SUBCOMMITTEE OF THE EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE
TAKEN AT WYNDHAM
MONDAY, 2 AUGUST 2010

SESSION THREE

Members

Mr P. Abetz (Chairman)
Mr P.B. Watson

Hearing commenced at 2.10 pm

BATH, MS RUTH ALISON
District Director of Nursing, Wyndham and Kununurra Hospitals, examined:

McKINLEY, MS WENDY
Acting Operations Manager, Kununurra, Halls Creek and Wyndham Hospitals, WACHS, examined:

FRAIN, MS MONICA
Acting Director, Population Health — Kimberley Region, WACHS, examined:

The CHAIRMAN: Thank you very much for taking the time to be with us here and on behalf of the Education and Health Standing Committee, welcome. I acknowledge and pay respect to the traditional owners, past, present and future, of the land on which we are meeting today. The purpose of this hearing is to assist us in gathering evidence for our inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in WA, so it is not just the Kimberley but the whole of WA. However, the Kimberley has some specific issues so we are here to learn from you. I formally introduce myself, Peter Abetz, I am the vice chairman of the committee; and Peter Watson, the member for Albany. The other committee members are in Kununurra doing some hearings there; we have split up to try to gather as much evidence as possible. Alice is the parliamentary officer assisting us with all the admin side of things and Judith is the Hansard reporter who is recording everything. The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of WA, so this hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house itself. This is a public hearing so Hansard will be making a transcript that will be on the public record. If there is anything that you want to tell us that you think would be useful for us to know but you do not believe is appropriate to be on the public record, just indicate that and I will say, "We're going into closed session". The recording will be switched off and when we have finished being in closed session, it will be switched back on again. We appreciate that, particularly in a small community, sometimes there may be things that you feel that we should know, but it may not be helpful for it to be on public record.

Ms Bath: Would that be put down on the public record against our name as "Ruth Bath said".

The CHAIRMAN: Yes.

Ms Bath: This is the quietest that I am ever going to be!

The CHAIRMAN: The good thing is that because this is a parliamentary committee, none of your bosses are allowed to give you a hard time for what you have said here so if they do, they are in trouble with Parliament! You should feel free to say what you want to say.

Ms Bath: That was just a general question—no inference.

The CHAIRMAN: Before we proceed to the questions we have for you today, I need to ask you a series of formal questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at the hearing today?

The Witnesses: No.

The CHAIRMAN: Basically, we are trying to gain information about drug and alcohol issues in terms of what is being done at the moment, what is working well, what are the gaps, what could we be doing better, what things are not being funded that should be funded and so on. We are really here to learn from you, as I said before. Perhaps the best way would be for each of you to just give us a bit of a picture of how you see things and then we will throw it open to questions to you, if that is okay with you. Do each of you want to give a little opening statement?

Ms Bath: I cannot say much about the drug side from the inpatient in the hospital, I think that other agencies will have a better idea. Certainly, a proportion of our clients are affected by alcohol, which would be their primary admission. When I say that I mean that they have been in a fight whilst under the influence and have come into hospital and then need observation to see that they have not got a head injury is the most common characteristic that we are faced with, and that is here and in Kununurra. Is this for both?

The CHAIRMAN: Basically, wherever you work or have any knowledge of.

Mr P.B. WATSON: It is mainly Wyndham that we are doing at the moment.

The CHAIRMAN: But if you are involved in Kununurra by all means share that with us here.

Ms Bath: The most common picture is the fighting, the head injury or possible head injury and admission for that.

Mr P.B. WATSON: Is there a particular age group that appear?

Ms Bath: I do not know the details—I do not think there is a particular age group for it.

Mr P.B. WATSON: So it is not young people fighting, getting into fights —

Ms Bath: Not to the best of my knowledge. It is not sort of a 12 to 16-year-old age group; no, I think it is probably more a mature grouping that we see as inpatients anyway or presentations to the emergency department.

The CHAIRMAN: Have you seen any differences in the admission rates since the restrictions came into place in Fitzroy Crossing and that? Has that had any impact up here?

Ms Bath: I am not aware of that having any impact.

Mr P.B. WATSON: What about Oombulgurri?

Ms Bath: I cannot speak on behalf of Oombulgurri; Monica might have more information about that.

Ms Frain: Part of the role of population health is to manage the remote area clinics and Oombulgurri is one of those. We still provide the same level of service in Oombulgurri that we did pre and post–alcohol restrictions, though our client base is much reduced. The numbers in the community really fluctuate and the speculation is that sometimes there are 10 people in the community up to 50 or 60. I do not think we ever really clear about how many —

Mr P.B. WATSON: I was just going to ask because we are getting different versions everywhere.

Ms Frain: I can say that during the wet season there was a time when the river was coming up and we had had lots of rain so we were getting people together in the community. I think that is the only day we could actually say, "Yes, there are 57 people in the community", because we actually collected everybody together.

Mr P.B. WATSON: So how spread out is the community out there?

Ms Frain: It is a little community town; three or four streets in a block and people live there. There are no outstations that people go to.

The CHAIRMAN: We were told just recently there are eight people there at the moment or something and other times it sort of swells a little. Is that your experience too, that it really fluctuates all over the place?

Ms Frain: It really fluctuates but the norm for Oombulgurri is not one of the larger communities, it is probably 150 through to 200 people and that is over years. But now, it could be eight but that sounds a wee bit too small for me to think. There are certain families who are very happy and very stable in Oombi and I think that is a bit more than eight people, but it is certainly small.

The CHAIRMAN: Population health, you indicated, is responsible for running the remote clinics?

Ms Frain: Yes

[2.20 pm]

The CHAIRMAN: What other services do you provide for the communities?

Ms Frain: Population health has a number of different services and we are a region-based service. I normally live in Broome—that is where our office is—but I spend quite a bit of time in the east Kimberley. We provide community health services based out of each of the towns. If you are from a metropolitan area, the community health services that we provide up here are vastly different; they are much more clinically based than what they are in the metropolitan areas. Community health services and child and maternity health are rolled into that, generalist chronic disease management and those sorts of things, in six major towns. That is a nine to five service; there is no on-call involved. We manage six residential remote area clinics across the region, three of them over here—Kalumburu, Oombulgurri and Warmun. We have residential nurses at each of those sites, and that is all of the above—all the community health and public health services are provided on a 7.30 to 4.30 basis from those clinics, plus those nurses provide a 24-hour emergency on-call service, and they are visited by a number of specialists, generally a weekly, if not a couple of times a week, medical clinic, fly in, fly out service, so that provides that backup. Visiting mental health services, visiting drug and alcohol services, visiting child and maternal health services, visiting allied health services, spread out over the area.

The CHAIRMAN: How many alcohol and drug issues do you see in that type of work? Would you say a big proportion of the workload is alcohol and drug-related?

Ms Frain: In all honesty, the police presence in each of these communities has been heaven on a stick. It has made a huge difference. I have been around and been involved in those communities prior to there being a police presence. The police presence and DCP presence takes that case management load off; otherwise, there were nurses basically providing all those services around drug and alcohol-related issues, legal issues, domestic violence and all those sorts of things. It is a huge workload, particularly after hours. That has really made a big difference as far as the roles and workloads for individuals are concerned. Some are changing quicker than others; it just depends on the circumstances. Some of the communities have only sporadically had issues with binge drinking, but some of them have fairly constant issues, depending on access. People go from Warmun community and drive to wherever they need to drive to; they cannot have it at Kalumburu, there has to be some sort of service route that gets interrupted.

Mr P.B. WATSON: I was going to ask Ruth or Wendy this, but when someone comes to you at the hospital in an inebriated state, what is your next step? Do you get onto the sobering-up shelter if they have been injured and have had maybe a few stitches in the eye, or something like that? What is your next step?

Ms Bath: In Kununurra there is a bus service, but it is spasmodic. Again, it only works for limited hours. Most times we end up having to admit them because there is a concern, even though it might be a small percentage, that there could be an injury and it is safer to put them into hospital immediately.

Mr P.B. WATSON: What is the bed situation like?

Ms Bath: We have five beds; one is for palliative care and four are acute. We have two long-stay patients at the moment, so that leaves us with three acute beds, of which they are full most of the time now. We have only had hospital inpatient services once it reopened since August and there has been a steady trending to use all our beds most of the time. Because we get a couple of long-stay patients, it radically reduces —

Mr P.B. WATSON: How long are they allowed to stay?

Ms Bath: There is no limit. One is an aged-care lady who has lived in Wyndham all her life, and the other one is a terminally ill child. We do not know how long that piece of string is.

The CHAIRMAN: With the ageing of the population to some degree, what happens with people who have lived in this area, the Indigenous people here? Obviously they do not want to be sent to some other place for palliative care. What sort of palliative care is available here? Five beds in total does not give you a lot of scope, does it?

Ms Bath: No. If I can take the question in two parts, in relation to palliative care, that can depend on what the patient needs, if we can manage the service. Wyndham, obviously having such a small number of beds, has a very small nursing staff and medical staff, and really cannot deal with complex matters. It either flies out or some can be transferred to Kununurra. Much of it depends on whether we can act to provide the level of service at the time. Terminal care is resource dependent. Again, we cannot provide all of it here with our staffing profile. We have not been confronted with a situation since I have been here a year where we have not been able to reasonably manage palliative care. With aged care, you have lifted the lid off a very big issue.

Mr P.B. WATSON: Yes, we were told this morning.

The CHAIRMAN: Yes, somebody whispered in our ear.

Mr P.B. WATSON: I was trying to be diplomatic.

Ms Bath: It is an enormous problem no matter where you live, but when you multiply the distances, which might be 40 kilometres in the city, but you have got to go north of the river or south of the river to a nursing home, and you multiply that by 10, because there is a high-care nursing care in Halls Creek and Kununurra. Kununurra has got 10 beds, of which one is designated as a respite bed, which means that we can provide respite so that people can stay in their homes longer, because the family are exhausted. That is full, and then there is Halls Creek, and I must admit that I do not know a great deal about the centre.

Ms Frain: The hostel in Halls Creek.

Ms Bath: But they have a high turnover.

Ms Frain: High-care hostel.

Ms McKinley: It is not affiliated with the hospital though. The Kununurra aged-care facility is co-located with the hospital itself.

Ms Bath: That is only one of three state nursing homes that are still managed; the rest are all commonwealth here in Port Hedland.

Ms McKinley: In Wyndham we have a low-care, aged-care facility. We do not have it ourselves, but there exists a low-care, aged-care facility, which I believe is nine beds; I could be proven wrong. It is called Marlgu Village. It is run by Frontier Services.

The CHAIRMAN: That is one of the church groups, is it not?

Ms McKinley: Yes. They also have another facility just out of Derby, which used to be run by WA Country Health, but a couple of years ago we excised the land or gave them the land and so now they are running that service. There is a low-care facility here, but of course that does not meet the needs of the high-care patients, so what we see is people coming from the low-care facility to the health service and then getting requests from the community for patients to be housed in the hospital, which is not really adequate. The hospital is not designed for aged-care clients; it is difficult to provide diversional therapy and the allied health stuff—physio, OT and that kind of thing. One of the major complicating factors for us, I understand, up here, is culture. For the Indigenous people, country is very important and this is why the community gets involved. They want to see their elderly staying in country and dying in country. I think I could say that the community would rather trade off higher aged-care services for the ability to state in country. Our qualities and standards that we are held to do not necessarily apply in the same way to Indigenous people.

Ms Frain: Certainly in communities, with the new housing structures they are putting in, you see individual units more regularly now for mum and dad, or grandma and grandpa—that sort of stuff. So you have those, and the potential for them to be nursed at home and in the community is quite high.

Ms Bath: However, in saying that, Wendy is absolutely right: people like to have their old ones in country. However, in saying that, in managing a healthcare facility, we have a duty of care, so if we have got an elderly person who is high risk of falls, wandering, demented, then how do you balance that when the family would much prefer them to be here? But from my hat I wear—I completely understand that—I am going to have a broken hip, a chest infection —

Ms Frain: There are no domiciliary services. There is no Silver Chain across —

Ms Bath: HACC has not developed in Wyndham to have a nursing domiciliary service, which is certainly whole. I think that we need to explore that there is scope to have some home —

Mr P.B. WATSON: Is there anything like Meals on Wheels here?

Ms Bath: HACC does that; in fact, most of the Meals on Wheels—I am not sure about here—are actually managed from the hospital, so the food is cooked at the hospital and goes out. I do not quite know about —

Ms Frain: And in lots of the communities, too; certainly in Kalumburu and Warmun.

The CHAIRMAN: How big is the alcohol problem among the aged people? Have they outlived their propensity to consume alcohol? To what extent is —

Ms Frain: I would say yes. It depends what you call "aged", really.

Ms McKinley: If you look at aged for Indigenous people, you are looking at a different group of people.

Ms Bath: I think there are some people who probably do not drink as much as they get older, and other people who just hammer it just as hard.

Mr P.B. WATSON: Who lives the longest?

Ms Bath: Just looking at this week alone, there has been a lot more money in Kununurra; there has been some additional Centrelink pay and since Thursday we have been hammered every night with alcohol-related injuries because the extra money was around.

Mr P.B. WATSON: What was the extra money around for?

Ms Bath: I do not know.

The CHAIRMAN: Tax returns, probably.

Ms Bath: Might well be.

Ms McKinley: I think some of our difficulty is around the way we capture that data as well, to be able to plan our services and to look at what we are actually doing currently. I do not think that our coding system really allows for us to capture secondary or cause—do you know what I mean?

Ms Bath: If somebody comes up and they have got gastritis, bowel cancer or something like that, or even just minor gastritis, which might be alcohol-related, but they have come up in a sober, sane state, then it is probably not going to go down as alcohol-related, so we do not pick up half our stuff. We actually collect manual stats here at Wyndham and I can say that over the year the nurses put down on a monthly basis anything from 10 to 15 people affected by alcohol. My assumption from that is that those who come in drunk —

Mr P. B. WATSON: What about death certificates? Do they put "heart attack", "lung disease"?

Ms Frain: They will not put alcohol as a cause of death.

The CHAIRMAN: Unless it is alcohol poisoning.

Ms Bath: Unless it is alcohol poisoning or there is cirrhosis of the liver; I think that is a private area.

Ms Frain: Certainly the same thing applies in the communities as well, and community health. We actually run on two different sets of statistics. There is the hospital-based ones of the community health–based ones, and neither the twain shall meet. Certainly the community health statistics and the remote area health statistics are nowhere near enough to plan; they do not provide you with scope. It is purely numbers. There is no recall in the care planning capacity. If I had to suggest anything that was going to allow us more time to be able to devote to brief intervention issues around drugs and alcohol, I would say fix that up, really.

Ms Frain: I was just going to mention aged care again. We know that it is a huge burden that is coming into every society and certainly here it has hit us right between the eyes very strongly over the last couple of weeks and it is very difficult to plan for as well. I remember a year ago I had discussions with the Frontier Services people about whether they thought there was immediate demand and so on, and they were quite comfortable with it. We have had an empty long-stay bed in Kununurra, which has 10 beds, for several months, then all of a sudden we have got people knocking from everywhere.

Ms McKinley: The other aspect to it of course is not just around getting the resources in terms of dollars; it is also about finding the staff, the physical resources. So you might get approval to put on an extra two or three FTE or an extra Aboriginal liaison officer, or what have you, but if you do not have someone to be able to put down on the ground, it is just notional, and with that comes accommodation, of course, so it is not just the salary.

The CHAIRMAN: Yes, we have heard that everywhere.

[2.35 pm]

Ms Frain: It is very true.

Ms McKinley: And the cost of accommodation is huge.

Ms Bath: And then the maintenance that goes with it.

Mr P.B. WATSON: We are talking about the number of people who come in with alcohol. What percentage of those would be white Australians?

Ms Bath: I would say pretty high. A portion would have problems but probably do not front the health services as often.

Ms Frain: You mean for emergencies?

Mr P.B. WATSON: No; from alcohol.

The CHAIRMAN: At the emergency departments?

Mr P.B. WATSON: Yes.

Ms Bath: The majority would be Aboriginal.

Ms Frain: What is the population breakdown here—80–20 Aboriginal–non-Aboriginal?

Ms Bath: No. I think it is much closer. But then we cannot rely on the ABS stats. You have heard that one as well, have you?

The CHAIRMAN: Yes. Oombulgurri is a classic example: is it 8–250?

Ms Frain: Yes, that is right.

The CHAIRMAN: It depends where the funeral was on census night.

Mr P.B. WATSON: Do you think there is a problem with alcohol within the white community?

Ms Bath: Yes.

Mr P.B. WATSON: Someone mentioned to us earlier that we are concentrating on the Aboriginals with drug and alcohol —

Ms Frain: These are hard towns. They have hard histories. People are hard workers —

Ms Bath: Hard drinkers.

Ms McKinley: In the north and the north west of Australia, it is fairly well documented that the alcohol consumption around this area is much higher than —

Ms Bath: Germany.

Mr P.B. WATSON: What is the other main drug then, apart from alcohol?

Ms Frain: Ganja—I would say that. That causes more issues in the remote communities than the actual —

Mr P.B. WATSON: Mental health?

Ms Frain: Yes, mental health issues. And just those social issues that go around with the younger groups of people spending lots of their money that they do not have, or they have got somewhere else, on very expensive ganja.

Mr P.B. WATSON: Is it grown locally?

Ms Frain: No.

Mr P.B. WATSON: Where does it come from?

Ms Frain: I do not know! I have been looking! We have been out looking. It is not locally grown, no. It is not an industry, if that is what you mean.

Mr P.B. WATSON: When we were in Beagle Bay, they said they went out with the police plane and did not find a leaf, but it is rife in the area.

Ms Frain: I would say it is the same. We were tipped off about things and I have been out looking as well. We did actually find something many, many years ago, which was quite a big plantation, but it had nothing to do with local people.

Mr P.B. WATSON: Is it an organised drug trade?

Ms Bath: I do not know.

Mr P.B. WATSON: Sorry, I should not be asking you this. I should have asked the police before.

Ms Bath: I cannot help you with that.

Ms Frain: I do not think it is —

Mr P.B. WATSON: In small country towns everybody knows everybody's business.

Ms Frain: I do not think it is big, big.

Ms Bath: There certainly are enough rumours around. Where I live there is a public phone box, and apparently that is where half of the exchanges take place. How true that is I have no idea.

The CHAIRMAN: In terms of the alcohol issues, say, here in Wyndham—you also cover some of the surrounding areas, the greater Wyndham area—if you were given the power to do whatever you wanted and you were given a pretty big pot of money to fund whatever you would want to fund, what would you do?

Ms Bath: I would certainly be concentrating on the young people. There is one issue we have not mentioned. We have talked about the drunks coming through the front door, but we have young women who are handicapped because of foetal alcohol syndrome, who are having children. They are foetal–alcohol affected. We have now got a second generation. You would have seen that. There is one particular person, and the nurses have so much angst over this because they have already got one child they are not looking after, so DCP are hugely involved. This woman, as soon as she comes in, is supposed to be looking after the little one. She has gone down to the pub and comes back absolutely inebriated and the cycle continues. I do not know the answer to any of these things, but if I was God for the day I would certainly be putting a lot of work into the young.

Mr P.B. WATSON: The education of the young.

Ms Bath: Yes. Forget the old; they are done!

Ms Frain: It is not even the extreme end of the foetal alcohol syndrome that is the concern; it is all these kids who are hitting 15 and 16 and really going off the rails, or even younger than that. They start to push the boundaries. They do not learn from their mistakes. At the other end of the spectrum it is repetitive —

Mr P.B. WATSON: They leave school and they cannot read and write.

Ms Frain: They cannot read and write; they have trouble with numbers. Cognitive behaviour is not there. It is that whole propensity —

Ms McKinley: All you have to do is look around you and you can see behaviours being learnt from very early on. Early intervention is really important, personally.

Mr P.B. WATSON: But also involve the families.

Ms McKinley: That is the second point that I am sitting here thinking in my head that I must get that across. There is no point coming in over the top of people and telling them how it needs to be done. It needs to be with the engagement of community. They need to be the ones actively involved in driving any change. Anecdotally, certainly from discussions I have had with people who live up in the Northern Territory, the places where the communities have been actively involved in making changes—putting bans in place, that kind of thing—have had much better outcomes. That is only anecdotal.

Mr P.B. WATSON: That is not really your job at the hospital, is it?

Ms McKinley: No, it is not.

Mr P.B. WATSON: You see the end result.

Ms Bath: I certainly would like to have 24-hour sobering-up centres. Again I wear my nursing hat here and say that Kununurra and Wyndham are growing areas. We are getting far more pressure on us to do more things in the hospital, which we are doing. We have all these so-called soft admissions "just in case". They should not be in hospital.

Mr P.B. WATSON: Are there any doctors in town?

Ms Bath: Yes, we have got permanent doctors in both towns.

Ms McKinley: Two in Wyndham.

Mr P.B. WATSON: Do they bulk-bill?

Ms Bath: No; it is all hospital.

Ms Frain: The 19(2) application is just about in, is it not, for Wyndham? It is just about to be signed off for Wyndham.

Ms McKinley: There is a process we are going through. We are in the consultation process at the moment.

Ms Bath: At the moment it is all free; it is hospital.

Mr P.B. WATSON: It is all free?

Ms Bath: It is all free.

The CHAIRMAN: So it is state funded, which means there is no Medicare contribution. I think there is some work going on to try to get Medicare funding for that so somehow doctors can at least bulk-bill Medicare so it brings a bit more funds into —

Ms McKinley: And then the community is actively involved, as we alluded to earlier in a different light. But then the community is actively involved in making those decisions because you have a community forum. Consultation decides how that money is spent.

Ms Frain: So the money does not come back to the individual practitioner; it comes back to the service, so it is for the community.

Ms Bath: At the moment, because we are small enough that you do not have every service going, therefore the local hospital picks up all the gaps and the other health services as well. We pick up the gap as being a sobering-up shelter as well.

The CHAIRMAN: There is a sobering-up shelter here, is there not—or not?

Ms Bath: Not an acute one, not after hours. But there is a program people can go to here from Wyndham.

Ms McKinley: Is that the Ngnowar–Aerwah?

Ms Bath: But there is no "ring this number and somebody will come".

The CHAIRMAN: I thought there was.

Ms Frain: I think their bus goes —

The Advisory Officer: There is a sobering-up centre and a patrol in Wyndham at night.

Ms Bath: But it is not open at night.

The Advisory Officer: It is here.

Ms Frain: It is open at night, but it is not open —

Ms Bath: But we do not use it to refer to at night for people to come and pick people up.

The Advisory Officer: You can do.

Ms Bath: That is obviously some area we are not familiar with.

The Advisory Officer: I can talk to you about that later.

The CHAIRMAN: Sometimes these things get lost in the cracks.

Ms Frain: Sometimes they do with the turnover of staff et cetera. I think the other thing that you would do around hospital staff with the 19(2) would come the supply of section 100 medications to Wyndham to be available —

The CHAIRMAN: Section 100 medication—that is the —

Ms Frain: Section 100 of the pharmaceutical act, which allows free access to medications for people with chronic diseases—PBS medications generally. Specifically, that has been in areas where the population is Indigenous and the access to chemists and that sort of stuff is not available.

The CHAIRMAN: So the nurses can do the prescribing?

Ms Frain: No; the actual cost. The population here would not need to pay for their medicines. They do not even have to pay the gap on it. That is available in all of our remote communities across the region now. It is available at Fitzroy Crossing and Halls Creek. For some bizarre reason the application, which has been in for about two years, for Wyndham does not seem to be getting past anything.

The CHAIRMAN: Who needs to push that?

Ms Frain: Who needs to push that?

The CHAIRMAN: Who lodges the application?

Ms Frain: Who drives that? The regional pharmacist lodged the application. We have been pushing it through the Pharmacy Guild and through the chief pharmacist in the state, but it just seems that the decision has not been made around Wyndham. What you have is a very fragmented service and a fragmented record of clients, because they will travel to Kununurra to go to the AMS because they get their medicines for nothing. What people have to do here is they come to see a doctor, they get a prescription, it gets sent over by the bus to Kununurra, and then it comes back again. The money transactions are all very complicated. Consequently, a lot of the population do not have transport, and that makes compliance really, really difficult. I think you would find yourself an awful lot busier in the hospital and probably for the betterment if people had access to section 100. They would come to see the same doctor and get the medicines. They can be dispensed from the hospital, but the nurses do not actually do that. It is the same process for the doctor—he writes the script or however you manage that. They can actually put that hat on and hand it out. They do not actually have the pharmacist hat on. That is a general health–type thing.

The CHAIRMAN: In terms of alcohol and drugs, would you say it has been getting worse over the past few years or pretty static?

Ms Frain: I cannot say.

The CHAIRMAN: It is a bit difficult to say if you have not been here very long, I guess.

Ms Bath: Certainly the message I get from the staff is "same old, same old". I certainly have not heard that it has got worse. Certainly, just the manual stats we have from here have not increased or decreased over the year. I do not know if you see things from your perspective. But, again, we are very much focused on the acute—dealing with the sick at the time.

Ms Frain: I think that Wyndham misses a lot. Wyndham does not capture a lot of service activity at all because of those things around section 100. There are only so many appointments that you can have for the one and only health service in town, and the doctors work all day every day.

Mr P.B. WATSON: With young people coming into the hospital on their own through injuries—bashings and things like that—how effective is the Department for Child Protection?

Ms Bath: I think DCP are probably just overwhelmed with the pure volume of —

Mr P.B. WATSON: Understaffed?

Ms Bath: I cannot speak on their behalf, but certainly when we want to contact them, there is often a perception that they are just overwhelmed with the pure volume of it or there is not a feedback movement —

Mr P.B. WATSON: What happens at night?

Ms Bath: I think there are so many children who are at risk.

Ms Frain: At night, depending on the degree of concern the clinician has, there are —

Mr P.B. WATSON: Do they work at night?

Ms Frain: No, they do not. But we use a 1800 number.

The CHAIRMAN: Where does that take you?

Ms Frain: You go to Perth, and Perth can ring someone. They can actually do that, and they do do that. There is always someone on call here, but we do not contact them directly.

The CHAIRMAN: It is screened.

Ms Bath: And that is fine as well. That mechanism works. There are just so many people at risk who are on the books and things.

The CHAIRMAN: Do you think there is a reluctance when kids are in really quite dangerous situations, because of the stolen generation history and so on, for DCP to actually take kids out of those dangerous situations?

Ms Bath: I cannot comment on that.

Ms Frain: Across the board, I think across the Kimberley, there is 250-odd kids in care at the moment. I think they work with the child's best interests at heart. Sometimes that situation may not be up and out of country, or out in the community and that sort of business, or sometimes it might have to be—I know instances of both.

The CHAIRMAN: Is there anything else that you would like to enlighten us about in terms of the whole drug and alcohol issue? If you get people admitted to hospital under the influence of alcohol or drugs, and they got bashed or whatever reason they present, do you often get an opportunity to refer them to rehab or that is not something —

[2.50 pm]

Ms Bath: No, they certainly can be referred, but usually by the morning they are up and out: "Thank you very much. I've had my sleep and that bloody nurse kept me awake with that torch in my eyes all night!" We were trying to see if they had a head injury, and the nurse is being abused, and then they are usually off in the morning—breakfast and gone.

Mr P.B. WATSON: They all wait for the breakfast!

Ms Bath: All wait for the breakfast! It can at times be seen as a bit of an easy stop off as well, but, again, that is probably the exception rather than the rule.

Mr P.B. WATSON: How many beds do you have?

Ms Bath: We have four acute beds.

Mr P.B. WATSON: Say you get someone who has come in with an alcohol problem, disease or incident; if you cannot take them in, where do they go?

Ms Bath: If we were more concerned about their health and in the situation that we did not have the level of care that we could provide, then again they would have to go to Kununurra probably.

Mr P.B. WATSON: How would they get there?

Ms Bath: They would be transferred by ambulance—a volunteer ambulance.

Mr P.B. WATSON: Does the RFDS come here at all?

Ms Bath: Yes. We would have a couple of evacuations a month.

Mr P.B. WATSON: Is there a strip here?

Ms Bath: Yes. There would be up to six evacuations, and that could be to a number of places—Derby, Broome, or the larger centres of Darwin or Perth—depending on the severity.

Mr P.B. WATSON: How far is Darwin from here?

Ms Bath: Darwin is about 900 kilometres by road, but it is only just over an hour by air, so that is a far better option, and that is an arrangement that was developed just over a year ago that we would transfer —

Ms Frain: We have purchased six beds at Royal Darwin Hospital.

Ms Bath: Increasing to eight.

Ms Frain: It has been an informal arrangement when people are critical that they are transferred to Darwin, and Darwin through their intensivist beds—I would say 99 per cent of the time, except antenates who are —

Ms Bath: But now it is a formal arrangement.

Ms Frain: But now it is a formal arrangement; we have actually purchased those beds.

Ms Bath: It is the best thing since sliced bread. It just means that to get down to Perth you have got a nine to 10-hour journey because they have often got to stop and refuel and that sort of thing—change planes.

Ms Frain: The only issue is mental health people, under the forms and stuff, they cannot cross the state line.

The CHAIRMAN: They still cannot do that?

Ms Frain: No. The forms are not valid there.

Ms Bath: The border is 40 kays that way.

Ms Frain: There are some clients that we do not refer there and some we can, because they have limited services too. They are much bigger than ours, but limited services as well.

Ms Bath: Certainly it would appear that a lot of patients prefer to go to Darwin because a lot of them are still part of the country, and the care there and the weather is far more familiar than what they would have down in the big smoke. From our point of view, that is a really good arrangement and I would like to see it get bigger.

The CHAIRMAN: Do you mean having more beds available?

Ms Bath: Yes. Darwin still cannot deal with some of the specialties. They do not have that themselves and they would have to evacuate out. It is certainly an arrangement that has been monitored and managed extremely well.

The CHAIRMAN: It would actually save the WA government a lot of money too in the sense that the flying doctor taking somebody all the way down to Perth would cost an awful lot more than flying them across the border.

Ms McKinley: I do not have any figures on that, but I would not have thought there would be a lot of saving. I would imagine that the cost would be very similar.

The CHAIRMAN: With the hours of operation for the flying doctor service —

Ms Bath: They still have got to come from Derby probably to here. Some of those patients would go back to Derby or Broome.

Ms Frain: And it is the cost of the beds, because they are intensivist beds that are purchased, because nine times out of 10 that is what the transfer is about.

The CHAIRMAN: Any other issues you would like to raise with us on the drug and alcohol side of things?

Ms McKinley: Have you got enough on aged care?

Mr P.B. WATSON: I am looking into that because I am pretty close!

Ms Bath: It is a very big issue.

Ms Frain: With the drug and alcohol issues, if we had more services and more staff in our services that we could reorientate the services in the smaller places particularly so that we were able to provide that acute education in those intervention issues constantly, because it all takes time. And when you are under the pump and running people through ED —

Ms McKinley: As someone in administrative services, I have to say that with additional clinical resources we need to have additional support services as well.

Ms Frain: All of those things. I am not saying that more is always better —

Ms McKinley: We need to be sustainable.

Ms Frain: We are adequate. That is just it and if we are talking about limited services on the ground you would want to have this multi-pronged approach to these very complex problems and people getting the same information and the ability to refer from numerous sources—that would be well and truly those people who are providing the drug and alcohol services now.

The CHAIRMAN: I want to thank you very much for taking the time to be with us today. What will happen now is the transcript will be prepared and mailed to you and we ask that you have a close look at it, especially the spelling of names and that type of thing, and return it within 28 days of receiving it. If we do not get it back from you, we will assume that it is correct—even if it is not correct, we will make that assumption. If after leaving here, you wish you had told us this or that—obviously you cannot add that into the transcript—but simply add an extra sheet of people outlining the issue and your thoughts and we will accept that as a supplementary submission to our inquiry. That is how you can add extra material if you have any brainwaves after you leave here. Thank you very much.

Mr P.B. WATSON: That you very much for your time.

Hearing concluded at 2.57 pm