Kimberley Aboriginal Primary Health Plan

2012-2015

Produced by the
Kimberley Aboriginal Health Planning Forum (KAHPF)

FROM THE KAHPF CHAIRPERSON

The first Kimberley Aboriginal Health Plan was written in 1999. That plan laid the groundwork for the many important developments in health that have occurred in the Kimberley in the last ten years. The Kimberley Aboriginal Health Planning Forum (KAHPF) was formed because of the desire by all signatories to the first plan to keep working in partnership to achieve better health outcomes for Aboriginal people in the region.

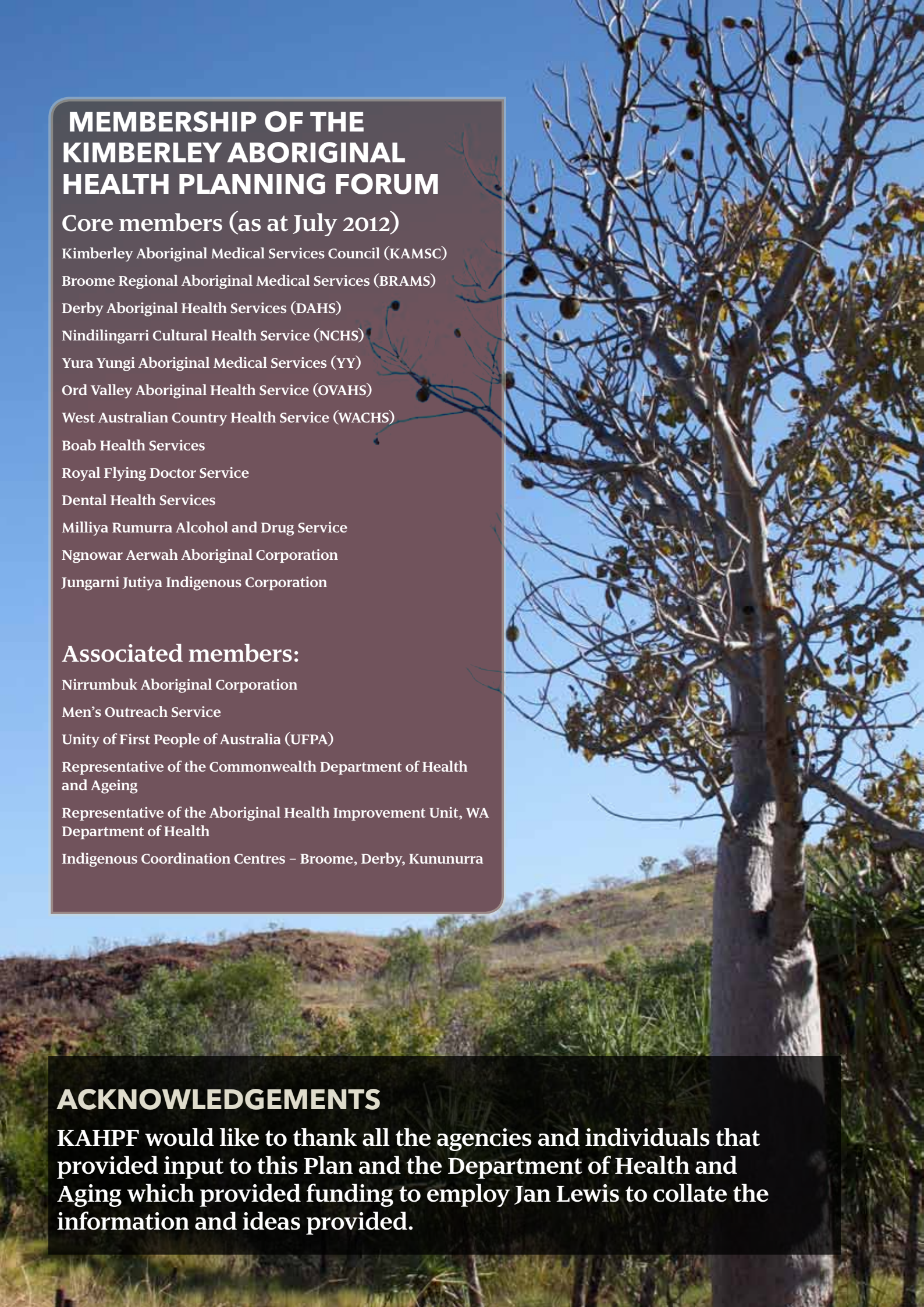
Many things have changed since 1999. The Aboriginal population of the region has grown at least three-fold. An ever-increasing tidal wave of diabetes, renal disease and mental health issues has emerged. To break the cycle and prevent further generations of Aboriginal people having poor health, it has become clear that health services must put greater effort into health promotion and early intervention activities which motivate people to take greater care of their own health.

This Plan lays out the future direction for health services in the region for the next few years. It identifies particular locations and programmes where new funding should be channelled and where better working partnerships could be developed. It includes ideas and recommendations about how organisations could restructure to better meet the challenges ahead. It also identifies where current government policy hinders service development and needs changing, and the urgency for government to act to improve the environmental health and housing conditions where many people live.

If we are to 'Close the Gap' between Aboriginal and non-Aboriginal people we must make sure that our Aboriginal children grow up more healthy than their parents. Health service providers and our Aboriginal people have a lot of work ahead of them. This plan points them in the right direction.

I look forward to working with other KAHPF members to make the recommendations in this Plan happen.

MAXINE ARMSTRONG
CHAIRPERSON
Kimberley Aboriginal Health Planning Forum
April 2012



MEMBERSHIP OF THE KIMBERLEY ABORIGINAL HEALTH PLANNING FORUM

Core members (as at July 2012)

Kimberley Aboriginal Medical Services Council (KAMSC)

Broome Regional Aboriginal Medical Services (BRAMS)

Derby Aboriginal Health Services (DAHS)

Nindilingarri Cultural Health Service (NCHS)

Yura Yungi Aboriginal Medical Services (YY)

Ord Valley Aboriginal Health Service (OVAHS)

West Australian Country Health Service (WACHS)

Boab Health Services

Royal Flying Doctor Service

Dental Health Services

Milliya Rumurra Alcohol and Drug Service

Ngnowar Aerwah Aboriginal Corporation

Jungarni Jutiya Indigenous Corporation

Associated members:

Nirrumbuk Aboriginal Corporation

Men's Outreach Service

Unity of First People of Australia (UFPA)

Representative of the Commonwealth Department of Health and Ageing

Representative of the Aboriginal Health Improvement Unit, WA Department of Health

Indigenous Coordination Centres – Broome, Derby, Kununurra

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Contents

Acronyms

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AHCWA	Aboriginal Health Council of Western Australia
BRAMS	Broome Regional Aboriginal Medical Service
DAHS	Derby Aboriginal Health Service
DAO	Drug and Alcohol Office (WA Government)
DoHA	Department of Health and Ageing (Commonwealth)
ED	Emergency Department
EHO	Environmental Health Officer
ICC	Indigenous Coordination Centre
KACS	Kimberley Aged and Community Services
KAHPF	Kimberley Aboriginal Health Planning Forum
KAMSC	Kimberley Aboriginal Medical Services Council
KMHDS	Kimberley Mental Health and Drug Services
KPHU	Kimberley Population Health Unit
LIP	Local Implementation Plan (for the RSD project)
NCHS	Nindilingarri Cultural Health Service
OVAHS	Ord Valley Aboriginal Health Service
PIP	Practice Incentive payment
RSD	Remote Service Delivery Project
SAMHS	Specialised Aboriginal Mental Health Service
SEWB	Social and Emotional Well-being
WACHS	WA Country Health Services
UFPA	Unity of First People in Australia
YYMS	Yura Yungi Aboriginal Medical Service

NB: *Where this plan refers to Aboriginal people, it is referring to Aboriginal and Torres Strait Islander people. The term Indigenous has only been used in this document where it appears in data collected by an organisation such as the ABS.*

1. INTRODUCTION

This 2012 version of the Kimberley Aboriginal Primary Health Plan is written at a time when chronic disease prevalence is increasing in Australia, and Aboriginal and Torres Strait Islander people continue to have the worst health outcomes and lowest life expectancy of any cultural group in the country. The Federal government has set ambitious targets for 'Closing the Gap' aiming to close the gap in life expectancy between Indigenous and non-Indigenous Australians by 2031 and halve the gap in mortality rates for Indigenous children aged under five by 2018. The spotlight is firmly on health service providers to deliver on their contribution to achieving these targets.

The development of this Plan provides an opportunity for all members of the Kimberley Aboriginal Health Planning Forum to reconsider the best way that they can respond to what has been described as[1] a 'tidal wave' of chronic disease and mental health issues in the Kimberley. Continuing to try and do more of the same may well result in more of the same results. Change involves risk, but not changing incurs the risk of failing to meet community needs and expectations. New and more strategic ways of working may be necessary to ensure that service activity delivers improved health outcomes. It is timely to review and reassess service priorities, working arrangements, partnerships and collaborations.

To support the review process, this Plan contains information on current primary health care delivery in the Kimberley region and an assessment of immediate and future needs. The focus is on a 1-3 year timeframe. The Plan builds on, rather than supersedes, the 1999 Kimberley Aboriginal Health Plan. It contains recommendations for improving the design and delivery of current health programmes and alerts decision makers to current policies and practices that should be reconsidered due to their negative impacts on service delivery.

The Plan has been developed in consultation with service providers in the region, wherever possible using existing planning documents. These include the minutes of KAHPF working group and subcommittee meetings, Remote Service Delivery (RSD) Local Implementation Plans, individual health service's Business, Strategic and Operational Plans and records of community consultations.

The recommendations in this Plan have been endorsed by the Kimberley Aboriginal Health Planning Forum.

1 KAMSC Strategic Plan 2011-2020

2. CHANGES IN THE OPERATING ENVIRONMENT SINCE 1999

THE PLANNING ENVIRONMENT FOR KIMBERLEY SERVICES

All health service providers have to contend with aspects of service delivery that are unique to the Kimberley region. These issues need to be acknowledged by funding providers and planning teams if effective services are to be delivered.

Re population:

- In 2008 the Kimberley population was estimated by the Australian Bureau of Statistics (ABS) to be 31,926.2 47.7% of respondents in the 2006 Census self-identified as being Aboriginal and Torres Strait Islander[3]. This makes the population unique, comprising almost equal numbers of Indigenous and non-Indigenous people. This is starkly different from the total Western Australian population where around 3.5% are Indigenous, and much higher than the 25% Indigenous population of the Northern Territory. In some Kimberley sub-regions the majority of the population are Indigenous and provide the core business of all service providers. All health service providers should therefore be able to access 'mainstream' funding for servicing the Aboriginal population.
- The Aboriginal population is growing rapidly. Between 1984 and 2008, the Aboriginal population increased by 47%, from 10,610 to 18,553 persons, with an average increase of 209 persons (2%) per year[4]. There will therefore be an ongoing and increasing demand for Maternal and Child Health services.
- The Kimberley as a whole is expected to be one of the fastest growing regions in Western Australia over the next 15 years. The Department of Planning's projections for the region's population indicate an average growth rate of 2.7 per cent per annum from 2006 to 2021 which will result in the Kimberley's population being 57,900 by 2021.[5] These growth figures suggest a need to double the level of service provision over the next 25-30 years.
- The Aboriginal population is significantly younger than that of other Australians[6]. The 2006 Census revealed 56% of the indigenous population was aged 0-24, with 25% aged 0-9. To meet this growing population, services need to be designed in ways that engage young people. This requires trials and innovation and the willingness of funding bodies to take risks.

Re the burden of illness

The Kimberley Health Profile[7] reveals that the burden of illness in the region is high compared both to other Aboriginal populations in WA and the total WA population. For example:

From 1998 to 2007, the mortality rate for all conditions (where a rate ratio was measurable) was significantly higher in the Kimberley Aboriginal population compared with the WA population. Over the period 1997 to 2006, the leading causes of mortality for the Kimberley Aboriginal population were cancer and ischaemic heart disease, followed by diabetes.

From 1998 to 2007, the infant mortality rate for the Kimberley Aboriginal population was 15 deaths per 1,000 lives. This rate was 1.2 times higher than in the WA Aboriginal population and 4.0 times higher compared with the total State population.

From 1998 to 2007, the mortality rate for Kimberley Aboriginal children aged 0–17 years was significantly higher compared with the State Aboriginal population and the WA State population.

From 2004 to 2008, the hospitalisation rates for diabetes, cardiovascular disease, respiratory disease, injury and poisoning, kidney disease, alcohol-related conditions and tobacco-related conditions were significantly higher for the Kimberley Aboriginal population compared with the State Aboriginal population and the non Aboriginal Kimberley population.

From 2004 to 2008, the hospital separation rates for renal disease for the Kimberley Aboriginal population increased significantly, with an average increase of 1.5% annually.

2 Australian Bureau of Statistics. 2006 Census
3 Australian Bureau of Statistics. 2006 Census
4 Dept. of Health (2009) Aboriginal Health Profile. Kimberley Health Region.
5 Department of Planning & Infrastructure WA (2005) WA Tomorrow Population Report No 6 cited on Kimberley Development Commission website: http://www.kdc.wa.gov.au/kimberley/tk_popproj.asp
6 Australian Bureau of Statistics 2006 Census available from www.kdc.wa.gov.au
7 Dept. of Health (2009) Aboriginal Health Profile. Kimberley Health Region.

For Aboriginal males from the Kimberley, separation rates for acute respiratory infections, miscellaneous accidents, mental and behavioural disorders and diseases of the oral cavity and digestive system were significantly higher for 2004 to 2008 compared with 1999 to 2003. Hospitalisation for assault remained high but stable.

Of all Aboriginal people living in the Kimberley the most common Major Disease Categories that people presented with to Emergency Department s in 2008/09, regardless of triage category, was skin, subcutaneous tissue and breast conditions followed by injury poisoning and toxic drug effects. These are preventable conditions linked to socioeconomic circumstances that should largely be avoidable or managed within the primary health care sector.

Re cost of service delivery

It is more expensive to deliver services in the Kimberley than in metropolitan Australia. Some evidence of this is provided by the Regional Prices Index, a WA project undertaken to compare the pricing of a basket of 250 goods and services purchased in Perth with the same goods purchased at 21 regional locations. The 2007 Regional Prices Index found that, across a broad range of goods and services, Kimberley towns were 14-21% more expensive than Perth. Delivery of services to remote towns and communities is obviously even more expensive.

Commodity	Kimberley	Broome	Derby	Kununurra
Food	110.8	109.5	115.4	116
Clothing	105.2	101.9	115.9	122.1
Housing	127.1	131.8	104.9	136.6
Household Equipment & operation	110.4	109.9	111.6	113
Transport	101.2	101.1	101.5	102.2
Cigarettes, Tobacco & Alcoholic Drinks	103.8	102.7	107.1	110.2
Health & Personal Care	102.5	101.8	105.2	103.1
Recreation & Education	144.3	143.5	147.4	144.4
All Groups	116.9	117.2	114.5	121.6

Table 1[8]: Price of goods in Kimberley towns relative to Perth prices, with Perth being the base of 100.

8 Department of Regional Development and Lands - Regional Prices Index November 2007 available from: http://www.kdc.wa.gov.au/Statistics/Cost-of-Living

House price data for 2011[9] reveals that the Kimberley is the second most expensive region in WA (the Pilbara being the most expensive) with median house prices averaging $600,000 compared to $352,000 in the Great Southern. Median Kimberley housing costs have increased on average by 10.2% in the last 5 years, with Derby recording a 28% increase.

The per capita cost to improve life expectancy and health status is greater in the Kimberley than in less remote regions. Funding level calculations have to acknowledge the additional costs of providing services to the Kimberley region, and that costs within the region are variable. A flexible funding model is required.

Re employment issues

The 2006 Census[10] revealed that the health care and social assistance industry employs almost 2,000 people - more people in the Kimberley than any other industry. As a major employer, services have a responsibility to demonstrate best practice human resource management. This comes at a cost. Recruitment and retention of staff is one of the most significant issues for the region, which will be discussed in later chapters.

Re inequities in service delivery within the region

Over the past few years decisions by governments to choose parts of the Kimberley for particular attention has had the effect of drawing all new funding to that particular sub-region, regardless of whether that was the area of greatest need or not. Past tendencies towards providing more visiting services to more easily accessible remote communities, locating new staff where there is spare space to operate from or to communities which have made themselves noticed on the front page of newspapers can be noted.

The net effect of these historical decisions is an unacceptably uneven distribution of services throughout the region. This is further discussed in chapter 4.

9 Real Estate Institute of WA available from http://www.kdc.wa.gov.au/Statistics/Real-Estate

10 Australian Bureau of Statistics 2006 Census available from http://www.kdc.wa.gov.au/Statistics/Employment

Production of the Kimberley Aboriginal Health Plan in 1999 marked the first time that health service providers in the region worked collaboratively on a joint project. While they acknowledge that much more needs to be done to address health issues in the region, members of the Kimberley Aboriginal Health Planning Forum are justifiably proud of the gains that have been made in the last 10 years in providing best practice primary health care to the region. This chapter identifies the key gains, but also highlights a number of issues that are proving difficult to resolve.

A snapshot of achievements:

- In 1999 health services worked competitively and in isolation. In 2012 joint planning, collaborative inter-agency activity and partnership approaches underpinned by Memorandum of Understanding (MOU) and Letters of Agreement are becoming the norm, evidenced by the way the WA application for Council of Australian Governments (COAG) funding was prepared in 2009-10.
- The Kimberley Aboriginal Health Planning Forum (KAHPF) was formed in 2000 and has met regularly since that time. Nine sub-committees and working groups were formed to operate under the auspices of KAHPF and met regularly until 2009. See Appendix 1 for more details.
- A Kimberley Standard Drug List for use by all health services has been developed and is regularly reviewed.
- Inter-agency collaboration has lead to the development of Kimberley therapeutic treatments protocols that have been endorsed and adopted for use by all Kimberley service providers. These include:

Chronic Disease	Maternal and Child Health
Rheumatic Health Disease	Anaemia in children
Coronary Artery Disease	Diabetes in pregnancy
Diabetes Type II	Ear Health
Chronic Kidney Disease	Failure to thrive
Hypertension	Perinatal depression
Dyslipidaemia	Child sexual abuse
Heart Failure	Type II diabetes in children
Proteinuria & normal eGFR	Respiratory disease in children

- All West Australian Country Health Services (WACHS) - operated remote clinics now provide drugs at no cost to patients under Section 100.
- Increased numbers of General Practice (GP) Registrars from the collaboration between KAMSC and Western Australian General Practice Education and Training (WAGPET) have increased GP capacity in the region.
- The provision of 19.2 exemptions in WACHS remote clinics and some hospitals will facilitate the generation of revenue for the purpose of primary health service enhancement in each community. In the first community implementation site, Warmun, the income has been used to part-fund the employment of the Gija Health Coordinator. The 19(2) exemption has been in place in Fitzroy Crossing since August 2009, the most notable result being a paradigm shift from an acute care to a primary care focus. Significant work has occurred around management of recalls and development and management of chronic disease care plans and Aboriginal Health Checks.
- Kimberley services have successfully lobbied for increased funding to address renal issues in the region. Dialysis services in Broome opened in 2002. Services in Derby and Kununurra will follow in 2012 and services for Fitzroy Crossing are planned. The Kimberley Renal Support Service has been established.

However, there are some major issues and challenges which continue to pose problems for Kimberley services. These include:

Recruitment and retention issues

Staff turnover in the region is high, and recruitment and retention of staff remains an ongoing challenge. Some of the reasons why this is so cannot be resolved at the regional level. National shortages of staff with particular skills, for example child health nurses and midwives will always make recruitment to remote towns difficult. New staff from outside the region may not be physically and emotionally prepared for the living and working conditions, or for separation from their families. Local Aboriginal staff may find that changed circumstances in their personal lives prevent their ongoing participation in the workforce. However there is also a major structural impediment to recruiting and retaining staff which must be resolved as a matter of urgency and that is the lack of suitable staff housing, both in Kimberley towns and remote communities. This issue is addressed further in Chapter 7.

Integrated data systems

To provide best practice health services to a highly transient population there is an urgent need to improve patient record information-sharing arrangements. At present Aboriginal Community Controlled Health Service (ACCHS) and some allied health providers can share information with each other, but there is no interface between town-based WACHS Community Health, some remote clinic data or that of ACCHS. This urgent issue is addressed further in Chapter 6.

The interface with hospital sector

Continuity of care is an important aspect of providing best practice health care. While it is not generally practical for a primary health care provider to physically follow a patient into a hospital system, it is essential that the primary health care provider's knowledge of the patient is transferred into the hospital system with the patient and that information from the hospital returns home with the patient. Due to the lack of integrated data systems too much reliance is still placed on failure-prone systems to exchange information. Discharge planning is of particular concern. Too often, patients arrive back in their community or aged care facility with no advance notice of their arrival, changed medications and no discharge notes advising what follow up treatment is required. This issue is further addressed in Chapter 6.

Funding shortages for KPHU Community Health Clinics

There has been no increase in base funding from the WA Government for the employment of staff in town-based Community Health clinics since 1999, despite the steadily increasing population of the region and the expectation that a wider range of services will be provided. The only increase in Community Health funding has come from gaining access to Commonwealth funding.

Suicide rates in the region

The Kimberley has the highest rate of suicide in the state of Western Australia and one of the highest rates in Australia, with more than 20 people per 100,000 taking their own lives each year.[11] The 2008 Coronial Inquest into the deaths of 22 Aboriginal people in the region showed that, although in 2006 there were 21 self-harm deaths in the Kimberley compared to three in the rest of WA, only two of those who died in the Kimberley had a formal history of mental illness and were known Kimberley Mental Health Service clients [12]. This statistic highlights the fact that the majority of people who suicide in the Kimberley region do not have a diagnosed mental illness and therefore do not receive any clinical mental health assessment or coordinated suicide intervention prior to their deaths.

There are many behavioural, social, emotional, historical and economic factors that contribute to the high rate of suicide in the region. Building resilience in the community and increasing early intervention services are seen as key ways of addressing the issue. This is discussed in Chapter 5.7.

Child Sexual Abuse

In 2002 the Gordon Enquiry[13] examined the level of family violence and child abuse in Aboriginal communities. The report identified that some children were growing up in communities where violence was so endemic it had become a normal and ordinary part of life. It also lifted the carpet on a major underlying issue in the region, one that may well be the root cause of many of the Social Emotional Well Being (SEWB) and alcohol and other drug (AOD) issues in the region - that of child sexual abuse. A number of new initiatives were implemented as a result of the Enquiry, largely focussed at government service provider level. Few resources were directed at community-based initiatives.

In the region, a Broome-based inter-agency Working Group of health service providers, counselling services, Deptartment of Child Protection (DCP) workers and other stakeholders was formed to advocate for and implement additional responses. However, since the de-funding of the position which acted as chair and secretariat of the Working Group (the Department of Health and Aging (DoHA) Regional Coordinator), the Group has lost focus. No-one believes that child abuse in the region has ceased. Many problems remain unresolved. For example:

- Shortage of counsellors working with children who are victims of sexual abuse;
- Shortage of police resources to monitor adherence to bail conditions by alleged perpetrators, particularly to prevent the intimidation of witnesses prior to trial;
- Lack of culturally appropriate education materials

11 Kimberley Mental Health and Drug Service (2009) submission to Senate Enquiry into Suicide. *http://www.aph.gov.au/senate/committee/clac_ctte/suicide/submissions/sub118.pdf*

12 Western Australian State Coroner, Mr Alastair Hope (2008). Inquest into 22 deaths in the Kimberley Region. Ref No: 37/07.

13 Putting the picture together. Inquiry into Response by Government agencies to complaints of Family Violence and child Abuse in Aboriginal communities. Sue Gordon, Kay Hallahan and Darrell Henry. 2002.

to educate families about the harm caused by the protection of family members who abuse children;

- Education for the community on the use of restraining orders to protect children;
- Monitoring of/issues surrounding convicted paedophiles who have completed their sentence and return back into the community where their victims and other children live –probably without receiving any treatment while in jail.

For staff in remote clinics the mandatory requirement to report suspected cases of child sexual abuse poses an additional strain requiring ongoing training and support. The potential for retribution on staff is a risk that has to be managed.

The lack of oral health services in the region

Lack of access to comprehensive oral health services for Aboriginal people in the region is now a key gap in service provision in the region, particularly because of its implications for chronic disease prevention and management. This is discussed further in Chapter 5.6.

Accurately counting the Aboriginal population in the region

To plan health services it is essential to start with an accurate estimation of the size of the population to be serviced. One of the major difficulties in planning services for the Kimberley region is obtaining realistic and consistent population figures of the Aboriginal population. Since the 1976 Census, the Australian Bureau of Statistics (ABS) has used an evolving set of procedures tailored to the enumeration of Indigenous people.[14] However, the most recent Census for which results are available, undertaken in 2006, is not held to be any more reliable than previous counts. ABS has admitted to an undercount of Aboriginal people of as much as 24% in parts of the region. KAHPF members have spent time and energy advising ABS staff about issues with census collection methodology and the implications of the undercount. This is not a major issue as long as population-based funding formulae are not adopted by governments. If they ever are, this problem must be resolved.

14 Morphy, Frances (editor) (2007) Agency, contingency and census process: observations of the 2006 Indigenous enumeration strategy in remote Aboriginal Australia. CAEPR Research Monograph. ANU E Press, Canberra.

Overcrowding

Overcrowding is believed to be a significant cause of many of the social health problems in the region, including neglect of children and Foetal Alcohol Spectrum Disorder (FASD). KAHPF members strongly applaud and support a new initiative which allows people to take out a restraining order on their own house to stop people drinking and gambling there.

3. THE SOCIAL DETERMINANTS OF HEALTH

The health status of the Kimberley Aboriginal community is determined by many factors that lie outside the mandate of health services. These include the physical living environment, family social circumstances, lifestyle choices and risk patterns of behaviour. There is now considerable evidence that subtle changes in a child's early environment influence whether people develop chronic disease in adulthood. Studies have also shown that the early environment modulates or "programmes" key hormonal systems involved in growth, metabolism, coping-with-stress mechanisms, and reproduction. This chapter outlines some of the issues influencing children's growth that Aboriginal families have to contend with. Without doubt there is an urgent need to address the matters raised. Some fall clearly into the mandate of government departments, others fall between the cracks. Regardless, it will only be possible to 'close the gap' in Indigenous health by addressing the full range of the social determinants of health. Unless the issues are resolved, health will continue to 'pick up the bill'.

3.1 THE PHYSICAL LIVING ENVIRONMENT

The availability of adequate and functional housing, access to safe drinking water, a consistent electricity supply and an organised waste disposal system are basic elements that preserve and protect life. For most of the mainstream Australian population, these are taken for granted. Despite a significant increase in the proportion of Kimberley Aboriginal communities whose water, electricity and sewerage are provided for by either mainstream utility arrangements or via the Remote Areas Essential Services Program (RAESP) programme, several smaller and/or more remote Aboriginal communities in the region still do not have access to safe drinking water or adequate sewerage disposal arrangements. The resultant poor living conditions contribute to the higher prevalence of disease, injury and premature death.

Examples provided by Kullari Regional Environmental Health Team highlight the situation:

- At Ardyaloon the water usage of the community is too high for the current treatment lagoons to cope with. After a final chlorination treatment, excess water is discharged into the sea.
- At Djarindjin the sewage lagoons have a constant overflow.
- Septic tanks in many outstations and major communities are constantly subject to failure, for a variety of reasons - inadequate maintenance, inappropriate installation eg. groundwater level rising in the wet or on spring tides. Many outstations have toilets that cannot be used in the wet season.

The 2008 Environmental Health Needs Survey (EHNS)[15] provided data on the level of environmental health service provision in Aboriginal communities in each Kimberley Shire and identified the WA priorities for improved infrastructure. These data suggest that much still needs to be done to improve environmental health in the region. For example:

RE WATER SUPPLY

Shire	Wyndham/E Kimberley	Halls Creek	Derby/ West Kimberley	Broome
% population with inadequate source of water	4.8	9.4	11.3	8.8
% population with no disinfection of their water supply	26.9	8.1	6.7	20.7
% population with no monthly water quality testing	23.3	10.1	5.9	21.1
% population with unsatisfactory water supply	20.8	9.9	30.7	11.9

Table 2: 2008 ENHS Water supply data by usual community population

Nine Wyndham-East Kimberley communities were in the top 20% of communities in WA with a usual population of <100 in which water was considered an action priority.

15 Government of Western Australia (2008) Environmental Health needs of Aboriginal communities in Western Australia. Findings of the 2008 survey. Perth.

Seven communities in the Shire of Derby/West Kimberley – Wangkatjunkga, Bayulu, Ngalingkadji, Pandanus Park, Looma, Jimbalakudunj and Jarlmadangah - which had regular testing of their water supply showed issues with microbiological contamination.

RE POWER SUPPLY:

A large increase in the number of communities with unsatisfactory power supplies was noted between the previous Environmental Health Needs Survey EHNS survey in 2004 and the results in 2008. This related to equipment break down (59% of mentions), lack of fuel (45% of mentions), equipment damage (14% of mentions) and no maintenance (10% of mentions).

In the Shire of Broome 57% of communities housing 16% of the remote community population recorded unsatisfactory power supply. In the Shire of Wyndham-East Kimberley, 43% of communities comprising 17% of remote community population recorded unsatisfactory power supply.

RE SANITATION/SEWERAGE:

The top WA communities in need of urgent action due to a greater level of sewage overflow, no connection to a sanitary disposal system or a non-functioning one were:

- In communities with a usual population >100 Kalumburu, Bayulu, Looma and Bidyadanga ranked priority 2-5.
- In communities with a usual population <100: Mindi Rardi, Woolah and Kurnangki ranked priority 1-3.

Of communities using septic tanks/leach drains to dispose of sewage:

- In the Halls Creek Shire 95% of communities (20 out of 21) did not have access to appropriate pump-out equipment.
- In the Broome Shire, 40 out of 50 communities had the same problem.

Of communities using sewage lagoons 6 out of 8 communities in the Broome Shire, 8 out of 19 communities in the Halls Creek Shire and 2 out of 5 in the Shire of Wyndham-East Kimberley reported having inadequate fencing around the lagoons.

RE RUBBISH DISPOSAL:

The top WA priorities for action around rubbish disposal were:

- In communities with usual population >100: Bidydanga, Balgo, Bardi, Bayulu ranked priority 2-5.
- In communities with usual population <100: Djugerari, Billard, Glen Hill ranked 1-3.
- Six communities in the Shire of Derby/West Kimberley reported high numbers of unwanted cars/car bodies littering their community. These were Yakanarra (37 cars), Bayulu (25 cars), Pandanus Park (24), Bedunburra (20), Looma (10) and Gillaroong (10).

RE HIGH DUST LEVELS:

In the Shire of Derby-West Kimberley 23 out of 39 communities affecting a total of 1,610 people recorded high dust levels. In the Shire of Wyndham-East Kimberley 20 out of 35 communities affecting a total of 829 people reported a similar problem.

Two Derby-West Kimberley communities with usual populations >100 and nine communities with usual populations <100 are in the top 20% of communities in WA in which dust was considered an action priority.

Recommendations about improving Environmental Health outcomes are detailed in Chapter 5.12.

3.2 HOUSING

The links between overcrowding and infectious diseases such as scabies, gastro-intestinal infections, trachoma, hookworm and life-threatening diseases such as pneumonia, rheumatic heart disease and renal failure are well established. According to ABS 1996 Census data, between a quarter and a third of all Aboriginal people in the Kimberley lived in households with 8 or more people and most of these were living in houses with three or fewer bedrooms. The 1999 Kimberley Aboriginal Health Plan calculated a deficit of 700 houses for Aboriginal people living in remote communities and the need to build 70 houses per year to keep up with population growth. This matter was taken up with the Kimberley Inter-agency Working Group, a group that included the regional managers of all government Department s in 2005.

More current data from the 2006 Census and the 2008 EHNS suggests there may have been some improvement in the situation if, and only if, the population data collected and/or used is accurate:

> The 2006 Census counted 2,820 indigenous households in the Kimberley. Data from this count show that 450 indigenous households, (16%), consisted of 7 or more people, and that the majority of their houses had 4 or less bedrooms. (However, as the number of indigenous households equates to only 36% of the total households counted, it is possible that not all households were counted or identified as indigenous).
>
> In 2008 the EHNS surveyed the number of people living in houses in remote communities. Their findings were that in the Kimberley dwellings classified as adequate (ie connected to power, water and sewerage) there was an average of 6.45 people living in or sharing each dwelling.

However, while the situation for some people may be improving, there is obviously still a long way to go to end overcrowding and regional inequity. For example;

- The 2006 Census recorded that 27% of the indigenous households living in a 3 bed-roomed house in the Shire of Halls Creek consisted of 7 or more people, whereas only 10% of households living in the same size house in Broome Shire had an equivalent level of overcrowding.
- In 2008 the 400 people living in Balgo community reportedly had access to 30 houses that were fit to live in[16].
- An investment of new housing in Halls Creek did little to alleviate the chronic shortage of housing in that town, with a net gain of only 3 to 4 houses as many older houses had to be demolished[17].

Recent years have seen a complete change in government arrangements for funding the building and refurbishment of Aboriginal housing, including some privatisation of housing provision and management. It remains to be seen whether this will deliver better outcomes for Aboriginal people. The tension between building 'modern' houses and the need for locally-appropriate houses that have large, breezy outdoor areas and can easily be cleaned remains unresolved.

16 Parliament of Australia, Senate daily summary updates, No. 50/2008 Tuesday, 2 September 2008

17 Information cited in KDGP (2008) Kimberley Primary Health Care Sustainability Study 2008 – 2030.

Further, recommendations in the Fitzroy Crossing Local Implementation Plan (LIP) 2010 identified that the provision of housing without additional support is not enough. The advice from the Fitzroy Crossing community was:

> in addition to providing public housing, Homeswest should be funded to provide very basic furniture, particularly beds which would raise mattresses off the floors. Provision of such furniture should only occur in circumstances where an identified person has accepted responsibility for the furniture and the furniture should, like the housing provided, be subject to audit.
>
> a home maker programme should be developed to improve people's life skills so that they understand how to maintain the homes provided to them in a clean and hygienic state.
>
> future planning for construction of public housing for Aboriginal residents of the Kimberley must specifically addresses the particular wants and needs of the people involved and includes consideration of alternatives to individual houses designed for the needs of nuclear families, such as provision of cluster housing and other forms of housing which enable different levels of communal living, particularly when these alternatives provide a less expensive option.

3.3 FOOD SECURITY

Food security is defined as "access by all people at all times to the food needed for a healthy life. Achieving food security means ensuring that sufficient food is available, that supplies are relatively stable and those in need of food can obtain it".[18]

Although access to adequate food for a nutritious diet is a basic human right, many Aboriginal and Torres Strait Islander people do not have the same access to safe and healthy food as non-Indigenous people. For most people who live in remote communities the major source of food is the community store. Food is transported across great distances and in extreme temperatures which adds to the cost of delivery. Issues concerning food supply relate to the cost and quality of goods for sale, in particular

18 National Rural Health Alliance (2006) Providing fresh food in remote Indigenous communities. Position Paper. Deakin West, ACT from http://nrha.ruralhealth.org.au/cms/uploads/publications

for perishable foods, governance of the store, transport of the food from the source to the community, health hardware in the home for storage and preparation of the food, and the income required to buy the food in the first place. In many families people humbugging others for food or taking food without permission is a constant problem that remains to be solved.

Over the last few decades lifestyle conditions, such as diabetes, heart disease and obesity, have become more prevalent in remote communities. Eating good food is an essential part of the prevention and management of chronic diseases. The inability of people to access nutritionally adequate and culturally acceptable food at all times is contributing to the incidence of chronic disease and the difference in life expectancy between Indigenous and non-Indigenous Australians. Also, to reduce the risk of children suffering nutritional anaemia or malnutrition, there is a need for good food to support maternal and child health.

Anecdotal observations of people making poor food choices abound. Highly-sugared cool drinks, chips and pies rather than fruit and vegetables continue to be the food choice of many in the Kimberley. This is supported by evidence gathered in the Northern Territory (NT) during 2005 which found that Aboriginal people's dietary decisions, when made within the context of sustained budgetary constraints (i.e. little money) were driven by maximising energy value for money (calories for dollars spent) resulting in energy-dense, nutrient-poor diets, high in refined carbohydrates and low in fresh fruit and vegetables. The researchers[19] contend that this is consistent with the 'economics of food choice' theory, whereby people on low incomes maximise energy availability per dollar in their food purchasing patterns.

The local store has the potential to play a pivotal role in improving the social, economic and health outcomes of remote communities. Reliable, community based information, describing the impact that community stores have on the health and wellbeing of Aboriginal people in the Kimberley is limited.

While community stores represent an opportunity to lead change and there are positive examples of stores that provide a wealth of services, training and health benefits, these successes are scattered. In too many communities, the high prices and limited availability of healthy food, combined with low income and social dysfunction which means people cannot store food securely in their houses, are continuing barriers to healthy eating. A recently published study of the correlation between the quality of food sold in 6 community stores in the Fitzroy Valley[20] found stores ranking higher in quality correlated positively with self-assessed health status as well as individual triglyceride levels. Participants who purchased foods from stores with higher quality scores felt they had enough money to purchase healthy food and they purchased significantly more vegetables, even though stores with higher quality scores were more expensive overall.

The Kimberley has more remote community stores than any other region in WA. Given their importance, more can and must be done to ensure these stores meet the needs of the communities they serve. The 2009 Everybody's Business report into community stores by the House of Representatives Aboriginal and Torres Strait Islander Affairs Committee[21] noted:

> It is the Government's role to ensure that Aboriginal and Torres Strait Islander people along with non-Indigenous Australians living in remote areas of Australia have access to a secure food supply.....

KAHPF believes it is time Government fulfilled their role in this regard. The COAG National Food Strategy was signed off more than 12 months ago, and it is unacceptable that no implementation funding has been provided by the WA or Federal Government.

Recommendations:
KAHPF supports the following recommendations adopted from the FoodNorth report produced by the North Australia Nutrition Group[22]:

A. Despite a number of initiatives, there is still a need for a high level 'whole of government approach' to resolving food security issues across the whole of Northern Australia. This includes support for price control, reducing freight costs, requiring adherence to food safety and transport regulations coupled with capacity building initiatives for stores to establish clear governance mechanisms, cost structures and pricing policies, transparency in accounting and reporting and for communities to decide if stores are profit making enterprises or essential community services.

19 Julie Brimblecombe, Menzies School of Health Research, Darwin, and Prof Kerin O'Dea, Sansom Institute of Health, University of South Australia

20 Bussey, C (2012) Community stores influence the health of Aboriginal people living in the Fitzroy Valley region of the Kimberley. Australian Indigenous Health Bulletin 12(1)available from http://healthbulltein.org.au/articles/community-stores-influence-the-health-of Aboriginal-people-living-in-the-fitzroy-valley-region-of-the-kimberley/

21 House of Representatives Aboriginal and Torres Strait Islander Affairs Committee (2009) Everybody's Business. Remote Aboriginal and Torres Strait Community Stores. Commonwealth of Australia.

22 Leonard D, Turner C, Hobson V, Pollard C, Lewis J, Bowcock R (2003). FoodNorth: food for health in north Australia. North Australia Nutrition Group, Department of Health, Western Australia.

B. The need for the implementation of a range of initiatives which improve food supply, including:

- Improving retail practices via an accreditation system.
- Development and dissemination of healthy food stocking guidelines for stores and take-aways.
- Improved food preparation in take-aways.
- Introduction of a standardised system to identify healthy foods in stores and take-aways.
- Collaboration with industry to produce products suitable for remote stores.
- Investigation and implementation of mechanisms to subsidise healthy food in community stores, including investigation of ways to reduce freight costs.
- Development of standardised training for store managers which includes transport and storage of food, nutrition, training local staff and business skills.

C. Establishment of a standardised system for monitoring and evaluating the availability and cost of food in remote communities in the Kimberley.

D. Expansion of the nutrition workforce in the region via:

- Ensuring that all Aboriginal Health Workers (AHW) are trained in nutrition.
- Providing improved/standardised training to store workers regarding looking after fruit/veg and organising store layout to promote healthy food choices.
- Providing cold chain management training for transport workers.
- Including a basic nutrition component in Food Safety training.

E. Increasing the demand for healthy food via community based programmes and local media promotions such as that implemented in Billiluna community in 2009.

In addition, KAHPF also supports initiatives which lead to the establishment of community gardens and orchards.

3.4 EDUCATION

The strong links between levels of education and improved health outcomes have been the subject of many studies. It is of concern that the 2011 report on Overcoming Indigenous Disadvantage[23] found that:

- Evidence suggests that many Indigenous children are leaving school in years 9 and 10 with poor literacy and numeracy skills, and with limited post school options.
- almost one-half of Indigenous young people in remote areas are not working and not studying.
- The 2006 Census found that while 73% of indigenous 15 year olds are attending school, this figure drops to 36% for 17 year olds[24]. Secondary school attendance for the Indigenous population generally decreased with remoteness.

Data from the Kimberley confirms these trends. National Assessment Program – Literacy and Numeracy (NAPLAN) data, which is used to evaluate literacy and numeracy achievements of Year 3, 5, 7 and 9 students across Australia, indicates that in Kimberley public schools, Aboriginal students consistently perform at lower levels than non-Aboriginal students. In 2011, Aboriginal attendance in Kimberley government schools was 75.27% in Years K-7 and 60.06% in Years 8-12.

The WA Education Department has a number of programmes to attempt to close the gap between the attendance rates of Aboriginal and non-Aboriginal students. At the present rate of annual improvement, the gap between Aboriginal and non-Aboriginal students in the region will be only 7.1% by 2014. These programmes include:

- Employment of 15 School-based Attendance Officers - Aboriginal workers whose role is to work with non-attending students and their families on a 1 on 1 basis to address the issues impacting on school attendance.
- Implementation of the Stronger Smarter schools programme developed as a result of the transformational leadership of Dr Chris Sarra at Cherbourg government school in Queensland, an approach that embraces a positive Indigenous student identity; Indigenous leadership in schools and communities; high expectations for teacher-student relationships; and innovative, flexible and receptive staffing and schooling models.

23 Commonwealth of Australia Steering Committee for the Review of Government Service Provision. (2011) Overcoming Indigenous Disadvantage: Key Indicators 2011. www.pc.gov.au/gsp

24 Australian Bureau of Statistics (2006) Indigenous Statistics for schools

- A new liaison position has been created – a teacher who will work with Child and Adolescent Mental Health Services in Broome to provide a holistic service for children in need.
- A central schools database has been created, covering government, catholic and independent schools in the region. This makes it possible to track the location of every student in the region.

The Department of Education acknowledges it is a challenge to provide a programme for secondary students in remote communities, as community schools are staffed as primary schools. Parents are encouraged to consider boarding school or residential college as options. School partnerships with VET in school (VETIS) providers has also proved to be a good way of keeping male Aboriginal students involved in school/training. For example, VET pays for a bus to take 17 students from Wangkatjungka into Fitzroy Crossing to attend Technical and Further Education (TAFE) one day a week. A similar programme funds Looma students to attend TAFE in Derby.

It is the view of staff in the Education Department that the answer to improving school attendance is not more programmes. Neither is it prosecution of a family which does not send its children to school - an action that has never yet been taken in the Kimberley. Rather it is improved inter-agency collaboration, information-sharing and referrals between organisations such as the Department of Child Protection and health service staff which may improve family functioning and thereby school attendance. Measures such as allowing the Department of Education to refer families to the Strong Families programme may also assist.

A trial in Broome has also demonstrated how clinical input in the classroom provided by allied health staff has generated improved education outcomes for the children involved. While there will be long term health benefits for these children, the immediate benefit is to education providers who have less under-performing/disruptive/demanding children in their school. If this trial is to be repeated and/or applied more extensively, it is the view of health service providers that as both Health and Education providers benefit, costs should be born equally.

Recommendations:

- That school sectors and health service providers establish processes for sharing information and working collaboratively to provide services that support each Kimberley child's development through schooling to successful post-school options.
- That KAHPF advocates with the WA Department of Education for the costs of providing allied health support to children in classrooms to be born equally by themselves and the relevant health service provider.

A LOOMING ISSUE

Findings of the study into the prevalence of children with FASD in the Fitzroy Valley will be released in 2013. The issues these children face may also be affecting their school attendance. If, as is expected, prevalence rates are found to be high, this has an enormous impact on support needs for these children, both at school and in the community. The issue is further discussed in Chapter 5.2.

3.5 FAMILY FUNCTIONING

Aboriginal community consultations associated with the WA Aboriginal Child Health Survey[25] stressed the importance of family as a major source of strength to Aboriginal people. Family is important in defining identity and a sense of connectedness to kinship and culture. The ways in which families operate can help children cope with disadvantage, adverse life experiences and stress.

The study examined several aspects of children's lives including family functioning. The factors most commonly associated with poor family functioning appeared to be financial strain, over-use of alcohol causing problems in the household, isolation (not having someone to yarn to) and relationship issues (not doing things together, not showing signs that they care, arguments etc). A strong association was found between poor family functioning and children's behaviour problems. Almost half of the children at high risk of clinically significant prosocial behaviour (45.8%) were in families with poor family functioning. Problems included emotional and conduct problems, hyperactivity and peer problems.

25 Western Australian Aboriginal Child Health Survey vol 4: pg 263. (2006) Telethon Institute for Child Health Research.

Data on Aboriginal families in the Broome/Kullari region[26] provide an indication of the situation in the region:

- 37% of children in the Broome region were looked after by a sole parent; 14% of children were in the care of someone other than an original parent; 39% of children were with both original parents.
- Financial strain was experienced by 52% of families (i.e. they were spending more money than they got, or had just enough money to get through to next pay.) Financial strain was more likely in sole parent households than in two original parent households.
- 400 (26%) children and 140 (27%) primary carers were in families that were functioning poorly.

Questions were also asked about the quality of parenting – respondents being asked how often they hit their children, how often they laughed together with their children and how often they praised their children. From their answers it was found that 19% of Aboriginal children in the Broome region live in families with poor quality of parenting; 52% live in families where the quality of parenting is very good.

The WA Aboriginal Child Health survey also examined the impact of stress on families. Families of Aboriginal children reported extraordinary levels of stress – death, violence, incarceration, and severe hardship. For example 14% of Aboriginal children in the Broome region aged 0-17 were living in families where 7 to 14 major life stress events had occurred over the preceding 12 months.

The findings of the True Words – Real Life[27] report produced by KAMSC in 2002 reinforce the findings of the WA Aboriginal Child Health Survey in regard to the level of stress occurring in Aboriginal families in the Kimberley. The KAMSC research involved 368 Aboriginal and 283 non-Aboriginal youth, average age 14-15, from across the Kimberley. It found that Aboriginal youth had experienced and witnessed far more trauma than non-Aboriginal youth and that many young people reported symptoms suggestive of post traumatic stress disorder. Findings included:

- 65% of Aboriginal youth had witnessed domestic violence; 50% had witnessed criminal behaviour; 37% had witnessed suicide attempts, 32% had witnessed drug deals and 24% had witnessed sexual abuse.
- 32% had experienced an attempted suicide of a family member, 28% had experienced threats of violence, and 25% had experienced actual violence; 19% had experienced gang fighting and 11% had attempted suicide.
- Aboriginal youth used negative coping skills eg smoking gunja, running away, getting wild, thinking about suicide much more often than non Aboriginal youth, and much more often than they used strategies such as seeking help to deal with the problem.

These young people who provided insights into their lives as teenagers are the young parents of today – very probably still facing exactly the same problems that they faced as teenagers. It is important to recognise that their life experiences may not have equipped them with the appropriate understandings and skills to be parents of strong healthy children. Measures that support men to be fathers and more engaged with their families are particularly necessary.

Recommendations:

- KAHPF continues and enhances its lobbying and advocacy efforts to get issues of overcrowding, environmental health and access to municipal services addressed.
- All KAHPF members make additional efforts to raise awareness in the population they serve of the crucial importance of the physical and social environmental in the early years of a child's life.
- KAHPF supports the rollout of culturally-appropriate parenting programmes, for example the "Hey Dad - for Indigenous Dads Pops and Uncles program."

26 The Kullari region was the old ATSIC region covering the town of Broome, the Dampier Peninsula and the community of Bidyadanga.

27 Kimberley Aboriginal Medical Services Council (2002) True Words – Real Life.

4. PREPARING FOR THE FUTURE: NEW WAYS OF WORKING

This plan is focused on the delivery of primary health care services to the Aboriginal population of the Kimberley, services that are provided in an ACCHS, a Kimberley Public Health Unit (KPHU) clinic, out in a community or school, or in the emergency Department of a Kimberley hospital.

For the past ten years most services in the region have essentially been configured and focussed as they are today. This chapter makes a case that, if the burgeoning health needs of the region are to be addressed, new ways of working and new models of service delivery are required. Increased access to Medicare payments and flexibility of Commonwealth grant funding provide an opportunity to change focus and work smarter rather than harder. Innovative inter-agency service delivery models are now possible.

This chapter of the Plan gives examples of some of the different service delivery models that are being/could be trialled and highlights some of the possibilities that new funding arrangements provide. It raises a number of issues that boards and managers need to consider, and canvasses the opportunities and threats presented by changes to decision-making in the region.

Best practice, comprehensive primary health care delivery in a remote Australian context has the following characteristics:

- Freely available and accessible.
- Provided locally and managed locally or regionally, with significant Aboriginal community 'buy in'.
- Cultural health practices are valued and cultural beliefs about health are preserved.
- A holistic approach to health issues is adopted, encompassing medical, psychological, family, social and cultural dimensions which may require an inter-agency or team-based approach.
- Generalist health staff provide most care for conditions which are common in the region, even if in urban settings these conditions are mainly managed by specialised services. In the Kimberley this includes conditions such as diabetes including foot care, chronic kidney disease, growth faltering in children, acute and chronic lung conditions, sexually transmitted infections and cardiovascular risk factors.
- Rather than a focus on clinical service provision, local specialised services (regional medical specialists, regional allied health staff, regional specialised nursing staff etc) provide a greater amount of education and support for local staff than they might provide in an urban setting to support generalist provision of care (eg podiatrists support PHC staff to provide routine foot care for diabetics without significant foot problems). Direct clinical services are primarily only provided to patients with high/complex care needs.
- Provision of medical specialist services involves substantial regional input and management of waiting lists to maximise productivity.
- Collaborative partnerships exist with other community and government bodies involved in Aboriginal health.

Kimberley ACCHS believe that the status of Aboriginal health in the Kimberley is at a critical tipping point as a result of a 'tidal wave' of chronic disease and mental health issues[28]. Addressing this requires new ways of thinking and working, particularly and as a priority:

> Recognition that achieving significant improvement in the health status of Kimberley Aboriginal people requires much greater emphasis on early intervention and prevention.
>
> Changing work practices to trial and implement ways which empower Kimberley Aboriginal people to accept greater responsibility for their own health. For example placing greater emphasis on promoting personal and family responsibility for diet and nutrition, physical exercise and self management of chronic diseases.
>
> The need for greater involvement of Aboriginal people at all levels in the planning, implementation and delivery of health services across the region and across service providers to make services more appropriate, effective and culturally safe
>
> Developing stronger service delivery

28 KAMSC Strategic Plan 2011-2020

partnerships and new cross-sector linkages that strengthen care pathways and deliver a more seamless continuum of Aboriginal patient care encompassing many providers.

Providing equitable access to service across the region

In reality, primary health care providers operate in a complex and difficult environment. There are inevitable and unavoidable tensions involved in continually balancing competing priorities and expectations which require managers and boards to make difficult decisions about where their service will focus its energies, for example:

High health needs	v	Limited resources
Initiating new services and programmes	v	Consolidating existing services and activities
Empowering families to take greater responsibility for their own health	v	Provision of high-quality clinical services to patients
Responding to the needs of the community	v	Meeting the expectations of funding bodies
Resourcing clinical services	v	Resourcing preventive services
Employing Kimberley Aboriginal people	v	Employing formally qualified people
Providing services where they are needed	v	Recruiting and housing staff to work in remote communities

4.1 THE NEED FOR EQUITABLE SERVICE DELIVERY

The distribution of health programmes in the Kimberley resembles a patchwork rather than a consistent pattern. While there are historical reasons why this has occurred, continuation of the inequity revealed in Appendix 2 is not acceptable. As a basic principle, remote communities of a similar size and distance from town-based services should have equivalent levels of service, regardless of who their preferred service provider is. KAHPF recommends that at a minimum:

- Communities with regular populations of over 250 should have an onsite health service with an on call capacity.
- Communities with a regular population of between 100 and 250 should have an onsite health clinic staffed by 2 health professionals, either Senior Aboriginal Health Workers (SAHW) or Registered Nurses (RN).
- Communities with a regular population of 50-100 which are not within easy access of a community or town clinic should have a fortnightly visit by a health team.
- Communities with regular populations of less than 50 should be serviced on an as-needed basis.

These recommendations should be varied for communities such as Ringers Soak, where seasonal access to town is impossible/particularly difficult. To achieve this equity requires considerable additional funding for staff housing, staff positions, vehicles and operating costs. New capital works for Noonkanbah are scheduled for completion at the end of 2012, but no allocations for staffing have been made to date.

Recommendation:

Increased provision of primary care services to communities in the Fitzroy Valley, particularly the provision of onsite services at Noonkanbah and Wangatjunka, is the first priority for additional funding. An increase in operational funding for Noonkanbah and capital and operational funding for Wangkatjungka are required.

4.2 POTENTIAL NEW SERVICE DELIVERY MODELS

In the towns of Broome, Kununurra and Derby which have sufficient Aboriginal population and a significant non-Aboriginal population to support a number of discrete primary health care services, patient choice is encouraged. However, in smaller towns, where a number of services are providing the same/similar services to a relatively small number of predominately Aboriginal people, a strong argument can be made for the need to coordinate/divide service delivery to ensure roles and responsibilities are clear and no duplication occurs.

Halls Creek is an example of a site where it is probable that fine tuning the service delivery arrangements would result in better patient outcomes. At present, Yura Yungi Aboriginal Medical Services, Halls Creek Community Health and Halls Creek Hospital Emergency Department all provide similar services and it is highly likely that clients attend each service at some time. All 3 organisations face the same problems of recruitment and retention. The Local Implementation Plan (LIP) for the Halls Creek Remote Service Delivery site states that, in 2011, meetings were held to identify the strategies

required to improve local service coordination and partnership planning. Blockers to implementing the strategies identified included service capacity and resourcing for a coordination role.

KAHPF recommends that a priority initiative for 2012-13 is employment of a project officer with health service experience by a Kimberley health service provider to initiate and lead discussions on how health services in Halls Creek could establish better arrangements for working together or be reconfigured to best meet community needs.

PROVISION OF PRIMARY HEALTH CARE IN EMERGENCY DEPARTMENTS

82% of Aboriginal attendees in emergency Department s (ED) in the Kimberley are for non-urgent services (triaged at level 4 or 5)[29] – typically upper respiratory tract infections, feverish babies, skin infections and refilling of repeat prescriptions. Patients present with minor conditions that could be self-managed with mild pain relief or over the counter medicines. These presentations provide an opportunity to provide best practice primary health care services in the ED to a cohort of the population who may not attend regular Primary Health Care (PHC) services. The availability of Section 19.2 funding provides an incentive for this type of restructuring.

A change in ED arrangements currently being trialled in the hospital at Fitzroy Crossing has resulted in a shift of category 4 and 5 patients who would previously been seen in the ED to the GP outpatient clinics. This has resulted in greater patient-centred primary health care in accordance with the Royal Australian College of General Practitioners definition of primary health Care. Elements of the model include:

- A revised appointment booking system as a result of a consumer survey. Greater access to walk-in appointments in the morning and additional booked appointments in the late afternoon. Results can be demonstrated by the following data:
  - For the period August 2010 to August 2011 the GP clinic attendance rate was 67% compared to 85% from August 2011 to March 2012 year to date.
  - There has been an approximate 300% decrease in reportable triage category 4 and 5 attendances, with an approximate subsequent 300% increase in GP outpatient attendances.
- A practice nurse managing patient recalls, Aboriginal Health Checks, management plans and team care arrangements.
- An additional Aboriginal Liaison Officer working with the practice nurse managing patient transport and ensuring improved access to the hospital by managing notification of appointments and required follow-ups and collecting patients for recalls.
- A dedicated Clinical Nurse managing specialist outpatient referrals and clinics.
- Adherence to regional chronic disease treatment protocols.

The key to the success of this model is the availability of a primary health care-focussed doctor working in a multi-disciplinary team.

A trial in Broome also yielded positive outcomes. Aboriginal people who regularly attended ED at Broome Health Services were supported to become more proactive in managing their health. An appointment was made for them at BRAMS, and assistance provided to ensure they attended. A number of screenings and checks were performed at the first appointment and, over time, a care plan was developed.

KAHPF recommends that the possibility of restructuring ED arrangements in other Kimberley towns, particularly Halls Creek, Derby and Wyndham, should be explored.

BEST PRACTICE WAYS OF WORKING COLLABORATIVELY AT THE LOCAL LEVEL: SOME EXAMPLES

The development of the shared care model for the New Directions-funded Midwife on the Dampier Peninsula, who will work in 4 communities and in both WACHS and KAMSC clinics, provides an example of a strategic way of ensuring that effective working arrangements are established. Components of this model include:

- A MOU between the services that will be working together, including Save the Children, WACHS and the Dampier Peninsula communities.

29 Dept. Of Health Epidemiology Branch and WACHS (2009) Aboriginal Health Profile. Kimberley Health Region. Perth

- Employment of Local Family Support workers to ensure the Community Midwife has access to community members and works in a culturally appropriate way.
- Formation of a Community Engagement Group comprising the locally-employed Family Support workers and community representatives from all four communities to advise and provide feedback on engagement strategies.
- Formation of a Technical Advisory Group to identify processes to ensure the model of care developed provides effective service delivery in the Dampier Peninsula.

The Health Mob in Broome

Engaging itinerant people in primary health care is a challenge. The usual pattern is for people to wait until they are very sick and then present at the Emergency Department . To address this issue in Broome, an innovative project has been designed to take health to the people. Once every two months a Health Mob team comprising doctors from BRAMS and chronic disease nurses from Boab Health and KPHU spend two weeks providing a morning clinic either at the Sobering Up Shelter or the Father McMahon Centre's breakfast club. Services provided include screening, health checks, blood tests, immunisations, sexually transmitted infection (STI) checks, medication reviews and any other follow up required. As a result, several people who were on insulin have been encouraged to begin taking it again; 6 people have been hospitalised – admitting them before a crisis meaning that less bed days were required. In 2012 this programme will be expanded to include a monthly clinic at the One Mile community.

An example from OVAHS is provided in Chapter 5.11

4.3 STAFF CONFIGURATIONS

THE ROLE OF AHWS IN THE PROVISION OF PRIMARY HEALTH CARE

Primary health care provision in the Kimberley, particularly in ACCHS, relies strongly on Aboriginal Health Workers. These staff members have the local knowledge and cultural skills to ensure that the service provided meets the needs of the local community. Their role in the early identification of children at risk and chronic disease is crucial. Over the past 5 years[30] KAMSC has graduated the following numbers of students who could occupy positions in the region:

52	Certificate III in Aboriginal Health Work
29	Certificate IV in Aboriginal Primary Health Care Practice
34	Diploma in Aboriginal Primary Health Care Practice
63	Advanced Diploma in Aboriginal Primary Health Care Practice (Medication II)

New national AHW training standards and registration facilitate the movement of AHWs between employers.

Many Aboriginal Health Workers have provided invaluable service to their employers and community for many years. However, in other instances, the sad reality is that positions are vacant or AHWs with performance and attendance issues are left unmotivated and un-managed for long periods of time. The reasons for this under-performance are, of course, multiple. Aboriginal Health Workers may have all the health burden and family problems of the community they are serving. The negative impact of Homeswest's income test on access to housing is discussed in detail in Chapter 7. Poor or frequent change of managers or supervisors often results in demoralised staff and unstructured work plans. Regularly pulling programme staff into the clinic to cover staff shortages sends a negative signal about the value of their early intervention programmes. Within WACHS, accepted scope of practice provisions limit the tasks Aboriginal Health Workers can do. Comparatively low pay rates, the lack of a career path within the WACHS structure and lack of fluidity across award streams makes WACHS uncompetitive in sourcing AHWs. Unfortunately, some AHWs may need to be performance-managed or encouraged to consider alternative employment options.

However, under-performance may also relate to organisational culture. For any worker, job satisfaction comes from the sense that they are providing an important and valued service in an organisation which they feel proud of and where they are treated with respect. Getting the best out of all workers is the job of managers/team leaders – to create structured team environments where roles are clear, adequate training, supervision and support is provided and employees have the opportunity to gain professional development and advance their career. Excellent Nurses and SAHWs do not automatically make good team leaders and managers. Management requires a different set of skills which have to be learnt. In all services, recruitment issues mean finding team leaders with the required clinical and management skills may involve compromise. Without doubt, the management skills of team leaders to

30 Students graduating between 2007 and 2011 inclusive

motivate, support, task and review staff performance can be improved.

New Practice Incentive Payments (PIP) from Medicare, which allow practices to claim payments for up to 5 visits to AHWs with provider numbers as part of a Chronic Disease Management Plan and follow up care (Item 721/723) or for a patient of any age needing follow up care (Item 715), provide an incentive to review and re-envision the role of AHWs in services. In these times when the demands on services are increasing, it is important to have every member of a team working at full capacity. It is therefore timely for all services to be investing in leadership, supervision and performance management training for managers and team leaders.

KAHPF recommendations:

- KAMSC and WACHS work together to develop a standardised scope of practice for AWHs across the region.
- Resolution of issues around industrial awards for AHWs in WACHS should be explored.
- KAMSC Centre for Aboriginal Primary Health Care Training, Education and Research (CAPTER) unit develop a clear training pathway which enables AHWs to progress to graduate qualification level.
- In 2012-2013 and then annually, KAMSC CAPTER unit organise for supervision/ team leadership training to be provided in each Kimberley town, and open to all health service providers, on a cost-recovery basis (with the cost to attendees to include KAMSC's administrative costs).

THE POTENTIAL ROLE OF NURSE PRACTITIONERS

In locations where there is no permanent GP presence and access to medical staff is difficult, it may be timely to review the potential for employing nurse practitioners, particularly in remote clinics.

In the words of the Department of Health [31], a nurse practitioner is a registered nurse educated to a master's degree level and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include, but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. Nurse Practitioners are already employed in at least one ACCHS – Geraldton Regional Aboriginal Medical Service - where they perform adult and women's health checks. The availability of PIP payments for services undertaken by Nurse Practitioners provides an added incentive for organisations to consider the possibility of their use.

31 Department of Health website. What is a nurse practitioner from http://www.nursing.health.wa.gov.au/career/np_what.cfm

4.4 THE POTENTIAL FOR USER PAYS ARRANGEMENTS

The presence of prisons, work camps and detention centres in the region provides the potential for user-pays arrangements to be established for provision of health services to these facilities. WACHS is already providing services to the Curtin Detention Centre paid for by the Commonwealth Government. Boab Health Services is also exploring user pays options for some allied health services.

4.5 BUILDING THE LOCAL WORKFORCE

A key strategy for resolving the issues of staff housing and staff retention is to build the local workforce. A number of ways of doing this are being implemented in the region. These include:

- Providing staff with paid study leave to gain/improve their qualifications.
- Employing people when they begin training so their financial situation allows them to study.
- Buddying up new staff and staff in training with experienced/senior staff members.
- Encouraging people in entry level positions to consider taking on a more challenging role.

Recommendation:

All services need to review and strengthen the measures they are taking to build their local workforce.

4.6 IMPROVING ACCOUNTABILITY: THE NEED TO EVALUATE ACTIVITIES

At present boards and managers tend to focus on financial accountability. However, accountability for the quality and effectiveness of the services provided must also be considered if organisations are going to work smarter and improve health outcomes. This requires much more than merely counting health outputs (for example, how many people seen, how many children weighed). The real questions are: how much positive change has your activity generated, and if not much, why not and what needs to change?

Best practice evaluation involves assessing the strengths and weaknesses of programmes, policies, personnel, products, and working arrangements to improve their effectiveness. Major reviews should involve something more rigorous and credible than an organisation evaluating their own activities. However, while external expertise may be deployed, if at all possible, evaluations should be undertaken by local professionals who understand the particulars of operating in a Kimberley environment. Ideally, the evaluation criterion should be identified before a project is implemented and incorporated as part of a continuous quality improvement cycle.

In 2009 Dr David Atkinson suggested the establishment of a local joint (KPHU,KAMSC and others) body to oversee the monitoring and evaluation of outcomes of preventive and curative primary care services for Aboriginal people. He envisaged teams of local clinicians with additional coordination and administrative support. This idea was well received but, due to other priorities, has not progressed further.

Other possible ways of ensuring more programme/ service evaluation occurs in the region could be:

- Whilst organisations may already employ Quality Officers to ensure they remain compliant with accreditation requirements, their role could be widened and teams strengthened so that they form a nucleus of staff available to undertake programme evaluation in other services in the region. Organisations that do not have quality officers should consider the long-term value of such appointments.
- The presence of the Nulungu Centre for Indigenous Studies at the Broome Campus of Notre Dame University and the Rural Clinical School of WA provide an opportunity to consider external programme evaluation. Whilst engaging with external academic units may, in general, be considered risky and expensive, involving ongoing effort to ensure they follow your agency's agenda rather than their own academic imperatives, the rhetoric from Nulungu[32] implies a new style of partnership which may be worth exploring.

Recommendations:

Wherever possible, all future applications for programme funding will be evidence-based and include a specific amount for evaluation.

KAHPF will establish an inter-agency Working Group to explore options and make recommendations about ways that the evaluation of health programmes in the region can be improved.

4.7 PREVENTING FRAGMENTATION OF SERVICE DELIVERY

An issue which KAFPF must manage is the increasing tendency towards fragmentation of service provision in the region as more providers appear on the scene. Multiple organisations delivering similar services to small populations often result in confusion and people falling through the cracks. Small offices with only one or two staff in a town often result in poorly coordinated and inconsistent service delivery where staff are 'set up to fail' due to lack of local support and supervision and their perceptions about their inability to make inroads into the needs they are addressing.

KAHPF recommends that if, for some reason, future funding cannot be channelled through an existing major service provider, the funding body must require the development of MOUs, referral arrangements and initial and ongoing joint service planning with existing local providers before a new provider can begin operating in the region.

32 See http://www.ndcis.org.au/

4.8 FUTURE CHANGES TO DECISION-MAKING FOR THE KIMBERLEY

THE CREATION OF MEDICARE LOCALS

Structural reform being driven by the Commonwealth government will see the establishment of Medicare Locals as independent primary health care organisations in WA. Their role will be to work with the full range of GP, allied health and community health providers to provide better services, improve access to care and drive integration between services.

As with past national approaches, it is difficult to see immediately how this 'one shoe fits all' approach will benefit Aboriginal health in the region. However, to ensure it at least does no harm, KAMSC has worked closely with Boab Health Services (previously the Kimberley Division of General Practice) in planning for the new service.

The application [33] for the new Pilbara Kimberley Medicare Local contains a number of provisions which should ensure ongoing collaboration between the new organisation and the KAHPF whilst protecting the integrity of the current KAHPF arrangements.

- The new Medicare Local will not be a service provider.
- Office of Aboriginal and Torres Strait Islander Health (OATSIH) or WACHS funding will not be channelled through the Medicare Local.
- The governance arrangements will be clearly set out in a constitution and explanatory memorandum.
- The Chairperson of the KAHPF will be a non-voting advisory member of the Governing Body of the new Medicare Local.
- A Heads of Agreement which sets out the basis of an agreement between parties regarding the formation of the Pilbara Kimberley Medicare Local was signed in July 2011 and operates for 2 years.
- In relation to planning to address community needs, the application for Pilbara Kimberley Medicare Local states: "These organisations (ie Planning Forums) being properly governed, being inclusive and acting in a collaborative manner and with the sole object of better outcomes for their constituency seem well placed to fill the role of providing planning and service delivery strategies to the Medicare Local."

33 Pilbara Kimberley Medicare Local Application Attachment 3 Heads of Agreement

Recommendation:

That a report on activities and issues for the new Pilbara Kimberley Medicare Local becomes a standing agenda item on the agenda for KAHPF meetings and that KAPHF strongly resist any future attempts to have the Medicare Local make decisions about funding for services to Aboriginal people in the Kimberley.

THE TRANSITION FROM WACHS TO NORTHERN AND REMOTE COUNTRY HEALTH SERVICE

On 1st July 2012 WA Country Health Services (WACHS) will cease to exist. Kimberley services will be provided by the Northern and Remote Country Health Service. The Northern and Remote Country Health Service will comprise:

- Four regional health campuses at Broome, Geraldton, Kalgoorlie and South Hedland.
- Six integrated hospitals at Carnarvon, Derby, Esperance, Kununurra, Newman and Nickol Bay.
- 19 small hospitals and 4 nursing posts in regional and remote locations.
- Numerous community based health centres.

The impact, if any, of this new arrangement remains to be seen. Some issues that may require close attention from KAHPF:

- The new health service includes the current WA Country Health Service regions of Goldfields, Kimberley, Midwest and Pilbara. No reduction in or redistribution of the WACHS Kimberley budget, particularly the Population Health budget, should occur as part of this restructure.
- Recent arrangements which provided additional Commonwealth funding to WACHS-Kimberley on the basis that there would be no reduction of WA government effort, must be adhered to.
- The new Health Service will have a Governing Council of community members and clinicians. District Health Advisory Committees will continue to exist. Calls for Expressions of Interest for positions on the Council have already been made.[34] Preliminary information about the new Health

34 For example in the Broome Advertiser on 18th January 2012

Service lists, under the heading Challenges, Priorities and Initiatives, "Aboriginal people are involved in both the planning and development process to improve the delivery of Aboriginal health services". KAHPF must establish close contact mechanisms with the Governing Council of the new Health Service to ensure that this occurs.

- Integration of the new Northern and Remote Country Health Service with Medicare Locals.

Recommendation:

That a report on the transition arrangements from WACHS to Northern and Remote Country Health Service (NRCHS) be a standing agenda item on the KAHPF agenda until the end of 2012 and that an invitation be extended to the new Manager and new Chair of the Governing Council of NRCHS to attend a KAHPF meeting as soon as possible.

5. CURRENT SERVICE PROVISION: ISSUES AND NEEDS

A holistic approach and integrated service delivery are key components of providing best practice primary health care. However, for the sake of clarity, this chapter, which highlights the issues and needs in current service delivery, has been divided into 12 programme areas:

5.1	Health promotion and disease prevention
5.2	Maternal and Child Health
5.3	Men's Health
5.4	Chronic Disease
5.5	Communicable Disease Control
5.6	Oral Health
5.7	Mental Health and Social and Emotional Wellbeing
5.8	Allied Health
5.9	Alcohol and other Drugs
5.10	Aged Care
5.11	Palliative Care
5.12	Environmental Health

Each programme area considers:

- Key successful initiatives in the last 10 years
- Additional needs to make current initiatives work more effectively and to address outstanding immediate needs
- Additional needs that must be addressed in the next 1-3 years
- Potential looming issues that may need to be addressed in the next 5 years.

Data showing current service provision is available as appendices. It consists of:

Appendix 2	Service delivery to remote communities
Appendix 3	Oral Health service delivery to remote communities
Appendix 5	Aged care places in the region.

5.1 HEALTH PROMOTION AND DISEASE PREVENTION

> Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Health promotion focuses not just on individual knowledge and behaviour change, but also community capacity building and empowerment and policy change. (WHO 2009)

To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realise aspirations, to satisfy needs, and to change or cope with their environment. To break the cycle of disempowerment that Kimberley Aboriginal people face and prevent further generations having poor health, improvements in the delivery of coordinated, comprehensive health promotion programmes in the region are a necessity.

Successful comprehensive health promotion programmes need to be multi-strategic. For this to occur health promotion professionals must familiarise themselves with the Ottawa Charter framework[35] and work towards incorporating as many aspects of the Ottawa Charter five action areas as possible into their work, including:

- Developing Personal Skills
- Creating Supportive Environments
- Strengthening Community Action
- Reorienting Health Services
- Building Healthy Public Policy

Until recently health promotion programmes targeting the promotion of healthy lifestyles (eg. smoking cessation, overweight and obesity, alcohol and other drugs) have not been a priority for most health services. Measures to prevent chronic disease have taken second place to treating them. There has been very little recurrent funding allocated to health promotion programmes. To date, initiatives have largely been localised, poorly funded or funded through one-off grants - with a consequent loss of energy as staff have

35 Ottawa Charter for Health Promotion 1986 - WHO/HPR/HEP/95.1 from http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

to seek their own resources, devise and organise their own activities, write detailed project reports for small amounts of money etc. Each year the wheel is reinvented due to high levels of staff turnover and consequent loss of corporate knowledge. In larger organisations, teams have been small, often marginalised within their organisation, and too busy delivering activities rather than comprehensive region-wide programmes.

The situation changed somewhat in 2010 as a result of COAG funding, with the addition of a large number of health promotion positions (although several of these are still to be filled). However, a number of challenges remain outstanding:

1. Lack of coordination and inter-agency activity

At present Health Promotion resources are fragmented across the Kimberley and there are no regionally developed, jointly-implemented health promotion programmes. For example, alcohol dollars are with Kimberley Medical Health and Drug Service (KMHDS), tobacco dollars are with KAMSC/ACCHS, nutrition $ are with KPHU. The region receives no dedicated physical activity funding allocated to health services. There is an urgent need to improve coordination and planning to create an integrated approach to region-wide, sustainable health promotion programmes.

A start has been made. The Health Promotion Network provides a forum for local agencies delivering services to Broome and West Kimberley communities. Members include Boab Health Services, Headspace, KMHDS and WACHS Health Promotion Team. The network aims to improve coordination of local health promotion initiatives, identify and address community needs, and provide a forum for the development of partnership projects and delivering consistent promotional messages. A similar initiative is required for the Central and East Kimberley.

One way to achieve regional coverage and planning is via the establishment and strengthening of the KAHPF Health Promotion Planning Subcommittee (or Working Group). This was agreed to in 2008 and again in 2011 but needs additional support/capacity to get off the ground.

2. The need for innovative health promotion programmes targeted at specific groups identified as needing intervention

All programmes need to include community (target group) participation in planning and decision making. Those programmes that do not adopt this planning strategy do not meet the basic tenets of health promotion i.e. individual and community empowerment strategies, and should be evaluated regarding their continuation.

Schools must continue to be a particular focus. School Health nurses are the bedrock when it comes to providing health education and disease prevention in schools, but are time- and skills-limited to undertake health promotion. Several external agencies provide health promotion activities in schools, particularly in the areas of nutrition and physical activity. These include FoodBank WA, WA School Canteens Association, Garnduwa and the Indigenous Hip Hop Project. Better coordination is needed to ensure that schools are not overloaded with visitors. More innovative activities, such as the Kimberley Challenge [36] have proved very popular in schools. The need to develop and support other innovative school-based activities is apparent, particularly as schools are so busy working on improving literacy outcomes that many do not teach Health Studies. However, the experience of introducing the SNAP into LIFE game into schools has revealed the need to embed a health promotion activity into the school curriculum and to reinforce the value of its use over a long period of time.

3. The need for health promotion programmes and resources to be localised/suitable for the target group

In many cases health promotion programmes developed outside the Kimberley are not appropriate for Kimberley settings. Their supporting resources do not use language or concepts suitable for a Kimberley audience. The work of the KAMSC Health Promotion unit has shown the value of locally developed programmes and resources. However, in some cases there is need for even more localised programmes with Kimberley appropriate strategies including social marketing and resources. For example, when producing visual material to educate pregnant women about their pregnancy journey it is important to have images/information about the relevant hospital/maternity ward and hostel where they will stay etc. The material is even more effective if it is made by the people who need to hear the health promotion message. There needs to be increased recognition of the value of relatively small amounts of funding for the production of low-budget locally made materials.

36 Formerly called the Canning Stock Route Challenge

4. The need for longer term funding to support successful programmes

Several communities have initiated their own health promotion activities. Many are reliant on short-term or start-up funding from non-government sources eg. Healthway. Unfortunately, whilst keen to fund trials, most of these funding bodies are not interested in long term funding of ongoing projects. Yet to effect real/sustainable change in Aboriginal communities may take longer than the 1-2 year timeframes that funding bodies operate under. Projects where rigorous evaluation shows that health gains/lifestyle changes are being made should be promoted/funded over those that do not. There is therefore need for a government funding stream that allows for the continuation of successful health promotion programmes until sustainability is achieved.

5. Lack of support to explore/establish new initiatives

While it is relatively easy to obtain funding to trial new community-based activities, the problem is that many community organisations in the region lack the capacity to make the application. Staff lack relevant skills/experience and are too busy/too locked into immediate demands/crisis management to have spare capacity to research, discuss and develop programme plans and applications for new activities. The need for someone with community development skills who is willing to spend extensive time in communities building trust and has the expertise to assist services to access funding is apparent.

6. Ongoing health promotion training for both health promotion staff and other professionals working in this area.

Too often staff employed in health promotion positions do not have the knowledge or skills to conduct health promotion. Training and ongoing mentoring and support are required.

7. Injury prevention

Apart from Roadwise, there are few resources addressing the high rate of injury in the Kimberley.

CREATING A NEW PARTNERSHIP ARRANGEMENT FOR DELIVERING HEALTH PROMOTION IN THE REGION

To create a strategic, integrated, multi-agency response to the challenges of providing sustainable health promotion in the region, the creation of an inter-agency Health Promotion Unit is proposed. This unit would combine the current resources allocated to Aboriginal health promotion across the region to create a unit that has the leadership and strategic planning capacity to generate best practice health promotion programmes focussed on regionally agreed priorities and delivered across the region.

Further consideration of the service delivery model is required. One option is for staff resources to be re-distributed across the region to create sustainable local teams. It is also envisaged that the Health Promotion team would be more effective if it did not work alongside clinical service providers thereby reducing the risk of them being diverted to work in clinical areas when there is a shortage or diverted into producing resources for clinicians rather than running comprehensive programmes. A Regional Health Promotion Coordinator could be located in Broome, with a Senior Team Leader based in Kununurra. To obtain the best results both these employees would have qualifications in Health Promotion and extensive experience of leading staff and planning and implementing health promotion campaigns in regional areas. The East and West Kimberley teams should both have access to administrative support, including access to a graphic designer allocated to the team.

In the interim, the importance of using the Health Promotion Planning committee to achieve an integrated and coordinated approach and strategic direction for Health Promotion in the Kimberley, changing the focus from a lot of individual activities to a number of region-wide comprehensive programmes targeting major risk factors such as smoking, overweight and obesity is acknowledged.

Recommendations:

- KAHPF supports and encourages measures to support the formation and effective functioning of the KAHPF Health Promotion Planning Working Group and its task to achieve an integrated approach and strategic direction for Health Promotion delivery in the region.
- To enable KAHPF members to consider the proposal to create an inter-agency Health Promotion Unit in more detail, a short-term project officer will be appointed to prepare a paper exploring the feasibility of establishing a co-located, interagency health promotion unit.
- Regular workshops on how to organise and run health promotion activities are held across the region.
- The Health Promotion needs of particular communities are identified through a needs assessment process.

5.2 MATERNAL AND CHILD HEALTH

A number of successful initiatives have been implemented since publication of the 1999 Kimberley Health Plan. These include:

- Kimberley Maternal and Child Health (M&CH) Protocols are in place, developed and reviewed by the inter-agency M&CH Working Group. Membership includes all ACCHSs, WACHS, Boab Health Services, KAMSC and St John of God.
- A standard Kimberley antenatal record has been developed and is used by all services.
- Immunisation rates in the Kimberley are high – the best in WA[37] at over 90% for all 3 age group categories.
- The identification and case-management of children at risk has improved. In most towns there are now regular meetings of clinicians regarding children at risk. KAMSC, KPHU and DCP have worked together to develop a pre-birth MOU as a strategy to identify and support children at risk before they are born. This will be launched and promoted in 2012.
- Annual M&CH workshops organised via a partnership between KAMSC, Boab Health Services and WACHS have been held since 2007 in different Kimberley towns, with over 80 participants at some workshops. These workshops build skills and facilitate inter-agency planning.
- Growth in Maternal and Child Health service provision due to Healthy for Life and New Directions funding, outreach funding for Kununurra Hospital midwives and an Antenatal and Paediatric Regional Nutritionist position located at Boab Health Services
- A number of research projects including Kununurra Breastfeeding Study, Growth and Anaemia Project, a Folate Intake study and the Early Childhood Nutrition and Anaemia Prevention Project: Tjiitji Marrka Manguwa.
- Recent funding to WACHS to provide group practice midwifery services (initially in Broome in 2012, then across the Kimberley) will improve coordination and continuity of care, with women able to have consistent midwives to see them ante-natally, deliver them and provide immediate post natal home care.

There are also a number of new initiatives and collaborative projects in the region which indicate a high level of inter-agency activity to address M&CH issues. These include:

- A project to translate the Edinburgh Post Natal Depression Scale (EPDS) into an appropriate tool to identify post natal depression in Kimberley women.
- A project to develop radio and television ads by Goolari Media to raise awareness of signs and treatment for postnatal depression across communities in the Kimberley
- The development of a DVD titled "How to have a healthy pregnancy and a healthy baby" filmed in Kununurra featured a local women's journey through pregnancy and delivery at Kununurra hospital
- Core of Life facilitator education programmes were held in Kununurra in 2007, Broome in 2009 and Kununurra in March 2012. These are aimed at introducing Aboriginal youth into the realities of parenting in an effort to reduce unplanned and teenage pregnancies.
- The establishment in 2011 of an inter-agency Kimberley perinatal mental health group which keeps the issue of perinatal mental health on the agenda for all staff and co-ordinates the bi annual

37 ACIR Quarterly Report for WA. Kimberley Report 5 on 30th September 2011

training in use of the EPDS for all staff in the region.

Despite this very positive investment in new services and initiatives over the last few years, data from the Department of Health[38] reveal that there is still a good deal of work to be done:

- For Kimberley Aboriginal children aged 0–4 years, the separation rates for acute respiratory infections, slow foetal growth, foetal malnutrition, short gestation and low birth weight were higher for 2004 to 2008 compared with 1999 to 2003.
- In 2008, 14.3% of all Aboriginal babies born in the Kimberley had a low birth weight compared with 4.0% in the non-Aboriginal Kimberley population and 6.2% for the total State population.
- During the period from 2004 to 2008 approximately one quarter of Kimberley Aboriginal women giving birth were teenagers compared with less than 5% women from the non-Aboriginal Kimberley population. Similar trends were seen for Aboriginal compared with non-Aboriginal women from the total State.

In 2010-11 an audit was conducted by the Senior Regional Paediatrician of mortality of children under the age of 5 years between 2005 and 2010[39]. There were 39 deaths, all under the age of three years. The post-neonatal mortality rate was ten times the WA State average. Beyond the neonatal period, four died from trauma, four from SIDS and ten from infection. There was clinical evidence of infection in a further six cases but the death was not attributed to it. 15 had clinical evidence of sepsis with three cases with *Streptococcus pneumonia* and four with *Staphylococcus aureus*. Adenovirus caused one death from respiratory failure. In terms of previous risk, on case review, the presence of previous risk was evident in 17 cases. These risks included being preterm; presence of known previous serious illness; previous presentations to hospital with same illness; known growth faltering from neglect; or the child was known to the Department for Child Protection.

A common contributing factor to mortality was that on presentation to a health care facility, it was not recognized how sick the child was, nor that sepsis was a possible cause of the child's illness. The audit informed a strategic response to the management of children who present at any health clinic in the region. This Risk Reduction Strategy for the Febrile Child was adopted by all Kimberley hospitals and, in 2011, became a mandatory site instruction in WACHS clinics in remote communities and a guideline in ACCHS clinics.

38 Dept. of Health (2009) Aboriginal Health Profile. Kimberley Health Region.

39 Boulton J. et al (2011) Childhood Mortality in the First Five Years of Life: Kimberley Health Region 2005-2010. An audit of mortality incidence by age, causality, and locality. Paper prepared for the Kimberley Health Regional Patient Safety Committee

KEY M&CH ISSUES THAT NEED TO BE ADDRESSED:

Growth faltering (Failure to Thrive): early identification and management of children whose growth is not progressing satisfactorily is key to reducing the number of children whose condition becomes acute enough for them to be hospitalised.

This requires every mother to have access to a well-structured and well-resourced, culturally appropriate 0-5 programme, preferably implemented by Aboriginal Health Workers. An ongoing staff development programme must be structured into this programme to ensure that staff have the skills to identify children at risk/potentially at risk and in need of more frequent monitoring, as well as the skills to support management of the child in the community setting. Management programmes need to consider health and social factors influencing growth.

There are some communities where mothers do not have access to a 0-5 programme or a similar proactive programme which ensures that children do not "fall off the radar" or indeed never get put on the radar. As the Health Department data shows Growth Faltering in the region is widespread, proactive efforts to identify and support mothers with children at risk are required. While this may be addressed by the launch and consequent development of education packages to support the new Enhanced Aboriginal Child Health Schedule (EACHS), ongoing monitoring will also be required.

Better links between 0-5 programmes and programmes beyond the health sector which support families with children at risk, for example money matters must also be established.

Recommendation:

The KAMSC and WACHS Maternal and Child Health Coordinators undertake a joint project to investigate the barriers which prevent 0-5 programmes being established and continually operated from all clinics, make recommendations on how issues and barriers can be addressed and identify how services within districts/towns can be better coordinated to achieve better outcomes for children.

The high percentage of children with anaemia: Anaemia in children in the Kimberley is nearly always due to iron deficiency. This may be related to a child's diet, parasite infections or their high burden of infection. Activities to address this have to focus both on the education of mothers/carers and on efforts to ensure community stores can supply affordable iron-rich foods suitable for young children.

Innovative programmes to encourage and support mothers to feed their children more iron rich food are required. A pilot study on the feasibility of using a multimicronutrient supplement on food - Sprinkles - to prevent anaemia is currently underway in Balgo and across Northern Australia. This has already revealed the need to have engaged, trained and motivated health and community based workers to lead the project, with adequate support from Health Professionals. Recommendations regarding improving food availability in remote communities have already been made in Chapter 3.

Recommendations:
Antenatal care to minimise maternal anaemia, Low Birth Weight and Intra-Uterine Growth Retardation (IUGR) is an important factor in the prevention of anaemia and growth faltering, and needs an ongoing focus within the Kimberley.

Ongoing training and support for community-based workers, AHWs and other health professionals to support anaemia prevention and management programmes across the region is required.

Foetal Alcohol Spectrum Disorder (FASD): One issue of great concern in the region, that has become apparent since the 1999 Health Plan was written, is the high incidence of children that may have Foetal Alcohol Spectrum Disorder (FASD). This is an entirely preventable condition caused by a mother drinking during her pregnancy. The issue is currently the subject of a prevalence study in Fitzroy Crossing. The Lililwans Survey of the Marulu Programme "Helping to overcome FASD in the Fitzroy Valley through community education, diagnosis and support" has identified the extent of disability[40] and steps are currently underway to publish the findings of the study. Project partners hope that the report will provide evidence to government of the extent of the problem and underpin attempts to have the condition recognised as a disability for which the government provides funding and resources.

If the incidence is as high as early reports suggest, it raises a number of issues and challenges for service planning:

- Children with FASD have some degree of development delays or behavioural problems which impact on a range of service providers, including health, education, family support and respite for carers.
- Early identification and treatment for children (and support for their families) achieves better long term outcomes.
- The development of a diagnostic tool is not yet finalised.
- The treatment regime for identified children is resource intensive.
- Funding for specialised FASD response services creates a risk that resources may be diverted away from other children at risk.
- There is likely to be a high need for services to support parents with the mental health and parenting issues which result from having a child diagnosed with FASD.

The high resource demands for treating diagnosed children should not draw all resources away from health promotion activities aimed at reducing the future incidence.

40 Results of the survey will be formally published in 2012. At the time of publication, precise details of the incidence are not available.

Recommendations:

- KAHPF support efforts in Fitzroy Crossing to publish and promote the findings of the Liliwans survey of the Marulu programme, particularly the prevalence study and culturally appropriate diagnostic tool.
- KAHPF agrees, in principle, that the solution to supporting communities with high numbers of FASD children should be a general increase in allied health and support services (including child and adolescent mental health staff) into a high-need community, rather than the provision of services that are targeted specifically towards flagged/diagnosed individuals or of funding to specialised/non-mainstream services.
- Any additional resources/services provided to target high need communities must operate as a multidisciplinary team rather than as separate stand-alone services.
- The need for more/ongoing proactive, innovative region-wide campaigns to raise awareness of the risks of drinking during pregnancy is a priority.

Ear Health: An audit of available ear health data in 2007 confirmed that ear disease is a significant health issue among Aboriginal children in the Kimberley. Problems include otitis media/middle ear dysfunction, hearing loss and tympanic membrane perforation. Hearing loss in children has a range of behavioural, cultural, emotional, social and educational effects, particularly on the acquisition of language in very small children. The provision of COAG funding for 2 regional Ear Health positions has resulted in raised awareness of the need for, and better training in, ear health assessment and treatment. Technology has allowed for practical solutions to the lack of specialists in the region, eg images of children's ears can be gathered via video otoscope and sent to Perth. Video conferencing allows the specialist to look at the images and provide advice to the mother/carer and the treating nurse without the need of additional appointments.

The role of these positions to drive improvements in ear health via better detection and treatment of ear disease is very important. However, increased activity has revealed some additional needs. These include:

- Two additional hearing health trainers, one to be employed by KAMSC and one by WACHS. Having 2 trainers extra will enable services to provide both adequate frequency of training and appropriate follow up and mentoring of staff regarding their activities and the results of their activities in both the East and West Kimberley.
- Five additional local ear health positions to be employed by KAMSC or KPHU in:
  - Kununurra (including remote communities serviced from Kununurra by KAMSC and WACHS),
  - Halls Creek (including Kutjungka and other communities serviced out of Halls Creek),
  - Derby (including remote and less remote communities serviced out of Derby except Dampier peninsula communities),
  - Broome (including Dampier peninsula communities and Bidyadanga,)
  - Fitzroy Crossing (including remote surrounding communities) to be employed by WACHS/NCHS.
- Resources to further develop the regional electronic record system used by KAMSC, Boab Health Service and some areas of WACHS to improve ease of capture of hearing health data. This will involve developing specialised tools for managing hearing health data capture within the Medical Message Exchange (MMEx) system and training for staff in MMEx usage. Most of this will be an up-front cost, with some on-going training in the use of the electronic system being recurrent. The recurrent training will become part of the role of the hearing health trainers and will not require additional resources.
- A review of the referral model: In the past WACHS and KAMSC have employed audiologists. All positions have been vacant for some time and are proving difficult to recruit to. A more realistic approach therefore is to up-skill primary health care staff in screening audiometry.
- More efficient use of visiting ear health specialist clinics and theatre lists by improving the referral process.
- Funding for additional equipment. An equipment

audit in Chapter 7 has revealed that only 2 remote clinics have video otoscopes and only 2 have access to video conferencing facilities that allow a hook up with specialists.

Recommendation:
In recognition of the importance of good ear health to children's language acquisition and education, providing additional resources to the Ear Health Programme is viewed as a priority. This should include funding for:

- 2 additional ear health trainers and 5 local ear health positions to be located across the region.
- Additional ear health and video conferencing equipment.
- Resources to further develop the regional electronic record system to improve ease of capture of hearing health data and to train staff in its use.

In many ways improving the treatment of these four conditions requires the same solutions:

- More trained and motivated generalist staff to identify children in need, provide ongoing treatment according to the Kimberley protocols and actively follow up non-compliant patients.
- A standardised 0-5 programme for the region. The development of a M&CH module in MMEx creates the opportunity for ACCHS to develop a standardised programme but it is not yet in place. KPHU's standardised 0-5 programme has been used to develop a state-wide Aboriginal child health schedule called Enhanced Aboriginal Child Health Schedule (EACHS). However, early feedback suggests that the programme involves advanced skills and the asking of personal questions which make it unsuitable for Kimberley Aboriginal Health Workers to administer.
- Strategies in place to track mobile/transient clients.
- An information management system that supports these activities.
- An ongoing workforce development programme which both imparts new skills to staff and supports them to put the new skills into practice.
- Good links, partnership arrangements and referral arrangements to other agencies who can provide ongoing support to parents/families on how to grow up healthy children.
- Better coordination, links and referral arrangements between on site staff, paediatric teams and other health teams.
- More effective use of specialist resources.

The recently-launched Aboriginal Health Council of Western Australia (AHCWA) publication, *Maternal and Child Health Model of Care in the Aboriginal Community Controlled Sector* details an evidenced-based, best-practice model of care which highlights the needs above and emphasises the need for a 'culture of collaboration involving stakeholders working closely across professional disciplines and fully involving service users'. It notes that there is good evidence that the outcomes both for children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life, and that the importance of early intervention and prevention are evidenced by recent research examining neurological development, the impact of pregnancy stress and the importance of attachment.

The need to provide best practice care for mothers and children highlights some additional issues to those already discussed around current Maternal and Child Health Service provision in the region. The ACHWA model of care (pg 27 and 50) notes the core requirements of service provision include:

- Promote, support and enable access to universal child health screening, support and referral. The service should encourage and assist parents to access universal child health services.
- Ensure care pathways are personalised according to risk, need and choices.
- Enable a stream-lined integrated patient journey across all providers with the women's and family needs as the focal point.
- There should be clear pathways of care and standardised protocols and guidelines including effective communication processes between services, specialities and health professionals.

Access to Universal Child Health Checks

As the WA Auditor General noted in a performance audit of Child Health Checks in 2010, Western Australia has a free universal child health check programme that promotes the best possible early development for all Western Australian children. It offers seven health and

development checks to children aged between birth and school entry. Take-up of universal child health checks is voluntary.

Although this programme is supposed to be universal, it is not currently available to all children in the Kimberley, particularly not to children living in remote communities. Not all Kimberley parents have the opportunity to have their child's development checked by a qualified Child Health Nurse who has extensive skills and experience in the early detection of issues that may arise in a child's growth and development.

There are a number of factors which must be considered when seeking a solution to this issue:

- There are not enough Child Health Nurse positions in the region to ensure regular visits to remote communities. Even if more positions were created, there is a state-wide shortage of Child Health Nurses which would impact on recruitment/retention.
- Irregular visiting schedules and high rates of staff turnover in community clinics mitigate against the development of the trusting, team-based approach recommended in best practice models. The result is either too many 'no shows' or Child Health nurses being expected to do tasks such as immunisations which should be the role of generalist staff.
- Disagreement between practitioners as to whether completion of Medicare funded Child Health checks replaces the need for developmental assessments.
- Lack of acknowledgement of the Child Health nurse qualification which is a 2 year postgraduate course. A nurse who works with children is not a Child Health Nurse.
- Lack of watertight recall arrangements to ensure no child falls through the cracks. Child Health Nurses are proactive in recalling children who are due a developmental assessment. If services are providing an alternative Child Health Check, systems must be put in place to ensure that these occur regularly.
- The need for performance accountability at clinic level to be monitored. Healthy for Life sites are required to collect and review data on levels of service provision. KPHU requires all their community clinics to collect Healthy for Life data. Other clinics have no mechanism for tracking their performance.

The need to ensure all children entering school receive a School Health entry check.

While the School Health Programme in Kimberley towns is working well, with over 87% of children receiving a School Health entry check, the provision of School Health in some remote communities continues to be contentious. Problems centre around:

- contractual arrangements about who should provide school health (in the Kutjungka),
- continual turnover of RN/Remote Area Nurse (RAN) staff who need orientation to the programme before they can provide it (in some remote WACHS clinics),
- claims that staff are too busy to take on the programme (in other WACHS clinics) and
- work load issues for town-based KPHU School Health Nurses who should still service ACCHS remote clinics.

Increasing workloads: An additional issue for all services is that the number of children in the region continues to increase, but the number of School Health Nurses and Child Health Nurse positions do not. The inability to provide regular screening and assessment could result in an increased number of children at risk not being identified as needing support and treatment.

Recommendations:
To ensure all Kimberley children have access to best practice M&CH care, managers in KPHU, KAMSC and ACCHSs will form a high-level working group to plan and agree on a model of Child Health care for the Kimberley, specifically to ensure that:

- No child entering school in 2013 misses out on their School Entry Check.
- All children in the Kimberley, particularly those identified as being at risk, have access to developmental assessments carried out by a qualified Child Health Nurse in a timely manner.
- Pathways of care are clearly identified, and agreed inter-agency protocols, referral arrangements and communication arrangements are in place.
- Other matters relating to the provision of best practice M&CH are raised and discussed.

OTHER GAPS AND/OR ISSUES IN CURRENT SERVICE DELIVERY

The high number of women with Gestational Diabetes Mellitus (GDM): Diabetes in women of reproductive age can significantly influence neonatal outcomes and the longer term health outcomes for both mother and child. For women with diabetes prior to conception, high HbA1c levels at conception can relate to a child facing a much higher risk of birth and pregnancy complications, and higher likelihood of chronic disease as they grow. Women who are diagnosed with GDM during pregnancy are also in need of significant support to manage their diabetes and their weight gain.

Diagnostic criteria for GDM are in the process of review, and implemention of the new criteria is likely to see an estimated 40% increase in numbers of women diagnosed with GDM. This has implications for the already over-burdened workforce, including Diabetes Educators, Dieticians, Midwives, GPs, Obstetricians and Gynaecologists.

The need to improve coordination between King Edward Hospital (KEH) and local clinics: Pregnant women at risk are sent to King Edward Hospital in Perth to give birth. There have been many instances of young mothers returning to their community without their clinic or the Child Health Nurse being aware of their return. A new Aboriginal support unit funded by COAG may help to resolve this. The issue also relates to a point made in Chapter 6 re the general need to improve discharge planning.

The need for improved accommodation for pregnant women who have to move to Broome or Derby to await the birth of their child: Tourist accommodation or caravans are not considered appropriate, particularly for young women from remote communities. Specific accommodation for mothers-to-be is required, where family and partners can visit but not stay, and where parenting education and antenatal education and support from midwives can be provided on site. A possible venue has been identified in Broome, but funding to acquire and operate the facility is required.

Updating and referencing of the Maternal and Child Health protocols: A project officer is required to coordinate the review and updating of all M&CH protocols.

The need to ensure the Paediatric team in the region is available and sustainable: The Kimberley Paediatrics and Child Health team comprises 3 FTE Paediatricians with no leave cover (usually provided at 0.2 FTE). At present the team is made up of a group of permanent part-time staff who work in blocks of time. In the words of the Senior Paediatrician "This model provides an innovative and robust solution to staffing as it is not possible to work full time due to the extreme demands of the role, with exhausting travel to fulfil the requirements for outreach to the most isolated communities in the nation, almost continuous on-call for emergencies, and the toll of vicarious emotional trauma from the high rate of death and severe illness amongst patients and inter-personal violence amongst the patients' families". KAHPF members, however, have a preference for full time employees, based in the region.

Increase in the number of opportunistic immunisations provided in all remote clinics: This is discussed in Chapter 5.5 on disease control.

The relationship with the Department of Child Protection: The working relationship with the Department of Child Protection and the Paediatric and Child Health team is well established and working effectively. However, in most districts, despite the development of MOUs, the working relationship with local clinics regarding children that may potentially be at risk continues to be problematic. Health Staff complaints centre around communication; particularly that health services do not receive feedback about referrals they have made to DCP unless the case is subsequently raised at a children at risk meeting.

Recommendations:

- M&CH Coordinators monitor the discharge planning issue and provide feedback to KEH re the improvement or otherwise resulting from the new Aboriginal support unit.
- KAHPF support the provision of funding to acquire and operate residential hostels for pregnant women in Broome and Derby.
- Employment in the paediatric team reverts to full-time positions and that leave cover be provided for all positions.
- M&CH Managers Working Group (see above) also consider ways to improve the exchange of information between health service providers and DCP about children potentially at risk.

FUTURE ISSUES THAT SHOULD BE PLANNED FOR NOW

Increasing incidence of childhood obesity

There are multiple factors influencing growth outcomes for Kimberley children. Low Birth Weight children are a group that need particular attention and monitoring to ensure healthy weight gain occurs to maximise potential. However, it is now apparent that many of these children later become obese and therefore face a higher risk of developing diabetes or other chronic complications related to obesity.

Effectively addressing this issue requires health services to work in partnership with organisations that provide effective interventions. These include support for school interventions, for example Take The Challenge, school canteen programmes and physical activity programmes operated by local shires/Police Citizens Youth Club or remote communities.

Increasing incidence of children with Type II Diabetes

There are increasing numbers of children being diagnosed with Type II diabetes throughout Australia. There are currently 7 children diagnosed with Type II diabetes in the Kimberley.

Type II Diabetes stems from a complex chain of events that starts in-utero. The best preventive approach is early and comprehensive antenatal care. Effective management of diabetes involves a range of treatments, including changes to lifestyle. Factors such as a person's diet, their exercise habits and stress levels all impact on a person's ability to manage their diabetes effectively. Children, in particular, need extra support to make the lifestyle changes required to keep their blood glucose levels within the target range. Families, the community, local healthcare providers and schools need to acquire the skills and knowledge to actively participate in the prevention of childhood diabetes and to support those children who do develop diabetes to adopt and maintain healthy lifestyle habits.

The tertiary care for children with diabetes is provided by the Diabetes and Endocrinology Team at Princess Margaret Hospital (PMH). The distance of the Kimberley from this tertiary centre results in children with diabetes being seen infrequently by this team, so local service providers are required to provide the majority of care for these children and their families. It is therefore important that the team from PMH develop close and effective links with healthcare providers in the Kimberley so that a high standard of care, based on the principles of best practice, can be provided to the increasing numbers of children with Type II diabetes in the Kimberley.

5.3 MEN'S HEALTH

Anecdotal evidence from across the Kimberley supports research from elsewhere which emphasises that providing health services to men is challenging. This is because of a number of factors including:

- Men do not present at medical services unless their needs are urgent and serious. Then, if they are not comfortable in the clinic/hospital environment, they will seek a quick fix rather than a holistic response.
- Men are not comfortable talking about their personal situation or feelings until a good deal of time has been spent on trust-building activities.
- Men are unlikely follow up on referrals they may be given without considerable support to do so.
- Men do not respond well to interventions by female health service staff.

Yet, if the cycle of unemployment, boredom, alcohol abuse and family breakdown is to be broken so that men are motivated to care about the years ahead and the future health of themselves and their family, an investment of money, time and energy must be made into programmes which operate in ways that men respond positively to. In essence there is an urgent need to build the profile of men's health so that government and community recognise men's health as an issue that needs to be taken as seriously as any other.

EXAMPLES OF MEN'S HEALTH INITIATIVES

In December 2005 33 men from around the Kimberley including Derby, Fitzroy Crossing and Balgo attended the Inaugural Men's Health conference held in Broome. The programme included an open forum discussing the future of male health in the Kimberley. Recommendations from the discussion included:

- To continue with forums in different places across the Kimberley to maintain contact with individuals and agencies.
- To consider the possibility of operating, at future date, on a regional or sub regional basis

- To get and keep older people involved
- To connect and work with Kimberley Aboriginal Law And Culture Centre (KALACC)
- To ensure community needs and the community voice is heard by the providers
- To use the community media to talk of male health
- To form town-based male health groups
- To investigate Male Health group constitutions from other regions such as the Wheatbelt, Goldfields, and the Great Southern
- To work with industry
- To form an umbrella organisation
- To consider having two-day conferences
- To interact with local, state and federal governments

Broome Men's Group is a model that may be applicable for other sites in the Kimberley. This group operates at two levels:

- As a steering body bringing together a variety of organizations concerned with men's well being. Their combined resources are used to devise and implement innovative strategies to improve the wellbeing of men, to provide advocacy for men needing support and to provide support to each other in their work.
- As a grass roots group aiming to bring men together for social events, health education and life skills building while emphasizing support, self esteem and getting together.

The group is open to all men in Broome. It aims to hold 2 social gatherings per month and is currently seeking funding for a 0.2 project officer who will organise gatherings and continue the production of a bi-monthly BMG newsletter "True Fellas" which will cover what's going on in Broome, report on events of significance and send a healthy living message out into the community.

IMMEDIATE NEEDS IN THE MEN'S HEALTH SECTOR

The need to recruit more Aboriginal men into health service delivery

Given the experience that men relate best to other Kimberley Aboriginal men, there is a need to recruit more older men who can provide positive role models into health service delivery. The example of a man working at the Derby Aboriginal Health Service (DAHS) is instructive:

> Former driver and now Aboriginal Health Worker Stanley Ozies is a great example of life's journey taking some unusual turns. Stanley had been an underground worker and a heavy machine operator when he came to the Derby Aboriginal Health Service as a temporary driver. "I had been working as a grader driver and came into town on a break," he recalls. "I was asked if I could do some driving for a couple of weeks, and it led to a full-time job." It was then that he "started to see things differently" – particularly the issue of men's health and how men like himself weren't very good at looking after themselves, and were reluctant to see a doctor or have a check up. "People like me are too proud and too stubborn to get treatment," he says. He'd seen about five mates die from prostate cancer – and he asked himself: "What's the point of being so tough? We need to get some help". Stanley is keen to see more Aboriginal men in health services. "It would make things better for our blokes – bring them out of their shell so that they know that, if they need help, we're here.."[41]

There is large unmet need for counselling and individual and group engagement with men across the whole Kimberley region.

Even in areas such as Broome where there are positive developments and success stories in meeting men's health needs, there are still many men engaging in self-destructive behaviours who are not engaging with health and/or support services. In other parts of the Kimberley, for example Halls Creek, there are no men's services for them to engage with. Unresolved grief, lack of a role in their family and community, unemployment, crime and punishment are all part of a negative cycle that includes risky and unhealthy behaviours.

More dedicated men's spaces

There is a need for dedicated men's spaces in most communities (e.g. men's sheds, men's resource centres, men's clinics) to help men engage with health providers

41 See stories on http://dosomethingreal.govspace.gov.au/stanley-ozies/

and other agencies that can give them the resources/ support they need.

The work of Ngnowar Aerwah Aboriginal Corporation in Wyndham (a service that provides a range of counselling and support services) provides an example of a positive initiative. They employ a Men's Coordinator who provides the following programmes:

- A Monday – Friday day programme in the on-site Men's Shed, currently used by 10-20 men. This targets displaced/homeless men (many of them from the community of Oombulgurri) and offers a safe "chill out" space and a range of programmes and workshops including sexual health, AOD counselling and general counselling in conjunction with music and art programmes. In the dry season a programme of visits takes men back to country, hunting and fishing. Men who wish to are encouraged to enter Ngnowar Aerwah's AOD residential rehabilitation programme. Wives often accompany the men to the Men's Shed, sitting outside and having their own conversations.
- Regular visits to the 2 schools in Wyndham, wherever possible with a female worker from Community Health. Talks and workshops on sexual health, family violence and mental health issues (including the Resourceful Adolescent Program (RAP) programme) are provided aimed at building the coping skills of boys and their sense that Ngnowar Aerwah is a place where help can be found.
- A weekly Young Men's Group targeting boys aged 8-13. This programme is promoted via school visits and the Aboriginal Police Liaison Officer. Boys are taken out bush and exposed to new ideas about discipline whilst enjoying fishing and cultural activities.
- As part of a programme operating from the Dept. of Justice Work Camp, the Men's Coordinator provides talks and workshops on life-skills such as anger management, dealing with AOD issues, family violence and managing change.

The Men's Coordinator has been trained as a trainer for the "Hey Dad" programme and can run that programme as required. He is also an experienced Aboriginal Health Worker. Future plans for the Men's programme include more bush trips and an East Kimberley camp involving men from Wyndham and other East Kimberley towns and communities. What is missing from this programme are men's health checks. Community Health cannot provide these as they do not have any male staff members. It is hoped that OVAHS will begin visiting Wyndham to provide male health checks and Pit Stop type programmes in 2012[42].

One of the keys to the success of this programme is the long term relationships the Men's Coordinator has been able to build with local men, which highlights the need for programme funding to be long term rather than short term pilots/trials/one-offs.

Increased profile for men's health needs

Men's health issues of obesity, diabetes and related conditions such as renal and heart disease are appearing more frequently in younger men. Innovative programmes need to be designed to encourage men to take greater care of their health. The need for specific activity to capture young men in screening programmes is discussed in the sections on Chronic Disease and Disease Control.

Addressing the particular needs of young men at risk of suicide

Young indigenous men are at most risk of suicide and there is a need for current programmes to expand (and the development of new ones) to tackle this problem. This is further discussed in chapter 5.7 on mental health.

Addressing the particular needs of homeless and isolated men

There is a cohort of isolated and homeless men in each Kimberley town whose health is deteriorating as they age. This group will need more specialised support services and accommodation near health services as they age further.

Further rolling out of programmes that work

Men's Outreach Service is trialling a number of programmes, often in collaboration with other agencies, for example, facilitator training in the "Hey Dad - Indigenous" short course and the "Headstone - Grief and Loss" project, to help men and their families to deal with the unresolved grief in their lives. If, on evaluation, these programmes achieve positive results, funding should be sought to roll them out across the Kimberley.

42 For more information contact David Cox (0891) 611 496

Improving collaborations

There is a good collaborative process among agencies dealing with men's health and SEWB in Broome, but in other towns and sub-regions inter-agency partnerships are less well developed, in part because there are less services working in the men's health sector and no long-standing men's service to drive the collaboration.

In other health fields, it has been the opportunity to discuss common problems and the need for regional approaches to resolving these problems during regional meetings, on regional phone hook-ups or at regional training workshops that has raised the profile of the issues and lead to increased efforts to seek solutions. Small regional gatherings of men have been held in the past, and a Kimberley Men's Summit has been discussed. It is timely for more opportunities for men to get together to be organised, so that men themselves can identify the next steps that are needed to improve men's health in the region.

Recommendations:

- KAHPF supports the efforts of Aboriginal and Torres Straight Islander Men's Services to organise a regional men's gathering in 2012, including applications made to employ a project officer to assist with organising the gathering.
- KAHPF will develop a communication strategy to formalise reporting from existing ATSI men's groups and will consider the value of forming a Men's Health working group/sub-committee.
- A short term project officer should be employed to research and map the scope of ATSI men's health services in the Kimberley.
- KAHPF supports efforts to seek funding to establish ATSI Men's Health Project Officers positions in each town and larger remote communities.
- There is a need for more men's spaces and men's programmes in the region. KAHPF supports the development of a business case for more ATSI Men's wellbeing centres.
- Health services will review and redouble their attempts to attract more local Aboriginal men to work in the health sector.

5.4 CHRONIC DISEASE

> "Putting more effort into prevention, early intervention, and effective management of chronic illness will reduce the complications, disability and death associated with these diseases and conditions. It has been proven that patients who receive effective treatments, self management support and regular follow up do better than those who do not. Evidence also suggests that organised systems of care, not just individual health care workers are essential for producing positive outcomes". WHO 2002

SUCCESSFUL INITIATIVES IN THE REGION IN THE LAST 10 YEARS

- Development of the chronic disease treatment protocols.
- Improved screening, monitoring and management, and institution of comprehensive health care plans for chronic disease sufferers in response to an epidemic of chronic disease.
- The successful trialling of the availability of a doctor focussed specifically on chronic disease in the Dampier Peninsula who works in both ACCHS and WACHS clinics.
- Establishment of the Kimberley Renal Support Service (KRSS) to provide education, training and support to all PHC clinic staff in awareness, screening and management of renal patients via the Chronic Disease protocols and locally produced education materials. Also, KRSS assists in the tracking of patients to ensure no-one falls through the cracks.

IMMEDIATE AND ADDITIONAL NEEDS

The 4 chronic disease conditions which produce the highest levels of morbidity and mortality in the region are renal failure, cardiovascular disease, chronic lung disease and diabetes. Hospitalisation rates for these diseases are high, providing a drain on hospital resources and a strong argument for resources to better identify and manage these conditions.

Effective management of people with chronic diseases requires:

- Integration of chronic disease services across the Kimberley
- Early identification using best practice, evidence-based screening approaches.
- A work force with the capacity, training and motivation to undertake regular screening, health check and recall activities.
- The development of care plans with the client with consideration of client readiness for behaviour change.
- Effective support for self management and lifestyle changes.
- Regular monitoring of clinical indicators and medications.
- Timely provision of allied health services eg podiatry, oral health.
- Effective organisational systems which ensure clients are recalled, followed up and encouraged as often is necessary to ensure adherence to their care plan.

In addition, chronic disease management requires a multi-pronged approach that addresses the social determinants of health and increases the emphasis on primary prevention within the community and across the age span. As discussed in Chapter 5.1, a mix of health promotion interventions from individual to whole of population need to be planned, implemented and evaluated. This requires the development of culturally appropriate educational resources which consider language, consistent key messages and literacy levels.

IMMEDIATE NEEDS

- An injection of Secretariat resources to revitalise the Chronic Disease Steering Committee so that the following tasks can be undertaken:
- Review and update the chronic disease protocols.
- Finalise the draft Kimberley Chronic Disease strategy.
- Address training and coordination needs.
- Initiate discussion on how to integrate all chronic disease activity into primary health care service delivery.
- Improved information sharing between primary health care providers and hospitals via the development of a shared data system. This is further discussed in Chapter 6.
- Training in the electronic data systems that organisations are currently using so that maximum benefit is obtained in relation to chronic disease management.
- Dissemination of accurate and current statistics on incidence of chronic disease and risk factors to health care providers.

ADDITIONAL NEEDS

- Review of the issues surrounding the recruitment, management, support and retention of Aboriginal Health Workers. Ideally, it should be AHWs who undertake a good deal of the initial screening and follow up work for chronic diseases. To do this, they need a clear understanding of the key role of screening and health checks and the important role they play in identifying chronic disease and assisting people to self-manage their condition. Refer to Chapter 4 for recommendations in this regard.
- More training in how to provide brief intervention to people regarding smoking, alcohol and drug use, the need for healthy eating and the importance of physical activity is required, to be delivered regularly to all staff across the region.
- There is an ongoing requirement for staff to be trained in care planning.
- A particular challenge for the region is to find effective ways to break the cycle of dependency and encourage and support people to self-manage their chronic disease. Training and ongoing support for health staff in how to create and work with self-help groups in ways that suit Aboriginal people must be a priority.
- Resources to employ more Diabetes Educators and Chronic Disease Coordinators (CDC) who will focus on self-management and care planning. At minimum each Kimberley ACCHS and Community Health Centre should have at least one Diabetes Educator or CDC.
- Increased delivery of Diabetes Management in the General Care training (developed by the National

Association of Diabetes Centres) provided by Boab Health Service in partnership with WACHS. This training is currently offered annually to AHWs, RNs, students, GPs, allied health and aged care staff but, given the high staff turnover rates, would be better provided across the region on a quarterly basis. To ensure the success of the initiative, consistent management support for staff to attend the training is also required. Boab Health Services would require additional staff to coordinate increased delivery of this course.

- Expansion of the pilot self-management project trialled at Broome Hospital (see chapter 4) to every Kimberley town.
- Measures to address the comorbidity of chronic disease and mild mental illness eg depression and anxiety. This is further discussed in Chapter 5.7 on Mental Illness.
- Discussion between WACHS and KAMSC has occurred about the need for additional support to maintain people on home dialysis, both home haemodialysis and Peritoneal Dialysis/Continous Ambulatory Peritoneal Dialysis - to keep in regular contact with dialysis clients, make sure they regularly attend their GP, dialyse regularly, have their scripts filled, take their medication, help to sort out any family issues, provide practical support for dialysis, and making sure Fresenius/ Kimberley Renal Support Services (KRSS) /GP are alerted to any issues for the patient. Development of a remote area workforce specifically to provide local support for home dialysis patients and their carers is one means by which this could be achieved. In the meantime, the KRSS believes that each primary health care service should identify a dedicated renal AHW/RN from within their chronic disease team that the KRSS will train and support to manage the renal clients associated with their service. It is their view that the current wide scope of practice for Chronic Disease AHW/RNs is a significant cause of burn out.

IMPROVING IDENTIFICATION OF PATIENTS NEEDING EARLY INTERVENTION

Best practice primary health care includes regular screening to identify people who require early intervention to prevent/delay the development of chronic disease. This involves:

- Use of best practice screening tools.
- Including both clinical indicators (eg Blood Pressure, Body Mass Index, Blood Glucose Levels) and risky behaviours (especially smoking, alcohol and drug use, physical activity and mood) in any screening activity.
- Providing brief intervention re risky behaviours.
- A systematic approach to the follow up of abnormal results.
- Providing further testing and examination for people who require it.
- Providing targeted interventions for sub-groups deemed to be at risk.
- Referring people in an effective way.

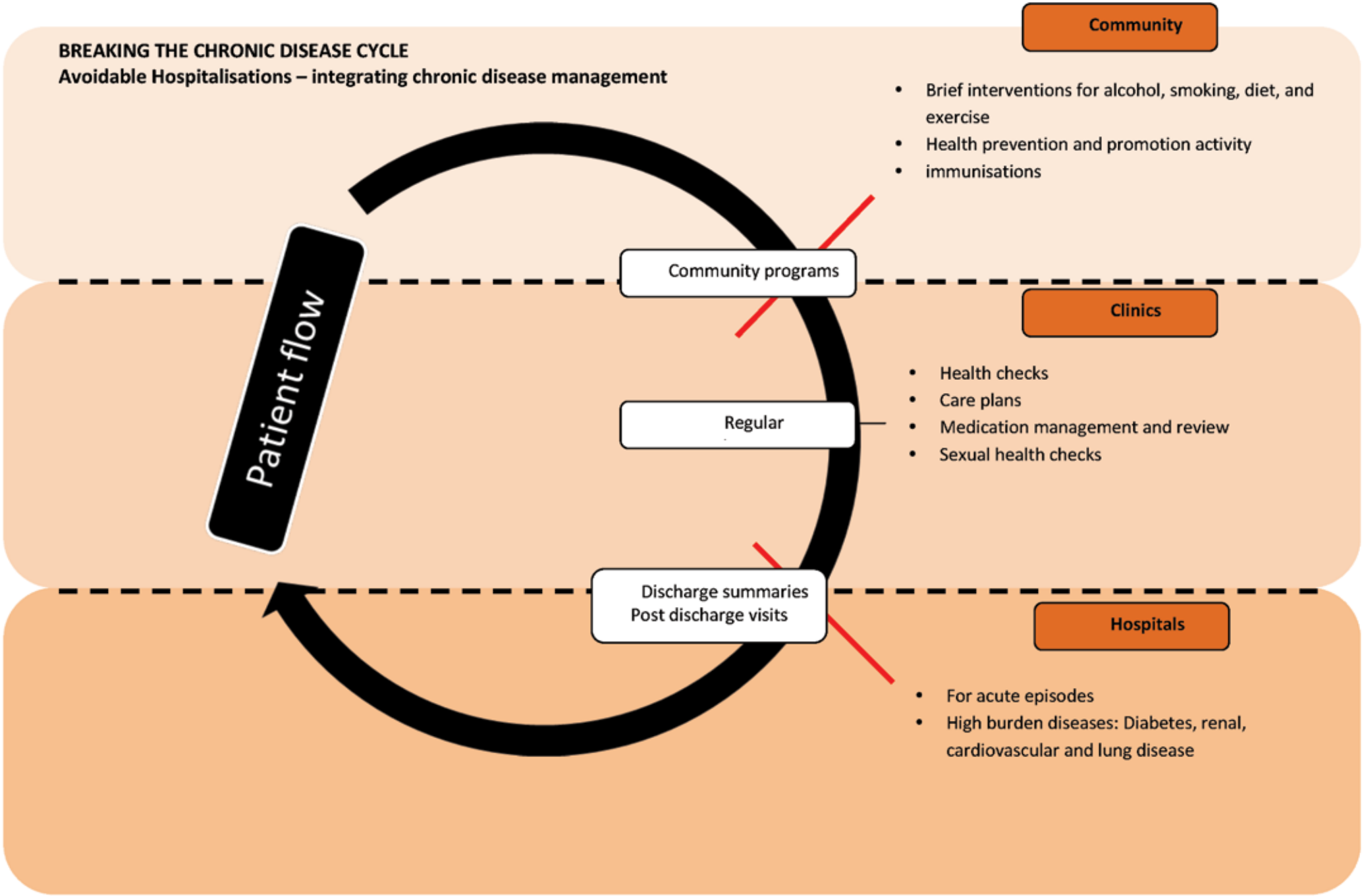
This type of screening is resource intensive, both on the day and because of the follow up that is required. Some services are reluctant to screen because they do not have the capacity to address what is found. Others do not have the expertise that is required in brief intervention. Some services screen people they see, but do not follow up those that are not screened. Over time, if the same screening strategies are deployed, there is risk that cohorts of people who are potentially most at risk miss being screened.

Screening activities that do occur in the region continue to identify cohorts of people with previously undiagnosed chronic disease. Evidence from the Kimberley Renal Support Service demonstrates that when resources are applied, the progress of chronic disease to the end stage can be delayed and, in some cases, halted. However any additional resources must be used to employ staff employed by, or with strong links with, community clinics rather than operating separate stand-alone programmes.

Consideration should also be given to establishing a regional database of at-risk clients.

Recommendations:

- Funding is required to revitalise the Chronic Disease Steering Committee, finalise the Kimberley Chronic Disease strategy and develop a regional training plan. The urgent and ongoing need for training across the region in brief intervention therapy, care planning and ways to encourage and support self management of chronic disease is stressed. The CD Steering Committee must then provide the leadership and impetus to implement the recommendations in the Strategy.
- Ways of providing additional support to successfully maintain people in remote communities on home dialysis must be further explored, including the possibility of developing a remote area health care workforce to provide local support for home dialysis patients and their carers within their own communities. In the meantime, each service will review the merits of identifying members of their Chronic Disease teams who will be specifically trained by KRSS to support and manage renal clients.
- Additional qualified Diabetes Educators and Chronic Disease Coordinators are required across the region to increase the focus on and support for self management and the development of patient-focussed, self-managed care plans. At minimum each Kimberley ACCHS and each Community Health Centre should have at least one Diabetes Educator or Chronic Disease Coordinator.
- Boab Health Services requires an additional full time equivelant to allow the regular region-wide delivery of Diabetes Management in the General Care training. Consistent management support which allows the release of staff to attend this training must be given by all health service providers.
- Each service should review its own activities to ensure whether adequate early intervention activities are included in their annual programme.
- In each year from 2012-2014, KAMSC CAPTER unit will organise for brief intervention training to be provided in each Kimberley town, open to staff from all health service providers on a cost-recovery basis (with the cost to attendees to include KAMSC's administrative costs).
- After the Chronic Disease Steering Committee identifies how many additional staff resources dedicated to early identification and management of chronic disease are required, KAHPF will advocate for the additional funding required.
- Formal evaluation processes of intervention programmes, including accurate data collection and dissemination of information across the region must be put in place.


BREAKING THE CHRONIC DISEASE CYCLE
Avoidable Hospitalisations – integrating chronic disease management
Community
Brief interventions for alcohol, smoking, diet, and exercise
Health prevention and promotion activity
immunisations
Patient flow
Community programs
Clinics
Regular
Health checks
Care plans
Medication management and review
Sexual health checks
Discharge summaries
Post discharge visits
Hospitals
For acute episodes
High burden diseases: Diabetes, renal, cardiovascular and lung disease

5.5 DISEASE CONTROL

IMMUNISATION

Immunisation rates in the Kimberley are high – the best in WA,[43] at over 90% for all 3 age group categories. For Kimberley Aboriginal children in June 2011:

- 93% aged 12 to less than 15 months were fully vaccinated;
- 96% aged 24 to less than 27 months were fully vaccinated;
- 94% aged 60 to less than 63 months were fully vaccinated.

Although immunisation rates are high, this has required a lot of work and effort. To spread the load, more opportunistic immunisation by clinic staff is required. The difficulties of becoming credentialed as an immunisation provider are often cited as the reason why more nurses in remote towns and clinics do not give immunisations. However all Registered Nurses are able to administer immunisations under the order of a doctor. Opportunistic immunisation on doctor days in remote clinics or by written order should be maximised. In addition, information from the KPHU Immunisation Coordinator suggests these difficulties are not impossible to solve. To become registered several steps are required:

1. A five week period to become familiar with the theory – this period can be extended by the Immunisation Coordinator if unexpected obstacles arise.
2. An open book exam which is provided via email.
3. A clinical assessment which requires 3 days work in Broome, Derby or Kununurra. However, for experienced nurses, recognition of prior learning provisions allow the Immunisation Coordinator to conduct the clinical assessment via a phone interview.

To remain a provider a mandatory update course is required. The Department of Health is working on making this an online update/exam rather than requiring providers to attend a course.

> Recommendation:
>
> In all services, relevant Job Descriptions are updated to require RNs and RANs to become an immunisation provider within 3 months of commencing employment.

43 ACIR Quarterly Report for WA. Kimberley Report 5 on 30th September 2011

RHEUMATIC HEART DISEASE

In 2010 the Statewide Acute Rheumatic Fever/Rheumatic Heart Disease register was developed and is now maintained by KPHU in Broome. Support, clinical management tools and education for health care providers, community education and support to improve self management by clients are also provided.

Better access to echocardiogram testing and review of patients by a specialist are aspects of this service that need to be improved.

TRACHOMA

Trachoma in Aboriginal communities in Australia is of sufficient concern that the Australian Government has committed to the WHO's Global Elimination of Trachoma 2020 trachoma elimination campaign and provided increased funding for screening and treatment activities. The WHO campaign aims to reduce trachoma prevalence in children 1-9 years old to less than 5%.

Improved collaboration between KPHU, the local Shire Environmental Health Officers and local health services has resulted in increased trachoma screening and immediate[44] treatment of infected children in at-risk communities. Rates of trachoma are improving.

The results for 2010 show 32 of 34 at-risk communities were screened[45]. Over 80% of children had clean faces.[46] 10% of children aged 5-9 had trachoma; 99% of infected children were treated within 2 weeks. 99% of the 591 contacts identified were screened within 2 weeks.

In 2011, KPHU data show that approximately 900 children aged 5-9 in 35 at-risk communities were screened. There was a 7% prevalence of trachoma. However, there is a huge variation in rates across the region and those with high rates require additional funding for preventive activities.

SEXUAL HEALTH

Rates of Sexually Transmitted Iinfections remain high compared to the rest of WA. The rates of gonorrhoea have decreased over the past 10 years, however rates of chlamydia have increased (though less than elsewhere in WA). There is currently no community-acquired HIV in the Kimberley and the number of people with HIV is low.

Interestingly, a significant decline in the rates of both

44 For the purposes of the trachoma programme, 'immediate' is defined as within two weeks of screening.

45 The Kirby Institute for infection and immunity in society (2010) Australian Trachoma Surveillance Report 2010. University of NSW.

46 Clean Face is defined as the absence of dirt, dust or crusting on the cheeks and forehead. Lower levels of facial cleanliness are a recognised risk factor for trachoma.

gonorrhoea and chlamydia were noted for the two years after the introduction of the alcohol restrictions in Fitzroy Crossing compared to the two years before[47]. Analysis of data from Halls Creek shows a similar trend. The reasons for this are unknown. They may relate to clinical factors such as drinkers having compromised immune systems or the effects of alcohol on sexual arousal and/or behaviour and boundaries.

In 2005 the establishment of a Regional STI Team of 5 people, based partly in WACHS services and partly in ACCHS, provided the impetus for increased rates of testing. However, in recent years, due mainly to housing issues, recruitment to the East and Central Kimberley positions has been a problem.

Fitzroy Crossing is currently the site of a trial called STI in remote communities: Improved and enhanced primary health care (STRIVE) which aims to reduce levels of STIs in participating trial clusters over a three year period. In the trial, the practice targets for clinical services are:

- 80% of the resident population aged 16-34 tested annually.
- 95% of syndromically diagnosed infections treated immediately.
- 80% of asymptomatic STI infections treated within 7 days of the positive result being received from the laboratory.
- 80% of STI infections re-tested with 3 months of treatment.
- In 50% of STI infections where the named sexual partner/s is documented, to be treated within 14 days.

These conditions may be regarded as best practice and the standard to which all services should be working.

Across the Kimberley screening rates are not this high and, in most services, not focussed on the age group most likely to have STIs. From 2005-2010 the majority of STI tests (40%) were conducted among females aged 24+, while the majority of notifications (36%) were among females aged 15-24.[48] The serious consequences of STIs in women (Pelvic Inflammatory Disease, fertility issues and ectopic pregnancies) mean there should be no reduction of the screening rates in women, particularly in the 15-24 age group, but an increase in the education and opportunistic screening of males, particularly 15-25 year olds males, is also needed.

47 Revle Bangor-Jones et al (2011) Alcohol restrictions and STIs: is there a link. ANZ Journal of Public Health

48 Testing data on Chlamydia, gonorrhoea and infectious syphilis reported by PathWest, Western Diagnostics and Healthscope

The Central Kimberley has the largest pool of infection, but less screening due to recruitment issues. The recruitment issue could be addressed if there was a change of attitude which removes the taboos and stigmas surrounding sexual health and normalises STI screening as a routine part of checking health by primary health care staff. In many cases urine is already collected. It merely requires asking another question eg - as you live in area with high rates of STIs, would you mind if some of your sample was used to test for STIs?

The STI team have a programme which attracts professional development credits and orientates new generalist staff to the STI programme, but the uptake is not high enough. Other ways of generating the attitudinal change are required.

ADDITIONAL NEEDS

- Community consultation to develop appropriate health promotion materials to engage and target the 15-24 age group, particularly those who may not have good literacy skills. This could involve using community radio and TV, DVDs and pamphlets that use pictures to convey messages.
- The compulsory addition of sexual health education into the school curriculum.
- Ratification of the protocols which have been developed to identify best practice management of the particular care-needs of patients with Hepatitis B and C virus and the high risks for mothers caring for babies.

A LOOMING ISSUE

The low incidence of community-acquired Human Immunodeficiency Virus (HIV) is attributed to the relative isolation of the region, the limited interaction between communities and the low incidence of HIV in visiting tourists. Developments being planned for the region have the potential to change this, particularly if the huge numbers of fly in fly out workers that are required for major developments begin to mingle with the local population.

The experience from the HIV referral centres in Perth suggests that the potential for increased HIV rates and possible transmission is high if resource developments use overseas labour on 457 work visas. There is no requirement for these workers to be HIV tested before

they enter Australia and they have no access to Medicare. If they are found to be HIV-positive, they have to fund their own treatment.

In addition, the experience from other regions in WA is the high cost involved in monitoring a HIV positive patient who will not accept treatment. A state-wide funding resource is available to meet these costs which must be accessible by the Kimberley should the need arise.

Recommendations

- Increased efforts must be made to ensure there are no vacant positions in the Regional STI team.
- There should be no reduction in the screening rates in women, particularly in the 15-24 age group, but an increase in the education and opportunistic screening of males, particularly 15-25 year olds males, is needed.
- Funding must be allocated for improved sexual health education and the development of sexual health promotion resources.
- If the Kimberley has an HIV case that requires intensive case management, KAHPF understands that resourcing treatment is the responsibility of the state-wide funds holder in Perth.

HANSEN'S DISEASE

There have been no new cases since 2010. KPHU holds the register of patients and undertakes any follow up required. Vigilance will be maintained while the possibility of an outbreak remains.

5.6 ORAL HEALTH

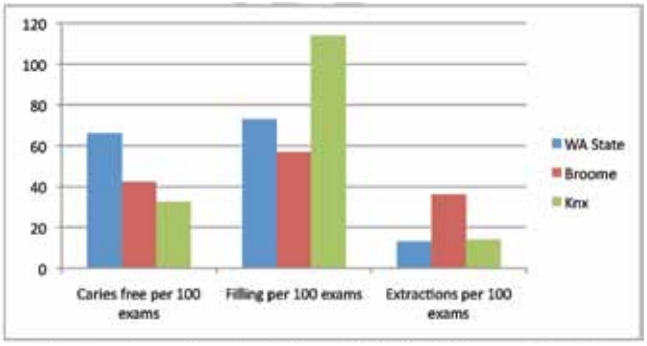
Nationally, discrepant patterns of oral ill-health appear from childhood with evidence that Aboriginal and Torres Strait Islander children at all ages have higher levels of dental caries than their non-Aboriginal counterparts, and those under 5 years are hospitalised for dental disease at 1.5 times the rate of non-Aboriginal children in the same age range, with rates of hospitalisation increasing with geographic remoteness.[49]

The need to address the overwhelming burden of dental disease among Aboriginal people in the Kimberley is urgent and continuing. Despite the importance of good oral health for people with chronic disease being well known, the oral health of people living in the region is vastly poorer than the broader population in WA. Children with dental decay experience difficulty eating (especially hard or warm food), continual pain especially at night (resulting in sleep deprivation for both the individual child and the entire family in high occupancy housing), chronic ill health and lethargy. A child who can't eat, sleep or even think for pain and discomfort cannot be fit to attend school, let alone be ready to learn and retain.

Evidence of the level of need in the Kimberley is provided by the following data:

- Of the 223 children screened in remote desert communities in May 2011 by the Kimberley Dental Team (KDT) more than half (120 children - 54%) required urgent dental care, 89 (40%) were caries free and 14 (6%) required moderate care ideally within six months.[49] KDT currently has 57 children from the Kutjungka region on their general anaesthetic waiting list, an overwhelming number for a voluntary organisation to treat.
- At Halls Creek District High School 207 children (aged 5-13) were screened in May 2011. 62 (30%) required urgent care.[50]

Figures provided by the Dental Health Service (DHS) School Dental Service (SDS) for the period January to June 2011 (see graph below) also demonstrate the poor oral health in the region. The rate of fillings in the east Kimberley is 1.5 times greater than the state average. In Broome, the rate of extractions is nearly 2.8 times greater than the state average. Twice as many children in the East Kimberley examined by a dentist have tooth decay compared to the WA average.



Dental treatment comparison of east and west Kimberley SDS January to June 2011

Source: Dental Health Services January 2012

49 Australian Institute of Health and Welfare, Dental Statistics and Research Unit: Jamieson LM, Armfield JM & Roberts-Thomson KF (2007). Oral health of Aboriginal and Torres Strait Islander children. AIHW cat. no. DEN 167. Canberra: Australian Institute of Health and Welfare (Dental Statistics and Research Series No. 35).

50 KDT report to Liz Constable "State of dental health in school children in the East Kimberley of Western Australia". Feb 2012

Evidence also suggests the need is worsening. A cross-sectional population survey in the West Kimberley highlighted the overall state of poor oral health amongst Aboriginal people in this region[51]. A high prevalence of caries was identified, with the average decayed, missing and filled teeth score worse than had been previously reported. Periodontal disease was also widespread, particularly amongst those with diabetes.

ISSUES WITH THE CURRENT DELIVERY OF DENTAL SERVICES IN THE KIMBERLEY

1. Disparity of access to dental services between towns

Dental services in the region are primarily provided by the WA Dental Health Service (DHS). Government Dental Clinics are located in the towns of Fitzroy Crossing, Kununurra, Broome and Derby. Clinics have 1 dentist and 1 dental assistant/nurse/ receptionist, with the exception of Broome which has 2 dentists and 2 dental assistants. Private dental practices only exist in Broome (3 practices) and Kununurra (1 practice). The Kununurra private practice provides a monthly service to Wyndham for 1 day each month. The town of Halls Creek is only serviced by the dentist visiting from Kununurra. In 2011 this occurred 3 times, for a week on each visit including travel time.

Recruitment and retention of DHS staff in the region is difficult and staff turnover is high, particularly in the areas of Derby, Fitzroy Crossing and Kununurra. For example, Fitzroy Crossing was without a dentist between the years 2003 –2009. The position was filled in 2010 for 12 months but the dental assistant position was unable to be filled for much of that time which limited service delivery. In 2011 the position was staffed for a total of 8 months of the year, with 3 different dentists filling the position. The current dental officer has been in the role since November 2011 and is only expected to remain until June 2012.

2. Disparity of service level to remote communities

Frequency of DHS service provision to remote communities is listed in Appendix 3. This reveals the inequity in service provision, particularly the unacceptably low level of services provided to anywhere in the region apart from the Dampier Peninsula and Bidyadanga. In other remote communities that did receive a visit in 2011, the one-off nature and short duration of the visit provided no opportunity for ongoing treatment. The focus is on pulling/filling rather than on preventative work. Services to the remote communities in the Broome region are provided on a regular and consistent basis as 1 dentist and dental assistant in Broome are employed for this purpose. However, records suggest that this team is only in the field for 17 weeks of the year. Dental service continuity to other remote communities is compromised by the lack of professional and support staff willing to commit to the challenges of working remotely.

Many people with a chronic disease have a care plan that recommends that their teeth are scaled and cleaned once a year. Their inability to fulfil this condition is a major contributor to the poor health outcomes in the region, particularly in the areas of diabetes and rheumatic heart disease.

3. Inadequate preventive treatment for school children

There is a marked inequality in services provided to school children in the region. DHS has a School Dental Service based in Broome which rotates among 3 of the 4 schools in Broome and a service based in Kununurra. This provides services to Kununurra and mobile services to Wyndham, Warmun and Halls Creek, visiting each of the 7 schools approximately once every 2 years. No children at schools in remote communities apart from Warmun have access to school dental services.

4. Payment of fees is a barrier to accessing treatment

Adults with a current Centrelink, HealthCare or Pensioner Concession Card are eligible to access DHS. While the services are heavily subsidised, patients are required to pay fees. In Derby and Fitzroy Crossing where there are no private dentists, the DHS dentist also provides a service for private patients at non-subsidised rates, which may reduce availability for concessional patients.

When DHS provides services to remote clinics, patients do not pay a fee for services provided. However, when the same patients attend the town-based DHS clinic, they are required to pay. This inconsistency is confusing for some patients and is a barrier to consistent, ongoing treatment.

51 Kruger, E., Smith, K., Atkinson, D.N. and Tennant, M. The oral health status and treatment needs of Indigenous adults in the Kimberly region of Western Australia, Australian Journal of Rural Health, 16: pp 283-289

5. Visiting dental service providers mask the inequity

Visiting dental services have been used to fill some of the gaps. Their presence, however welcome, should not be used as a reason to avoid government responsibility to provide dental health services to the region. In the past 2 years these visiting services have been:

The Army Aboriginal Community Assistance Program (AACAP) is a co-operative initiative between government and the Australian Army to improve environmental and other health conditions within remote Aboriginal communities. AACAP dental division provided a dental service in the Fitzroy Valley during June and July 2011. This included screening, treatment and education to patients and to local schools. AACAP deployment may be anywhere in northern Australia. Decisions are based on a number of factors, but the health needs of a region are not a deciding factor. This service should therefore be regarded as a bonus rather than a regular means of meeting community needs.

The Kimberley Dental Team was established in 2009 by Dr John Owen (Specialist Orthodontist, member of the WA Dental Board, inaugural member of the Dental Board of Australia and Member of the Order of Australia), and Jan Owen (Dental Nurse and dental health educator). KDT is a non-government organisation relying on dental and allied health specialists who volunteer for one to two weeks at a time to deliver outreach oral health services, including screening, treatment and education, aimed particularly at improving the oral health well-being of Aboriginal children and their families in the Kimberley region. KDT works in locations where services are most lacking. In 2010 and 2011 KDT provided 7 to 8 weeks of dental education and dental treatment with a team of 6 to 8 dental staff each week. KDT covers 70% of costs through fund raising and sponsors, covering the rest of the costs themselves. They believe their model has demonstrated that KDT is twice as productive per unit time at half the cost of a government service, a fourfold benefit, going direct to communities.

While KDT provides a much needed, supplementary service to the Kimberley region, they do not have a long term plan to service the region, nor is there a succession plan in place. ie. KDT are not a long-term solution to the current fractured and inconsistent service in the region.

6. Provision of culturally appropriate services

DHS has identified poor uptake of dental services by Aboriginal people in the region as an issue. However the experience of KDT suggests a different story. They have found when services are provided where they are most needed, are flexible, fully staffed and focussed towards building rapport with the community, uptake is not an issue.

7. Recruitment and retention issues for DHS staff

Anecdotal evidence suggests that poor remuneration, professional isolation, limited professional support and recognition, limited cultural awareness or sensitivity and poor uptake of services are contributing factors to the high turnover of DHS staff in the region. This high-turnover results in fractured, unreliable and inconsistent service delivery and a lack of opportunity to build rapport with community members and forge partnerships with other agencies. DHS has a poor profile in the region in relation to providing consistent and reliable service delivery, which further hinders recruitment.

Poor remuneration also extends to dental therapists. For example, SDS dental therapists do not get paid for 6 weeks of the year during the school holidays. Furthermore, dental assistants do not receive any accommodation or accommodation subsidy in an area well known for its high cost of living and rental costs. The vast region and high number of schools that SDS staff are required to deliver services to in the east Kimberley are also not conducive to attracting or retaining staff. In addition SDS staff report frequent equipment malfunction, resulting in unnecessarily-delayed clinical service delivery in the region.

8. Lack of collaborative planning

There is no strategic dental plan for service delivery to remote communities in the Kimberley. Location and frequency of service delivery is determined by the capacity of the individual dental officer from the government clinic to deliver services to outlying communities. The development of transparent/ readily accessible performance indicators to measure service delivery and patient outcomes is required.

Limited partnerships have been forged between DHS and other agencies in the regions. DHS generally stands alone as an agency, limiting rapport and relationship building opportunities or mechanisms to work collaboratively on service planning in the region. DHS also need to do work on their community profile in the region. Patients report feeling discouraged from calling the dentist/SDS service as they are 'never there' or 'never answer the phone'.

9. Data management issues

The outdated and non-user friendly DOS patient record system used by DHS cannot readily capture data on patient attendance, treatments provided, oral health status, bookings etc. Again, this limits transparency and accountability of service delivery and service delivery planning. It would be useful to extract data pertaining to:

- Amount and types of dental services provided
- Locations services provide
- Extent of follow-up care with dental referrals
- Oral health status of children and adults in the region.

In summary:

- the condition of most peoples' teeth and gums in most communities is appalling.
- The majority of communities in the region are underserviced.
- There is marked inequity between the level of service that communities receive. The ongoing lack of services to communities in the Fitzroy Valley, Kutjungka, Halls Creek and Derby areas is of particular concern.
- The limited visiting service provides no opportunity for ongoing treatment.
- The lack of services is a significant limiting constraint on the effective management of Chronic Diseases in the region.

A NEW INITIATIVE: KIMBERLEY ORAL HEALTH PROJECT

Funding from the Department of Health and Ageing has been provided to:

- Build a mobile dental clinic to provide outreach services to remote clinics. This is due to be completed April 2012 and will initially be used by the KDT, with opportunity to extend the use to other agencies.
- Fit-out ACCHS in Broome, Derby, Halls Creek and Kununurra with dental infrastructure and equipment.
- Develop a partnership agreement between DHS, KAMSC, 4 x ACCHSs and KDT to deliver regular and reliable dental services to these ACCHSs.
- Increase the capacity of MMEX, the web-based health record system used by each of the ACCHSs, to capture consistent and reliable data on patterns of oral health, delivery and uptake of dental services, gaps in services in comparison to identify needs and outcomes of preventative and treatment interventions for the purpose of reporting, planning and quality improvement in oral health care delivery in the Kimberly.
- Develop an accredited Dental Assistant training programme through KAMSC School of Health in the Kimberley by 2013.

In addition Commonwealth funding has provided funding to employ a Project Coordinator for 2 years to coordinate the above mentioned project, as well as to:

- monitor the effectiveness of dental services operating out of Kimberley ACCHS;
- develop the Kimberley Dental Treatment Protocols;
- act as Secretariat for the Oral Health Subcommittee of KAHPF;
- disseminate oral health education resources and activities to health, education and community service organisation and workers;
- seek funding for additional dental health service delivery and oral health community education in the region;
- negotiate improved Patient Assisted Transport Scheme for patients travelling to dental hospitals for treatment.

URGENT REGIONAL NEEDS

The need for additional oral health funding for the region

There is an urgent need to increase dental staff numbers

in the Kimberley- to extend delivery in the region to meet existing unmet needs, particularly for increased outreach services. This expansion must be accompanied by funding for staff housing. The issue of attraction and retention initiatives for dentists and support staff is currently being considered on a whole of government basis. There is an urgent requirement to create a more attractive remuneration package for DHS dentists. In Fitzroy Crossing the dentist currently receives a one-off $50,000 incentive from Australia Children's Trust aimed at attracting and retaining a dentist to the region for a 12-month period. This situation is not continuing beyond 2012 increasing the urgency of exploring possible alternatives to recompense professional and support staff similar to the way medical staff are recompensed in the remote areas.

There is a need to fund positions to employ Aboriginal Dental Assistants within ACCHSs (as part of Kimberley Oral Health Project) and part of the DHS system.

The need for collaborative planning

There is an urgent need for a strategic long-term regional dental plan to be developed which identifies how outstanding regional needs can be met and how a more culturally appropriate service which meets the needs of the Aboriginal community can be provided. This must include discussion on the relative merits of taking the service to the community rather than requiring people to attend at hospitals, and of a multi-skilled team approach rather than stand-alone dentists.

The need for better integration between DHS and WACHS

There is a need for DHS to be better aligned with WACHS in order to access Aboriginal liaison officers, transport to assist with reminders, attendance, locating transient patients / patients who have moved, relationship building with the broader community etc. The DHS dental staff report often not being able to reach patients in order to make or confirm bookings and report high numbers of 'did not attend'. Similarly, there is a need to ensure that visiting dental services can access relevant information from both WACHS and DHS.

NEW PROGRAMMES / SERVICES NEEDED IN THE NEXT 1 TO 3 YEARS

- Greater collaboration between the government dental clinics, the school dental services and other agencies including community health, maternal and child health, ACCHS, childcare services, family centres, Department of Child Protection and foster carers is required to raise the profile of good oral hygiene for children in the region, including active follow up of children who do not attend school on a regular basis.
- Training of maternal and child health nurses / Aboriginal health workers and other clinical staff in assessment, oral hygiene education, appropriate referrals and awareness of the effect of poor oral health on overall health and wellbeing.
- Many children start preschool in an already degraded dental state. Oral health education, screening and treatment options are urgently needed for families of children in the 0-4 age group who are not currently part of the state Dental Therapy Scheme / Service.
- Region wide oral health promotion campaigns to increase awareness of the link between poor oral health and general health and wellbeing and to promote consistent key messages and resources. Education and interaction with mothers and older siblings about the benefits of tooth-brushing and the impact of high-sugar drinks on teeth is also required.
- A targeted approach to encourage parents to attended their child's SDS appointment in order to increase parent's knowledge of oral health and the effects on the body and to increase knowledge and skills relating to oral hygiene.
- Explore evidence on preventive treatments (such as fluoride applications currently being rolled out in the NT) and if positive, organise nationally recognised training to administer fluoride treatment for Aboriginal children / children at risk / disadvantaged children and incorporate this activity into Kimberley Dental Treatment Protocols.
- Provide more culturally appropriate resources and innovative tools to promote better oral hygiene in the region, for example by providing dental clinics with intra-oral cameras to show the patients / parents / carers the level of disease in the mouth.

GOVERNMENT POLICIES WHICH IMPEDE GOOD ORAL HEALTH CARE IN THE KIMBERLEY

Currently DHS only see children under 5 yrs old whose parent/s have a HealthCare or Pensioner card and

parents must pay for screening and treatment. This is a significant barrier to preventive treatment (routine check-ups), especially for low income families. WA government policy needs reconsideration. Options for new policy include:

- All children under 5 years old with parents holding a concession card should be treated at no charge (as done in Queensland Health).
- Providing free screening, cleaning and emergency treatment for all low income earners and Aboriginal people.
- Providing free dental treatment for Healthcare Card holders and Pensioner Concession Card holders (as is in NT, QLD and SA).
- Providing free dental treatment for all children aged 0 to 17 years.
- Providing free government dental care for Aboriginal people until their oral health rises to the same standard as non Aboriginal West Australians.
- Reviewing access to Patients Assisted Travel Scheme (PATS) issues for remote community clients - see chapter 6.

Recommendations:

- DHS should be invited to join the Kimberley Aboriginal Health Planning Forum.
- Progress to improve dental health service delivery in the region should be a standing agenda item on the KAHPF agenda.
- KAHPF and AHCWA will lobby the WA government to urgently conclude their consideration of ways to recompense professional and support staff similar to the way medical staff are recompensed in the remote areas, to change the policy about fees for Aboriginal people and to advocate that staffing by the State to government dental clinics in the north-west of WA should be declared a priority.
- KAHPF member organisations should consider whether they support the plans for a national Medicare Dental Scheme - Denticare.
- DHS identify, as priorities, employment of a dentist and dental therapist in Halls Creek to service the south- east Kimberley towns and communities including Halls Creek, Yiyili, Kutjungka (Balgo, Bililuna and Mulan) and Ringers Soak, and additional staff resources to undertake outreach from the Fitzroy Crossing clinic.
- That DHS gradually shift public dental officers into ACCHS for a percentage of the week equivalent to the percentage of Aboriginal people in the service area.
- That training organisations provide student dental placements in DHS clinics in the northwest from 2013.
- That ongoing sustained training is provided for Aboriginal Health Workers in basic oral health knowledge and up-skilling for some to Dental Assisting level. All government clinics in the Kimberley should aim to have at least one Aboriginal person employed within 2 years.

5.7 MENTAL HEALTH/SOCIAL AND EMOTIONAL WELLBEING

96% of the Aboriginal people in the Kimberley belong to a family where members of that family were removed. Contrary to the experience of the eastern States, it was only in 1982 that removal of children and placement with non-Indigenous families ceased. The trauma, grief and dislocation that resulted, combined with current levels of alcohol and drug abuse and family dysfunction manifest in an escalating burden of SEWB and mental health problems in the region.

Comorbidity is extremely prevalent in the Kimberley population – both alcohol-related disorders and cannabis dependency are very high. Further to this, there is emerging recognition of the prevalence of FASD affecting both children and adults (see chapter 5.2). Comorbidity of these types are recognised not only to increase the prevalence of psychiatric morbidity, but also to complicate assessement and treatment, and are associated with worse prognosis. Frequently, the theraeutic target is restricted to simple attempts at containment of behaviours within the community.

Coupled with the social issues of overcrowding, poor housing, homelessness, unemployment and cultural breakdown of the usual community coping mechanisms,

it is no surprise to find that the proportion of people in the Kimberly with a known mental health condition is at least 1.5 times greater compared with the rest of WA. Aboriginal people are over-represented in acute mental health care, comprising 70% of hospital admissions for mental health conditions in the Kimberley and 60% of community mental health clients compared with 42% of the total population[52].

SUCCESSFUL INITIATIVES SINCE THE 1999 PLAN

- The completion of the Kimberley Regional Aboriginal Mental Health Plan in 2002 was the first attempt to identify the needs and issues in the region. Amongst other things, it recommended the formation of inter-agency working groups focussing on mental health and alcohol and other drugs – which lead to the formation of Kimberley Regional Aboriginal Mental Health Plan (KRAMHP) and Drug and Alcohol Working Committee (DAWC).
- The delivery of a number of programmes and workshops such as Gatekeeper, Applied Suicide Intervention Skills Training (ASIST), Alive and Kicking Goals and Mental Health First Aid designed to support communities and agencies prevent suicide. On average in 2011, a Mental Health First Aid course was delivered somewhere in the region every week.
- Development of a series of popular resources as part of the Live Life, Stay Solid campaign aimed at de-stigmatising mental illness and building individual and family resilience.
- Establishment of KAMSC Headspace, a consortium of organisations addressing issues of social and emotional well being amongst the Aboriginal youth population in Broome.
- Funding for the StandBy Response Service which coordinates agency responses following a suicide in a community.
- Expansion of the number of mental health staff in the region.
- Adoption of a comorbidity model of care by several services in recognition that many mental health clients also have AOD issues, supported by resources adapted from those developed by Menzies School of Health as part of the Australian Integrated Mental Health Initiative.
- Establishment of Mental Health Professionals Network groups in several sites including Broome, Derby and Halls Creek. The groups meet every 2 months with guest speakers attending most meetings. This is a national initiative aiming to offer professional development, raise awareness of local services and strengthen the networks of mental health professionals.
- Opening in 2012 of a 14-bed inpatient mental health unit in Broome to service the Kimberley and Pilbara regions thereby reducing the issues associated with transferring patients to Perth and separation from family.

CURRENT INITIATIVES

After a good deal of advocacy by KAHPF and member services, the need for more mental health funding in the region has been realised, and considerable amounts of funding have been allocated to increase the provision of mental health services in the region. In 2012 organisations are no longer forced into competing for scarce funding and can focus on collaborative partnership arrangements to deliver the new recovery services that are planned.

New initiatives include:

- The Statewide Specialised Aboriginal Mental Health Services (SAMHS) initiative which will fund the employment of at least 12 additional specialised mental health workers in 5 of the 6 towns in the region.
- The development of a training continuum pathway which will allow local Kimberley people with no previous training in mental health to progress to being highly qualified mental health workers.
- Provision of mental health training for GP Registrars which will increase the capacity of ACCHS-based doctors in the region to treat conditions such as anxiety and depression, conditions that KMHS cannot accept referrals for.
- Placement of Mental Health GP registrars in ACCHS.
- The Kimberley Indigenous Suicide Prevention Initiative - a pilot program providing priority access to psychological support services for Indigenous people over 18 years who have self harmed, attempted suicide or have suicidal ideation and who are being managed in the primary health care setting.

52 Mental Health Information System, WA Department of Health quoted in KMHDS's 2010 submission to KAHPF re COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

- Opening of the Network Community Centre in Broome, extending the recovery model into the community. This consortium-based mental health initiative will focus on providing programmes which support mental health patients and their carers to live successfully in the community.
- Funding has been provided to build a 6-bed step-up / step-down inpatient facility in Broome. This new service will provide 24-hour care to people with mental health issues, and support their transition in and out of community life by building the links between service providers in the community.

Due, in part, to visits from both the Federal and WA Ministers for Mental Health and the Mental Health Commissioner, the region is in the spotlight. The challenge in 2012 will be to implement the programmes that have been funded.

As there are now a number of organisations providing mental health services in the region, improving and fine-tuning the linkages, working arrangements and referral pathways between providers and between those organisations and primary health care and community services is a priority, so that patients can receive the step up or step down support they require. For example, before the new Broome Psychiatric Unit and the Step Down service are operational, formalised processes and arrangements will be put in place between those services and primary health care providers in the region to ensure each client's transition back to receiving health services in their community works well.

ADDITIONAL NEEDS

For service growth:

- Despite new funding to the region, there is still a need to increase the staff numbers in KMHDS in Derby, Fitzroy Crossing and Halls Creek for service delivery to meet existing needs, particularly for increased outreach services. A permanent 6-person team is required in each town to provide services and enable effective outreach to outlying communities to occur. This expansion must be accompanied by funding for housing and the additional resources required to develop Aboriginal staff.
- There is growing evidence that for Mental Health Services to be truly preventative, they need to provide services for children and families with issues regarding attachment and trauma, in their formative years ie 0-5 years. Whilst the need to provide assessment, intervention and therapy services for this age group and other young children is recognised by Kimberley Child & Adolescent Mental Health Service (CAMHS) staff, the current resource level does not enable this to occur. Despite the increased population and complexity of mental health issues amongst children in the region, there has been no increase in Child & Adolescent Mental Health employee numbers for the Kimberley since the 2008-2009 financial year. The limited staffing numbers are further taxed through major increases in referrals for children with FASD resulting from the Liliwan project and growing concerns around volatile substance abuse amongst young people.
- Boab Health Services provides a counselling service for people with mild or moderate mental illnesses. There are 30 people on the waiting list in Broome and people have to wait 10-12 weeks to access the service in Kununurra. This level of demand demonstrates the need for additional resources to be provided for this programme.
- It is probable that post-natal depression is a significant and undiagnosed problem in the region. A specific service focussing on peri-natal mental health is required working at the therapeutic and preventive level. At present neither maternal and child health nor mental health staff have the skill or time to respond to this issue or to provide the level of ongoing support that mothers with post natal depression require. At minimum, two project officers are required working in the East and West Kimberley to build collaboration and coordination between M&CH and mental health staff and provide training in identifying and responding to the issue. Additional counsellors are also required to support the women who score moderately in the EPDS (and therefore cannot be seen by KMHDS staff) as current Boab Health Service waiting lists are excessively long.
- There is a need to provide early intervention support for young people living outside Broome who are experiencing SEWB / mental health issues. This should be based on the consortium approach used by the Headspace service in Broome. However, while this model works well in Broome, effective delivery outside Broome will require a more flexible model.

The model developed must also acknowledge the different skill sets required by mental health workers when working with pre-teenage children from those working with older youth. The lowering of the service age from 12 to 10 is also recommended, given that so many young people face issues at an early age.

- Anecdotal evidence suggests that most crises happen at night. This needs to be quantified and, if the need is justified, a 24 hour mental health crisis service, with capacity to respond in the East and West Kimberley and which includes the regional psychiatry team and has the capacity to pull in whichever additional counselling services established.
- Until the need for a 24 hour service is quantified, steps need to be taken immediately to establish after-hours access to a specialised mental health team until at least 10pm at night. Coupled with this there is the need to build the triage capacity of staff in A&E Department s to respond to clients with mental illness. This could be via resourcing for the position of a psychiatric liaison officer who would provide education and support to frontline staff and clinical support for acute patients.

New ways of working are required:

- All Kimberley health and community services need to adopt a 'No Wrong Door' [53] policy. This way of operating formally recognizes:

  "that individuals ... may enter a range of community service sites; that they are a high priority for engagement and that proactive efforts are necessary to welcome them into treatment. "

  Particularly when clients present in crisis, it is important that referrals are followed up to ensure the client receives the treatment they need. Implementing this may require building relationships and formalising referral arrangements between community support organisations and mental health providers.

- Care planning for clients needs to become more client-centred, holistic, and family and user-friendly. The care plan developed between the client and the lead agency case-managing that client must prioritise client choices and be developed across the continuum of care. This requires best practice case-conferencing and referral arrangements to be in place.
- Evidence suggests that 25-30% of patients with a chronic disease have an undiagnosed, co-existing mental illness such as anxiety or depression. Unless this is resolved, it is generally impossible for the client to achieve the lifestyle changes that need to be made to address their chronic disease. Responding to this requires a coordinated approach which places mental health workers in primary health services where they build the skills of GPs and nursing staff to identify and refer people with mental illness.
- Similarly, many clients have both mental health and AOD issues, therefore AOD workers need to be trained in Mental Health issues and Mental Health workers in AOD. Wherever possible, KAHPF supports co-location of client service provision and/or AOD services employing staff with mental health expertise.

New activities are needed:

- There is a need for further region-wide mental health campaigns which address suicide prevention by focussing on life affirming/preserving strategies, and particularly focus on hard-to-reach clients.
- Progress must be made with implementing the Halls Creek Healing Centre, an initiative being progressed under the Remote Services Delivery (RSD) project.
- Evidence shows that many homeless people have mental illnesses. Treatment for these people is particularly difficult if they have no stable home. There is a need for temporary, hostel-type accommodation in each Kimberley town to address this issue.
- Kimberley Regional Aboriginal Mental Health Planning Forum (KRAMHPF) members have discussed the issues arising from the very high prevalence of expressions of suicidal intent in the community, specifically the great difficulty (perhaps impossibility) in distinguishing people who are crying for help and might benefit from a psychological and/or medical intervention from those using threats to suicide as a means of advancing their own immediate needs, and how to respond appropriately in both cases.

53 Described in WACHS/KAMSC Partnership Submission for Kimberley Specialised Aboriginal Mental Health Services (SAMHS) 2011.

- Expansion of the current CAMHS workforce to enable programs to provide infant mental health services.

Support services/activities:

- Funding for the Secretariat function for the KRAMHPF is required. This subcommittee of KAHPF provides an essential way for mental health/SEWB providers to meet, exchange information, grow partnerships, and discuss issues and new service needs in the region. As mental health issues and services in the region grow in size and complexity, the need for KRAMHPF to crystallise their vision for service provision in the region, and jointly identify new issues and priorities to feed up to KAHPF, will grow. This will place increasing demands on the Secretariat to distribute information and produce evidence-based reports. KAMSC have advised they are unable to provide this service without funding to purchase additional administrative support.
- Development of an updated map of mental health/SEWB services in the region. The 2008 map cannot be updated. A new version needs to be developed.
- There is a particular need to review existing evidence-based research into the strategies and activities used in non-western models of preventative mental health. If this is not appropriate, additional work to recommend new programmes and evaluation strategies that could be trialled in the region must be undertaken.

Recommendations:

Immediate funding should be provided for:

- A project officer to update the Kimberley mental health and SEWB services map.
- The Secretariat function for the KRAMHPF.

KAHPF identifies the following mental health priorities:

- Region-wide mental health campaigns focussed on building resilience by highlighting life affirming/preserving strategies.
- Additional mental health workers in the region:
- Establishment of after-hours access to a specialised mental health team until at least 10pm at night.
- Increased staff numbers in KMHDS services in Derby, Fitzroy Crossing and Halls Creek to create permanent 6-person teams at each site.
- Expansion of the current CAMHS workforce to enable programs to provide infant mental health services.
- At minimum two project officers to build collaboration and coordination between M&CH and mental health staff and provide training in identifying and responding to post natal depression.
- Additional early intervention services in the region outside Broome both for young people and people with mild or moderate mental illnesses.
- Additional step-down services throughout the region.

Additional training:

- For triage staff in hospitals. This could be via the creation of the position of psychiatric liaison officer who would provide education and support to frontline staff and clinical support for acute patients.
- For workers in AOD services.
- For workers in primary health services.

Projects should be established to gather data on:

- The need for a 24 hour crisis service,
- On appropriate treatment models for Aboriginal people,
- the need for hostel accommodation for homeless mental health clients in Broome and Kununurra.

5.8 ALLIED HEALTH

Allied Health services are primarily delivered by two health service providers in the region, Kimberley Population Health Unit and Boab Health Services. As of January 2012 the region had 43.5 Allied Health professional positions as follows:

	KPHU	Boab Health	Other
Physiotherapy	8.5		
Speech Therapy	7		
Occupational Therapy	7		
Dietetics	3	3	
Diabetes Education	1	2	
Nutrition	1		1
Paediatric Nutrition		1	
Podiatry		3	
Audiology	1 vacant		2 vacant
Therapy assistants	3		

Points to note re the data above:

- The number of Allied Health staff in the region is continually increasing.[54]
- There are MOUs in place with ACCHSs across the Kimberley to support AHWs to work with Boab Health Allied Health staff, further increasing client access to services.
- As a valuable initiative KPHU also employs Aboriginal Therapy Assistants in Derby who increase the capacity of Allied Health staff working with Aboriginal clients. They accompany Derby Allied Health Staff on most remote trips.
- Additional Physiotherapist and Occupational Therapists based in Derby have resulted in increased trips to Fitzroy Crossing and Fitzroy Valley communities.
- KPHU has one designated Diabetes Nurse Educator position which is based at Community Health in Fitzroy Crossing and travels to the Fitzroy Valley communities. At other sites KPHU uses Generalist Nurses based in Community Health with responsibility for diabetes and chronic disease education.

54 From 25.5 Allied Health professionals in June 2008 to 43.5 in January 2012.

CURRENT ISSUES

Staffing levels

Allied Health staff are based primarily in Broome, Kununurra and Derby and provide visiting services to smaller towns and communities across the region. This requires significant clinician travel, which reduces clinical service capacity. Providing formal clinical supervision and peer support options for staff is essential for retention of staff within the region[55].

While no formal studies have been done on future needs, an increase in Allied Health staff in the region is obviously required to catch up with current demand for services. For example:

- there are only 7 FTE Occupational Therapists in the region, 2 in Broome, 3 in Derby and 2 in Kununurra. The median wait time to see an Occupational Therapist in Broome or Kununurra is 420 days.
- The West Kimberley WACHS dietician reports a long list of referrals from clients living in smaller Fitzroy Valley communities who cannot be seen as there is no capacity for KPHU or Boab Health Services to provide a visiting service to all communities.
- After Speech Pathologists undertook a project in Broome primary schools there was an increase in referral numbers for school-aged clients, indicative of education staff seeing the benefit of referring their students for speech pathology. This was considered to be due to the increased profile of speech pathologists in Broome schools, the development of positive relationships, the effectiveness of therapy (and teachers witnessing this) and the sharing of skills and knowledge that has occurred as a result of the new programmes. The project has been successful in targeting children at educational risk and Aboriginal children who were previously missing out on services.
- Best practice management of diabetes requires a multi-disciplinary team approach, including input from the Diabetes Educator, Dietician, Podiatrist, Physiotherapist, Psychologist, Social Work, GP and Endocrinologist. Given the increasing rate of diabetes in the region, as noted in Chapter 5.4, there is a need for Diabetes Educators and Chronic Disease Coordinators to focus both on prevention and self management and care planning. At minimum each Kimberley ACCHS and Community Health Centre

55 SARRAH (2008) Provision of Allied Health Services to Australian Regional & Remote Aboriginal and Torres Strait Islander Communities.

should have at least one Diabetes Educator or Chronic Disease Coordinator.

- With the growth of renal dialysis services in the region there will be an increased need for allied health support consistent with this growth. This includes, but is not limited to, Dietetics, Diabetes Education, Podiatry, Physiotherapy and Occupational Therapy.

Allied Health staff are constantly required to juggle the increasing pressure created by demands for service from hospitals, Disability Services clients, primary health care providers (ACCHS and Community Health), DCP-referred families and groups and communities seeking education and support. When more widespread use of the diagnostic tool for FASD is made, it is likely that an even higher demand for services will occur.

Aboriginal population projections suggest that the current numbers of professionals in the region will at least need to be doubled over the next 25 years. To catch up with the existing unmet need, it is likely that the actual need for additional staff will be even higher. Changes to funding models and opportunities for partnerships with other providers create possibilities which support an increase in Allied Health Professionals in the region. It is important that accurate assessment of the current and future needs be made as soon as possible.

Recommendation:

An inter-agency business case detailing the immediate and future Allied Health needs in the region must be developed by the end of 2012.

Addressing regional inequity:

In 1999 there were no Allied Health visits to communities on the Gibb River Road, the Fitzroy Valley and few to the Kutjungka region outside Balgo. While the situation has improved, data provided at Appendix 2 reveals that closer/easier to access communities are still visited more frequently than remote communities and that when positions are vacant e.g. the East Kimberley Speech Pathologist in 2010-11, then no back-up arrangements are instituted to ensure that a skeleton service is provided. The economic cost of service delivery in remote communities is a limiting factor on the amount of services currently provided. Communities in the Fitzroy Valley, around Halls Creek and in the Kutjungka are still seriously under-serviced.

Addressing regional priorities:

Currently, due to the high demand for Allied Health services, the emphasis is on clinical service provision. However, Allied Health staff have another important role – to provide health promotion to the community and training, support and mentoring to individuals, community workers (for example on Best Beginning programmes), family members and staff in schools, DCP and Disability Services on how to manage people with particular conditions. Regional planning activities must recognise and resource this role.

Recommendations

A joint review and redesign of the current service delivery model should be undertaken by managers in KPHU/ WACHS and Boab Health Services to ensure that in future:

- Frequency of visits to remote communities is based on population size, caseload and community needs rather than accessibility.
- Visit schedules allow for health promotion activities and the support and mentoring role to be undertaken.
- Financial constraints do not restrict the level of service to communities that require access by plane.
- Flexible arrangements are explored and implemented to cover vacant positions in the region.eg to temporarily redeploy staff, recruit locums etc.
- The most effective therapy team arrangements are put in place, not only to ensure that travel arrangements are efficient, but that remote clinics are not overwhelmed by visiting clinician numbers.
- Benchmarks are set which identify minimum acceptable waiting times to see Allied Health Staff and are reported on quarterly at KAHPF meetings.

Ensuring care is coordinated/care pathways are seamless

There is an ongoing need to ensure that referral and transfer pathways are robust and ensure that care is provided in a timely manner and clients are not lost in transit between services. There is a similar need to ensure good clinical governance arrangements are in place which ensure coordinated care across

multiple services providers. This requires ongoing review of referral arrangements, excellent exchange of patient information to ensure treatment regimes are supported and followed up, and flexible service delivery arrangements to ensure parity within the region.

Boab Health Services Allied Health staff currently provide input to the orientation of new GP Registrars to the region which highlights client criteria and referral processes. Ongoing staff education also occurs to new community-based staff re Boab Health Services Allied Health referral processes. WACHS may need to consider a similar process. All services also need to review how they update and share client information.

Recommendation:

Quarterly inter-agency meetings are held between Allied Health providers (Boab Health and KPHU) and ACCHS and WACHS Managers to review referral and service delivery arrangements across the region, particularly at remote sites.

Additional resources to support speech pathology

Evaluation of a 2011 project which changed speech pathology provision to school aged clients in Broome[56] showed a positive impact on the equity and accessibility of the service for Aboriginal clients. It has also decreased waiting times and increased the amount of therapy available to both early intervention and school aged clients. Recommendations from the project included:

- Streamlining waiting lists to make Aboriginal children of kindergarten or pre-primary age higher priority on the initial assessment waiting list and for therapy if they have a moderate-severe speech and language difficulty, have not received any previous therapy blocks and were not seen as an early intervention client.
- Securing funding for an Aboriginal Health Worker to increase the accessibility and make the speech pathology service more culturally secure for Aboriginal families, in particular early intervention clients.
- Creating positions for school-based Speech Pathology Therapy Assistants who can support the implementation of speech pathology programmes in schools.
- Encouraging Education Department s to part-fund schoo-aged speech pathology services.

This has implications for delivery of speech pathology services to the rest of the region. The findings from Broome show that an injection of resources to address young children's speech problems make a positive difference, which without doubt impact on a child's learning ability. This programme should be extended across the Kimberley.

Recommendation:

That a business case be developed for providing increased Speech Pathology services to Aboriginal children of kindergarten and pre-primary age across the region.

Resolving the issue of unfilled audiology positions

This issue is of concern to the Ear Health Teams (discussed in Chapter 5.2 on Maternal and Child Health). Their short term recommendation is for primary health care staff to be up-skilled in screening audiometry.

In the current environment it cannot be considered acceptable for the funding for these 3 positions to remain unspent – or to be spent on matters that do not necessarily address ear health issues or allied health shortages in the region.

Recommendation:

That senior medical staff in WACHS and KAMSC meet to consider the future of Audiology positions in the region.

56 Evaluation of 2011 Service Re-design Laura Coakes, Broome Speech Pathology, KPHU

5.9 ALCOHOL AND OTHER DRUGS

Consuming alcohol is associated with significant levels of harm within the community. This harm impacts negatively upon the individual, family and community's physical, spiritual, mental, social and emotional wellbeing. Alcohol use is second only to tobacco as the leading preventable cause of death and hospitalisation in Australia[57]. The use of alcohol costs the Australian community more than $15 billion a year in terms of healthcare, road crashes, labour in the workforce, crime and resources used in prevention and treatment[58]. A further $14 billion per annum can be attributed as tangible costs of alcohol's harms to others and more than $6 billion in intangible costs.[59]

The WA Health and Wellbeing Surveillance System (HWSS) survey asks respondents about their alcohol drinking habits, including how many days a week they usually drink and how many drinks they usually have. The alcohol information is categorised into risk levels based on the 2009 National Health and Medical Research Council Australian Alcohol Guidelines. Results from the 2010 WA HWSS showed that the proportion of residents in the Kimberley who reported consuming alcohol at high-risk levels for long-term harm was significantly higher than the corresponding State rate (56.3% cf 38.8%). The proportion of adults who drank at low-risk levels for long-term harm was significantly lower in the Kimberley compared to the State (27.8% cf.37.9%). A significantly lower proportion of adults in the Kimberley reported not drinking compared to the State rate.[60]

The Kimberley region experiences disproportionate levels of alcohol related harm compared to the rest of the state. Data supplied by the WA Drug and Alcohol Office (DAO) reveals that:

- for the period from 2005-2009, the rate of all alcohol-related hospitalisations in the Kimberley Health Region was significantly higher (4.29 times) than the corresponding State rate. The highest rate of alcohol-related hospitalisations in the Kimberley compared to the State rate was for 'assaults' (11.12 times higher).[64]
- When the population was broken down by gender and Aboriginality, the rates of all alcohol-related hospitalisations and deaths for males, females, Aboriginal and non-Aboriginal populations were all significantly higher than the corresponding WA State rates.
- Overall, the total hospitalisation rate for 'all alcohol-related conditions' for Aboriginal residents was significantly higher (1.51 times) than the corresponding State rate. When looking at specific alcohol-related conditions, the rates of hospitalisations for 'alcoholism', 'cancers', 'other alcohol related diseases', 'road injuries', 'falls', 'suicide' and 'assaults' were significantly higher than the State rates. [61]
- For the period from 2005-2009, residents in the Kimberley Health Region were hospitalised a total of 3,875 times for alcohol-related causes. A total of 13,312 bed-days (80 per 1,000 persons) were used, at a cost of $18,182,083.29 ($109.43 per capita).[64]
- Overall, the total death rate for 'all alcohol-related conditions' for all persons during the period 1999-2007 was significantly higher (2.89 times) than the corresponding State rate. The rate of all alcohol-related deaths for Aboriginal residents during the same period was significantly higher (1.24 times) than the corresponding State rate.[64]

AOD services in the region report:

> Alcohol and marijuana are the most commonly abused substances.
>
> There is an increase in poly-drug use (use of two or more substances).
>
> The availability of other illicit drugs is increasing. Of particular note are stimulant drugs such as amphetamines and methamphetamines.
>
> Volatile substance abuse is generally localised and occurs sporadically within the region.
>
> FASD is a priority for communities within the region. The incidence and prevalence of the disorder is not known. This is further discussed in chapter 5.2.

THE PLANNING ENVIRONMENT FOR AOD SERVICES

Alcohol and drug issues are receiving increased attention from both the Commonwealth and State governments.

57 Gray & Wilkes, (2010) Reducing alcohol and other drug related harm. Resource sheet no. 3 Closing the Gap Clearinghouse.

58 Collins & Lapsley (2008)The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05. Commonwealth of Australia

59 Laslett, A.-M. et al. (2010). The Range and Magnitude of Alcohol's Harm to Others. Fitzroy, Victoria: AER Centre for Alcohol Policy

60 WA Health and Wellbeing Surveillance System (2010), Epidemiology, DOH

61 Drug and Alcohol Office WA and Epidemiology Branch of Department of Health WA (2011). Alcohol-Related Hospitalisations and Deaths: Kimberley. Pg 7

There are various strategies and plans which currently guide funding and service delivery priorities from both governments including the National Drug Strategy 2010-2015, the National Drug Strategy – Aboriginal and Torres Strait Islander Peoples Complimentary Action Plan 2003-2009, the Drug and Alcohol Strategic Framework for Western Australia 2011-2015 and the WA Drug and Alcohol Strategy, Strong Spirit Strong Mind – Aboriginal Drug and Alcohol Framework for Western Australia 2011-2015.

The National Drug Strategy 2010-2015 focuses on 3 key activities which support harm minimisation:

- demand reduction to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.
- supply reduction to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs and control, manage and/or regulate the availability of legal drugs.
- harm reduction to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The two core elements in the WA Drug and Alcohol Interagency Strategic Framework 2011-2015 are the prevention and early intervention of alcohol and other drug use problems, and provision of support to those who need it. Priority initiatives include:

- The continued development and implementation of Alcohol Management Plans in high-risk regional and remote communities.
- Prevention campaigns to inform and educate the community on key alcohol and other drug related issues.
- The expansion of integrated service delivery to improve access and more seamless service provision.
- Implementation of the Cannabis Law Reform Act 2010. Upon proclamation, the possession and cultivation of cannabis will be re-criminalised and a mandatory intervention treatment session for both adult and juvenile minor cannabis offenders will be introduced.

At the regional level, a number of plans have been made regarding AOD needs in the region:

- In 2009 the Kimberley DAWC a sub-committee of KAHPF attended by AOD service providers in the region, commissioned a Kimberley consultation with the aim of producing an AOD plan for the region. Key recommendations of the report 62 were:

  The importance of AOD services working partnership with both government and non-government agencies and across sectors.

  The importance of developing the AOD workforce to enable services to better respond and meet the needs of communities.

  Community involvement in informing service planning, development and implementation.

  The need for effective evaluation of programmes, to allow for the recognition of success factors and indicators of sustainable change.

- In 2008 a plan was also drafted by the Kimberley Alcohol Management Group, a group of government and non-government alcohol and other drug service providers, funding bodies and licensees auspiced by the Kimberley Inter-agency Working Group (KIWG). This plan is currently being reviewed.
- Each of the 4 Local Implementation Plans produced in 2010 as part of the Remote Service Delivery (RSD) programme makes reference to AOD needs.

PLANNING ISSUES

Distribution of services:

The level of service delivery in the region is not equitable. Some towns and remote communities are serviced far more extensively and/or regularly than other towns or communities with equivalent levels of need. The current DAO tender process for the expansion of AOD support services in the Kimberley region creates an opportunity for additional AOD services to be located within areas of greatest need.

Focus of services:

The current focus of most AOD services is too heavily weighted towards treating people with AOD problems rather than on preventing another generation adopting the same habits. There is a need for services to be holistic i.e. to provide a range of services from education and prevention to rehabilitation, continued care and support and to maintain good links with primary health care services. While the need to break the cycle of social conditioning and address the underlying causes

62 WANADA (2009) Kimberley Drug and Alcohol Working Committee Consultation Project.

of alcohol and drug abuse is primarily the role of housing, employment, training and child protection agencies, there is a role for AOD services to support changes in community lifestyles. This may involve supporting or assisting in organising alcohol-free activities or activities that change community attitudes to alcohol and drugs.

In 2009 the Kimberley consultation by Western Australia Networks of Alcohol and Other Drug Agencies (WANADA)[63] recommended that the focus of service development should be:

> 'on innovation and sustainable approaches that build relationships between other services and strengthen existing support networks and structures within Aboriginal families and communities'.

There is an overwhelming need to include families and whole of community when implementing AOD interventions. Many clients receiving treatment for alcohol and/or drug related issues are returning to environments where excessive drinking and / or drug taking is normalised and in some instances encouraged. At present Kimberley AOD services have limited capacity to provide community capacity- building interventions.

Level of service:

The 2009 WANADA consultation also found a consistent view that

> 'current service provision is not meeting community demand, which is clearly extensive and a challenge to meet with limited resources'.

Without doubt, more AOD workers are needed in the region. However, the recent experience of AOD services is that new funding for AOD positions does not reflect the realities of employment costs in the region, particularly for the employment of local Aboriginal workers who may require additional training, mentoring and support. Housing for these workers also needs to be provided as many local Aboriginal workers are living in overcrowded sub standard conditions. This situation contributes to high levels of stress and burnout within the local AOD workforce.

Planning style:

At present, most planning for additional services is done outside the region or within the region with Aboriginal people who may be impacted by, but do not have, AOD issues. A new style of consultation is required. This consultation process needs to engage directly with all members of the community, including those community residents that are responsible for contributing to the AOD related harm. Mobilisation and motivation of the entire community is essential for any sustainable behaviour change.

AOD INITIATIVES CURRENTLY BEING TRIALLED IN THE REGION

The use of alcohol restrictions as a circuit breaker

Since 2007 some communities have decided to use alcohol restrictions as a way of halting the alcohol-related anti-social behaviour and alcohol-related violence that was impacting negatively on their community. There are both voluntary and mandated restrictions in the region. Mandated restrictions are enforceable under the Liquor Control Act 1988. Section 64 and section 175 restrictions are the main enforceable restrictions within the Kimberley.

Section 64 restrictions

Conditions imposed by the Director of Liquor Licensing on licensees restricting the sale and supply of liquor from their premises. There are currently six section 64 restrictions in place within the Kimberley (Kimberley-wide, Fitzroy Crossing, Halls Creek, Derby, Kununurra and Wyndham).

Section 175 bans

This section enables the Governor, on the recommendation of the Minister, to declare a restricted area. Regulations then make it an offence to sell, supply, possess or bring liquor into these communities. Within the Kimberley region there are nine current section 175 restrictions.

There are also a number of communities who have adopted their own by-laws enabled by the Department of Indigenous Affairs (DIA). The towns of Broome, Kununurra and Wyndham have their own specific voluntary restrictions in place through their local alcohol accords.

The first community to adopt this approach was Fitzroy Crossing. On 27th Sept 2007, the Director of Liquor Licensing released his decision that, as of 2nd October 2007, restrictions of packaged liquor be imposed for a 6 month period. In May 2008 this restriction was extended for an indefinite period of time. Two years following the implementation of the restriction, the quantitative and

63 WANADA (2009) Kimberley Drug and Alcohol Working Committee Consultation Project. pg27

qualitative data[64] reveals continuing health and social benefits for the residents of Fitzroy Crossing and the Fitzroy Valley communities. These include:

- reduced severity and incidence of domestic violence;
- reduced severity and incidence of wounding from general public violence;
- families purchasing more food and clothing;
- families being more aware of their health and being proactive in regard to their children's health;
- generally better care of children and increased recreational activities.

Similar restrictions were put in place in Halls Creek in May 2009. A review of data two years later[65] suggests that restrictions have had an impact on presentations at the hospital and sobering shelter and in alcohol-related offences. For example: Since the introduction of the restriction, the total number of assault offences has decreased by 58%, from 278 pre-restriction to 116 from June 2010 to May 2011. Compared with the pre-restriction period, alcohol-related presentations to the Halls Creek Emergency Department fell by 34 percent in the period June 2009 to May 2010 and a further 45 percent in the following 12 months.

At the two year mark in Fitzroy Crossing, all 184 respondents to an evaluation of the effects of the restriction noted that the liquor restriction has not stopped domestic violence, alcohol abuse, neglect of children and other anti-social and criminal behaviour. No respondents expected that a restriction alone would resolve these problems. The evaluation also revealed that the benefits of restrictions could be considered to have reached a high point at the 12 month mark of the liquor restrictions. In the second twelve months there was a gradual erosion of these benefits. Many respondents believed that the reduced positive benefits could be considered to be due, partly, to the missed opportunity of the WA government to follow up on promised programmes and support, and due to the fire that destroyed the Fitzroy Crossing Shopping Centre on July 8 2009 (which forced people to travel out of Fitzroy to Derby or Broome for shopping). The need for, and lack of, a coordinated regional response to address the issue of collective social trauma experienced by residents of the Fitzroy Valley was noted. The majority of respondents believed that any relaxing of the restrictions would be premature and detrimental to the community and result in an immediate increase in alcohol related anti-social behaviour and alcohol related violence as there has not been enough time for the benefits of the restrictions to change people's behaviour in relation to alcohol.

All Kimberley towns have some restrictions on the timing and/or volume of alcohol sales. Several remote communities have adopted, or are in the process of applying for, liquor restrictions and there has been some discussion about Kimberley-wide restrictions. The Fitzroy Crossing experience highlights the need for appropriate follow up and support programmes to be planned in advance and implemented in conjunction with, not after, restrictions are in place.

64 Kinnane, S., Farringdon, F., Henderson-Yates, L., and Parker, H., (2010). Fitzroy Valley Alcohol Restriction Report: An evaluation of the effects of a restriction on take-away alcohol relating to measurable health and social outcomes, community perceptions and behaviours after a two year period.

65 DAO (November 2011). The Impact of Liquor Restrictions in Halls Creek - Quantitative Data - 24 month review.

TRANSITION HOUSING

AOD services report that it is common for consumers exiting residential rehabilitation to return to the same social environments they faced prior to entering into rehabilitation. Significant peer pressure within the community prevents the consumer from maintaining positive behaviour change. To address this, the use of transition housing is being trialled in Broome, Derby, Fitzroy Crossing, Kununurra and Halls Creek. Houses have been acquired for use by people exiting rehabilitation where continued support will be provided to assist people to positively reintegrating back into community life.

VOLATILE SUBSTANCE USE

Outbreaks of volatile substance use (VSU) in the Kimberley have been a concern to communities, government and non-government agencies for many years. Petrol sniffing is the most common volatile substance used in the Kimberley. This is consistent with other experiences in remote Indigenous communities throughout Australia. Despite many reviews, reports and research into volatile substances, communities remain frustrated with the lack of accessible and effective interventions to appropriately deal with the social and health impacts of VSU.

The prevalence of VSU is difficult to measure due to a number of factors. Within the Kimberley region, VSU is primarily sporadic and localized.

THE EAST KIMBERLEY PETROL SNIFFING STRATEGY

The East Kimberley Volatile Substance Use (VSU) Plan was developed to support the Australian Government's Petrol Sniffing Strategy (2005). The Kimberley Interagency Working Group (KIWG) has the responsibility to monitor the progress of the plan. A working group was established by the KIWG to be responsible for the development and implementation of the plan.

The plan has two main objectives:

(1) To prevent and reduce petrol sniffing and other volatile substance use in the East Kimberley region.

(2) To increase the resilience and wellbeing of children and young people, the target group most vulnerable to engaging in volatile and other substance use.

The plan also has eight strategic areas each with specific actions, responsibilities and timelines for achievement. There have been intitiaves implemented in nine communities within the East Kimberley as a result of the East Kimberley VSU plan. Recent VSU within West Kimberley communities has created an opportuntiy for the development of a similar VSU plan, or that the East Kimberley VSU Plan be adapted to include the entire Kimberley region.

A Kununurra Indigenous Coordination Centre (ICC) initiative has created a notification referral sheet to be used by all agencies that become aware of an incidence of sniffing. The referral is forwarded to KMHDS who identify the level of concern and coordinate a response. Escalation of the response to a whole of community approach can occur. The process allows both for a quick response and for sniffing trends to be monitored. There is a need to extend the use of notification form across the region.

The roll-out of Opal fuel supply in the region was delayed by supply issues. An Opal storage facility is currently being constructed in Darwin due for completion mid 2012. Further consultations with the towns of Halls Creek and Fitzroy Crossing are planned with regard to a regional roll -out of Opal.

IMMEDIATE NEEDS

Provision of support to communities who have adopted or are considering adopting Section 175 legislation to become dry communities:

There are currently 13 communities with Section 175 alcohol restrictions. Support is particularly needed in the first 6 months after communities become dry, to assist them to work with the Police, Department of Child Protection, health services and other non-government agencies to develop a practical plan for how they will implement and enforce their dry community status. Support and assistance must also be offered to community residents with AOD issues.

Early intervention support for young people at risk: Chronic/heavy use of marijuana has a major impact on family and community life by reducing the amount of time that parents and carers spend interacting with children and partners or joining in community initiatives. Sitting around stoned or 'bunged-up' is becoming normalised behaviour in some communities, and is being passed on to the next generation.

Supporting all Kimberley young people to make a healthy transition to adulthood requires an increased capacity to deliver culturally secure prevention and early intervention initiatives that build the resilience and protective factors which prevent or delay the onset of drug and alcohol use. There is a need to intervene before problems become entrenched by implementing a range of programmes and services that identify individuals, families and communities at risk and provide access to education and support to develop the knowledge, attitudes and skills to choose healthy lifestyles and promote healthy environments. More early detection and referral of those with potential drug and alcohol problems to appropriate treatment services is also required.

Revitalisation of the inter-agency working committee, DAWC: DAWC has not met regularly for the last two years. In the past it provided a useful forum for the exchange of information, fostering collaboration, ensuring no duplication of services and providing input into regional planning. Given the predominantly non government service provider membership, DAWC is well placed to provide leadership and advocacy for the region.

The need to build evaluation into all programme activity: The 2009 WANADA consultation[66] found there is currently very little formal service/programme evaluation conducted amongst AOD services across the Kimberley. As new strategies are implemented it is important that evaluation methodologies be considered in the planning stage of any programme development. Evaluation tools need to be easy to implement and workers need to be fully inducted into their use from the start of new initiatives. Evaluation needs to be conducted throughout programme/service implementation and long term outcomes established that recognise the complexity of the issues and outcomes being addressed.

66 WANADA (2009) Kimberley Drug and Alcohol Working Committee Consultation Project.pg27

Resolution of problems relating to the transport of people who wish to enter residential rehabilitation
Residential rehabilitation services are only available in two Kimberley towns. There is no funding that can be used to cover the costs of transport for a patient referred to rehabilitation. Services work around this first by referring a client to a nearby hospital for detoxification, which can be paid for by PATS. However, this only works if the local hospital will accept a patient for detox (hospitals may say they do not have the capacity to provide this service), if the referring service has an arrangement with a service that can access PATS, and if the client will remain engaged with the process while the paperwork is organised. Many opportunities to send clients to a residential rehabilitation facility have been lost due to this hurdle.

Workforce Issues

There is an overwhelming need to expand the existing AOD workforce within the Kimberley region. This is evidenced by the level of disproportionate harm experienced by Kimberley residents. Existing AOD services in the Kimberley do not have the capacity to appropriately respond to the identified need resulting from excessive alcohol use, emerging illicit drug use and volatile substances.

The need to train and support local community based AOD workers within the Kimberley is well recognised. Having a sustainable community based workforce is essential to address the AOD related harm within Kimberley communities. A skilled local Aboriginal workforce delivering AOD services and programmes based upon culturally secure service delivery models is the most effective and appropriate way to respond to the AOD issues in the Kimberley region.

A review of the role of the regional Training Coordinator position (funded by DoHA and based at KMHDS) is required to ensure that the focus is on identifying, coordinating and supporting training pathways within the region for local Aboriginal people to become qualified AOD counsellors and for remote community residents to gain the skills required to be employed as community-based AOD workers.

KAHPF therefore recommends:

- Prevention and early intervention strategies are to be a priority for the region.
- Measures must be taken to to address regional inequity and improve the planning and coordination of AOD services and interventions within the region.
- Improved communication and collaboration between communities, Government and non-government agencies when responding to AOD issues.
- Improved access to culturally secure AOD treatment and support is required including:
  - Increasing the availability of a range of holistic and culturally secure AOD interventions.
  - Family-based AOD interventions.
  - Improved services and support for men.
  - Increasing the capacity of communities to respond to AOD related harm.
  - Increasing the capacity of services to respond to youth issues.
- Improved monitoring and evaluation of all AOD services, programs and interventions.
- The East Kimbeley Volatile Substance Use (VSU) Plan be adapted to incorporate a Kimberley region wide VSU Plan.
- Building a community-based AOD workforce.
- Refocussing the role of the regional Training Coordinator onto:
  - identifying, coordinating and supporting training pathways within the region for local Aboriginal people to become qualified AOD counsellors and for remote community residents to gain sufficient skills to be employed as community-based AOD workers.
  - Implementing culturally secure mentoring programmes across the region.
- Investigating the possibility of implementing reciprocal placements with Aboriginal Medical Services, mental health and youth services to build cross-sectoral understanding and collaboration.

5.10 AGED CARE

> Community see the importance of keeping older community members in community as active participants for as long as possible.[67]

This view was expressed by the Bardi Jawi people, and it is a view held throughout the region. Residential aged care is the choice of last resort rather than the first option for most families. However, community expectations that aged care services should be available in all remote communities and provided by local people working out of community-based services will be difficult to meet for some time to come. Training, support, viability and governance are all issues discussed in the section that follows. Community Care and Extended Aged Care at Home (EACH) packages provide an option for elderly people to remain in their community for longer, but even with an organisation such as Kimberley Aged and Community Services (KACS) with the commitment to work in the flexible, collaborative way that service delivery requires, there will always be limitations to where these packages can be applied.

CURRENT DISTRIBUTION OF SERVICES IN THE REGION

A spreadsheet detailing the distribution of regional places is attached at Appendix 5. It reveals a significant growth and redistribution in residential places and community packages in the region. In 1999, Numbla Nunga Nursing home in Derby was the only facility providing residential high-care beds and Kimberley Aged and Community Services (KACS) were in the early days of implementing their model to support community-based Home and Community Care (HACC) services in remote communities. Nowadays high-care residential places are available in Broome, Derby, Halls Creek and Kununurra, and there are HACC Services in 13 communities and all Kimberley towns.

There are some points to note in relation to the distribution of services:

- For the first time in the region, there are waiting lists for residential care in Broome and Derby.
- In late 2011, Frontier Services secured $11 million capital to build and operate 30 high care residential places in Kununurra. When open, the transfer of the 10 places currently operated by WACHS in Kununurra Hospital to the new service will occur. All residential providers in the region will then be non-government organisations.

67 Bardi Jawi Local Implementation Plan 2010

- Service providers are noting an increasing and unexpected demand for care in the West Kimberley from high-needs clients. Data needs to be gathered to confirm this trend and identify the reasons why.

CURRENT ISSUES AND NEEDS

Meeting the needs for additional residential places

Not surprisingly, families in the region want their relatives who have to enter residential aged care to stay on country and be close to home. This leads to demands for high-care residential places in Fitzroy Crossing, Wyndham and remote communities where they are not currently available. What is not realised are the financial and operational difficulties involved in obtaining and maintaining the accreditation required to operate high care beds.

Meeting the needs of an ageing population are problematic throughout Australia. In recognition of this, in 2010, the Federal Government commissioned a Productivity Commission Inquiry – Caring for Older Australians. Public submissions were invited. Previous government enquiries failed to respond to the particular issues faced by providers delivering residential aged care in remote parts of Australia, despite input from Kimberley services. These issues were again detailed in the submission by Frontier Services, the major non-government aged care provider in the region, to the Caring for Older Australians enquiry, in which they stated[68]:

> Current policy and program design are metro centric in their focus and, as a result, disadvantage those delivering and receiving aged care services in remote settings. As we move into the 21st Century the continuation of this 'one size fits all' approach negates attempts to provide real reform that addresses the specifics of service delivery in a remote setting.

Particular points made in their submission:

- The current aged care regulatory framework translates into an over-zealous and culturally inadequate regulatory regime in remote Australia.
- the following issues impact on an organisation's capacity to meet staffing expectations under the *Aged Care Act*:
  - high staff turnover affects training and compliance knowledge and continuity;
  - lack of suitably qualified staff including Registered Nurses (RNs) impacting on the capacity to provide 24 hour RN coverage; and
  - lack of wage parity for aged care staff with those employed in the acute care sector.
- Services are burdened with an inflexible reporting and quality assurance process. In a small facility, much time is unnecessarily committed to addressing visits by regulatory bodies and completing reporting documentation.
- The current funding regime does not cover operational costs for small remote services Adjustments in government subsidies do not respond to operational cost increases.

All residential providers in the region agreed with the points raised above in a joint submission they made to a previous enquiry in 2003. In addition, two other matters impact on the capacity of residential services to expand:

- Residential services' access to capital funding for expansion and major maintenance is highly competitive and does not recognise the increased building costs or maintenance schedules required to operate in such an extreme climate as the Kimberley.
- The requirement for people who work in residential and community aged care to have a police clearance, even to provide sufficient identification to make an application, is proving an additional limitation on recruitment in an industry that already faces severe staff shortages and seeks to recruit greater numbers of Aboriginal staff. There is no right of appeal when excluded from employment for an offence that does not impact on a person's ability to provide competent levels of care for local, older people.

Having the capacity to deliver community care services in remote communities

Provision of quality community care to a person in a remote community is an ongoing challenge. The solution will always be by building the capacity of community members to care for their older members. However, due to transience, changes in community members' own life circumstances etc, training and support has to be provided on an ongoing basis. The current government arrangements for allocating training funding have resulted in a number of providers successfully tendering for work

68 Frontier Services (2010) Submission to the Productivity Commission Inquiry: Caring for Older Australians.

in the Kimberley. The lack of coordination and planning between these providers results in less than optimal outcomes.

In the past, aged care workers were employed on Community Development Employment Projects (CDEP) with top up. This enabled KACS to operate flexibly to employ a pool of employees who were paid when they attended work, to vary the number of HACC workers in a particular community as client numbers changed, and to establish services for small numbers of clients. Community aged care workers are now employed in 'real' jobs and are required to comply with employment provisions such as having identification and a police clearance. A human resources capacity and an understanding of aged care service delivery in their employing community organisation are also required, and not always present. This has limited the flexibility that was previously available in service delivery.

Access to accommodation in communities is often an issue. If appropriately skilled care workers are not available in community, the possibility of recruiting staff from outside the community to provide the services required is limited by the lack of housing available. This has an impact on ongoing care provision. This point is discussed further in Chapter 7.

Younger people requiring care

There is a cohort of younger people who require/will soon require community care or residential support - people who have prematurely aged due to their lifestyle and younger people with disabilities eg. acquired brain injuries or strokes. Their prevalence is currently being studied via the Kimberley Healthy Adults Project.

Experience from HACC services currently used by this cohort of disabled people is that:

- Ensuring the safety of other service-users tends to constrain activities.
- Old people do not like mixing/want to mix with these people. They are often larger and stronger & are perceived as being threatening, especially when their behaviour is erratic.
- The younger people may have children themselves. Services are not set up to meet the needs of younger people with different attitudes and needs.

The lack of rehabilitation and specialised community care services to address this group of patients needs is further discussed in Chapter 6.2.

Improving the patient journey between hospital, community and home

Despite attempts to work on this issue for many years, aged care providers still experience instances of elderly people unexpectedly being returned to their residential aged care home from hospitals in the region with new medicine and without discharge papers. In other cases, communication between inpatient services and the community breaks down and individuals are returned to living situations that are unsuitable for their care needs[69]. A structural solution, one that does not depend on the strength of personal relationships, must be put in place. This issue is further discussed in Chapter 6.2.

Infrastructure for older people

Government arrangements for building and maintaining housing in towns and remote communities have changed in the last few years and provision of some services privatised. However, it appears that despite the increasing incidence of disability in communities as people age, new houses are still generally not being built with disabled access. The reason for this may be cost pressure, but it is far more expensive to alter a house to provide wheelchair access later.

> Recommendation:
>
> KAHPF will engage in discussions with the Department of Housing to ensure that in the future all houses are built with doorways wide enough to allow passage of a wheelchair, with no impediments to wheelchair access into the shower and with a design that allows rails or ramps to be added to stairs at a later date.

At present, once people in remote communities have been granted a Community Aged Care package (CACP), the process required to have their accommodation assessed and made safe and suitable for them to live in can take an excessive amount of time. This is in part, due to the relatively infrequent visits of Allied Health staff (see Appendix 2) who are required to inspect and write a plan, and in part due to delays in implementation by the Department of Housing due to their issues with sourcing contractors.

69 Issue raised in WACHS (2011) Kutjunkga region Clinical Services Plan

Recommendation:

KAHPF will discuss ways of reducing this delay with the Dept. of Housing (DoH) and the possibility of DoH investigating the cost effectiveness of creating and managing a pool of mobile facilities eg. a portable bathroom unit or mobile wheelchair ramp that can be added to houses when needed.

Continence Management

A study in 2001 revealed that, for a range of reasons, less than 4% who present at clinics get their incontinence treated. This finding led KACS to employ a regional continence advisor to work in remote locations, not in towns. However, the fear of being 'taken away" still results in many older Aboriginal people denying that they have incontinence, so they then suffer the shame, discomfort and isolation which results from being wet and smelly. For some time, KACS has been unsuccessfully applying for additional funding for 2 AHWs to work in communities with the regional advisor – to raise community awareness of continence as a health issue that can be prevented and treated and to provide education which overcomes the shame and stigma associated with discussing continence issues.

Recommendation:

That KAHPF support the need for funding for these 2 positions as a priority.

Access to residential aged care for dialysis patients

At present finding appropriate housing for ageing dialysis patients with additional care needs is an issue. The Broome Dialysis hostel will not admit clients unless they are totally self-caring and it is likely that hostels planned for Derby, Kununurra and Fitzroy will have the same policy. Residential aged care providers are reluctant to admit such clients as the aged care funding model does not pay for the additional amount of work that is required to support dialysis needs, particulary CAPD and hostels' ongoing turnover of staff means there is a continual training requirement. Further exploration of the needs of this cohort of patients is required.

Recommendation:

That further consideration be given to the accomodation needs of ageing dialysis patients with additional care needs.

Regional Coordination between service providers

Since 1998 a phone hook-up and annual face-to-face meeting between aged care service providers facilitated the exchange of information and discussion about regional issues and needs, provided service managers with peer support and an opportunity to attend off-site training. Since the end of funding for the Regional Residential Aged Care Training Coordinator position who acted as Secretariat for this network in 2010, it has not met. Given the constant turn-over of service managers, a return to a situation where services had no links or regional perspective on issues and needs is likely.

Recommendation:

In recognition that all residential aged care providers in the region will shortly be not-for- profit organisations with special support needs, KAHPF recommends that DoHA provide funding for Secretariat support to the Aged Care Providers Network.

A LOOMING AGED CARE NEED

The Kimberley Indigenous Cognitive Assessment (KICA) study has revealed a high rate of dementia in the region amongst Aboriginal people over 45 – at 12.4%, 5.2 times greater than the Australian dementia rate of 2.4% for the same age group[70]. Alzheimers and vascular dementia were the most common types of dementia. The study found that the dementia risk factors for Aboriginal people living in the Kimberley are older age, male gender, no formal education, being a smoker, or having had a previous stroke or head injury.[71] Prevalence of falls (31%), pain (55%) and incontinence (9%) were also high in this group. [72]

Dementia is the second highest cause of disability burden (years lost to disability) in Australia.[73] Most people with dementia have one or more carers who face

70 Smith K et al. (2008) High prevalence of dementia and cognitive impairment in Indigenous Australians. Neurology 71, pg 1470 – 1473.

71 Smith K et al (2010) 'Factors associated with dementia in Aboriginal Australians.' Australian and NZ Journal of Psychiatry 44 pg 888–893.

72 LoGiudice D et al (2012) Preliminary evaluation of the prevalence of falls, pain and urinary incontinence in remote living Indigenous Australians over the age of 45 years. Internal Medicine Journal "Accepted Article"; doi: 10.1111/j.1445-5994.2010.02332.x

73 Mathers C, et al (2000) The Australian Burden of Disease Study MJA 172 pg: 592-596

psychological, physical, social and financial burden. Although the impact on family and communities is high, appropriate community-based education and support for caregivers of people with dementia is lacking.

The dementia unmet needs study [74] determined that in the Kimberley region people living with dementia and their caregivers are struggling. Overcrowding, transport and elder abuse were also identified as issues. The study identified there is a need for:

- greater community engagement,
- improved communication and the creation of real partnerships between services and communities for community based care,
- a need for dementia education and training for caregivers, community care workers and health professionals,
- a wider flexible range of community based services providing respite, activities, home and ADL support and transport,
- community-based management and support for an Aboriginal community care workforce.

As the disease progresses so that people require residential care, they will find there are limited dementia-secure places in the region. Broome, Derby and Kununurra have secure high care facilities - services in Fitzroy, Halls Creek and Wyndham do not and probably will not in the near future. Planning to address the potential needs of this group of people and their carers needs to commence now.

5.11 PALLIATIVE CARE

Since 1999 there have been a number of attempts to establish a regional palliative care service in the Kimberley. The lack of success in no way reflects on the individuals involved, but rather on funding levels, auspicing arrangements and the service delivery model adopted. In particular, the expectation that one person, employed under the title of Regional Coordinator, could meet the capacity-building and clinical needs of a region the size of the Kimberley proved to be totally unrealistic.

In recognition of this and the potential demand for services created by clients with Chronic Kidney Disease using the Kimberley Dialysis Centre, since 2010 additional funding for palliative care has been supplied via the Department of Health's WA Cancer and Palliative Care Network. The current Kimberley service consists of a 1.0 FTE Regional Nurse Coordinator, a 0.4 Clinical nurse [unfilled since July 2011], a 0.5 Social Worker, a 1.0 Aboriginal Health Worker and a 0.5 Administration Officer.

As at February 2012 there were 52 palliative care clients in the Kimberley. Monthly numbers have varied between 44 and 53 in the months from July 2011 to Feb 2012. The current geographical breakdown is as follows:

> Broome patients 25, Beagle Bay 2, Balgo 1, Derby 13, Halls Creek 5, Looma 1, Kununurra 1, Fitzroy Crossing 1, Wyndham 3

Despite the increase in capacity, the service struggles with retaining staff and can still do little more than provide telephone support to clinicians and families in most of the region outside Broome. Feedback from community consultations in Balgo[75] highlights a situation that is common across the region:

> The majority of terminally ill patients are flown to Halls Creek hospital to die, with their extended family usually unable to accompany them. Older people who wish to die on their country and/or at home with their families currently do not have the option or nursing support to do so.

The Palliative Approach was integrated into the Kimberley Renal Support Service (KRSS) from its inception. This involves educating patients and staff about the options available to people with a life limiting illness including not choosing dialysis, holistic approaches to care and palliative care. The aim is to start the dialogue at the early stage so when patients come to end of life management they are prepared and have an Advanced Care Plan in place. The issues that have arisen over the years are renal staffs' lack of skills in talking about /introducing palliative care to the patient and the lack of consistent palliative care service delivery in the Kimberley.

OUTSTANDING ISSUES

The Kimberley Palliative Care Service (KPS) is vital to the Kimberley Renal Service and to all people in the Kimberley. The need to create a stronger, more consistent model of service delivery across the region is a matter of general concern. It may be timely to evaluate whether WACHS is best placed to auspice the service,

74 Smith K, Flicker L, Shadforth G, Carroll E, Ralph N, Atkinson D, Lindeman M, Schaper F, Lautenschlager NT, LoGiudice D. (2011). 'Gotta be sit down and worked out together': views of Aboriginal caregivers and service providers on ways to improve dementia care for Aboriginal Australians. Rural and Remote Health, Issue 3, volume 11 Available from: http://www.rrh.org.au

75 Consultations occurred as part of the development of the Kutjungka Region Clinical Services Plan by WACHS

due to the reduced flexibility to respond to community needs that results. For example, even though there is a separate allocation for the KPS, the service is required to adhere to generic WACHS restrictions on travel or staff recruitment when budgets are tight. The requirement that palliative care staff only provide home visits during normal working hours is particularly counter-productive.

A number of other issues which prevent the provision of best practice palliative care remain to be resolved. These include:

- Despite previous community education activities, there is a low level of awareness in the community about the concept of palliative care and the services offered by the Palliative Care team. People are also not aware that they have the right to refuse further treatment and choose to return to their community to await their end in country, rather than go to Perth for further tests and then be too unwell to return. Community education and empowerment needs to be provided regularly via staff visits to communities.
- KAHPF believes that, in principle, people should have the right to die at home. The current service does not have the capacity to provide support to people who want to die at home in their remote community or in some Kimberley towns.
- As most palliative care clients currently die in hospital, hospitals must ensure that they have facilities which support this process. This includes the capacity for family members to stay with a dying relative. Volunteer members of the Wyndham Palliative care group raised funds to purchase a sofa bed, fridge, kettle and radio to create a family room that was separated from the palliative care by a bathroom. When the hospital was refurbished, this room was no longer available to palliative care.
- It should also be a key principle of all Kimberley services that no person should die in pain. Due to the high turnover of doctors and nurses in the region and their relatively infrequent involvement in managing palliative care, this does not always occur. There is an ongoing need for doctors to build partnerships with the Palliative Care specialists in Perth and for the provision of professional development to doctors on the management of pain, the role of the Kimberley Palliative Care Service and the support that is available from the 24 hour on call palliative service in Perth.
- Workers in aged care, dialysis units and other services are not equipped to prepare a person for death. A culturally appropriate kit needs to be developed and workshopped which supports Aboriginal workers in services to guide palliative care clients through the decisions that they need to make before their death, for example, regarding their funeral and sharing of their belongings.
- Training in palliative care should be included in Aboriginal Health Worker training in the KAMSC School of Health Studies.
- At present the Cancer Council also funds a small separate regional service. As the needs of clients are often similar, discussion on integrating or increasing collaborative activity between the two services is recommended.
- Access to PATS for family members to travel to be with a dying relative is also an issue in some areas. Decisions should not be based on the flexibility of a particular PATS clerk, but on a policy that acknowledges that a dying palliative care patient needs to finalise matters with his or her family.

IMMEDIATE NEEDS

There is an urgent and ongoing need to provide additional staff and resources for palliative care in the region. As a priority, recruitment should occur to fund vacant positions in the current service and to ensure that planned/funded regional travel occurs.

This should be followed by the funding of additional palliative care positions and their associated on costs. It is possible that a case can be made for a Regional Nurse Coordinator plus 3 palliative care teams comprising an RN, an Aboriginal Liaison Officer and a 0.5 administration officer which would service the West, the Central and the East Kimberley, together with a full time Social Worker in the East and West Kimberley. All positions should have built in flexibility to enable temporary movement of staff to a different sub-region during times of high need.

As new dialysis units in the region open, the needs of patients who chose to end dialysis or whose kidney disease is reaching end stage must be considered. This could be via additional resources allocated to the Kimberley Palliative Care Service or via the creation of a palliative care section within each dialysis unit. The need for education and support of dialysis staff in regards to palliative care will be ongoing.

Recommendations

- A Kimberley protocol be developed to cover palliative care pain management.
- Ongoing, regular professional development for doctors must be provided in management of pain for palliative care clients, the role of the Kimberley Palliative Care Service and the support that is available from the 24 hour on-call palliative service in Perth.
- Funding is required for the development and workshopping of a culturally appropriate kit which supports Aboriginal workers in services to guide palliative care clients through the decisions that they need to make before their death, for example, regarding their funeral and sharing of their belongings.
- A scoping study should be undertaken regarding ways to meet the needs of East and Central Kimberley palliative care patients.
- PATS guidelines should be changed to incorporate travel for the relatives of people who are dying.
- A review of the options and arrangements for auspicing the Kimberley Palliative Care Service should occur.

5.12 ENVIRONMENTAL HEALTH

In Aboriginal culture the environment is regarded as a force for healing. Yet many people in the Kimberley live in an environment that is not conducive to health and wellbeing. Management of rubbish, dogs, pests, dust and infrastructure maintenance has largely been neglected as each level of government refused to take responsibility for addressing the obvious needs. The Environmental Health Directorate[76] has been the sole funding body delivering Aboriginal environmental health programmes and services across WA. Their funding was primarily used to employ Aboriginal Environmental Health Officers (EHOs) in Shires or community organisations such as Nirrumbuk Aboriginal Corporation.

Essentially, environmental health programmes are about preventing the transmission of communicable diseases and reducing the impact of environmental conditions on community health. Despite the limited amount of funding available, there have been some very positive achievements. For example:

- Due to improved partnerships between the Shires and health services all 4 Kimberley Shires now participate in monitoring notifiable diseases to the source of contamination.
- In the East Kimberley a partnership has been set up between KPHU and Shire Environmental Health workers, OVAHS and the Hospital regarding infectious diseases that are not notifiable but impact on people's health, e.g. skin diseases and diarrhoea. OVAHS patients with frequent and repeated presentations are questioned about their home circumstances. OVAHS staff refer issues of broken plumbing or septic tanks to the Environmental Health Team who check to see if they can locate the cause of the patient's disease, arrange for the appropriate agency to fix it and follow up to put strategies in place which prevent the same problem occurring again. This has resulted in a significant improvement in the time it takes to get faulty housing hardware fixed and increased understanding by patients of the impact living conditions can have on health and wellbeing.
- Nirrumbuk Aboriginal Corporation has developed a positive dog programme for communities on the Dampier Peninsula. This began with community education on worm control and how to look after dogs, progressed to microchipping and, in some communities, competitions for the healthiest community dog, community-funded de-sexing programmes and cheeky dog control. Nirrumbuk now has two years pilot funding to explore ways to make the projects sustainable.
- In 2009, a partnership between the Shire of Derby/West Kimberley Environmental Health team and Sims Metal resulted in over 400 car bodies collected from 15 communities being crushed and removed. Communities were cleaned up, the potential for mosquito and snake breeding reduced and a safer environment for children to play in created. As a bonus, because Sims Metal paid on average $50 per car, the project generated income which is being used to enhance the Shire's dog de-sexing programmes.

Twice a year a Kimberley and Pilbara Forum is held – an opportunity for Environmental Health workers to meet together face to face to discuss common problems and share positive solutions. KPHU provides support for this forum.

76 Formerly the Office of Aboriginal Health

MAJOR ISSUES THAT NEED RESOLVING

In June 2006 the Government of Western Australia and the Australian Government signed a Bilateral Agreement on Indigenous Affairs which included a commitment for local government to take responsibility for providing local government services in Aboriginal communities. Local government services include waste management, road, recreational facilities and airstrip maintenance, street lighting, dog control, town planning and building control, and emergency management.

Effective provision of these services will have a major impact on health and wellbeing in remote communities. Yet, in 2012, this transfer of responsibility still has not occurred. The number and complexity of issues that remain unresolved is highlighted by a joint communiqué [77] from the 22 Local Governments in WA affected by these changes, issued in December 2011 which states:

> "Local governments do not think that adequate provisions have been made to enable Local Government to assume responsibility for service delivery to Aboriginal communities in a fiscally responsible or acceptable manner."

The communiqué listed 12 pre-requisites that must be in place before the transfer of responsibilities can occur. These included:

- Funding certainty: The Shire of Broome, for example, describes itself as[78]

  > "risk adverse from providing these services without long term generational funding guarantees from Government."

  To date government has only committed to 4 year cycles of funding.
- Agreement on the minimum size of community that local government is expected to provide services to. i.e. Does the agreement include small outstations?
- Confirmation of the range of services that are to be provided.
- Funding to undertake the community consultations and planning that will be required to effect change.
- No withdrawal of Federal and WA government resources until a transition process has been agreed.

There must also be resolution of issues regarding development on Aboriginal Lands Trust (ALT) land where buildings and infrastructure are not currently required to comply with local government regulations, apart from in relation to the Food Act. There has been discussion on the need to change the WA Health Act to address this issue for several years, but to date the changes required "to bind the Crown" have not been made.

From a community perspective there are other matters of concern. For example:

- Many current municipal services are not currently up to Shire standards. Where will the resources for upgrading come from to enable them to comply with these standards?
- Will community assets become Shire assets?
- What role will Shires have in future land tenure arrangements?

It is important that these matters are resolved as soon as possible.

> Recommendation:
>
> That KAHPF should make representations to the WA and Federal Health Ministers advising of the unacceptability of further delay in resolving funding issues, reminding them of the links between good environmental health and positive health outcomes and recommending that they provide the funding that is required.

Plumbing Licenses: Under the *Water Services Licensing (Plumbers Licensing and Plumbing Standards) Regulations 2000* plumbing maintenance and repairs can only be carried out by a licensed plumber. This includes minor repairs such as changing tap washers and shower heads and unblocking drains. Despite Aboriginal Environmental Health workers (AEHW) passing relevant TAFE courses, under current regulations an AEHW cannot even change a tap washer. Getting a licensed plumber can take weeks/months, when an AEHW who lives in the community could be carrying out the maintenance and/or repairs in a timely manner and at a much lower cost. For example, in 2010 the community of Bayulu in the Fitzroy Valley, only 20 km from Fitzroy Crossing with a bitumen road all the way, waited 8 weeks for a plumber to attend to a burst water pipe.

This issue has been ongoing for over ten years, but is finally being progressed by the Plumbing Licensing Board. A briefing to the Honourable Simon O'Brien MLC, Minister for Finance, Commerce and Small

77 Forum of WA Local Governments (2011). Communique to the WA State Government. Future local government service delivery to Aboriginal communities available from http://www.broome.wa.gov.au/council/pdf/attach/2011/December/12.1.pdf

78 Shire of Broome Strategic and Corporate Plan 2011-2016

Business occurred in late 2011 with the recommendation that exemptions be provided for work in Aboriginal communities. The proposal will require amendment to the *Water Services Licensing (Plumbers Licensing and Plumbing Standards) Regulations 2000*.

> Recommendation:
>
> That KAHPF member organisations make representations to the Minister for Finance, Commerce and Small Business asking him to make a timely decision to amend the legislation.

OTHER ISSUES

- The WA Health Act needs strengthening so that the same standard of health legislation applies on all forms of land tenure, including where management is vested in any organisation (including government and their agencies). Environmental Health workers could then require people to take action to address problems, rather than being reduced to negotiating to secure outcomes.
- Environmental Health Practitioners (EHOs, Environment Health Workers, Field Support Officers) may need some image building. They are much more than merely the guys who fix plumbing and are seeking a new way of working with primary health care providers. Linkages and relationships need to be strengthened so that services work together in partnership to jointly identify issues and plan how these issues will be managed. The environmental health team has the added advantage of working with people in their homes where on the ground health promotion can be provided. These partnerships could be formally supported by the development of MOUs between health and environmental health service providers.
- Not every community has immediate access to the support of an Environmental Health worker. Resourcing should be needs driven, and the need is high. Ideally, every community with a regular population of over 250 people should have an on-site EH practitioner to monitor environmental health matters and undertake small jobs. Smaller communities should be serviced by a roving team based either in a nearby town or larger community. The roving team should also provide support for community-based Enviromental Health staff to undertake larger tasks. The cost to employ an Enviromental Health practitioner, lease a car and provide an operational budget for the work required is in the region of $120,000.
- Potentially, dogs can be problems in communities across the region. Awareness of the links between human health and well-being and the health of community dogs needs increasing. A community awareness raising programme based on the findings from successful dog programmes which is implemented across the Kimberley needs to be developed and implemented.

Recommendations:

KAHPF will write to the WA Minister for Health asking that, as a matter of urgency, he act to:

- Progress changes to the WA Health Act which ensure all communities and individual developments are required to adhere to the provisions of the WA Health Act.
- Provide additional resources for Environmental Health practitioners to ensure best practice programmes are delivered across the region, with continuity ensured beyond the commencement of Local Government responsibility through the new Bilateral Agreement.
- Provide additional resources to support a region-wide programme to raise community awareness about the links between human health and healthy dogs.

- WACHS and ACCHS will formally seek partnerships with their local Environmental Health practitioners via development of an MOU and include partnership development and planning in future work plans for each community clinic.
- KAHPF encourages health service providers to collaborate with environmental health service providers where there is emergent or existing high rate of communicable disease transmission, to promote partnerships which allow sound management and control of the related environmental health risks (to target disease transmission).

POTENTIAL FUTURE ISSUES

Dengue Fever in WA is generally regarded as a disease that is contracted via overseas travel. However, outbreaks have occurred in northern Queensland since the 1880s and, in 2011, there were 69 reported cases.[79] Dengue management in Queensland focuses on disease surveillance, mosquito control and education. EHOs have an important role to play in all these activities. In late 2011 an infestation of the potentially dengue fever-carrying mosquito *Aedes aegypti* was detected in the town of Tennant Creek, Northern Territory.[80] According to the NT Government, surveying for, and elimination of, the mosquito will require an intensive and ongoing programme for up to two years - including a property by property programme on public and private land to treat all water-holding receptacles with insecticide. This is a highly resource-intensive programme. Tennant Creek is approximately 750 km from Kununurra. Should a similar infestation of mosquitoes occur in the Kimberley, it is important that resources are immediately available to address the issue.

Promoting proactive management of the current mosquito-borne disease risks (Murray Valley Encephalitis, Ross River, Barmah Forest and Kunjin viruses) across the Kimberley through sufficient resourcing, will reduce the potential impact of new and emergent mosquito-borne disease threats such as dengue fever.

79 Data sourced from http://www.health.qld.gov.au/dengue/outbreak_update/previous.asp

80 Department of Health NT (2011) NT Disease Control Bulletin 18(4). Dec 2011 pg 23.

6 CROSS-PROGRAMME NEEDS AND ISSUES WHERE POLICY CHANGES AND/ OR POLICY DECISIONS ARE REQUIRED.

6.1 THE URGENT NEED TO IMPLEMENT A SYSTEM FOR SHARING PATIENT INFORMATION

For some considerable time, Kimberley health service providers have agreed that to provide best practice continuing care to a highly transient population there is an urgent need to improve patient record information-sharing arrangements. The days of card indexes, lists in diaries, illegible faxed discharge summaries and other people-dependent systems must end!

This is in line with a national programme[81] to create a Personally Controlled Electronic Health Record (PCEHR) for every Australian who wants one. As part of the 2010/11 Budget, the Federal Government announced it would spend $466.7 million over two years. This funding is intended to establish a secure system of personally controlled electronic health records that will provide:

- Summaries of patients' health information;
- Secure access for patients and healthcare providers to their e-Health records;
- Rigorous governance and oversight to maintain privacy.

It is the Government's intention to introduce PCEHRs on 1st July 2012. A National E-Health Transition Authority (NEHTA) has been established to develop and progress the national infrastructure and adoption support required for e-Health in Australia, as mandated and funded by the Council of Australian Governments (COAG). In 2010/2011 NEHTA called for proposals to establish a panel of general practice clinical desktop vendors interested in working with NEHTA to incorporate new national e-Health specifications and standards into their existing products. Communicare is on the vendor panel; MMEx is not.

Currently WACHS Kimberley largely uses a paper-based system, while all Kimberley ACCHS, apart from Nindilingarri, use MMEx. Nindilingarri uses Communicare.

On 1st July 2012 the national system will go live. At this point, software developed by vendors on the NEHTA vendor panel will have a common set of specifications that meet the requirements to exchange information through the national PCEHR. This exchange of information is subject to the usual legal requirements including patient's consent. In concept, data from one service can be made available to the national PCEHR and be available for viewing by another service. It is likely that Health Information Network (HIN) will not support the development of cross-platform information exchange outside the national agenda.

Given this situation, what is urgently needed in the Kimberley is comprehensive deployment of a clinical information system (CIS) across all WACHS activity and a methodology to exchange relevant patient information between this system and MMEx within the context of the emerging state and national electronic health record architecture.

> Recommendation:
>
> WACHS and the ACCHS sector support plans to have WACHS-Kimberley prioritised for roll out of CIS and to develop cross platform sharing arrangements between MMEx and WACHS electronic systems as a matter of urgency.

6.2 IMPROVING THE TRANSITION BETWEEN HOSPITAL AND THE HOME

As the population in the region grows, so too will the demands on the limited number of hospital beds available. KACS already receives a number of inappropriate referrals for respite as there are almost no rehabilitation, ambulatory care or home nursing programmes in the region. At present, recovering patients are kept in the regional hospital in Broome until pressure on beds means they are sent to Derby or Kununurra until other arrangements can be made.

There is an urgent need to begin planning for improvements to the transition between hospital and the home. This must include consideration of the need for:

- Rehabilitation services, both residential and community-based

81 National E-Health Transition Authority (NEHTA): http://www.nehta.gov.au/

- Step down facilities which may include transitional housing
- Community nursing
- Additional community support

Good coordination between these services will be required to ensure the patient's journey from home to hospital and back is smooth.

In addition, when there is a transfer between services patients, particularly Aboriginal patients, risk slipping through the gaps. The Kimberley with 16 staffed remote clinics and a large number of other clinics with visiting staff has a very large number of transfers to and from secondary care. The region also regularly transfers patients between Perth or Darwin and both Primary Health Care (PHC) and secondary services in the region. All of these transfers present serious risks of problems which can and do impact on patient outcomes and the effectiveness of PHC services. None of the three secondary hospitals in the region have staff dedicated to clinical liaison with primary care. A large and crucial component of this work is for maternal and child health with women (and men) often having to travel and stay near these three hospitals remote from their home when their children are ill, leaving other children without one or both parents. There is a need to ensure admissions and discharges for children are more patient and family friendly, follow up outpatient care is attended and hence further morbidity and mortality is prevented.

In 2009 an application for COAG funding for teams of 2 people in each of Kununurra, Derby and Broome hospitals (one RN and one Aboriginal staff member) with the specific task of ensuring smooth patient movement and improved efficiency for services within the health care system was unsuccessful. Creation of these positions would result in:

- more efficient travel between PHC and secondary care
- reduced missed appointments for review or for procedures by children and adults
- decreased readmissions of children and adults due to improved discharge planning
- improved adherence to changes in therapy
- improved patient outcomes due to more timely assessment and treatment.

Recommendations:

- WACHS and KAMSC jointly seeking funding to undertake a scoping study of the immediate and future needs for step down services including rehabilitation, home nursing and step down care.
- Funding be sought to create clinical care liaison teams in Broome, Derby and Kununurra hospitals.

6.3 IMPROVEMENTS IN ARRANGEMENTS FOR PATIENTS REQUIRED TO TRAVEL TO PERTH FOR HOSPITAL TREATMENT

In relation to non-emergency transport of patients, recommendation 19 of the 1999 Kimberley Aboriginal Health Plan stated[82]:

> It is recommended, for the non-emergency transport of patients, that first and foremost health services need to acknowledge a duty of care to their patients, including, where necessary:
>
> the provision of escorts;
>
> acceptable arrangements for meeting patients on arrival at their destination (including formal arrangements with airlines to provide assistance where patients do not require escorts); and
>
> travel arrangements that take into account the circumstances of the patient and their community (including mode of transport, time of day, condition of patient, degree of infirmity, language/cultural barriers, presence of children or babies, and need for accommodation).

In 2001 the Patient Assisted Transport Scheme (PATS) was reviewed.[83] Despite the provision of additional funding to improve the Scheme, in 2011 evidence suggests that under-estimation of how daunting and frightening it is for Aboriginal people from the Kimberley to go to Perth continues. It is arguable whether any of the recommendations in the 1999 KAHPF Plan have been implemented adequately. KAHPF members were able to provide a long list of incidents including:

- Failures of the Meet and Greet Service in Perth

82 Atkinson. D et al (1999) Kimberley Aboriginal Health Plan pg 80

83 Dept. of Health (2002) PATS Review Report. Government of Western Australia.

leaving people stranded at the airport or trying to negotiate long taxi queues late at night.

- People unable to pay the gap between PATS payment and the actual cost of staying at Aarons Hotel (because if Jewell House is full, single patients receive a $60 accommodation voucher with $75 for a couple).
- Patients without sufficient taxi vouchers to attend all their appointments.
- Immobile patients expected to travel alone even though they had no way to collect their luggage.

The lack of escorts allowed to travel with PATS patients is in fact a matter of regular concern. This and many other PATS issues were raised by community members at a recent visit to the region by the Equal Opportunity Commissioner, Yvonne Henderson[84].

Some of the issues can be addressed at the regional level. New doctors and nurses need to be orientated to the importance of completing PATS forms correctly, so a patient receives the support that is required. WACHS could make a policy that PATS do not book patients onto flights that arrive in Perth late in the evening or depart early in the morning (unless the patient specifically agrees to this option). Other matters require the attention of the Department of Health.

Recommendations:

- KAHPF again makes representations to the WA Health Minister regarding the deficiencies in the current PATS scheme.
- The Meet and Greet scheme is reviewed and changed to meet Kimberley needs.
- New doctors and nurses to the Kimberley receive orientation to the PATS system to ensure that they complete the forms which determine a patient's needs correctly.
- Orientation manuals of all services are updated to include a section on completing PATS forms and the need to consider patient's Webster® pack needs when travelling.
- WACHS reclassify the pay level of PATS clerks to ensure the recruitment of staff who can show initiative and who are sensitive to patients' needs.

84 A report on the visit will shortly be available on the Equal Opportunity Commission website.

6.4 PATS ISSUES WITHIN THE KIMBERLEY

Transport arrangements for patients within the Kimberley are also an ongoing concern. The arrangements made for pregnant women attending their birthing hospital and their return to their community with a baby are often totally unsuitable. There are too many instances of mothers with young babies descending from a Greyhound bus in the middle of the night with no way of getting to the accommodation that has been arranged for them. The fact that this is sometimes a Women's Safe House is also not ideal. Similarly, the lack of escorts for old people and the use of bus transport to return people to their community after a major operation are totally unacceptable.

The PATS policy on air travel[85] states:

> People living in the Kimberley may be eligible for air travel within the region if the travel distance is in excess of 1,000 km.

This effectively precludes air travel within the Kimberley. As there are now regular internal flights within the Kimberley and travelling 1,000 km by bus is a 12+ hour trip which cannot improve the health of any patient, an argument can be made for more use of air transport rather than the bus.

Recommendations:

- KAHPF lobbies the Department and Minister of Health to change the rules/policies re access to internal flights within the Kimberley.
- KAMSC organise workshops in the East and West Kimberley which bring together Doctors, PATS clerks and community members so that staff can hear first-hand the issues their decisions cause, and community members can better understand the limitations of the PATS system.

85 Sourced from PATS Scheme overview on http://www.wacountry.health.wa.gov.au

6.5 THE NEED TO EXPAND THE PATS SCHEME TO COVER DENTAL TREATMENT.

The 2001 Review of PATS received submissions on this issue from several dental associations and dentists as well as PATS clients. The review noted that the current arrangements provide for country patients to access emergency and urgent specialist dental treatment under a general anaesthetic and did not recommend any expansion of PATS in this area.

Therefore at present PATS only provides assistance for trauma / maxillofacial surgery requirements, not for the patients that Kimberley Dental Team (KDT) encounter in remote communities who require so much treatment that it must be delivered under an anaesthetic in a district hospital. See chapter 5.6 for more details on oral health issues.

6.6 VALUING LOCAL KNOWLEDGE AND EXPERIENCE

Recent funding allocations for the implementation of state-wide initiatives have revealed an issue of concern, namely government's preference for funding a single service based outside the region to deliver services throughout the state, including in the Kimberley.

This raises issues similar to those discussed in Chapter 4 in regards to fragmentation. Centrally-managed programmes have had very limited effect on Aboriginal health in the region over the past 40 years. Organisations providing a state-wide service tend to have a one-shoe-fits-all approach which means that programmes are not appropriate for or accessible to Aboriginal people in the region. Extensive examples of this can be provided by the Regional Aged Care Training Coordinator who, between 2005 and 2010, spent a good proportion of their time working with external state-wide providers encouraging them to make their training programmes appropriate for Kimberley people.

Recommendation:

New funding for programmes in the region should be allocated to Kimberley services rather than centralised, state-wide services.

6.7 STAFF RETENTION AND SUCCESSION PLANNING

Some of the issues associated with recruitment and retention of staff are discussed in Chapter 7 in relation to staff housing. An associated problem is succession planning in an ageing work place. Given the high turn-over of staff in the region, the fact that service provision has not stalled completely has probably been due to the presence of a small number of highly experienced staff who have been around for a long time. These individuals often hold the corporate knowledge of their organisation and the health knowledge of the region in their heads. Several are reaching retirement age. It is important to ensure their corporate/Kimberley knowledge is not lost to the region.

Recommendations:

- All future funding submissions build in a component to support staff handovers.
- Departing staff are placed off-line before they depart to empty their heads/ensure their corporate knowledge is not lost.
- All staff complete an exit interview.

7. KEY CAPITAL WORKS AND INFRASTRUCTURE NEEDS

This chapter identifies and provides justification for a range of additional infrastructure needs in the region. These include:

7.1 MORE FUNDING FOR STAFF HOUSING IN KIMBERLEY TOWNS

In a competitive staff environment, access to suitable staff housing is an essential element of any recruitment strategy.

In reality, Broome and Kununurra are the only Kimberley towns where there is a credible likelihood of sourcing staff housing on the private rental market. There is almost no private rental market in Fitzroy Crossing or Halls Creek. Houses that are available are only on short term leases or uncertain tenures. Rental costs in Derby have become prohibitively expensive. There are few houses of a suitable standard available for rent in Wyndham. Sharing of houses directly impacts on staff morale and exacerbates staff retention problems. Therefore, services need to enlarge the pool of housing they own and rent to staff.

As an example of the urgency of the situation - the provision of much-needed additional COAG-funded positions in Fitzroy Crossing has required 3 staff to be based in private rental accommodation in Broome over the weekend, fly into Fitzroy Crossing on a charted flight on Monday morning, stay in shared or tourist accommodation during the week and fly back to Broome on Friday. These working conditions do nothing to encourage long term retention of staff.

An additional consequence of the shortage of staff housing is that services have been unable to accept offers of new funding which involve the employment of additional staff. For Nindilingarri Cultural Health Services in Fitzroy Crossing in particular, this has restrained the extent of the services able to be offered to local communities.

Recommendations:

- It is essential that front-end funding for infrastructure/capital works is included in all future programme funding allocations.
- The need for additional staff housing includes:
  - 7 staff accommodation units in Broome for BRAMS.
  - Additional staff housing in Beagle Bay for a Peninsula GP, an AOD counsellor and visiting health specialists.
  - At any location on the Dampier Peninsula, housing for a Headspace counsellor and the new Peninsula Midwife.
  - Additional staff housing and visitor accommodation at Balgo.
  - In Fitzroy Crossing for existing and future positions at Community Health and Nindilingarri Cultural Health.
  - In Halls Creek.
- Consideration must be given to allowing ACCHS health staff access to Government Regional Officers' Housing.
- If governments are not prepared to provide funding for more staff housing, then robust alternative solutions must be considered. This may have to include diversion of programme funding into funding for staff transport solutions. For example, the need to regularly transport health care providers between Broome, Derby and Fitzroy Crossing or between Kununurra and Halls Creek is now so great, that an Investigation into cost effective, regular air transport options is more than warranted.

7.2 MORE FUNDING FOR STAFF HOUSING IN REMOTE COMMUNITIES

The shortage of housing in remote communities has led to the unrealistic expectation that every community will be able to identify, train and retain local staff to work as Aboriginal Health Workers, Environmental Health workers or Aged Care workers in services based in their communities. Even if such people can be recruited, they are denied any possibility of a career structure as there are no opportunities for advancement in their community and no housing available should they wish to move to town. In many communities the pressure on local staff (who are basically on duty 24/7) is unsustainable. Yet external staff cannot be recruited due to the lack of housing, so positions stay vacant.

In addition, there is a need for accommodation for staff visiting communities to do assessments, provide clinical services or to provide mentoring and support for community-based workers or clinic staff. Community clinics rarely have visitor's accommodation. Access to safe and suitable community-owned accommodation is often an issue. Some communities have no visitor's accommodation. In others the accommodation may be booked out by building contractors for long periods or occupied by tourists in the dry season.

Provision of staff accommodation in remote communities is an issue that Government has been reluctant to address because of the costs involved. However, the situation is such that it can no longer be ignored.

Recommendation:

KAHPF write to the Federal and WA Ministers for Health, National Aboriginal Community Controlled Health Organisation, AHCWA and any other relevant body advising of the need to provide more funding for staff housing in remote communities.

7.3 CHANGES TO HOMESWEST INCOME-TESTING POLICIES

In some towns, living in Homeswest housing is the only realistic option for an Aboriginal person employed in a health service. Private rental housing is either not available or beyond the means of an AHW salary. Committing to a long term loan arrangement to fund the purchase of a very expensive housing asset is also not feasible for most Aboriginal staff. This means that, once locally recruited staff have managed to access Homeswest housing, they are reluctant to consider moving towns to advance their careers or gain further experience due to the potential loss of their accommodation and their realistic expectation that they might not find another house should they return to that town. More flexible tenancy arrangements are required which facilitate the movement of tenants between towns.

In addition, Homeswest income policy has a high impact on the retention of Aboriginal staff. If an AHW works on a full time basis their income exceeds the cut-off limit for Homeswest housing. Due to the lack of staff housing in Kimberley towns, the reality is that staff will chose to leave/ work part-time or not attend work for several months of each year rather than lose their access to Homeswest housing. The input of resources involved in training, mentoring and supporting an Aboriginal Health Worker are considerable.

Although KAHPF has made a number of representations to the WA government over the past few years regarding the need to create more realistic Homeswest income policy cut-offs, no progress on this issue has been achieved.

Recommendation:

KAHPF will seek the support of AHCWA to progress the Homeswest income policy issue with the WA Government, and write directly to the Ministers of Health, Indigenous Affairs and Housing asking them to hold high-level discussions to resolve the issue.

7.4 ADDITIONAL RESOURCES REQUIRED TO EXPAND OR RELOCATE CLINICS AND OFFICES

While capital works funding from Commonwealth and State sources has resulted in improvements in working conditions for some services, there are outstanding needs. These include:

REQUIRED NOW:

In/around Broome:

- New office space for KAMSC (which will enable BRAMS to meet their need for more space by expanding into the vacated premises)
- Additional office space and counselling rooms for Kimberley Mental Health and Drug Service
- Upgrade and extension of the clinic to include a sound-proofed room and additional consulting capacity at Bidyadanga

In Kununurra

- Additional office space and counselling rooms for Kimberley Mental Health and Drug Service
- Additional treatment/consulting areas in OVAHS

In/around Derby

- New premises for Community Health
- Additional office space and counselling rooms for Kimberley Mental Health and Drug Service
- Additional clinic space at Looma
- Refurbishment of Dodnun clinic

In the Kutjungka region

- Renovation and redesign of the Balgo Clinic[86]
- Additional staff housing and visitor accommodation Balgo

In addition, the Remote Service Delivery (RSD) project has identified infrastructure needs in Kimberley RSD sites[87].

In Halls Creek:

- A comprehensive scoping exercise to determine the current and future infrastructure needs related to the existing health services and visiting services has been completed. It includes clinical, primary health, emergency, training/education and programme delivery space, as well as accommodation needs for permanent staff and visiting services to/in Halls Creek and out stations. The development of a Halls Creek Health Infrastructure project plan that describes strategies to address resource and funding requirements is proceeding and is due for completion in December 2012. It will include strategies to address the current lack of land available for building projects.

In Fitzroy Crossing[88]

- Establishing suitable housing stock for existing and future positions at Community Health and Nindilingarri Cultural Health is identified as a priority.
- In addition, clinic space for Community Health is an issue. 3 additional consulting rooms plus space for administration are required.
- Refurbishment of the Town Clinic.

On the Dampier Peninsula:

- Replacement of the clinics at **One Arm Point and Lombardina/Djarindjin**[89]
- In **Beagle Bay**[90] Additional staff housing is required to house the new Peninsula Midwife position, a Peninsula GP, an AOD counsellor and visiting health specialists.
- Somewhere on the Dampier Peninsula there is also need for an additional house for a Headspace counsellor.

86 The limitations of the current clinic are identified in WACHS (2011) Kutjungka Clinical Services Plan pg 64-66

87 Halls Creek LIP master document 2011. Office of the Coordinator General for Remote Indigenous Services

88 Fitzroy Crossing Local Implementation Plan 2010.

89 Bardi Jawi Local Implementation Plan 2010

90 Beagle Bay Health Local Implementation Plan updated Dec 2011

7.5 RESOLUTION OF THE ISSUES ASSOCIATED WITH BUILDING INFRASTRUCTURE ON LAND UNDER THE JURISDICTION OF THE ABORIGINAL LANDS TRUST

For many years the WA government has been discussing the transfer of Aboriginal Lands Trust (ALT) land back to community control. Delays in implementing this continue to cause headaches for ACCHSs wishing to build infrastructure on ALT land in remote communities. As an example, the Commonwealth government provided additional Healthy for Life funding to improve maternal and child health services at Balgo. The funding included an allocation for staff housing. In 2012 this housing still has not been built. There is an urgent need for the Department of Indigenous Affairs (DIA) to facilitate a process that ensures the relevant government Department s understand the impact of the delays and work to resolve the issues.

Recommendation: KAHPF will invite a senior representative from DIA to attend a KAHPF meeting in 2012 to provide members with an opportunity to express their concerns about this issue

7.6 EQUIPMENT NEEDS

An audit of the provision and the state of major items of equipment in remote community clinics is detailed in Appendix 4. Discussion about the results of this audit between KAMSC and KPHU representatives resulted in the development of an agreed list of minimum major equipment that all clinics should contain.

AT LEAST ONE PER CLINIC (depending on community size)	
Vaccine Fridge	**ONE PER CONSULT ROOM**
Defibrillator	Non invasive Blood Pressure Machine
Monitor	PO_2 monitor
ECG machine	Otoscope
OXY-viva	Ophthalmoscope
Ambulance Stretcher on wheels	Doppler
Portable emergency First Aid kit /Parry pack	
2 active oxygen cylinders , appropriate storage capacity and a trolley to move cylinders	
Suction equipment	
Syringe driver	
Infusion pump	
Point of Care testing equipment:	**OTHER EQUIPMENT**: at least 1 per clinic
Centrifuge	Adjustable height resuscitation bed
ISTAT machine	Lifting equipment for very heavy patients
Haemocure	Sat phone for ambulance vehicle
HbA1C	Sat phone for patient transport vehicle
Lipids	Dedicated dispensing printer
INR	Functioning video conferencing capacity
Spirometer	Back-up generator
Non invasive BP machine	Networked computer systems
Ultrasound	Computer terminals/ printers for all staff
Doppler	
PROGRAMME EQUIPMENT:	
Retinal camera	
Video otoscope	
Audiometer	

The audit revealed a range of matters which services may need to address:

- Each health service provider needs to ensure they have policies and procedures to ensure their equipment is regularly serviced, and that back up equipment is available while that occurs. Machines that need calibrating must be properly maintained or results may not be accurate, leaving organisations open to prosecution.
- Each service must develop and review their equipment replacement budget to ensure that future equipment needs can be met.

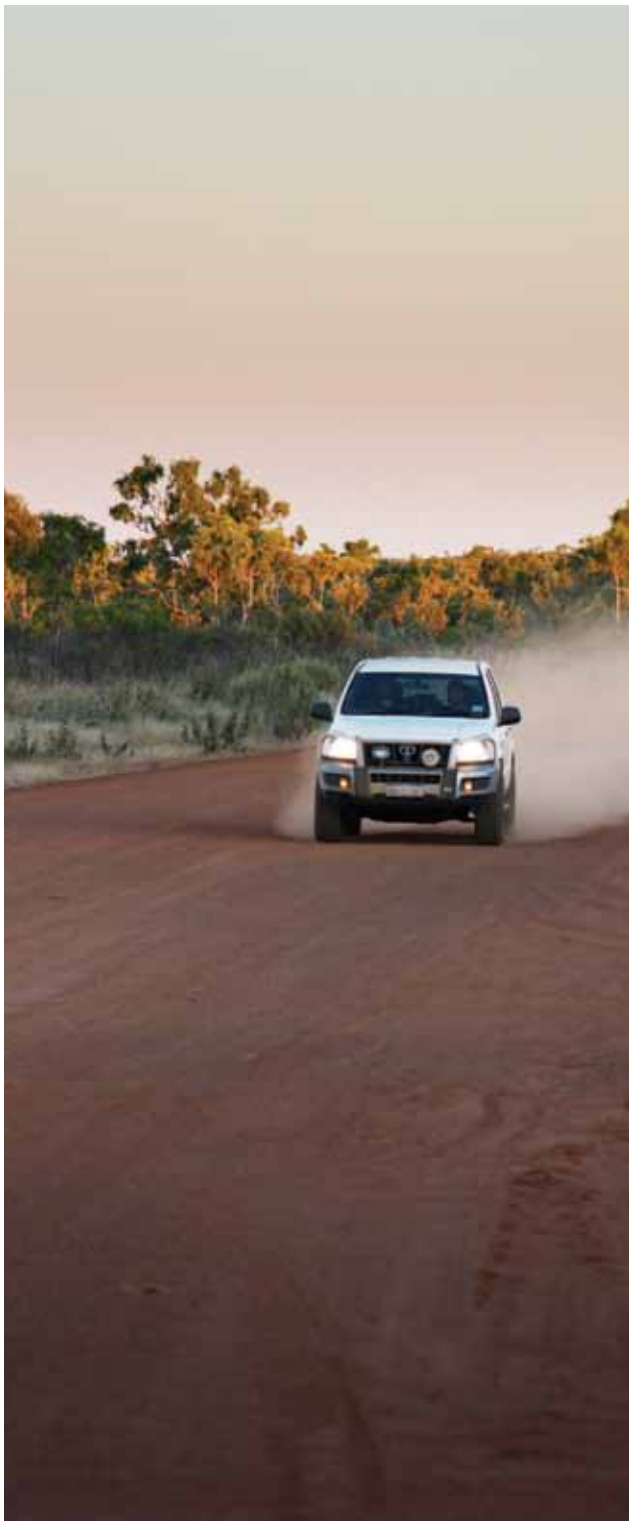
- A large number of clinics report that they do not have sufficient storage space. It was agreed that all clinics being built or redeveloped in the future should have:
  - A dental equipment store room
  - Separate secured storage for spare oxygen cylinders
  - Haemodialysis supplies storage
  - Storage for archived medical records
- If services are to take advantage of new e-health capacities which can link patients to specialists via email and video conferencing, there must be an investment in additional equipment. Very few remote clinics had either video otoscopes or retinal cameras.
- All clinics should have a back-up generator to provide the capacity to operate when community power supplies may be shut down.
- The need for additional patient transport vehicles was identified in the two largest communities of Bidyadanga and Kalumburu.
- A cost-benefit analysis should be undertaken regarding the merits of installing an X-ray machine at Balgo and/or Kalumburu. This analysis should include matters relating to space requirements, equipment costs and maintenance, staff training, staff housing, PATS savings and treatment implications.

Recommendations:

All health services to review the equipment in their remote clinics and:

- Ensure they have appropriate maintenance arrangements and replacement provisions in place to ensure that equipment standards are maintained.
- Where necessary, seek funding to bring each clinic up to the agreed equipment standard.
- Ensure budgets for new clinics or clinic refurbishments include appropriate amounts for equipment and storage.

Funding be sought to undertake a cost-benefit analysis regarding the merits of installing an X-ray machine at Balgo and/or Kalumburu.



APPENDIX 1

KIMBERLEY ABORIGINAL HEALTH PLANNING FORUM CORE MEMBERS SUBCOMMITTEES AND WORKING GROUPS

APPENDIX 2

SERVICE PROVISION TO REMOTE COMMUNITIES FROM JULY 1 2010 TO JUNE 30 2011

East Kimberley

Community	Travel time	Clinic Staffing (resident)			GP Visits	Specialist visits			Allied Health Services Visits									Health service visits or other visiting service			
Population Yellow >500 Green >250 Blue 100-250 White <100	(hours to nearest town by road)	Nurse (FTE)	AHW (FTE)	AHW in training/ Family Support worker	(days per week)	Paediatrician	Physician	Optometrist clinic days	Audiologist	Physiotherapist	OT	Speech Pathologist	Dietician	Diabetes Educator	Podiatrist	Pharmacist	RN Generalist	School Nurse	Child Health Nurse	Midwife
Doon Doon	1	0	0	0	1/fort	##	0	0		****	1	****	4	0	0	0	1/fort	1	6	6
Glen Hill	1.5	0	0	0	1/fort	##	0	0		****	****	****	2	0	0	0	1/fort	1	6	6
Kalumburu	12	3	1	0	1.5	6	7	2		2	3	2	5	9	4	12		3 ###	###	###
Mindibungu-Bililuna	2	2	1	0	1	6	0	2		2			3	3	2	5		0	By Balgo MCH RN	By Balgo MCH RN
Mulan	4.5	2	0	0	1	6	0	2		2	2	2	2	3	3	5		0	By Balgo MCH RN	By Balgo MCH RN
Ringers Soak	2.5	2.5		0.5	1/fort	0	0	0		2	2		5	0	2	2			4	2
Warmun	2	3	1	0	2	8	7	4		5	4	3	3	5	10	12		by on site RNs	4	4
Wirrimanu-Balgo	3.5	6	1	0	3	6	0	4		2	2		9	4	4	2		0	0.5 FTE On site	0.5 FTE On site
Yiyili	1.5	0	0	0	1	0	0	0		2	1			1	1	0	1 dy/wk	4	24	If required

Key to Appendix 2

Points to note re Appendix 2:

^ RFDS ceased visiting Gibb River Road communities on 1 July 2011

* RFDS RN is also a Midwife;

** DAHS RN sees Child Health clients and checks the school children

*** Allied Health trips to the Fitzroy Valley are scheduled every 2 weeks (for 4 days). OT and SP travel together with the Therapy Assistant and stay for 4 days, then Physio and Therapy Assistant travel the following fortnight. A number of smaller communities are visited on a needs basis (eg Mt Pierre, Mimbi, 8 Mile, Karnparmi, Ngumpan, Ngurtawarta, Bungardi, Moongardie, Jimbalakadunj). Allied Health visits to the Gibb River Road communities are scheduled as two x 4 day road trips each year. Communities are also accessed as needed via RFDS clinic flights during the rest of the year.

**** Allied health visits to Doon Doon and Glen Hill are on request/receipt of a referral from OVAHS.

Populations for Fitzroy Valley communities taken from Frances Morphy (2010) Population, People and Place. The Fitzroy Valley Population Project. CAEPR WORKING PAPER No. 70/2010.

Dr Kay is now based part time in Kununurra so Doon Doon and Glen Hill receive visits from a Paediatrician.

From March – June 2011 KPHU employed an RN who provided school, child and maternal health services 1-3 weeks per month

APPENDIX 2

SERVICE PROVISION TO REMOTE COMMUNITIES FROM JULY 1 2010 TO JUNE 30 2011 WEST KIMBERLEY

	Travel time	Clinic Staffing (resident)			GP Visits	Specialist visits			Allied Health visits								Health service visits or other visiting service				
Population Yellow >500 Green>250 Blue 100-250 White <100	(hours to nearest town by road)	Nurse (FTE)	AHW (FTE)	AHW in train-ing	(days per week)	Paediatri-cian	Physician	Optometrist clinic days	Audiologist	Physio	OT	Speech Pathologist	Dietician	Diabetes Educator	Podiatrist	Pharmacist	RN Generalist	School nurse	Child health nurse	Mid-wife
Beagle Bay	2	2	1	2	2	6		2		7	1	5	5	5	4	4		12	12	2/wk
Bidyadanga	3	4	3		1 on site + 4 visit-ing	6		4		6	3	7	7	11	8	5		12	26	0
Dodnun	4.5	0	0		1/month	4		0		2	2	1				1	^ 12 RFDS RN	0	0	by on site RNs
Imintji	3	0	0		1/month	4		0		2	2	2			1	1	^ 1 RFDS RN	by on site RNs	by on site RNs	by on site RNs
Kupungarri	4	1	0		1/month	4		0		2	2	2		1		1	^ 12 RFDS RN	by on site RNs	by on site RNs	by on site RNs
Jarlmadangah	1.5	0	3		1	0		0		4	4	2			3	2	46**	46 **	46**	0
Pandanus Park	1				1			0					1		3		46 **	46**	46**	0
Lombadina/ Djarindjin	3	2	1		1.5	4	3	2		1	1	4	4	8	5	12		by on site RNs	12	0
Looma	1.5	2	2	1	1.5	6	3	4		10	10	3	8	10	9	12	12 RFDS RN	5	by on site RNs	8
Milligidee/ Kadjina #	3	0	0		1/month RFDS			1		1		2			1	0	12 RFDS RN	5		
Muludja #	0.4	0	0		0			2		3	6	5				0		5	4	1
Ngallagunda	5	1	0		1/month	4		0		2	2	2	0		0	1	^ 12 RFDS RN	0	0	by on site RNs
One Arm Point	3.5	2	1		1.5	4	3	2		5	3	4	4	5	4	12		by on site RNs	12	0
Wangkatjungka #	1.5	0	0		1/fort FC Dr	8		2		4	3	2	4		9	2	4 dys/wk	5	12	10
Yakannarra #	2	0	0		1/month RFDS			2		1	1	0			1	2	12 RFDS RN	5		12 RFDS
Noonkanbah/ Yungngora #	2	0	1		3/month RFDS	10		4		2	2	3	4		7	2	4 dys/wk +3/mnth	5	12	12 + 36 RFDS
Djugerari #	1.5	0	0		1/month RFDS			1		1	0	0			0	0	12 RFDS RN	5		2+ 12 RFDS
Koorabye/ Ngalapita #	2.5	0	0		1/month RFDS			0		1	1	1				0	12 RFDS RN	5		12 RFDS

APPENDIX 3

DENTAL SERVICES to KIMBERLEY TOWNS IN 2011

Town	Number of Dental Health Service (DHS) dentists/visits	Number of visits by School Dental Service (SHS)	Number of visits by Kimberley Dental Team (KDT)	Number of Private dentists	Comments
Broome	2 FT dentists	Rotates among 3 schools in Broome		3 private clinics 5 FTE dentists	
Derby	1 FT since Nov 2011	Visiting DT for 4-5 weeks Nov-Dec			
Fitzroy Crossing	1 FT since July 2011				
Halls Creek	3 x one week visits ex Kununurra: April, Aug, Oct	8 wks Halls Ck DHS and Red Hill	28 days May-June		KDT 22 days HC Hospital 1 day HC FA 5 days YY
Kununurra	1 FT Dentist	13-14 weeks in Kna		1 private clinic 2 dentists	Term 1 – KDHS x 9 weeks Terms 3 & 4 – St Josephs x 4 – 5 weeks
Wyndham	10 visits ex Kna	WDHS 6 weeks in Term 4		10 visits ex Kna	Trips began April 2011 SDS visits to St Josephs scheduled for 2012.

Under-serviced towns

DENTAL SERVICES to KIMBERLEY COMMUNITIES IN 2011

Community/ Population Yellow >500 Green>250 Blue 100-250 White <100	Number DHS dentists/visits	No. visits School Dental Service (SHS)	No. visits Kimberley Dental Team (KDT)	Army Aboriginal Community Assistance programme (AACAP)	Comments
Kalumburu	4 days in June		2 days in May		
Bidyadanga	5 weeks (3 x Jan & 2 x Dec)				
3 Kutjunkga communities	3 days in Nov		8 days May & June		KDT: Balgo: School x 1; Clinic x 4 Mulan: Sch x 1; Clinic x 1 Billiluna: Sch x 1; Clinic x 2
Beagle Bay	4 weeks (2 x Jun & 2 x Aug)				
Lombardina/ Djarindjin	4 weeks (2 x May & 2 x Nov)				
One Arm Point	4 weeks (2 x Mar & 2 x Sep)				
Looma	I day by visiting team ex Derby				
Warmun	Travel to Kununurra Dental clinic on a regular basis	6 – 7 weeks Term 3	6 days (3 dys Feb & Aug)		SDS visit included Frog Hollow students
Bayulu				3 days	12 km to Fitzroy Xing
Yiyili			I day in May		Children screened in 2010 by KDT
Noonkanbah					
Wangkatjungka	3 days at school Nov-Dec			2 months June/ July	Visited several F Valley communities
Ringers Soak			3 days May & June		School x 1 day Clinic x 3 days
Jarlmadangah					
Dodnun			1 day in June		Included other community people
Mt Barnett					

Under-serviced communities

APPENDIX 4

REMOTE CLINIC EQUIPMENT AUDIT 2012

Population Yellow >500 Green>250 Blue 100-250 White <100 ITEM	Bidyadanga	Beagle Bay	Lombo/Djarindjin	One Arm Point	Looma	Jarlmadangah	Pandanus Park	Ngallagunda	Kupungarri	Wangkatjungka	Bayulu	Noonkanbah	Balgo	Billiluna	Mulan	Ringers Soak	Warmun	Kalumburu
Vaccine Fridge			X	X						X	X	X						
Defibrillator						X	X											
Monitor	X					X	X	X								X		
ECG machine																		
Oxy viva resuscitator	X	X									X	X	X	X	X	X		
Ambulance Stretcher on wheels						X	X	X	X	X	X	X	X	X	X			
Portable emergency 1st Aid kit /Parry pack						X	X											
2 active O2 cylinders + storage capacity																		
Suction equipment																		
Syringe driver	X	X				X	X	X	X	X			X	X	X	X		
Infusion pump		X				X	X	X	X	X			X	X	X	X		
Point of Care testing equipment:																		
ISTAT machine	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Haemocure																		
HbA1C	X		X	X	X	X	X	X	X	X	X	X		X	X	X	X	X
Lipids	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
INR									X	X	X					X		X
PO2 monitor					X				X	X					X	X	X	
Spirometer	X					X	X	X	X	X	X	X		X	X			
BP machine																		
Ultrasound	X		X	X	X	X	X	X	X	X	X	X		X	X	X	X	X
Doppler		X											X	X	X			
X ray machine	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental chair fixed	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X		X
Dental chair mobile		X			X	X	X	X	X	X	X	X	X		X			
Dental steriliser	X	X			X	X	X		X	X	X	X	X	Y	X	X		
Dental X ray	X	X	X	X	X	X	X		X	X	X	X	X	X	X			X
Retinal camera			X	X	X	X	X	X	X	X	X	X		X	X	X	X	X
Video otoscope		X	X	X	X		X	X	X	X	X	X		X	X	X	X	X
Audiometer							X	X	X	X	X	X	X	X	X	X	X	
Tympanometer		X					X	X	?	X	X	X		X	X	X		

x Clinic does not have this equipment.
Clinic does not have this equipment and needs it ASAP.
Has equipment: needs replacing immediately.

Has equipment: needs replacing in next 1-3 years.
Has equipment: no need to replace in next 3 years.
? Equipment is in a cupboard. Condition unknown.

REMOTE CLINIC INFRASTRUCTURE NEEDS 2012

Population Yellow >500 Green>250 Blue 100-250 White <100	Bidyadanga	Beagle Bay	Lombo/Djarindjin	One Arm Point	Looma	Jarlmadangah	Pandanus Park	Ngallagunda	Kupungarri	Wangkatjungka	Bayulu	Noonkanbah	Balgo	Billiluna	Mulan	Ringers Soak	Warmun	Kalumburu
Number of consulting rooms	4	2	2	2	2	2	1	1	1	2	2	2	4	R	R	2	3T	4
How many additional consulting rooms are required?	2	2	2	2	2	1	1	1	2	4	0	2	2	R	R	0	2	0
Adequate storage space Yes/No	N	N	N	N	Y	N	N	N	Y	N	N	Y	Y	R	R	N	Y	Y
Has a dedicated resuscitation room or area Yes/No	N	Y	N	N	Y	N	N	N	Y	Y	Y	Y	Y	R	R	N	Y	N
Has adequate computer terminals and printers for all staff? Yes/No	Y	Y	Y	Y	Y	N	N	Y	Y	N		N	R	R	R	R	Y	Y
Has a functioning dedicated dispensing printer? Yes/No	Y	Y	Y	Y	Y	Y	Y	Y	Y	N		Y	Y	R	R	Y	Y	Y
Has functioning video Conferencing capacity? Yes/No	Y	N	N	N	N	N	N	N	N	N	N	N	Y	R	R	N	Y	N
Has a dedicated ambulance vehicle? Yes/No	2	Y	N	N	Y	Y	Y	N	N	N	N	N	R	R	R	Y	Y	N
No. of non-4 WD Multi-purpose patient transport vehicles	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
No. of 4 WD Multi-purpose patient transport vehicles	2	2	.5	.5	1	0	1	1	1	1	0	1	?			1	2	1
Method of internet access (S-satellite)	S	S	S	S	S	S	S	S	S	S	3G	S	S	S	S	S	S	S
Do you have back up internet access?	N	Y	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	N	Y	N
Back-up generator	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	Y	N	N	N	Y	Y

Key

R = Currently being replaced

T = Temporary

APPENDIX 5

AGED CARE RESIDENTIAL PLACES AND CARE PACKAGES IN THE KIMBERLEY 2012

Approved Provider	Service	Description	Based at	Coverage	Outputs Under Contract or Action Plan
Broome Aged & Disabled Services Inc	Southern Cross Care Services Kimberley	Community Aged Care Packages	Broome	Broome & Surrounds	16 packages
Frontier Services	Kununurra Home and Community Care Packages	Community Aged Care Packages	Kununurra	Kununurra & Surrounds	11 packages
Frontier Services	Warmun Community (Turkey Creek) CACPs	Community Aged Care Packages	Warmun	Warmun & Surrounds	11 packages
Warmun Community (Turkey Creek) Inc	Warmun Community (Turkey Creek) EACH	Extended Aged Care at Home	Warmun	Warmun & Surrounds	5 packages not yet activated
Western Australian Country Health Services	Kimberley Aged and Community Services	Community Aged Care Packages	Broome	Region Wide	48 packages delivered in remote locations with no CACP provider
Western Australian Country Health Services	Kimberley Aged and Community Services	Extended Aged Care at Home	Broome	Region Wide	12 packages delivered in remote locations with no EACH provider
Southern Cross Community Care Service	Southern Cross EACH Program (Kimberley)	Extended Aged Care at Home	Broome	Broome & Surrounds	12 packages
Hall's Creek Peoples' Church Inc	Menkawum Ngurra Hostel Frail Aged Hostel)	Residential Aged Care	Halls Creek	Halls Creek & Surrounds	7 pre-97 (low care), 12 low care, 7 high care + 1 additional high care emergency
Nindilingarri Cultural Health Service	Guwardi Ngadu	Residential Aged Care	Fitzroy Crossing	Fitzroy Crossing & Surrounds	14 pre-97 (low care), 10 low care
Southern Cross	Germanus Kent House	Residential Aged Care	Broome	Broome & Surrounds	10 pre-97 (low care), 14 pre-97 (high care), 12 high care, 19 low care
Frontier Services	Marlgu Village	Residential Aged Care	Wyndham	Wyndham & Surrounds	9 pre-97 (low care)
Frontier Services	Ngamang Bawoona Hostel	Residential Aged Care	Derby	Derby & Surrounds	11 pre-97 (low care), 6 low care
Frontier Services	Numbala Nunga Nursing Home	Residential Aged Care	Derby	Derby & Surrounds	26 pre-97 (high care)
Frontier Services	Kununurra Aged Care	Residential Aged Care	Kununurra	Kununurra & Surrounds	30 high care provisional places allocated to Frontier Services in 2011 ACAR
Western Australian Country Health Services	Kununurra Aged Care Facility (WACHS)	Residential Aged Care	Kununurra	Kununurra & Surrounds	10 pre-97 (high care)
Frontier Services	Frontier Services Community Services EACH	Extended Aged Care at Home	Kununurra	Kununurra & Surrounds	2 packages

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