**

Among many communities, voicing complaints about healthcare practice and providers is a particularly sensitive issue. For some groups, cultural expectations around deference to professional providers, and associations between criticism and shame, can make participation in explicitly improvement-oriented initiatives complex. For others, reliance on health systems and professionals for access to desired services brings with it reluctance to risk raising critique. Consultation with our focus communities highlighted the importance of providing participation opportunities that attend to the power dynamics involved in framing participation objectives, assembling participant groups, and communicating participation outcomes.

*“You wouldn’t want to complain or be annoying. It’s hard enough without getting in your own way” (trans community member)*

### **The importance of ‘warm referral’**

Members of each focus community identified the importance of a ‘warm referral’ in scaffolding engagement in participation opportunities. Individuals in each group reported that they were more likely to participate when an invitation is made by someone they know and trust, or with whom they feel a sense of mutual accountability grounded in shared experience. Individuals who indicated they would never “sign up to an unknown committee” explained that they would welcome opportunities to participate in health system engagement in collaboration with existing networks.

*“When [community organisation] sends health information around or have talks you can go to I always try to be involved because they know what’s useful for us, and we can talk about it together” (CALD community member)*

This insight reflects the important role played by community organisations in building and maintaining the consistent relationships that can facilitate health system engagement.

### **An individualised approach**

From members of culturally and linguistically diverse communities, we heard that it can be uncomfortable to be asked to speak on behalf of others, or to ‘represent’ a unified community position or perspective. Indeed, deference to the diversity of experience and perspectives within cultural groups can be an important mark of respect. Health engagement processes that require individual contributions or representation can therefore underplay the inherently relational nature of healthcare decision-making for many people, and may not make space for preferred modes of collective sense-making and communication around health concerns.

## Issues of health system accessibility and responsiveness: Emerging community perspectives

### Culturally and linguistically diverse communities



Members of culturally and linguistically diverse communities map health access barriers – PHV Workshop May, 2023

Consultation with members of culturally and linguistically diverse communities in SA identified issues of language and translation as key issues influencing health system access, inclusion and responsiveness.

*“The doctor got really angry because the interpreter was taking a long time to translate what that doctor said in just one sentence. The thing is – the interpreter had to explain the whole idea of the treatment, not just the words, because I never heard of this thing before” (CALD community member)*

In acute care settings, workshop participants reported that problems can arise when patients are provided with translators who:

- do not speak the patient’s dialect, giving rise to miscommunication, confusion and lengthy appointment times
- do not possess the understanding of health processes and terminology required to communicate complex medical information
- are inaccessible during time-critical presentations (e.g. in emergency and labour settings)
- are of an age or gender that makes interaction with the patient uncomfortable or inappropriate
- are known to the patient (a circumstance likely within particularly small communities), raising issues of privacy and confidentiality, or
- overlay medical communication with religious, gendered or other cultural perspectives that may influence patient decision-making.

Participants suggested that protocols restricting patients’ family members from providing translation can be distressing, and are unresponsive to the needs of those from cultures in which shared decision-making is preferred over processes privileging individual patient autonomy.

In primary care contexts, participants reported that difficulty communicating with care providers and administrative staff can affect patients’ ability to make and keep appointments, and to navigate follow-up care. Translation services are not widely available in general practice settings, which has cost implications for patients who must book and pay for long appointments to allow time to manage communication difficulties. To avoid this, participants reported that many members of CALD communities travel long distances to consult GPs who speak their language, and suggested that supporting international doctors to obtain local registration could ameliorate the resulting pressure on the small number of available bilingual clinicians.

For newly arrived migrants and refugees, understanding and navigating interconnected healthcare structures can be particularly difficult. For people whose home contexts do not differentiate between primary and specialist care, this distinction can be confusing. Likewise, the roles and responsibilities of different levels of government in healthcare provision, and their associated payment structures, may be entirely opaque.

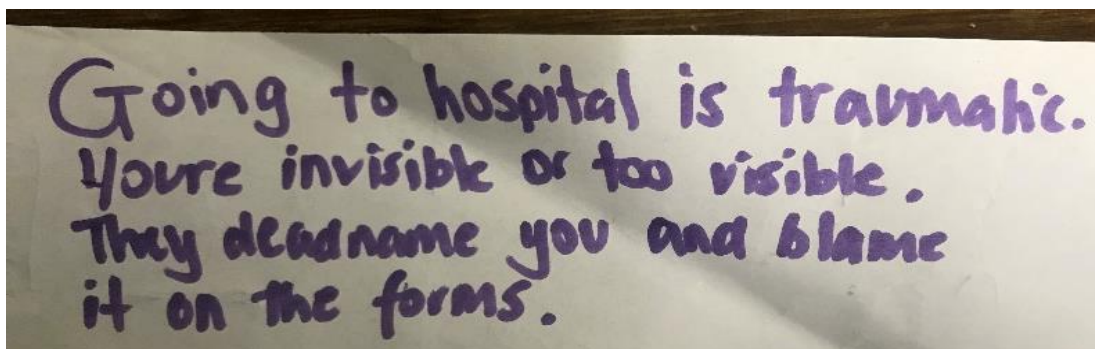
*“There was one woman from our community who kept her rubbish inside her house for three months when she arrived because she didn’t know the council would collect it. When she got sick, she only went to the pharmacy, not the doctor. She didn’t know” (CALD community member)*

For people who arrive in Australia unconnected to supportive institutions (schools, universities, employers) there may be no immediately accessible channels for information around how, where and from whom healthcare can be accessed. Workshop participants reported that both new and established migrants are therefore often reliant on health information accessed via in-person and online community connections as SA Health information is seen as being complicated and difficult to

navigate. As a result, they reported that health information circulated is often inflected by the views of community elders, and may reflect specific gendered, religious and generational perspectives on health issues and treatment options.

Issues of escalating costs and waiting times were identified as central barriers to health access for CALD communities. Workshop participants reported that waiting times for elective surgery, in particular, can lead some individuals to feel they have no option but to travel abroad for treatment (usually in their home country), a situation that can have implications on their return if post-surgical complications arise.

### Trans and gender diverse communities



Going to hospital is traumatic.  
You're invisible or too visible.  
They deadname you and blame  
it on the forms.

Participant response, PHV workshop with transgender and gender-diverse communities  
June 2023

Consultation with members of trans and gender diverse communities raised a range of health accessibility and inclusion barriers that have a significant impact on the safety and quality of care individuals receive. Of primary concern was the issue of waiting times for/access to gender-affirming interventions. Participants reported the devastating impact these delays can have on individuals' mental health, and on the ultimate cost and invasiveness of interventions when the pre-puberty window is missed. The scarcity of paediatric endocrinologists and waiting times for psychological assessments were raised as particular concerns.

In acute care contexts, participants reported serious concerns about emotional and physical safety. For example, we heard accounts of trans people with serious mental health challenges being repeatedly deadnamed by hospital staff (an issue they attributed to a lack of dedicated procedures around naming conventions in handover documentation), and refused the opportunity to have identity preferences noted if they did not match Medicare-recorded particulars. Participants explained that the feelings of invisibility engendered by hospital encounters often result in trans and gender-diverse individuals actively avoiding hospital admission.

Participants also raised the concern that many hospital care providers possess limited understanding of trans-specific issues. Of particular concern were circumstances in which trans men were physically restrained in response to mental health presentations while wearing chest binders. Without an understanding of the parameters around safe and unsafe binding (form of binder, length of time bound), it is possible that hospital staff inadvertently contribute to physical injury to trans men when physical restraint is employed.

A low level of professional expertise on trans health matters was also identified in primary health contexts. Numerous participants reported that it is common for them to have to 'educate GPs', who explain they have had little to no training in responding to trans health concerns. In turn, we heard that many trans young people feel entirely isolated when it comes to accessing information about transition: without the support of GPs who could provide reliable and supportive information they turn to online information sources (tiktok, Youtube) from which important age-specific and safety recommendations are generally absent. For homeless trans young people, the lack of a GP advocate can be particularly significant in that barriers to accessing gender-affirming healthcare are compounded in the absence of parental support.

Participants raised the notion that there is considerable overlap between trans and gender diverse identities and neurodivergence, suggesting a need for healthcare to be provided within a wrap-around model foregrounding accessibility and an emphasis on socio-emotional support. We heard that health professionals who provide such support are difficult to find, and are often overwhelmed by appointment requests when community members identify them as trans-friendly. The scarcity of supportive and inclusive health providers was noted by participants, who reported that many trans people continue to attend general practitioners who make them feel uncomfortable because they feel they have no other option.

*"I've definitely kept going back to doctors I hated because they were able to get me T [testosterone]. If you're really desperate, you'll just put up with people treating you badly"* (trans community member)

Trans participants also told us about the significant impact of the cost of transition and gender-affirming care. We heard that transition-related costs (hormone therapy, surgery etc.) hold many people back from reaching financial independence, entering the rental or housing market, or pursuing education and employment opportunities.

## Seniors

Consultation with South Australian seniors raised a range of health concerns, many of which stemmed from issues of access to high quality, low cost primary care.

Community members raised concern around GP access in rural contexts, particularly where workforce numbers are low, patients often live at a distance from family supports, and public transport is unavailable or unreliable. Telehealth options were depicted as an important workaround for these concerns, but participants noted patterns of variable digital access and proficiency among seniors living in rural settings.

In metro contexts, seniors identified long GP waiting times, increasing out-of-pocket costs and reduced bulk-billing options as key health access concerns. We heard that chronic disease management requiring regular long appointments can be particularly costly, and that expense can serve as a disincentive to engage in preventative primary health appointments and screening initiatives. As 'gate-keepers' to specialist services, long GP waiting times were reported to contribute to significant diagnostic and treatment delays.

*"It takes so long to get in to them [GP], and then they really rush you through. I bring up the main things, but I feel like I never get through all the things I should probably get to. And then it's a long time between drinks"* (senior)

Consultation with local government community development personnel raised the issue that social isolation both contributes to and exacerbates ill health for older people, many of whom approach GPs for support on what are essentially social issues. However, they suggested that GPs are ill-equipped for 'social prescribing' (e.g. connecting patients to local community and social service offerings) and thus an important touch-point for connection is under-utilised and this population under-served.

Concerns raised around acute care health services for older people focused on the compartmentalisation of primary and hospital care. We heard concern that patient information is not retained systematically between and across separate hospital admissions. Likewise, seniors reported a lack of follow-up of psychosocial concerns that may have received social worker support in hospital (e.g. trauma or grief support) because there is little continuity of care following hospital discharge.

### Advocacy organisations

Representative and advocacy organisation consulted during Phase 1 of this project reported a strong desire to inform and support systematic efforts to enhance the responsiveness, quality and equity of healthcare in South Australia.

Nonetheless, we note issues they raised as constraints on their capacity to engage in this work, including:

- the expectation that advocacy groups can provide immediate access to a cohort of available and willing community representatives when health engagement opportunities are opened.

We heard that maintaining relationships with community members, and supporting external engagement, requires ongoing communication, relationship-building and administration for which small advocacy groups are rarely funded or adequately resourced.

- that health engagement requests come to advocacy organisations from a range of disparate health departments, local networks and other service providers.

We heard that engagement requests are often connected to specific service areas or initiatives within a program or LHN, rather than reflecting a coordinated, systemic approach to improving health outcomes for a target community. As a result, advocacy organisations can be asked to duplicate contributions and effort across multiple settings, or to re-engage on issues ventilated thoroughly in other contexts.

- the fact that repeated engagement can result in consultation fatigue when participation outcomes are not actioned, embedded, or scaled up across the system.

We heard that advocacy organisations are keen to contribute to measurable, sustainable outcomes that make ongoing inroads on community-raised health priorities.

This feedback will inform the design of a People's Health Voice that seeks to support and amplify the impact of existing health advocacy platforms, and to connect and scale their efforts in support of equitable health outcomes.

## Emerging patterns: Overarching issues impacting upon health system access and equity

As engagement has commenced, we have been met with strong support for an independent, sustainable, action-oriented process through which community-driven health priorities can be channeled systematically into processes of health system reform. Community groups and leaders have indicated enthusiasm for ongoing collaboration, and involvement in all phases of hands-on co-design.

While we are still in Phase One of the PHV project, and will be collating the issues and proposals that are raised throughout our engagement with interest groups, there are emerging issues which can be flagged for consideration at this early stage. Across engagements undertaken thus far, a range of central issues affecting health system accessibility and responsiveness emerge as key concerns. These include:

- the impact of GP accessibility (including factors such as waiting time, costs, distance, transport, language support) on
  - upstream preventative health measures (screening, chronic disease prevention, early intervention around mental and social health concerns)
  - diagnostic and treatment delays
- the importance of connecting health information provision with community-preferred modes of health system navigation and help-seeking
- clinician understanding, and system responsiveness, to the healthcare needs of diverse communities
- the interrelationship between healthcare expenditure and financial/housing stress
- disconnections between primary, tertiary and community health services that see people with access support needs fall outside of optimal care pathways.

## Next steps: Framework for Phase 2 (Design) of the People's Health Voice Project

Engagement with focus communities will continue in the second half of 2023, before a combined community forum is held at the end of the year. This forum will represent an opportunity for members of all focus communities to reflect on shared and community-specific health equity concerns surfaced during Phase 1 engagement, and to consider how a co-designed People's Health Voice could function to advocate, inform and evaluate approaches designed to address them. At this forum, community members will be asked to nominate representatives to serve on a co-design group in Project Phase 2 which will be supported to

- reflect upon existing national and international examples of independent health participation mechanisms
- design a proposed structure and function for a South Australian People's Health Voice to be demonstrated and refined across subsequent project phases.

## Conclusion

The first phase of the People's Health Voice project has opened space for both deep and broad conversations about health equity, and the quality, inclusivity and responsiveness of our health system in South Australia. We look forward to further engagement with the SA Health project team, and ongoing collaboration with members of our focus communities as we co-design the architecture and function of a People's Health Voice for South Australia.



South Australian Council of Social Service

47 King William Road  
Unley, SA, 5061 Australia

p (08) 8305 4222  
f (08) 8272 9500  
e: [sacoss@sacoss.org.au](mailto:sacoss@sacoss.org.au)  
w: [sacoss.org.au](http://sacoss.org.au)

 [facebook.com/SACOSS](https://facebook.com/SACOSS)

 [@sacoss](https://twitter.com/sacoss)

 [linkedin.com/company/SACOSS](https://linkedin.com/company/SACOSS)

SACOSS acknowledges traditional owners of country throughout South Australia, and recognises the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures, and to elders past, present and future.