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 BROOME
MONDAY, 26 JULY 2010

SESSION TWO

Members

Dr J.M. Woollard (Chairman)
Mr P. Abetz (Deputy Chairman)
Ms L.L. Baker
Mr P.B. Watson
Mr I.C. Blayney

Hearing commenced at 10.40 am

GOODIE, MR ROBERT
Regional Manager, Kimberley Mental Health and Drug Service, examined:

PHILLIPS, DR SUZANNE MARIE ELIZABETH
Senior Medical Officer, Broome Hospital, examined:

WINSOR, MS KERRY LYNN
Regional Director, WA Country Health Service, Kimberley, examined:

DARBY, MR KIM
Operations Manager, WA Country Health Service, examined:

MALONE, MS SALLY
Regional Coordinator, KCDST, Kimberley Mental Health and Drug Service, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and appearance before us today. I would like to 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 the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia.

At this stage I would like to introduce myself, Janet Woollard, and next to me is Mr Peter Abetz, Mr Peter Watson and Mr Ian Blayney; on my right we have our research officer, Alice Murphy, and coming in and joining us at some stage will be our principal research officer, David Worth. For Hansard we have Judith Baverstock and Keith Jackman.

This committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure, and therefore commands the same respect given to proceedings in the house. As it is a public hearing, Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today I need to ask you a series of 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 today's hearing?

The Witnesses: No.

The CHAIRMAN: We will start with Sue, and then we will come around the table. I have met some of you before, but would you please state your full name and the capacity in which you appear before the committee today?

Dr Phillips: My full name is Suzanne Marie Elizabeth Phillips, and I the senior medical officer at Broome hospital.

Ms Winsor: Kerry Lynn Winsor, and I am the regional director of the WA Country Health Service, Kimberley.

Mr Goodie: Robert Goodie, and I am the regional manager of Kimberley Mental Health and Drug Service.

Mr Darby: Kim Darby, operations manager, Broome hospital.

The CHAIRMAN: Are you wearing another hat now, Sally?

Ms Malone: Yes, I am.

The CHAIRMAN: Sally, the hat now is—sorry?

Ms Malone: I am the regional coordinator of the Kimberley Community Drug Service Team.

The CHAIRMAN: You have all received a copy of the terms of reference for the inquiry that we are currently undertaking. Some of your local media contacted me last week and said, "Is this just another inquiry; are you going to make a difference?" We hope we are going to make a difference, but it is through your input to this inquiry that we will be able to make a difference. I am going to give each of you an opportunity as we go around the table. As Sally has been here before, we might start with Sally because that gives you a chance to think about what things you are going to address. Sally may be briefer than some of the others because she has already had an opportunity to present to the committee, but we are particularly looking for information about what the weaknesses and strengths are, where the problems are, and what can be done. What is there and where should the priorities be now? You know how far you have come over the last decade, maybe, in relation to the problems with alcohol and drugs, but what should be done now so that we can accelerate improvements? Is it funding? Is it positions? Is it resources? We will start with Sally, and then we will come round the table. I will give you each five to 10 minutes to make a presentation, and then we will go around the table and committee members will ask some of you some questions. Because time is limited, we may not get an opportunity to ask all the questions that we have for you today, so we may follow-up with some questions on notice to you. Sally, would you like to start?

Ms Malone: My role is to manage the Kimberley Community Drug Service Team, which is a team within the Kimberley mental health service. We are co-located alongside the mental health service and we operate from three regional sites in Broome, Derby and Kununurra. The mental health service also has a position in Fitzroy, which Bob will elaborate on further. The type of services that we, as an alcohol and drug service, provide are, basically, counselling, information, and education and support for individuals or families or communities that are experiencing problems related to their own or someone else's substance use. The team has other roles besides the provision of counselling services. We have a court diversion program and we have the Indigenous diversion program, which is an early intervention opportunity program for people whose offending is mild or moderate; we do not do the severe end of the spectrum of entrenched criminality. That operates out of two sites—Broome and Kununurra—with outreach right through the region. Basically, the role of that is support for people who are early in what we would call their criminal careers, and hopefully their substance abuse careers, as well as streaming them into treatment prior to sentencing. That program may or may not be taken into account at the time of sentencing. That is one of the aspects of what we do We also do quite a bit of regional capacity building and we do professional development of the staff for other agencies. We have our own regional training coordinator, whose role is to work with other alcohol and drug services to ensure that the training that their staff get best equips them to do the work that they do. We also support lots of other community programs. We work closely with the SDERA program, which you have heard about previously, and we provide support for the local drug action groups, which were an initiative of a previous drug strategy, and many of them are still going and still doing very good work. We

provide consultation around a range of issues—things like liquor restrictions, liquor accords, and things like that. We are pretty much an information conduit. We assist a lot in regional coordination and we sit on lots of committees and reference groups and things like that. We work closely with the non-government sector, I guess, assisting with expertise and other forms of support as needed in relation to alcohol and drug stuff.

The CHAIRMAN: That is who you are, but what do you need?

Ms Malone: What do we need? Of course, more resources. Housing is something that trips us up fairly regularly. There is just not enough housing for staff as we recruit them. We would probably recruit more people if we had the resources and the houses to put them in. I think you are probably going to hear that again and again from various people. Certainly, yes, resources for various things, but for more staff and more housing and building a regional workforce and, I guess, investing in prevention and community development.

The CHAIRMAN: Kim, would you like to go next?

Mr Darby: I will give a general overview of Broome hospital, and, more specifically, I think Sue will probably comment about medical recruitment as it impacts on the hospital. To start with, we have a modern, well-equipped health service that caters for a diverse multicultural community. Approximately 18 000 people are resident within Broome, but that can swell up enormously over this time of the year. The number is difficult to predict, but sometimes it is even double or treble what has been quoted, and it is difficult to actually quantify that number, although looking around town, it is pretty clear just how busy we are at the moment.

In the past, Derby has been our regional resource centre. In 2004, the Reid report on health services recommended that each region develop a resource centre as the main hospital site, and the WA Country Health Service has six regional resource centres. For the Kimberley it was decided to site that regional resource centre in Broome. To do that, we needed a substantial redevelopment program. Broome, typically, has been a small district hospital, and to expand it, a $42 million redevelopment commenced here in May 2007. That was completed in December 2009, and very shortly—imminently, in the next week or so—we will have another building crew on site who will start to develop a 14-bed acute psyche unit and a 10 to 12-bed paediatric wing. That should be completed in about September 2011. They are the capital works that are currently scheduled for the site, and we expect that will bring Broome into a fully fledged regional resource centre. That will give us a bed count of 66 beds, or 65 beds, including the mental health wing. Currently, though, while that redevelopment is underway, it is putting a lot of pressure on us; we have 33 overnight beds at the moment. Obviously, the paediatric wing has been decommissioned while the new one is getting built, and that is putting considerable pressure on us right now. We believe, on current population projections, that the bed capacity by September 2011 will see us through until approximately 2020, at which point, over these next five years, we will have to do more projections on our population for any future bed capacity that we will need to put on that site.

The main issues we have had more recently in Broome are around waitlist surgery. We now have two theatres—we previously had one theatre—and so therefore our access to specialist services and theatre has increased substantially. Surgical lists have therefore increased from two to three a week in 2009, to five-day elective surgical lists in 2010. Management of the elective surgical waitlist is a key priority for Broome hospital; I know the boundary cases of over 500 days sit at two patients, so we have done a lot of work to try to reduce the waitlist here in Broome.

Bed days are down 3.2 per cent, but we have an average length of stay of 3.29 days at the Broome hospital. Emergency department attendances have decreased by three per cent on last year. We believe that is largely due to some stability in private practice in town. Private practice had some changes here in 2008, and ED emergency attendances went up. That has now stabilised, and have gone back down to what we would expect to be a more typical range for the hospital here.

We have recently commenced the four-hour rule in Broome for our own program. I am sure the committee will be aware that that is a major key priority—to try to make a decision on patients entering the ED within a four-hour time frame. This will be a total redesign of our facility and it complements the capital works program very well. We have got a capital program that has allowed us to have a good facility, and now we are able to use the four-hour rule to redesign our work practices internally.

Another key initiative in recent times is that telehealth has expanded substantially in Broome over the last two years. The number of videoconferencing units have now increased from two in 2008, to 10 in 2010. This has resulted in 180 per cent increase in clinical VC occasions of service.

Patient transport is a substantial challenge for us, so whilst we have built a centre in town, regional hospital access to the hospital continues to be an issue for the outer communities. The broader public transport service coming into Broome puts a lot of pressure on us, and we recently made some of our own initiatives by putting Aboriginal liaison officers on to help coordinate some of that transport route, and there is a small commuter bus. There needs to be a far broader strategy around public transport and access to the regional centre.

Our workforce in town is in excess of 200 people, giving a full-item equivalent of 161 full-item equivalent staff. I mentioned that Dr Phillips will talk a bit more about the medical workforce, but generally recruitment and retention of permanent, professional staff continues to be a challenge for Broome, as it does to have a better balance between Aboriginal workers an non-Aboriginal workers. It is a key strategy to try to increase the Aboriginal workforce. Those vacancies are currently being covered through locums; however, it is obviously our preference to have a stable permanent workforce.

As Sally mentioned, housing is a substantial issue for us. The ability to retain a workforce, not just in the professional but in the non-professional areas, is heavily dependent on ability to find affordable housing in town. Whilst we can provide housing through our own health budget, clearly it is difficult for people who want to have their own property, particularly the lower income workers. Affordability of housing is a major issue for us. I will leave it at that point.

The CHAIRMAN: Shall we move to Sue first, because it really fits in? Sue, what would you like to add to what Kim has had to say?

[10.55 am]

Dr Phillips: If you are interested in what we need—we need social workers. The issues we have are around social stuff, above and beyond anything else. I think that you would all agree that is the case. We have issues with recruitment of medical staff and recruitment of nurses. We have high turnovers in the Kimberley; Broome less so. Broome has a relatively stable workforce in comparison with some of the other hospitals in the Kimberley. But the issues really around social stuff are the things that you find drive you crazy and are relatively insoluble. You can deal with an appendectomy—a patient comes in, has their appendix out and goes home. The difficulties we have are with the patients who have nowhere to go. It is the homelessness, it is the poverty, it is the alcohol abuse and the ramifications that has for the whole family. We need more social work. We need more hostel accommodation. Yes, we need accommodation for our staff but above all we need somewhere for people to stay.

The CHAIRMAN: So you are not operating on them and sending them out into the street?

Dr Phillips: You feel like you are doing bandaid stuff a lot of the time. It would help to be able to do things more holistically if there were stable places for people to go.

The CHAIRMAN: When you say that you need those social workers and hostels, that need is throughout the Kimberley?

Dr Phillips: It is throughout the Kimberley. Derby has a hostel. Broome has a hostel—a renal dialysis hostel—and it is full all the time. The type of care that is available in that hostel is really generous of spirit from the carers who are there but they are not really paid trained carers. They are people who work at the hostel, who take on case management type of stuff for very incapacitated, quite elderly and frail renal patients, often without really knowing much about patient care. A hostel where hostel care can be given by trained people would be really useful for the renal dialysis side of things but also for some of our frail elderly who are currently homeless. They are my issues.

If I was allowed to add a personal note I think that the federal government needs to change the welfare system so that people do not have unfettered access to cash to be able to just waste it and their family then goes without. I think the priority for federal government is to actually revamp the welfare system because we can put as much money into health as we want but if we are not addressing the underlying poverty and the social circumstances that cause people to come in with their malnourishment, their poor immune systems and their septic shock—because they live in a family with 12 people in a three-bedroom home and they do not wash and they do not eat properly so their immune systems are poor—they will keep coming and we will keep providing bandaid therapy, but the underlying issues are not being addressed.

The CHAIRMAN: What my deputy chair was just saying to me was that we have not, as part of this, looked at the drug and alcohol issues. As I was saying to him, we are actually moving now more with your presentation on drugs and alcohol. I know from Sue's comments she said in relation to the numbers that a lot of the problems with that overload are due to alcohol and drug problems, particularly alcohol problems, with the admissions that you have. We will come back to that. Bob, would you like to go next, and then Kerry.

Mr Goodie: Sure. Bob Goodie, Kimberley Mental Health and Drug Service. The Kimberley Mental Health and Drug Service is a very young service. We were established in 1994. At that point, there was a fly-in psychiatrist and maybe a drug and alcohol worker. To this point we have progressed in that we work in partnership with the drug and alcohol team. We are a co-located service, which I believe is the model for all drug and alcohol mental health services to be co-located. We have a staffing base in the region of 35 FTE. When you add Sally's FTE on to that, we have 46 to 47 if we are lucky. There are vast challenges for us in the delivery of acute mental health service and drug and alcohol service delivery across the region. We operate a hub-and-spoke model. Broome is our biggest site. We have our regional psychiatrist here. Our psychiatrist really has spread to the four wings through the region trying to work with our other clinics in Derby and Kununurra to provide appropriate mental health service delivery for very traumatised communities throughout the region. This is an exhausting workload for us as a service. The demand on service is very high. I think if you ask my partners here about presentations to our health services around the region, they are acute and traumatic, and very often fuelled with people who are intoxicated or affected by drugs presenting to very small and remote settings expecting acute service delivery. It is very challenging in this environment to have an adequate level of service delivery nonetheless. We are at a point in time where our resourcing level is improving slightly. I think part of this comes from Alastair Hope's report around the suicides in the Fitzroy Valley region where there were 22 suicides. Take note that only two of those patients had access to mental health services prior. This is a very big issue about how to get services out to communities with that sort of prevention–intervention message to them. Also to note that out of the recommendations from Alastair Hope's report, we got no increase in FTE from a drug and alcohol perspective. We had no increase in mental health workforce through either Fitzroy Crossing or Halls Creek, or anywhere where there has been implementation of alcohol restrictions. We applaud the implementation of alcohol restrictions because we know where there is a gross reduction it does give communities a chance to actually, if you like, sober up and address some of the core fundamental issues. What we know when communities actually have less alcohol is a lot of the underlying issues—and it is social–emotional wellbeing issues—rise to the surface. They are related to mental health issues; they are related to

trauma. I suppose starting from that point we, as a mental health service, note where alcohol restrictions are implemented a corresponding increase in mental health services should be focused in those regions.

We are also at a period of time when we are about to embark on a 14-bed acute mental health unit. We applaud this. We think that there are many difficulties transferring acutely unwell mental health clients across the region but more so down to Perth. These are very vast distances. The issue of acute sedation, long distance and adverse outcome for patient travel are very high. Along with applauding the establishment of the mental health unit, the Kimberley has done some very good cross-border work with Darwin. If you think about it, Kununurra is 67 kilometres from the NT border. From the Top End service delivery for mental health services, outpatients have a preference to cross into Darwin. The distances travelled are much shorter. We have an agreement with Darwin hospital around treatment of acute health presentations. We do not have such an agreement for mental health presentations. I think this is an area where some good outcomes could occur for mental health clients in the east Kimberley, much closer to resources in the Darwin area.

The delivery of mental health services and our strategic plan from Kimberley Mental Health and Drug Service, we would like to see a review of the delivery of primary health care services where mental health and drug and alcohol services are put right at the base of primary health services. What that translates to is we would like to see mental health and drug and alcohol services have more time in the region. We would like to see a permanent location within primary health care service delivery. Where you have a primary health care site, you would also have the nurses and doctors, and you would have your specialist services right there on site. I think there has been a view that we are complementing service delivery because we are viewed as a secondary consult model. We discussed previously: what does it mean when you come into a remote community or one of our other major hospitals in the region and you do not come back for six weeks—what is going on in the meantime? We do make use of all available communication to talk with our doctors and nurses across the region, but you cannot really substitute that for having expert staff on site. The mental health and drug and alcohol workforce needs development. We would view that we would want to raise the level of both those workforces to complement the work of each other, specifically an inquiry around appropriateness for treatment. I think the drug and alcohol sector does a very good job around engaging people who want to be engaged in treatment. There is a large area that does not want to be engaged in treatment. We know that sector needs the health messages to be at the base of communities. There needs to be a primary prevention message going on in the background.

In relation to our workforce, we are very committed to developing our Indigenous mental health and drug and alcohol workforce. We need some FTE to do this. The only initiative that is assisting us at the moment—and we still have our fingers crossed—is the Statewide Indigenous Mental Health Service. There is a rollout of COAG dollars. We are hopeful that those COAG dollars will land with state health services. At a very minimal calculation, we need 10 Indigenous FTE across the region so that wherever we have mental health services and drug and alcohol services we have trained Indigenous drug and alcohol and mental health staff. There is competition in the workforce for this type of staff. I believe our state health planners need to do some more work in this area about what is required to train our Indigenous mental health and drug and alcohol workforce.

As a service provider we are at the acute end. We are at the really pointy end. We are case managing the cases the worst of the worst. As a service, our strategic direction is to move into early intervention and prevention. We are not really funded to do this. The community expectation is that mental health services means that you will get access to mental health services when you need it. Most mental health services are needed a long way before they get to the level where we are intervening. I would suggest that you look at the headspace model of service delivery and that early intervention–early engagement model around drug and alcohol and mental health. I think that the community have responded well to those messages. We have very small drug and alcohol and

mental health organisational workforce partnerships up here. We do a very good job at putting those services together and trying to come up with a plan of intervention and service delivery. We believe we need to add community development workers and community wellness workers. What we are talking about is the concept of social–emotional wellbeing. You heard Sue talk about social workers. We have to take that another couple of steps and look at how you actually integrate health into communities. There are cultural mores and ways of working with Indigenous communities that need to be embedded within our health service delivery. I think in a lot of ways a lot of the community do not get the health intervention messages because of the language difference. We need some resources in amongst that arena to address that.

We want to build a better service through the region. We cannot do that, especially through the hubs that we talk about, through the COAG identified areas of Fitzroy and Halls Creek. Very simply, there are some mechanical things stopping this—it is housing. I have got workers who are willing to go into the region, stay longer, do more work, but I have got nowhere to put them. At the moment we have got one child and adolescent mental health worker in the Fitzroy Valley. She is there because her husband is a teacher. We think it is great that they are there, but if you want us to build through the region, we will build. We will train the workforce and we will work with our partners, but we just need some tools to do it with. There are many challenges. We really seek to develop a sustainable workforce through the region. We are on a pathway to developing Indigenous trainees. It sounds easy—it is not easy. To have a trainee, you have got to have a real job. We are not really geared or sophisticated enough in terms of having traineeships, but at the end where is the work going to be? They sort of go hand in hand. We are a small service. We have statutory obligations around the delivery of mental health services. It is a very complex arena to work within. Our clients suffer dual diagnosis to a large extent around drug and alcohol and mental health. We would like to see an increase in the availability of treatment services so where someone is requesting detox, where someone is wanting home-based withdrawal, where someone wants to deal with their drug and alcohol issue alongside their mental health issue, we would seek to develop that workforce. At the moment we have a workforce that is in the psychological world; as Sally was saying, in the counselling model. We, as a mental health service provider, would like to add the treatment component to that level of service. There are good outcomes to be gained there. Again, you need to be on a pathway where you want to build that side of the service.

The CHAIRMAN: Kerry, as several groups have identified that we need more social workers, more Aboriginal health workers and more mental health staff, could you, as part of your presentation, explain who prepares the business plan for the requirements in the Kimberley both for the hospital services and the mental health services? Who does that planning? Is it done on an annual basis or is there a five-year plan that is put in? Where do staff like Sue and Bob, they are saying who is needed, where are their needs documented and then put forward to the government? Are you responsible for that, or who actually oversees that? Could you describe that as part of your presentation?

Ms Winsor: Do you want me to address that one first?

The CHAIRMAN: Yes.

Ms Winsor: The Western Australian Country Health Service has a clinical service plan. That planning is ongoing. I have only been here a short time—about 16 months or so. That planning process is the overarching guide to the services that will be delivered. The funding for the Kimberley—I cannot speak for other regions—has certainly been historical. There is good recognition that that may not be the best model. You would be familiar with the activity-based funding that is about to come into play, and also RAM, which is a resource allocation model. The activity-based funding—it is difficult to say how we will go with that given a lot of our sites are very small. If you had to rely on simply the funding per activity going through the site, we probably would not do very well. The resource allocation model will be the model which will have a fair

impact on the Kimberley in that we are expecting that there will be an allocation of funds which takes account of the disadvantage in the distance, the smallness. There are no economies of scale. It is very difficult to build a service that is big enough to be able to provide the services where we need them.

[11.15 am]

The CHAIRMAN: But neither of those models—I am familiar with activity based—they are not going to take into account the needs of these people, because they are going to rely on who is there, and people will only go there if the services are there, so there are still going to be many people outside who are not receiving services. How are future budget plans going to address the problems that you have here now, and what is your input into that?

Ms Winsor: We will have input into the development of the resource allocation model. That is the one that is not the activity. So there will be some funding that will come on activity. Elective surgery is a good example of that. We get a certain amount of money per each case. But the resource allocation model is the funding that is required to overcome the disadvantage that we have through being small and remote. What we are currently doing, as an example—we have just done a big piece of work on the medical staffing rostering and activity, as well as the nursing staffing rostering and activity, and we are currently putting up business cases to increase our funded FTE right across the board. Obviously, that depends on what funding the WA Country Health Service has to be able to allocate it, because ultimately there is a finite budget.

The CHAIRMAN: That is elective surgery, but with these preventive areas, how are you going to tap into the preventive areas?

Ms Winsor: With mental health, you might want to talk to the commission. But the Mental Health Commission will buy services off us, as I understand, so it will be a case of negotiating with the commission, which Bob can speak more to. That is relatively new and we do not know how that will go. In respect to the development of services around social work, that is quite difficult. What we need to be able to do is to build the service growth, not just discipline growth. To look at an emergency department, for example, and say, "This is the growth in activity that we've had"—how many doctors, nurses and allied health, and, further to that, admin as well, because if you are going to increase the staffing, you are going to have an increase in processing things like travel claims and HR and all that type of thing. An appropriate way would be to build in a multidisciplinary process of asking for extra resources. It has been relatively single discipline focused, so if there is an increase in activity in ED, it is not too difficult to get an increase in doctors if you can show that increase in activity. Where it is problematic is where you have an increase in services, and allied health is a good example. If you have a couple of staff working to their absolute optimum, they can only see so many patients a day, because there are only so many of the staff. Trying to assess what the demand is coming through can be very difficult as well, and looking at the waitlists or what activity have we got where patients cannot get access. So we are doing a fair bit of work on that around the Derby–Fitzroy component, and social work has been identified as a top priority in both the west and east Kimberley, and comes up repeatedly. We have one social worker in Derby. That position has been difficult to recruit to, and we are currently recruiting to the cancer services; social work as well. But they will be pretty much taken up with the cancer-related services.

In any service like ours, my experience has been that you need to have a large number of staff with some skills in every field. It is unlikely that we will end up with a social worker based in some of our small sites. Therefore, the nursing staff tend to pick up that role, as they do with pharmacy or radiography. So in the small sites like Halls Creek and Fitzroy, those nursing staff become very multiskilled, multiple-disciplined workers, and they will take on the roles of social work as well as allied health, pharmacy and radiography. People will just assume that you need nursing staff, but in actual fact their scope of practice is really broad. So in those areas, even if we had funding for the

social worker, I am not sure we would be able to recruit one, and you may be better off to increase the scope of the nursing role than having a social worker.

The CHAIRMAN: With increasing that scope, are there increases in salaries for those people when they take on those —

Ms Winsor: There are. They are remote area nurses, and we have been increasing the remote area nurses. We are trying to put three into Fitzroy Crossing, and we would like to recruit three into Halls Creek as well. That does multiple things. First of all, it deals with the clinical activity, but it provides a high degree of support to the medical teams that are there, and there is a lot of turnover in those medical teams in Halls Creek and Fitzroy. So having the remote area nurses with a broadened scope of practice can actually sustain those services, and they can do a fair bit just in consultation with the doctor, sometimes by phone. But it is a multiskilled worker, and they have to have a range of skills that take you from the critically ill baby turning up on the doorstep right through to palliative care and everything in between. The funding, I think, has been historical, and there is not a lot we can do about that. Moving forward, we are hopeful that the combination of the activity-based funding and a really good resource allocation model that takes into account the disadvantages that we have —

The CHAIRMAN: And maybe a DG who has some knowledge of all the deficits in this area now.

Ms Winsor: Yes. I think our DG does. He has been very interested in and very committed to the region up here. Just recently, the director of finance came on a tour with me and the acting CEO out to the Kutjungka. Now, you are going out there some time this week, I think, to Balgo. The purpose of that visit was to ensure that our director of finance had some awareness of the geography and the time of travelling, and then the serious health needs of the community when you get there. It takes so long to get there. Even the three communities out there are quite remote from one another. In the tiny visit when we were there, we had a flat tyre on the way between two communities, so it took you hours to get from one to the other across the roads, and that is in the dry. This is a community of really high needs. So when you see the high needs of the community, then you add in the distance and our workforce, if you have got one of anybody, they spend a large amount of time travelling. Even with the use of telehealth and phones, there is still a high amount of travel that eats into what you can actually do clinically on the ground. The whole of the Kimberley, if you look at the population, faces really serious health conditions. There are really high rates of chronic disease, diabetes, renal disease particularly, and you will hear about that in Fitzroy, which there has been substantial investment in. But the health of the children is one of the worst in the nation. There are some of the highest rates of STIs, the highest rates of suicide, and basically the high rates of mortality that you would not see perhaps in other areas. So it is how to deliver health services, which is the acute end, over such a broad geography, with the workforce shortages that we have, but also how do you get in there and prevent it? It is really hard to get in there and prevent it without having people on the ground in those communities. That does not have to be state health people; it can be other providers. But there does need to be some way of living in the community and working with the people. Workforce and housing for patients, particularly in Broome—we are bringing patients into Broome, but other than the renal hostel, as Sue has said, there is no other accommodation. So children need to stay in town for 10 days after their tonsillectomy. There is really nowhere for that family to stay and wait. Derby is a little bit better, and Kununurra will be a little bit better shortly, because we have got funding under the east Kimberley package for a 16-bed hostel there. We are working closely with the Department of Housing to ensure that those people who need to live in Kununurra have access to public housing and that they do not start living in the short-stay hostel, which we need so badly for those people who need to stay for 10 days post-surgery.

The CHAIRMAN: Ian, shall we start with you? Any questions?

Mr I.C. BLAYNEY: No, I have not.

The CHAIRMAN: Peter?

Mr P. ABETZ: You have given a general overview of the whole health system. For this inquiry, we are particularly focusing on drug and alcohol issues. I am interested in what could be done in terms of addressing the drug and alcohol issues in your area to be more effective in those prevention and treatment services. You mentioned, for example, post-operative, kids who have tonsillectomies, and you say that that is not directly related to drugs and alcohol, but for people who want treatment for drug and alcohol issues, what is actually available here?

Ms Malone: In Broome, there is a residential rehab centre. I think they have 22 beds for adults, and they have the capacity to take up to four children, so that whole families can go there. We have a sober-up shelter. This is for the people whom services really have trouble with engaging—what we call the happy drinkers, the ones who are getting intoxicated on a regular basis. It is a place to go and then sober up in safety. It is actually very well run. I and one of the staff went there on night shift just to see how it works. People are very well looked after. They go in and their clothes are taken and washed. They have a shower and go straight to bed. They sleep until morning. They put their clean clothes back on, they have a proper, healthy breakfast, and off they go. That is an excellent service for keeping people, I guess, healthy and well looked after. They also have some contact with what treatment services are available. There is information and literature, and the staff there do engage them and talk about the possibility of change, but, really, that is not completely their role. The difficulty is engaging the group who do not want to go to the sober-up shelter, the ones who want to stay out all the time and just keep drinking, drinking, drinking. That is a real problem, and a lot of businesses in town complain. If you walk up past Kennedy Hill, you see little makeshift camps, and sometimes you see a pusher, a baby carriage, a pram there under a tree, and that is a tragedy—a young child in those conditions while the parents are drinking. So, yes, there is some work to be done about engaging the very difficult-to-engage client group. I am not sure what the answer is there, but I have heard of other projects around the region that perhaps we can discuss maybe outside this forum; but there are various ideas for engaging that group. There is no legislative base in Western Australia for compelling people to engage in treatment, like there is with the Mental Health Act.

So in Broome we have a sober-up shelter, a residential rehab. There are various counselling services. There are the specialist alcohol and drug services that are provided by our service, and we are co-located with mental health, so we can deal with the co-morbidities. There is the Division of General Practice. They provide psychological services under the Better Outcomes scheme. There is pharmacotherapy. There is not a huge problem with opiates up here. Most of the opiates that we see are redirected prescribed morphine tablets. There is not much actual powder heroin. So, yes, there is a range of services in Broome. Once you get out of Broome, there is actually another residential rehab in the Kimberley—that is Ngnowar Aerwah in Wyndham—and they have just had a massive boost in funding and resources. They also have a sober-up shelter in the town of Wyndham, and town-based counselling services, and they do an outreach service to Oombulgurri as well. In Halls Creek there is an alcohol centre, the Jungami-Jutiya health centre, which has got two councillors. There are various services dotted around the region, and generally we all link up and get along pretty well. But there are not a lot of resources to go around, and so we, as much as we can, try to share expertise and training and things like that. But in Broome we are actually fairly well resourced in comparison with some of the other towns.

The CHAIRMAN: Unfortunately, due to the time, we are going to have to finish. Normally I would give each of you an opportunity to sum up from here, but we will send you the statements from today that I am going to make, and we will be happy to receive supplementary information from you. So, if you would like to put down the points that you have not had an opportunity to raise, it can just be in point form. It does not have to be an essay that takes you weeks and weeks. I would also ask, Kerry, if you could, as part of the supplementary information, provide the current WACHS plan for the Kimberley area, because we could then put that up as a submission on the

internet, so that all the health professionals in this area and professionals working in this area are able to see what is being budgeted for over the next five years, and can then have input into whether they believe that funding is going to meet the current needs or not. So if you could provide us with the —

Ms Winsor: Yes. It would be the clinical service plan.

The CHAIRMAN: — clinical service plan for the Kimberley, that would be wonderful. I would like to thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 28 days from the date of the letter attached to it. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by corrections to the transcript and the sense of your evidence cannot be altered. However, you are able to provide additional information and elaborate on points that you have addressed during the hearing today. You can do that by way of a supplementary submission, which the committee can then consider with the corrected transcript of evidence. Thank you all once again very much for coming along this morning.

Hearing concluded at 11.31 am