J Cross Cult Gerontol (2008) 23:85–95
DOI 10.1007/s10823-007-9053-3

ORIGINAL ARTICLE

Assessment of Indigenous Older Peoples' Needs for Home and Community Care in Remote Central Australia

Melissa A. Lindeman · Robyn P. Pedler

Published online: 17 January 2008
© Springer Science + Business Media, LLC 2007

Abstract The Home and Community Care (HACC) program in Australia provides services which supports older people to live at home. Individual HACC organisations are generally responsible for initial assessment of eligibility and need of clients presenting for services. This paper reports on a project which aimed to develop an understanding of the various approaches to assessment of client needs in Central Australia. The majority of clients in this geographical area are indigenous. The project was initiated in recognition of the primary importance of assessment in determining service access and service delivery and of the particular challenges faced by service providers in remote areas. This paper discusses key project findings including the client group and services provided, initial needs assessment and care planning processes. Evident inconsistencies in practice reflect a variety of complex contextual factors. Staff in remote areas have an inadequate knowledge base to draw upon to assist them with assessment and care planning decisions, and further research and professional development is required.

Keywords Indigenous older people · Client assessment · Remote communities · Home and community care

Introduction

The Home and Community Care (HACC) program in Australia provides funding for services which support people who live at home and whose capacity for independent living

M. A. Lindeman (✉)
Faculty of Health, Medicine, Nursing and Behavioural Sciences, Deakin University, Waterfront Campus, Geelong, Victoria 3217, Australia
e-mail: melissa.lindeman@deakin.edu.au

R. P. Pedler
Batchelor Institute of Indigenous Tertiary Education, Alice Springs, Australia

is at risk or who are at risk of premature or inappropriate admission to long-term residential care. Access to services in the HACC Program is based on the assessed needs of individuals seeking assistance to remain at home in the community (Australian Government Department of Health and Ageing 2002). Funded services are expected to operate within program guidelines (Australian Government Department of Health and Ageing 2002) and to adhere to minimum-service standards (Commonwealth Department of Health and Aged Care 1998). These key policy documents outline certain requirements for the conduct of assessment including that access to services should be decided only on the basis of relative need, and that services should be coordinated, planned and reliable so that each client will have services provided to meet their specific ongoing needs (Commonwealth Department of Health and Aged Care 1998).

Whilst it is generally known that intervention or service responses will only be as good as the assessments from which they emerge (Hughes 1995, p.69), there are particular contextual issues that need to be understood for assessment in remote areas. The context of service delivery for HACC agencies in Central Australia is complex, and there is little information to draw upon to assist with understanding these complexities and how these relevant assessment policy frameworks and quality measures can be successfully and easily implemented. In these remote contexts, the majority of the clientele and most of the care workers are local indigenous people; however, the service coordinators are usually non-indigenous (HK Training and Consultancy 2002). This paper reports on the findings of a project which aimed to develop an understanding of the various approaches to assessment of client needs in Central Australia, including determination of the level of consistency between assessments conducted by individual HACC organisations. This information is important to improve equity of access and service delivery for clients. The project was initiated in recognition of the primary importance of assessment and of the particular challenges faced by service providers in remote areas.

Methods

The project was conducted by the Batchelor Institute of Indigenous Tertiary Education (Alice Springs campus) in July–October 2004 and guided by a steering committee comprising relevant service providers and others working in the field of aged and community care. All HACC service providers in Central Australia ($n=22$) were invited to participate in a brief telephone interview. A structured interview schedule with 18 open-ended questions was used. There was a participation rate of 95% ($n=21$); four of these agencies are regarded as regional (based in either the towns of Alice Springs or Tennant Creek) and 17 as remote. The participants were all involved in assessment of client needs in their agency and were generally the service coordinators. Two of the HACC coordinators (one from a remote agency and one from a regional agency) also participated in a further face-to-face, in-depth interview. Project staff also attended an annual forum for HACC coordinators in Central Australia. This opportunity was used to present brief preliminary findings from the interview phase to the forum participants and inviting small-group discussions on some key points to be incorporated into a final project report. Throughout this paper, quotes from the telephone survey are attributed to either “Remote HACC Agency” or “Regional HACC Agency”; quotes from the in-depth interviews are attributed to either “Remote HACC Coordinator” or “Regional HACC Coordinator”; and quotes from the forum small-group discussions are attributed to “HACC Forum”.

Findings

Client group and services provided

A total of 517 clients were being provided with a HACC service from the agencies interviewed. All the clients in the remote communities are indigenous, and two of the regional agencies also provide services exclusively to indigenous clients. These clients come from a large range of language groups including Eastern Arrerntre, Western Arrerntre, Warlpiri, Luritja, Warramunga, Pitjantjatjara, Ngangatjatjara, Yankunytjatjara, Pintubi, Yarrawa, Kayteyt and Alyawarra (Hobson 1990). English can be a second, third or fourth language for some clients. Clients in remote areas retain many traditional practices including social and ceremonial activities, hunting and collecting of traditional foods when the resources are available and if the opportunities arise, and other cultural practices relating to family obligations, kinship groups, gender roles and intergenerational position (HK Training and Consultancy 2002). HACC agencies in Central Australia are relatively small, with 81% (n=17) providing a service to less than 25 clients. Meals provision is by far the most common service provided in remote areas, although laundry, firewood collection, personal care, social support and advocacy may also be offered.

Table 1 summarises data relating to assessment, care planning and reassessment practice.

Receiving referrals and initial needs assessment

The two highest sources of referrals are the health clinic and family. Less than half of the agencies surveyed require referral documentation, and many referrals are received informally and often opportunistically. A range of practices are employed for initial needs assessment (the process of screening for eligibility, collecting client data and determining clients' needs). Written referrals from a medical source are required as a compulsory step in the process of getting a service by 14% (n=3) of the agencies surveyed; 19% (n=4) of the agencies have age qualifications in place to assist with eligibility determination, although these are not consistent between the different agencies. The procedure employed by one remote agency to assist them to determine relative need involved a judgement about clients' capacity to participate in activities including traditional cultural practices such as ceremonies or hunting. All survey respondents stated that they interview the client and family in the home or dwelling. However, service providers, in general, do not assess against any common criteria, with many tending to rely on their own judgement using information gained from:

- Questioning the client about their needs
- Personal knowledge of clients and family groups

Table 1 Overview of Referrals, Assessment, Care Plans and Reassessment

Assessment practice	Proportion of agencies, n=21 (%)
Form used to receive referrals from other service providers	47
Form always used to send referrals	19
Home/dwelling visit at initial assessment	100
Initial needs assessment form used	57
Care plan used	71
Clients formally reassessed	24

- Local familiarity of clients' living circumstances
- Instinct and common sense

A form or 'paper tool' is used by 57% (n=12) HACC agencies to guide their initial needs assessment. The forms in use range from the form provided by the HACC program in the Northern Territory, a version that is similar (simplified) to the form provided by the HACC program, to forms that are very simple, sharing only minimal items. Almost half of all HACC agencies have no document to guide initial needs assessment.

Determining level of service

Following an initial needs assessment and the determination of the type of service/s to be provided, HACC assessors must then determine the *level* of service that individual clients will receive. Two common approaches used by individual agencies in Central Australia is to (1) provide all clients with the same service levels or to (2) determine levels of service based on the resources available to the agency at the time:

> "We try and give them as much as they want and we try to balance that with how many hours and staff we have available" (Regional HACC Agency).

These practices could result in inequitable service provision between clients of different agencies. Decisions about levels of service appear to be directly related to agency resources. These are funded agencies that operate independently and in diverse contexts. Some tensions may result from these different contexts and the inevitably different approaches to service provision that arise. The request for food (which is the main type of service provided in remote communities) is seen as a high priority, and agencies will accommodate food requests in most cases.

Making referrals

The main trigger for referring on, identified by survey participants, is a change in health status, and there is a very high level of reliance on HACC staff and the client's family to notify the agency of the need for referral. However, the criteria used to make this judgement about a change in health status is not clear. The community health clinic/health service is the main destination for client referrals. Other specialist providers such as allied health were rarely identified as referral options.

Of all HACC agencies, only 19% (n=4) systematically used a form to pass on referral information. Some complete the forms provided by the referred to service provider, and others use their own versions of referral forms. Several agencies said that they used a consent form to enable them to pass on referral information to other agencies; however, much of this occurred verbally.

Managing supply and demand

Waiting lists are rarely used by agencies to manage the demand on their services, and the majority of agencies implement strategies of rationing services to manage demand. This is often needed because of staff shortages rather than an increased demand for

services. The staff shortages are often a result of cultural obligations of the indigenous staff. For example:

> "When there is lore business or sorry business I don't expect the ladies at work ….We get told who is going to sorry camp[1] so we let [clients] know that if [the workers] are away at business, we won't be doing the meals" (Remote HACC Agency).

Care plans

Of the surveyed agencies, 71% (n=15) indicated that they use a client-care plan, and the documents provided to project staff show that a range of domains are covered in the care plans. Some agencies have attempted to capture specific cultural information in the design of the care plan documents. However, most simply outline services to be provided. Those that did not use a care plan indicated that they have a high level of local community knowledge that assists them with their decision making and service provision that negated the need for care plans.

Reassessment and review

A review is a periodic mechanism for reassessment. The majority of HACC service providers in Central Australia rely on informal mechanisms for reassessment through monitoring. Only 24% (n=5) of the total number of survey participants undertook a formal reassessment or review, involving a home visit and completion of documentation. Of these, two agencies interview each client every 6 months, and three agencies interview each client every 3 months, although one of these could not review this frequently for all their clients:

> "Locals are interviewed every three months and at the outstations every six months—and it is a big job—or if circumstances change in-between those periods we respond to that….I need an interpreter because I don't speak the language" (Remote HACC Agency).

Discussion

Context of service provision

The small size of HACC agencies in Central Australia (ranging from providing services to less than ten clients in the smaller remote communities to 170 clients in one of the regional towns), and their geographical location (they can be as far away as a 7-h drive to the nearest town), gives rise to significant contextual issues relating to difficulties attracting staff, access to other specialist providers and the upkeep of basic services. HACC coordinators generally work in cross-cultural contexts involving many language, literacy and cultural complexities. HACC coordinators are "moving between two worlds" (HACC forum), maintaining accountability with government paperwork and legislation, at the same time as maintaining flexibility with the community. They may also be coordinating a range of other

[1] A 'sorry camp' is a meeting of relatives and other community members associated with a deceased person. It is part of the traditional funeral and mourning process, and certain people are expected to attend. These camps are generally located at special places some distance away from usual living areas, and length of stay can vary in length (Byard and Chivell 2005), often up to several days.

programs as well as HACC, adding to the complexity of their role. Coupled with professional and personal isolation and working and living cross-culturally, the chances of 'burning out' are therefore immense.

Allocating resources in a context of deprivation: remote indigenous Australia

Other characteristics of work in remote desert communities relate to poor living conditions of the local community members. According to the Remote HACC Coordinator, dwellings are often overcrowded, basic facilities including showers, toilets and cooking facilities can be inadequate and poorly maintained, and the presence of large numbers of dogs contribute to occupational health and safety issues and poor health suffered by community members. These factors can affect the whole family, not just the HACC client. It is not uncommon for HACC coordinators to see older people living in "very poor conditions" (Remote HACC Coordinator), and it is difficult for coordinators to reconcile that reality with the limitations of the HACC program. This accords with the account of Fitzgerald *et al.* (2005, p.341) of health workers caught between different "cultural paradigms" where different interpretations of cultural competence result in a "kind of cultural dissonance". In this case, the cultural standards of the organisation, the local community, the HACC program and their own personal values may conflict.

Practices relating to client access to services vary between the different HACC agencies. The practices of basing eligibility on age or a medical referral are contrary to program guidelines which stipulate that eligibility should be based on relative need. That is, a medical referral should not be necessary to determine eligibility, and likewise, basing eligibility on age may serve either to exclude some individuals who may have a need or, conversely, include some individuals who do not have a need for a service. HACC coordinators recognise that client eligibility is not applied consistently, and as a result, services may be provided to people who are not necessarily in need of the services:

> "[We] feel the assessment process could be tightened up. Not all people who are aged are necessarily in need of assistance. Clients can be getting services [who] are in less need of the service as other people in the community. Once on the service it is very difficult to take the service away from the client" (HACC forum).

It is evident from the research that HACC coordinators, between them, have many different perspectives on the concept of need. Further, their perspectives on need frequently differ from those of family and clients. This highlights a gulf between the comparative and normative needs understood by HACC coordinators and the felt and expressed needs of the client and the local community. This possibly relates to a lack of understanding of the goals of the HACC program by the community and/or the difficulty of reconciling these goals in remote Aboriginal community contexts. In other words, service coordinators struggle with the interpretation of eligibility criteria, with reconciling the poor living conditions of everyone on the community and only being able to support the clients of their service, and with perceived differing community expectations of how older people should and could be cared for. Even the notion of personal independence, one of the main tenets of the HACC program, is a cultural construct (Whybrow 1998, cited in Fitzgerald *et al.* 2005), and competence in daily life (which is assessed to determine need) is also culturally and contextually situated (Fitzgerald *et al.* 2005). To illustrate this tension, HACC coordinators need to remain flexible to provide culturally appropriate care, but there are few benchmarks common to both remote indigenous communities and the HACC coordinators. The "atrocious conditions in which people sleep" (Remote HACC Coordinator), for example,

may not seem to be a problem for the family or the older person, but for the HACC assessor this presents major difficulties. The lack of a knowledge base and comparative information about caring for older people in remote contexts contributes to these difficulties.

According to Hughes (1995), the various ingredients which are synthesised within the assessment process are factual detail (influenced by its quality of 'hardness' and by whether or not it has been specifically requested); knowledge and theory; skills; and professional judgement. Information about a person can only 'make sense' if it is set against some prevailing body of knowledge or theory about similar people or similar situations (Hughes 1995). Knowledge and theory is problematic for remote/indigenous contexts. Whilst some information is universal, much is contextually and culturally specific, and there has been very little research in this area. Assessors are likely to have little theory to draw upon that 'feels' right for them in assessing indigenous clients in remote areas. As others have noted, indigenous older people's priorities are not predictable according to non-indigenous criteria (Harrison 1997).

A majority of HACC agencies use a written document to guide initial needs assessment, but there is considerable variation in these forms in breadth and depth of information. Attempts have been made to incorporate indigenous contexts and practices as assessment domains. However, a significant proportion of all HACC agencies have no document to guide initial needs assessment, instead relying on instinct, common sense, and/or local knowledge. It is unclear the degree to which assessment outcomes that rely so heavily on instinct and common sense would elicit the same outcomes for clients if they were assessed by another person who is also largely using their own instincts and common sense. Certainly, in the absence of a standard set of criteria on which to base assessment decisions, the possibility of reliable assessment outcomes is much lower between different assessors. Whether or not reliability could be improved by the introduction of such a set of criteria is unknown for remote/indigenous contexts. The overwhelmingly significant variable for these contexts is that cultural awareness and understanding of the local community dynamics and relationships can only be learnt over time, and they are difficult to represent in formal assessment criteria. For example, HACC coordinators need time to get to know who the family groups are, which ones are less likely to provide good care for their older relatives, and also the relationships that those people have with other people in the community (Remote HACC Coordinator). These are very subjective judgements, and no formal set of criteria or guidelines can adequately capture this type of information. The difficulties of documenting cultural factors that may be important to guide assessment, care planning and service delivery were noted by both the Regional and Remote HACC Coordinator in the in-depth interviews. For example, it is not uncommon for people from one kinship group or family being prevented, for cultural reasons, from caring for other kinship groups or family (McGrath *et al.* 2006). However, most people in assessment and coordination roles are non-indigenous, and it is very difficult for them to develop understanding of such cultural practices because they are extremely complex and vary between different groups (HK Training and Consultancy 2002).

'Need' has a relationship with supply and demand (Vernon *et al.* 2000). In needs-based assessments, it is intended that needs would be determined independently of considerations relating to the agency resources; that is, that assessments consider generic needs for assistance, not just those for which the agency can cater. In remote Aboriginal communities in particular, it is almost impossible to maintain a separation between assessment of need and decisions about eligibility and availability. Notions of eligibility are contextually situated as much as decisions about allocations of service. Further, in many cases, the HACC agency is the only provider of basic support services for this target group, so there

are no other options for provision of other services to assist the person to remain living independently at home and in their community. If meals are the only, or main, service that the HACC agency provides, then meals will be the only basic-support service available to that client.

The assessment process should include the development of a care plan, which outlines the person's needs and the services to be provided, and should be reviewed regularly to ensure services remain responsive to the needs of the client (NT Department of Health and Community Services 2003). In essence, a care plan is an action statement about how the goals in respect of a particular client are to be achieved. A minority of agencies did not see a need for formal care plan documentation. There is substantial variation between the different care plan documents that were in use; some of these documents are more akin to a 'service plan' (simply outlining services to be provided) rather than a care plan which is more usually a document which identifies client's needs, individual goals, service objectives, service plan, and details of how the assessment and care plan will be reviewed. Some agencies have attempted to capture specific cultural information in the design of the care plan documents to ensure culturally responsive service provision. Planning culturally appropriate care and capturing this in care-plan documentation is an area that could receive further attention through research and professional development.

Individual HACC agencies in Central Australia, at least in remote contexts, offer little variation in the levels of service provided to their clients. This may be because it would add an additional complexity to service provision that may be too hard to manage in remote community contexts due to the range of staffing issues. These include staff shortages and the many cultural issues arising from indigenous direct-care staff providing care for individuals in their local community and problems experienced by other programs in similar contexts (McGrath *et al.* 2006). It may also contribute to raising community expectation that some are more 'deserving' than others and is therefore perhaps too difficult to introduce until people (clients/carers and locally employed HACC staff) have a greater understanding of the HACC program. The differences between HACC and programs that provide higher level care also complicate this understanding: "somebody is either just getting a meal or they (are on another program and) seem to have everything", and there is confusion about how this is determined (Remote HACC Coordinator). On the other hand, there is likely to be considerable variation in the service levels offered between individual agencies (that is, one agency may offer all their clients two or three meals a day plus other supports, and another may offer all their clients a very limited service). These trends suggest a general inability to develop care plans in response to individually assessed needs. Decisions about levels of service appear to be directly related to agency resources. When services have to be rationed due to staff shortages, the provision of food is always prioritised over other service types including laundry, personal hygiene, cultural and social support services.

The dynamics of the service system are heavily reliant on the local health clinic/health service. Change in health status is the main reason for triggering a referral. However, the criteria for determining change in health status may vary between individual agencies. The health centre or clinic is most likely to be the first place considered for referral if a client's needs are considered to have changed or are more complex. Other providers in the service system were identified infrequently as referral options by survey respondents. This may indicate a lack of awareness of the existence and/or role of other specialist providers, or it may indicate a preference to work collaboratively in the first instance with the service provider in close proximity to the HACC service. With the exception of two of the regional services, specialist providers would have to travel long distances to follow up on individual

referrals. This may be a barrier for HACC staff in that they may want more immediate follow-up, and they may prefer to refer to the organisation where the client is already likely to be known and where they themselves are also known and have professional relationships established. The triggers for HACC staff to refer clients on to these specialist services are also not very clear in Central Australia.

Hughes (1995, p.69) noted that assessment of older people has tended to be restricted to the assessment of need for specific services with standards of assessment falling short of those expected of other target groups such as children. Assessment processes in the HACC program have long been identified as an area requiring improvement, largely because of the recognition that conceptual, ideological, professional and practice differences have led to inequity for consumers and tensions in local service networks and between different interest groups (Commonwealth Department of Health and Family Services 2004). The program's response, broadly, has been to develop approaches to assessment, particularly for people with more complex needs, which is more comprehensive and not influenced by a particular service-provision perspective (Lincoln Gerontology Centre 1998). A cornerstone of this strategic approach is for decisions about assessed need to be independent of agency resources or, in other words, for assessment to be 'needs led' rather than 'service led'. The National HACC Program Guidelines state that assessment mechanisms are to be independent of service provision for consumers with multiple and/complex needs and that all such clients are individually assessed for all their care requirements rather than for a particular service. However, as we have seen, HACC agencies in Central Australia, in general, currently undertake 'service-led' assessments rather than 'needs-led' assessments, reflecting the contexts in which they work. The ideal of needs-led assessment is thus seriously challenged by the context of deprivation in remote communities relating to basic infrastructure, support services and staff (professional and direct care).

Another strategy to improve consistency in assessment practice in HACC has been to introduce a standard form for use at initial client contact (Australian Government Department of Health and Ageing 2002). Results from the survey indicate that the documents made available through the HACC program are not systematically used. The temptation is to assume that there is something wrong with the documents and to put additional energy into designing something that may be more likely to be accepted by HACC coordinators. Woods and Baldwin (1998) note that while needs-assessment processes that include predetermined lists are helpful to ensure that an adequate range of activities is considered for assessment, they cannot substitute for more open-ended techniques. They also note that while all clients share universal needs, most clients will have additional specific needs, often relating to religious, ethnic and other cultural factors as well as to specific aspects of their disabilities (Woods and Baldwin 1998). This suggests that it is not important to have an assessment tool/form that drives or directs practice; rather, a form should support good assessment practice as well as facilitate the basic client data-collection functions of the assessment process. Further, if services are to be tailored to individual need, a more client-centred approach which enhances both client's understanding and understanding the client's views is essential. This needs to be directly addressed in the development of assessment skills and procedures, in professional education and in on-going supervision (Richards 2000).

Learning about how to undertake assessment and care planning has been found to happen largely on the job, regardless of the professional background or prior training of the individuals employed in these roles (Lindeman *et al.* 2004). For workers in small agencies such as those in Central Australia, it is likely to be the case that learning about these important processes happens in professional isolation. The majority of HACC agencies

employ one person as the coordinator who takes responsibility for assessment and care planning as well as all aspects of care provision including staff management. The in-depth interview conducted with the Regional HACC Coordinator confirmed that learning about assessment and other aspects of service coordination has occurred on the job. Wilson (2002) notes that practice in remote indigenous communities is shaped by the nature of the practice setting and personal values of the worker rather than the legislative or policy framework within which practice takes place. The importance of professional development opportunities for these staff, which takes account of their local contexts, is clear. This work has commenced, supported by the HACC Program in the Northern Territory (Lindeman and Newman 2006).

Conclusion

The apparent inconsistent practice in HACC assessment in Central Australia reflects a variety of complex contextual factors. Any strategies to introduce measures to improve consistency must be tempered with the need for HACC agencies to remain flexible and culturally responsive in these unusual and diverse community contexts. Cultural awareness and understanding of the local community dynamics and relationships can only be learnt over time and are difficult to represent in formal assessment criteria. The project findings highlight an inadequate knowledge base for HACC coordinators/assessors to draw upon to assist them with assessment and care planning decisions in remote/indigenous contexts. Further research that will improve this situation should be encouraged. A focus on professional development for HACC assessors in remote/indigenous contexts which equips them with a solid and consistent conceptual framework for assessment and care planning would also assist.

Acknowledgements This project was funded by the Northern Territory Department of Heath and Community Services with a HACC “Innovative Project” grant. The authors would like to thank Ms Tahnia Edwards (Indigenous Academic, Centre for Remote Health, Alice Springs), for reviewing the final draft of this paper.

References

Australian Government Department of Health and Ageing (2002). *National program guidelines for the Home and Community Care program*. Canberra: Commonwealth of Australia.

Byard, R. W., & Chivell, W. C. (2005). The interaction of death, sorcery and coronial/forensic practices within traditional indigenous communities. *Journal of Clinical Forensic Medicine*, *12*, 242–244.

Commonwealth Department of Health and Aged Care (1998). *The home and community care national standards: instruments and guidelines*. Canberra: Commonwealth of Australia.

Commonwealth Department of Health and Family Services (2004). *National framework for comprehensive assessment in the HACC program. Resource kit*. Canberra: Commonwealth of Australia.

Fitzgerald, M. H., Williamson, P., Russell, C., & Manor, D. (2005). Doubling the cloak of (in)competence in client/therapist interactions. *Medical Anthropology Quarterly*, *19*(3), 331–347.

Harrison, J. (1997). Social policy and aboriginal people. In A. Borowski, S. Encel, & E. Ozanne (Eds.), *Ageing and social policy in Australia*. Melbourne: Cambridge University Press.

HK Training and Consultancy (2002). *Indigenous employment in the Northern Territory aged care sector.* Darwin: Department of Employment and Workplace Relations.

Hobson, J. (1990). *Current distribution of central Australian languages*. Alice Springs: Institute of Aboriginal Development.

Hughes, B. (1995). *Older people and community care. Critical theory and practice*. Buckingham: Open University Press.

Lincoln Gerontology Centre (1998). *National framework for comprehensive assessment in the HACC program*. Canberra: Commonwealth Department of Health and Family Services.
Lindeman, M. A., & Newman, V. (2006). Addressing training needs for community care assessment in remote indigenous communities. *Geriaction*, *24*(4), 15–21.
Lindeman, M. A, Ozanne, E., & Beckett, D. (2004). Assessment staff in home and community care: issues of learning and professional identity. Paper presented at the *International Federation on Ageing 7th Global Conference*, Singapore.
McGrath, P., Patton, M. A., McGrath, Z., Olgivie, K., Rayner, R., & Holewa, H. (2006). It's very difficult to get respite out here at the moment: Australian findings on end-of-life care for indigenous people. *Health and Social Care in the Community*, *14*(2), 147–155.
NT Department of Health and Community Services (2003). *HACC PACK. An induction manual for HACC providers in the Northern Territory*. Darwin.
Richards, S. (2000). Bridging the divide: elders and the assessment process. *British Journal of Social Work*, *30*, 37–49.
Vernon, S., Ross, F., & Gould, M. (2000). Assessment of older people: politics and practice in primary care. *Journal of Advanced Nursing*, *31*, 282–287.
Wilson, J. (2002). Social work practice and indigenous Australians. In P. A. Swain (Ed.), *In the shadow of the law. The legal context of social work practice* (2nd ed.). Sydney: The Federation Press.
Woods, P. A., & Baldwin, S. (1998). Assessment of need and case management: an evolving concept. In S. Baldwin (Ed.)*Needs assessment and community care: clinical practice and policy making* (pp. 25–42). Oxford: Butterworth-Heinemann.