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 KUNUNURRA
MONDAY, 2 AUGUST 2010

SESSION SEVEN

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 3.05 pm

BELTZ, DR ERIK KARL
Senior Medical Officer, WA Country Health Service, examined:

WILLIAMS, MR DAVID JOSEPH
Acting Operations Manager, Kununurra, Wyndham and Halls Creek District Hospitals, examined:

HOWE, MR TERRY
Registered Nurse, Kimberley Mental Health and Drug Service, examined:

MALONE, MS SALLY
Regional Coordinator, Kimberley Community Drug Service Team, examined:

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

The CHAIRMAN: On behalf of the Education and Health Standing Committee I thank you for your interest and for your appearance before us today. I acknowledge and pay respect to the traditional owners, past, present and future, of the land on which we are meeting. 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 introduce myself, Janet Woollard, and Mr Ian Blayney. Joining us shortly will be Dr David Worth, our principal research officer, and we have Keith Jackman with us from Hansard. The Education and Health Standing Committee is a committee of the Assembly and this hearing is a formal procedure of Parliament. This is a public hearing and Hansard will be 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.

Ms Malone: I have previously; I have not done one today.

The CHAIRMAN: We do not need another one today. 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 about being a witness at today's hearing.

The Witnesses: No.

The CHAIRMAN: This inquiry started over 12 months ago. We have had several hearings in the metropolitan area and some in other regional areas, but this last week we have had hearings throughout the Kimberley. We are looking at the problems in the community with alcohol, cannabis

and other drugs. You will see from our terms of reference that we initially thought about what happens in schools and with health professionals. Through the week we have realised that it starts very much with prevention. We have heard what is happening at the antenatal stage, what is happening before school and what is happening during school. We have heard about where there are some strengths in programs and about where there is a lack of resources. Suggestions have been put forward to the committee on where resources could be better spent to decrease both the medical costs associated with these problems, which you would see on a daily basis, but also the social costs to families when they become dysfunctional because one or more members of the family has alcohol or other drug problems. This is Sally's fourth bite now at the cherry. We are hoping today that you will paint a picture for us about those areas in the east Kimberley region. Where are the strengths, where are the weaknesses and what additional resources are required or could assist? We obviously hope to put forward some recommendations that the government will adopt. It may not adopt all of the recommendations, but we hope that it will adopt some and that that will go some way towards alleviating some of the problems that are occurring up here. Sally, would you like to go first this time? You only got a few minutes at the end of the last hearing.

Ms Malone: I will not talk too much about what the problems are, because you have obviously developed a pretty good sense of that throughout the week.

The CHAIRMAN: Maybe we will let you go last then, so that we can hear the local focus. Erik, would you like to go first?

Dr Beltz: Looking at the strengths first?

The CHAIRMAN: Yes.

Dr Beltz: I guess from the hospital's point of view we have a well functioning hospital with good teamwork between staff.

The CHAIRMAN: Is it well staffed? How many staff do you have?

Dr Beltz: It is fair staffed, not well staffed. We have eight full-time equivalent doctors. We could obviously use more because of the pressure on the doctors who are available for after-hours work. The doctors are split into a group of obstetric doctors and a group of —

The CHAIRMAN: Would you be doing one in four or something like that, taking into account annual leave and things?

Dr Beltz: One in three or four. We try to be not more than one in three, but sometimes there are periods when we have to do a one in two for a short time. That is extremely demanding on most of the staff. That can create some health problems. We are trying to get more FTE in Kununurra to be able to continue giving a good service.

The CHAIRMAN: How many FTE would bring your workload to what would be a workload of a similar size hospital in the metropolitan area?

Dr Beltz: I guess you heard about a study by Iain Hague last year.

The CHAIRMAN: No.

Dr Beltz: He did some work on the FTE needed for the hours that we are making. He advised at least two more FTE to cover us here.

The CHAIRMAN: Where is Iain Hague from?

Dr Beltz: He is the medical director for the Kimberley.

The CHAIRMAN: Oh right. Could you, by way of supplementary information, send us a copy of the report?

Dr Beltz: I am not sure whether there is a specific report.

Ms Winsor: It is a calculator.

The CHAIRMAN: Kerry, you might just want to pull up a chair. She is sitting in the background there. Kerry, I cannot remember your surname.

Ms Winsor: Winsor.

The CHAIRMAN: Kerry, are you able to supply that to us by way of supplementary information?

Ms Winsor: It is a calculator that Iain developed that tries to include all the award entitlements and the rostered responsibilities of each medical practitioner to determine how many doctors you would need. It is not a perfect calculator. In some cases it overestimates what you need. For Kununurra we would be looking at two extra FTE.

The CHAIRMAN: Did it look at medical nursing staff and allied health professionals or just medical staff?

Dr Beltz: It was medical, but I think the nursing staff would like to adopt part of it to see whether they can calculate it in a similar way for them.

The CHAIRMAN: That would be interesting.

Ms Winsor: For nursing, the calculation is of nursing hours per patient day. That is the standard calculation agreed by the union.

The CHAIRMAN: Per patient day and not by caseload?

Ms Winsor: No, it is hours per patient day in the inpatient areas. There has been some work done on that for the small hospitals like Halls Creek, because in Halls Creek the nursing staff also do X-rays, pathology and things like that because there is no pathology or X-ray staff on the shift.

The CHAIRMAN: Is that calculation for nursing days just for the Kimberley or has it moved to nursing days in the metropolitan area?

Ms Winsor: No, it is all over. I think most states have something equivalent for assessing hours per patient day. There is a way to work out the nursing staff required in acute areas. That is being revised for Kununurra because of the activity growth.

The CHAIRMAN: Sorry, back to you Erik.

Dr Beltz: We tried to get some statistics on the impact of alcohol on the attendances in ED. It is not easy to get because of the forms used in the emergency department. Alcohol is not ticked off as yet—there is no box for that—but we have a student at the moment working on it. He is going through the MR1 forms to see which ones were indicated as alcohol-related issues.

The CHAIRMAN: This is a general Department of Health form?

Dr Beltz: Yes.

The CHAIRMAN: With all the problems with alcohol, I am amazed that the form has not been modified. This is not a new problem.

Dr Beltz: I agree.

The CHAIRMAN: This really is unacceptable.

Dr Beltz: It is very easy to add a box marked "alcohol-related—yes or no". He has been looking at the past month's admittances to the emergency department. The scope was from six o'clock in the afternoon to eight o'clock in the morning; however, I think the main problems would be around 10 o'clock in the evening to two o'clock at night. Anyway, the overall percentage for that 14-hour period was about 17.5 to 20 per cent with alcohol-related issues. Everything is included there. If we looked at a more specific time, I think we would come up with 80 to 90 per cent alcohol-related issues in that period. What I think is very important is the relationship with the date in the month. If there has been a handout or a payment day, definitely the days after the payment—from the

Thursday to the Sunday—are a disaster for the ED. I mean really disastrous, with everything that you can think of happening.

The CHAIRMAN: So if people were paid on a daily basis or weekly basis, it may not have quite the —

Dr Beltz: It might reduce the influx of patients at that time—it would spread it a bit more, I guess. I want to find out also by checking day by day in terms of attendances. That is a part of it.

The CHAIRMAN: This data has been collected over the past month. Is there a plan to keep that going over several months? How many months are you —

Dr Beltz: This is what he has got so far. He did it over the weekend. The total number of attendances over the past month from six o'clock in the afternoon to eight o'clock in the morning was 252. Forty-four of those were alcohol-related, which is about 17.5 per cent. We could not determine whether the admittance was alcohol-related for seven cases. Most likely it was. If we cut out the children of, say, 12 years or so and below—although we see intoxicated kids also—I think it would increase to 40 per cent alcohol-related. If you limited it to the time frame between 10.00 pm and 2.00 am, for example, I think the percentage would increase even more. The impact on the ED service is significant. The doctors work the whole day and are often up all night because of these things and then have to work the next morning also. That has an impact on the recovery phase of doctors.

The CHAIRMAN: When we send you the transcript you will have 28 days before it needs to be returned. Would you be able to send us your analysis for the month at that time so that we could take that into consideration?

Dr Beltz: Yes. I will try to get some more figures from previous months also.

The CHAIRMAN: Thank you. You mentioned that you treated several children as well. What age children are coming in intoxicated and requiring care?

Dr Beltz: Last week, I think it was Thursday, we had a 14-year-old come in completely intoxicated and in a dangerous state.

The CHAIRMAN: So alcohol —

Dr Beltz: It was the third time that he has been admitted for an alcohol-related problem. It is not that common, but it does happen.

The CHAIRMAN: When children come into the hospital because they are intoxicated and it is quite serious, does the hospital have a policy of notifying DCP?

Dr Beltz: Yes. We often get younger kids who are admitted because of intoxicated parents and DCP are immediately involved. It is a regular occurrence when kids are admitted for whatever reason for the mother to come in drunk. It is a regular occurrence.

[3.20 pm]

The CHAIRMAN: This is one way of looking at the costs of alcohol. Are there any other dollar costs? For example, has the hospital done an analysis on the cost of operations?

Dr Beltz: We would like to be able to do a bit more investigation locally rather than looking at the CT scan because we do not have that facility. We have a lot of head injuries and take a deep risk at the moment by often not being able to do anything or have people walk out. If we have a CT scanner, we would at least be able to clear them and make sure that it is safe for them to walk out. Now we try to get them to Broome for a CT scan to rule out any more injuries. Last week a guy came in with a severe injury after being hit on the head with a brick several times. There was a huge swelling there, and bleeding. X-rays were done but we needed a CT scan to clear this guy's head.

The CHAIRMAN: We have been told by the ABS that the population is between 7 000 and 9 000. During the tourist season there could be an additional 4 000. The last hospital to get one was Esperance. I do not know that its population is as high.

Mr I.C. BLAYNEY: There are 15 000 in the town plus the region. Esperance serves about 20 000 people.

Dr Beltz: In the tourist season it swells to 30 000 or so.

Ms Winsor: It is in the capital infrastructure plan.

The CHAIRMAN: Is there one earmarked for Kununurra hospital?

Ms Winsor: Yes, in two or three years but it is relatively soon. We have been asking for it. We need the workforce to go with it and that could be a tad difficult. It is no good having a CT scanner without the workforce that can man it. We have to work on that at the same time.

Dr Beltz: And the space.

Ms Winsor: Yes, and the space.

The CHAIRMAN: David, would you like to come in? Eric told us about the issues involving alcohol. Maybe you would like to add to what Eric told us. Could you also tell us about cannabis and other drugs?

Mr Williams: It is probably not my area of knowledge, being more a clinical thing. I manage the staff, the buildings and budgets. We have about 150 employees here covering our 114 FTEs. Eric was saying that work is being done on the doctors' hours to get two extra doctors. We have just about completed a request based on nursing, using the nursing hours per patient day calculation. It looks like we will be asking for an extra 10 nurses.

The CHAIRMAN: Could you provide us with a copy of that assessment?

Mr Williams: Yes. The nursing hours per patient day is a statewide calculator that has been going for about seven or eight years.

The CHAIRMAN: I am a nurse. It was caseload. This is new.

Mr Williams: It is based on bed days—how long a person is in the bed divided by the number of hours a nurse puts into being there. That is the basic calculation.

The CHAIRMAN: So it would be better to keep more patients in overnight if you need more staff!

Mr Williams: Yes, if we have beds. It is calculator tool. It does not include boarders. We get a lot of people staying with the patients and stuff like that. None of those things are included. That impacts on our hotel services section—the making of beds, providing food and stuff like that. They are the areas that probably miss out the most. We have a lot of evidence on how many doctors we need and how many nurses we need. The pressure is put on our clerical staff, to a lesser extent, but probably to a greater extent the hotel service staff. We put more doctors and nurses on, which is great, but we have to make the beds and get the food. One of the issues that we have relates to transport because of the remoteness of where we are and getting people in from communities and then getting them out to communities, or even when they are here. We bring a lot of people in from Oombulgurri, Kalumburu, Warmun and places like that. There is not a lot of accommodation for them when they get here. That puts additional pressures on the town.

The CHAIRMAN: I think we were told that almost 2 000 children under the age of nine live in Kununurra. How many paediatric beds do you have and how many deliveries?

Dr Beltz: We have a little under 150 a year.

The CHAIRMAN: That would be about right.

Dr Beltz: We have one room allocated for kids, which has about five beds. We can allocate other rooms if needed. Often it is the other way around—the kids' beds are not full and we have to put adults in the rooms allocated to kids.

The CHAIRMAN: How often do you have children coming in who have been physically abused because of alcohol?

Dr Beltz: That is something that I would like to find out. There is mandatory reporting.

The CHAIRMAN: Those statistics should be available.

Dr Beltz: I think it is often relayed to DCP.

Mr Williams: Mandatory reporting is only fairly new. It only came in in the past six months.

The CHAIRMAN: I think mandatory reporting is for sexual abuse.

Ms Malone: It used to be; now it is for general abuse.

Mr Williams: We have patient transport issues and patient accommodation issues. When they are here for short stays, it is something that we have a lot of need for.

The CHAIRMAN: How many people are transported from Wyndham to here and roughly how many people would you have to transfer from here to Broome over a three-month period?

Dr Beltz: Broome is not our first port of call for emergencies. If we need ICU care, we send patients to Darwin. There are six ICU beds available in Darwin. We tend to utilise them fairly often from the east Kimberley. The advantage of Broome is the CT scanner and some specialists who are there. If we cannot manage, we usually send patients to Darwin or Perth direct. We have far more transfers to other centres rather than Broome.

The CHAIRMAN: So if a patient needs a CT scan, he or she might go to Broome. I guess next year you are looking forward to the mental health beds opening.

Dr Beltz: Hopefully that will also be part of the Darwin agreement in the future. It is still a long way from Kununurra to Broome. We are hoping it will be built in Darwin.

The CHAIRMAN: Are you hoping more beds will open up?

Ms Winsor: There may be. The current agreement with Darwin is just into its second year. Bed utilisation has been within the six beds that have been purchased. The beds are paid for, whether we use them or not. What we paid for from the budget, we were right on that at the end of the financial year. We have just been looking at whether we need to increase the beds in Darwin. On the current utilisation, it does not look that way this year, keeping in mind that the dialysis unit at Kununurra will open shortly. That will be in about 12 months. Patients who are having dialysis who deteriorate rapidly and need a higher level of care are a potential for Darwin. The others will be mental health patients. The mental health unit is not open yet. It will have 14 beds. We need to see whether the demand is there. The next two that we would look at for Darwin would be renal, mental health and potentially cancer—oncology and radiotherapy-type care. We are very mindful of those. We think this year it will probably stay at six. We will review it closer to the time.

The CHAIRMAN: How many renal beds do you have at the moment? Do you have them in both Kununurra and Wyndham?

Dr Beltz: We have no renal beds.

Ms Winsor: Four chairs are going into Kununurra. The building is currently being built. They will not go to the hospital but to OVAHS. The Ord Valley Aboriginal Health Service will run it under KAMS because KAMS does the dialysis in Broome, with the satellite in Derby and there is a new satellite to come into Kununurra. Derby is being increased from four now to 10. Kununurra will have four, which will allow for 16 patients to be dialysed.

The CHAIRMAN: There are two in Fitzroy.

Ms Winsor: They are home dialysis units. That means the patient has to be self-caring or well enough and have a carer.

The CHAIRMAN: Do you have any of those beds here at the moment?

Dr Beltz: There are no specific beds for them. There is one for one patient but that is specifically for her; she is the only one using it.

The CHAIRMAN: How many people in Kununurra and Wyndham have had to go elsewhere for care because they need dialysis? How many people do you anticipate will need to receive care over the next 12 months? During other hearings we have heard that renal failure is the number one health concern for Aboriginal people and diabetes is probably number two. How many people from this area need to be transferred?

Ms Winsor: We have a renal plan that has all that information in it. It is the WACHS renal plan, and also the dialysis plan. It shows the number of patients who are in Perth.

The CHAIRMAN: From this area?

Ms Winsor: Yes, to come home from Kununurra. We can nearly identify them because we have just done the same piece of work for Fitzroy Crossing. If we could get four chairs into Fitzroy Crossing—supported dialysis—eight patients could come home to Fitzroy immediately and 12 in the longer term. There are a couple who are not well enough. Whether we put it in there or not, they could not possibly come. The same exercise can be done at Kununurra but the four chairs was worked out on the demand and the projected demand. They are building the building to accommodate six.

The CHAIRMAN: Is this the new building in Kununurra?

[3.35 pm]

Ms Winsor: This is a new building so it will have the capacity to go to six, so that growth is built in. There is still a little shortfall over the next 10 or so years in the Kimberley for dialysis, but every new clinic that is being built is being built with the capacity to support at least home dialysis. If the Fitzroy model works at Fitzroy, we would look at that for Halls Creek and potentially that would get another eight or 12 patients to Halls Creek, certainly 16 in Kununurra and, if two more chairs go in, then you would get another eight.

The concern about the dialysis is, apart from patients having to go out and live away from home, when the dialysis opens having those patients have somewhere to live. If they do not already have a home to live in here or if they come from a surrounding region, to access the dialysis here they will have to have somewhere to live. We are building a 16-bed short-stay unit, but that is required to support the clinical services so people coming in from Oombulgurri, Kalumburu, Wyndham and Halls Creek to see specialists, children having tonsils out who have to stay in town for 10 days, will need to stay there. We believe we can almost fully occupy that just with the specialist patient activity, if the dialysis patients start moving in there as a permanent home because there is no other house, then our short-stay and the problem of housing people who need to be close to the service to access care will become a problem. So we have started to liaise with the Department of Housing on how do the dialysis patients get fast-tracked into public housing and they are doing a briefing note to start raising that now before the dialysis unit is open so that, hopefully, there is housing for those people who do not have a house in town.

The CHAIRMAN: Firstly, could we have a copy of the renal plan? Secondly, when were in Fitzroy Crossing we had a drive around the town and we actually noticed that there were some Department of Health houses on enormous blocks, because it was health department, and across the road some of the other government agencies on similar blocks might have 10 units for accommodation for staff. Who in the health department is looking at that so we can make some further inquiries?

Ms Winsor: Two ministers—the Minister for Health and the Minister for Housing—have committed to having Health involved in the GROH, Government Regional Officers' Housing; currently it is not. The other government departments can access GROH housing; we are not automatically accommodated. So the police just say, "We need two houses for police" and the GROH department finds them the houses. Health looks after its own houses.

The CHAIRMAN: Are you saying that an arrangement has now been made for Health to come under GROH?

Ms Winsor: The two ministers have committed to it and there is a major piece of work underway looking at what the implications are for that, what it will cost, which properties would go and which would stay. The health service, I think, is looking at hanging on to the housing for short-term frequent people, like locums, who are in here for a week and then gone. We need some housing that we can look after in regards to that because it would be too complex to give to GROH, but I think the plan is to give all the rest of the housing to GROH and that would mean assets and all that I expect so the finer detail about how that would happen is yet to be worked out. But in Halls Creek, certainly, it is the same thing; some blocks are huge big blocks. Even in Broome we have a huge big block with a dinky old little house on it. Even with or without the GROH arrangement we had spoken to the Department of Housing about the potential for them to take that land, knock down what is on it, build on it and we would lease it back—just take off the allowance that we gave you the land.

The CHAIRMAN: So you can see a light at the end of the tunnel, then?

Ms Winsor: Yes, there is.

Mr Williams: Sorry, but in Fitzroy Crossing there are not many houses. It has been a while since I have been there, but most of our staff are in that block around the back of the hospital there—aren't they? There are not that many houses.

Ms Winsor: No, we need about eight for health service right now—we are eight short—Nindilingarri is eight short and we have four staff living with other providers. There are other blocks of land that we can build on but we just have to find the money or hand the land over.

The CHAIRMAN: I saw four enormous blocks with houses in the middle and across the road were all these lovely units. We might move on to Terry. Would you like to join us?

Mr Howe: What would you like to know?

The CHAIRMAN: Back to alcohol, cannabis and other drugs, and knowing that really these drugs go hand in hand with mental health, so —

Mr Howe: Obviously, they have a great effect on people's mental health and marijuana in particular in the younger population.

The CHAIRMAN: When you say "marijuana in particular", which part—here in Kununurra? In Wyndham?

Mr Howe: All over the eastern Kimberley.

The CHAIRMAN: So what would the ages for the younger people be?

Mr Howe: Probably 15 onwards. That can create what is called a cannabinoid psychosis; people develop a psychosis that is purely and simply from the cannabis. Quite often they are treated with anti-psychotic medications but really you just take the cannabis away and the psychotic features go away, so people are unnecessarily on medications that if they just made a lifestyle change they would not need medication.

The CHAIRMAN: How many children were there in Kununurra roughly?

Mr Williams: You said earlier that there are 2 000 under nine.

The CHAIRMAN: But there are more under 18.

Mr I.C. BLAYNEY: There are 3 310 under 18.

The CHAIRMAN: How many of those children do you think might be on cannabis?

Mr Howe: I think probably 80 per cent in the Indigenous population. A high proportion of young Indigenous people smoke marijuana as do their parents.

The CHAIRMAN: Then going to the parents, of the 100 per cent of Aboriginal people in the east Kimberley area, how many of those do you think would be using cannabis—what percentage?

Ms Malone: I think it depends on where they are. I think for the town-based people it is probably around near the 70 per cent mark. But I do not think there are many who just use cannabis in isolation; I think it is the synchronicity between alcohol and cannabis that is probably increasing the problems. Out in the remoter communities it is more difficult to get both. Of course, cannabis you can grow out of the ground and alcohol, depending on where you live, you have to make a little more effort to access it. It does not always grow in every region —

The CHAIRMAN: So in some of the remote communities is it more that cannabis is a problem than alcohol?

Ms Malone: I do not know that it is more of a problem because they cause different problems but, certainly, cannabis is more accessible in some communities than others. For instance, we have had it reported that cannabis is grown in Kalumburu apparently, so they have problems with mental health and with, I guess, fighting and humbug over the money aspect of it. I think the actual intoxication from it is less a problem. It tends to affect people's motivation; their willingness to get up and do a day's work, their willingness to look after their kids, their willingness to get up in the morning and get the kids ready for school. It is lying around the house so the kids can access it; they will pinch it from their parents or from older siblings. Older kids will give it to younger kids and younger kids, like the world over, will slavishly copy what the older kids are doing anyway. So there are a whole lot of reasons why cannabis is causing problems up here, but the problems it causes are different from the problems related to alcohol. I guess another set of problems arise when they are both used together and they frequently are. It is the same in youth too. The young people are not just smoking cannabis; they are drinking alcohol as well. There is a little bit of a problem with solvents in Kununurra as well; not much, it is sporadic and episodic. But there is some regional coordination happening around solvent use anyway.

The CHAIRMAN: If there are so many people using cannabis, what is the effect going to be when the new legislation comes in that possession of over 10 grams is a criminal offence rather than over 30 grams?

Ms Malone: Even before the legislation came in when it was illegal to have any amount at all, the problems were similar and there were not that many people in the courts, I think, because of it. At the end of the day, I do not think that sanctions are much of a deterrent. Even if they were—this is an area that I have been meaning to raise with the committee—a large proportion of the prison population up here is Aboriginal and there is very little support available in prisons for people to turn their substance using behaviours around. We have an early intervention program for mild to moderate offenders, but by the time people get prison, their problems are out of control; that is why they are there. Also, there is so little available in the communities to help them turn that around and the problems are so complex anyway and so entrenched that the prisons really have the pointy end of the people with the problems. There are very few resources and it is an opportunity missed. With a captive prisoner population we could do so much more for people in prison but the resources just are not there in the justice system. So there is that. Would you like to go back to Terry?

The CHAIRMAN: Yes, back to Terry! Terry, you manage the east Kimberley so tell us about your staffing and in your staffing how many Aboriginal and non-Aboriginal staff would you have.

Mr Howe: Our staff here has improved considerably in the past two years with the creation of a team leader position, an extra clinician on the adult team and an extra child and adolescent clinician funded by DCP with mandatory reporting, so that has made a huge difference.

The CHAIRMAN: What is that in numbers?

Mr Howe: We have three adult clinicians, two child and adolescent clinicians and three community drug service positions, but only two filled at the moment.

Ms Malone: There are four positions in Kununurra but only two are filled at the moment.

Mr Howe: We have one vacant Indigenous mental health worker position that has not been filled for about 12 months; despite doing two recruitment drives, there have been no applicants. We have a 0.6 clerical worker, so about nine of us in the office.

The CHAIRMAN: How closely do you work with the council and other agencies? Are people aware of who you are and where you are?

Mr Howe: Which council do you mean?

The CHAIRMAN: This council—sorry, not the council; it is called the shire here.

Mr Howe: Probably we do not work very closely with the shire. Our child and adolescent workers have a lot to do with the youth workers who are employed by the shire.

The CHAIRMAN: I was just wondering because some people are unaware of the staffing capacity that you have, so there is possibly a lot more work out there for you that is not coming to you!

Mr Howe: There possibly is! But there certainly is a lot more work out there that is not coming to us in terms of access; a lot of Indigenous people out there are not comfortable to come into our office and seek help. Access is a huge problem for Indigenous people, I think. What else can I tell you?

The CHAIRMAN: When you say "access" would you like staffing to be able to work with people in their homes in the communities?

Mr Howe: We do work in people's homes and the communities. We do a lot of travel. We have travelled to Kalumburu, Oombulgurri, Wyndham, Halls Creek, Turkey Creek and in the past 12 months we have taken over Balgo as well. We have adult clinicians and our CAMH service go to Balgo. It is not without its difficulties; it is a lot of travel and it tires people out. But fortunately we have been able to, rather than drive, start to fly there. We have also engaged the service —

The CHAIRMAN: But are you seen as—what is the name they have for politicians—seagulls?

Mr I.C. BLAYNEY: Fly in, fly out workers at mines are called seagulls.

Mr Howe: Ideally to service that part of the area, if we had a mental health hub in Halls Creek, probably full-time workers in Halls Creek, we could spend more time in Balgo and Halls Creek to save the staff from Kununurra having to do so much travel. Certainly, with the fly in, fly out it is working a lot better than the driving was. We have also started to send a psychiatrist in there about three times every six months for the visits, so things are improving.

The CHAIRMAN: We have heard in other hearings that Aboriginal people, particularly down south, not so much in the hearings this week, do not like to be told that someone in the family has a mental illness. Is there a stigma here attached to the term "mental illness"? How do you describe your patients?

[3.50 pm]

Mr Howe: I would not think there was any more stigma attached to mental illness in Indigenous families than for anybody else. In fact, from what I have seen in my 10 years in working in the Kimberley, Indigenous families can be more supportive and more accepting of unusual behaviours with their family members than other families.

The CHAIRMAN: That is very interesting.

The CHAIRMAN: I am going to ask each of you—and we will also let Terry have another bite of the cherry—about priorities for funding. If funding were available in the near future, because of the unique problems in the Kimberley—housing, children not going to school, children being abused, all of the problems that you have had here the missions, healthcare costs—what two areas should that funding go to?

Ms Winsor: I am not a clinician on the ground here, but I would be thinking into child and maternal health and perhaps even family health; so working with children and the mum, but also picking up adults. If you went in looking after children, you would be able to interact with mum and provide her support and if there are problems in the family with alcohol and drugs, you could help with those as well. You would need a team that is set up to be able to do that. I think what we have got to do is try and take more of the services to where the people are, and working with the people there so they feel comfortable with us being there. And, if at all possible, to increase the number of those people that are Aboriginal themselves so that it is local people who are employed.

The CHAIRMAN: Terry, I am sure you are aware that the minister has been up here this week looking at implementing bans. Do you think that when the liquor bans are introduced, and hopefully they will be introduced—you have just heard from Sally and Terry about the number of people here using ganja—cannabis—do you think that is likely to increase and cause further problems?

Ms Winsor: I am probably not skilled to be able to say from a clinician's point of view whether that would happen. But we do know that where the alcohol restrictions or bans have gone in, as people have got the alcohol out of their system, they start to look for help and support to get the family back together and to start to take care of themselves, so there is an increase in requests for services to support people to get back on their feet. Whether they will swing over to an alternative drug, I probably cannot say.

Ms Malone: I think that cannabis is more a symptom than a cause. I absolutely agree with you that if we work with the children and the families and build up and work on some of the social determinate stuff—some of the disadvantages, some of the difficulties—I think some of the cannabis issues would naturally be resolved. We could throw as much resources as we like at trying to stamp out cannabis use, but I actually think if we build people's resilience and make their lives and their communities more liveable the cannabis thing would largely resolve itself.

Ms Winsor: The Fitzroy women are particularly strong women took a lead in FASD and alcohol restrictions in Fitzroy. I think they have shown that if the mums and the family can start to get a hold, they start to say, "Well, we didn't know alcohol would cause that." If you can get everyone not affected by alcohol and drugs and start talking to them about what cannabis does and that it causes illnesses, some of the things that Terry has been talking about, most people would be shocked if they thought that was happening. If we could gather some impetus for families to start taking that more seriously—that was the outcome from the Billard conference that I have heard just this morning, that it was very much around communities taking a stand and working together to manage some of the difficulties they are having in the community, not so much what the government can come in and do but what they can do for themselves. It was very empowering, apparently.

Dr Beltz: I am not sure whether you were told before, but in Kununurra there are often roaming kids in the night. From five or six years of age on there are just in big groups roaming the streets, often because their parents are drunk and it is unsafe for them to go home.

The CHAIRMAN: Because of physical abuse or physical and sexual abuse?

Dr Beltz: I guess both. But the thing is, when you approach them, they are very clear in saying that they do not want to go home, they want to go to the prison system where they are fed properly, where they can watch television and they are safe there. There is a huge problem, and I think it is

severely underestimated. To address that, I think you have to go to—there are lots of different programs here for the youth, but they are focused on separation instead of integration. You are allowed to attend certain programs if you are Aboriginal; you are not allowed if you are white. Occasionally you are allowed to attend, but you have to be a problem kid to attend or to be sent somewhere for camps and things. If you are doing well, you cannot access those services, which is the complete opposite of what we should be trying to achieve. You want integration in society, not separation. I would like a focus on integrating Aboriginal kids with Caucasian and with the rest of the population—and that needs a lot of support and input, I think. The way it is done with the children, the shire actually also separates instead of integrates. That is really a wrong approach, and those roaming kids need somewhere they can go. And just addressing one issue—it is only Aboriginal kids—until 10 o'clock in the evening I think there is some sort of program where kids can go to play and things. I do hope that the alcohol ban will have some positive effect on at least the home situation, for instance.

The CHAIRMAN: Many people in the different places we have gone to have said that in the towns like Kununurra, Fitzroy Crossing and Broome, there should be a halfway house for children who are found roaming the streets, particularly, as you say, those as young as five and six years old, where they can be taken and have a bed for the night and a meal in the morning, and for the slightly older children to be taken to school the next day so they are not missing out on school. I think that is something that we have heard from each place. You are not alone. There are a lot of people who are very concerned about that.

Mr Williams: Of course, more staff and housing to go with staff. That is probably across a greater level than just clinicians, particularly in places like Halls Creek where we really struggle to get our orderlies and cleaning and hotel services staff. We are really good at encouraging them to come to work, but we could make it better if we could access accommodation for our staff. Our other thing is the importance of getting Aboriginal people in our workforce to provide an Aboriginal face to the majority of our clientele that comes in. That also could help improve our transport issues and getting people to stay in hospital and not wander around. We would love a proper program of trying to get Aboriginal workers in, acknowledging that at the moment there are not a lot of Aboriginal nurses or doctors around. We have one Aboriginal health worker who is training to be an enrolled nurse, and then from there the next step is to be a registered nurse. It would be good if we could have some type of way of encouraging more Aboriginal people into our health workforce. Do you have a wand?

Mr Howe: I agree with David. The two issues for me are accommodation for families, for single men, for children when it is not safe to be at home—so a whole range of accommodation issues. Education for Indigenous people to come into the workforce as registered nurses—they would need to be strongly mentored—but some sort of program that guides them through training to be doctors, nurses and allied health staff rather than a health worker certificate being created which really does not have much career structure or very high level of wages.

The CHAIRMAN: I will come back to Terry and Eric on that one. Are you aware that St John of God hospital, Murdoch, is now running an enrolled nurses program, so it does not have to be through the university or the TAFE? It might well be that in these areas—Fitzroy, Kununurra, Wyndham, Halls Creek—that you could basically take the approach of St John of God Murdoch for the curriculum that they have developed and see whether you are able to adapt that curriculum here to try and get some Aboriginal enrolled nurses working here. Were you aware of that program?

Ms Winsor: I would not be, but I have not long been in Western Australia. I do know that there are a couple of girls interested in Wyndham. They are doing their enrolled nurse training, both with young babies, and we can support them to do their training here in Kununurra with Notre Dame in the links with that university here. They could do the bulk of their work here. They would still have

to do some time out of the region, but it is quite possible to move those two girls through if they wish to. I can have a look at it.

The CHAIRMAN: It might also be worth having a look at. Maybe we should let everyone finish. I have a couple of questions and I am sure Ian has a couple. Sally, did you have two areas?

[4.02 pm]

Ms Malone: Yes, I could add to all of those and throw in a little of my own just on the enrolled nurse thing. I believe Notre Dame has the online nurse training program, because whatever program was put in, it would have to be affiliated with a registered training organisation. That is certainly doable. In terms of resources, I think that the safety of children and young people is paramount. Some terrible things have happened and they will continue to happen while there is a lack of safe places for young people to go to. Part of the reason we have that situation is that there seems to be an accountability gap—who is accountable, who is responsible for doing that? We see a little of this with children who are alcohol and drug users. We have an agreement with DCP in the west Kimberley and we are still negotiating it in the east. There is a raft of problems with working with kids who are substance users themselves. Very often they are not at school, so they are missing the processes there. There may be developmental delays that could be related to foetal alcohol spectrum stuff. There may be learning difficulties. The traditional court-based and education-based interventions might not be the right approach. What you really probably need is a family system or multi-system intervention. There are various places around WA that do that. You really need to make it Indigenous specific or culturally specific and culturally secure up here. That is a massive gap. People think it is a drug and alcohol thing so drug and alcohol services can do that. We do not have the capacity. We do not have the funding or the staff. You would need some highly skilled staff to do that, and I do not think any agency up here has people who are skilled enough to do that. You would need to build it pretty much from the foundations upwards, but with a real safety, family and parenting focus. I maintain that the use of substances by children is, at the end of the day, a child protection issue and not an alcohol and drug issue. You would want to hope that they are very early in their substance use career and that it is something that could be turned around. With the right sort of protections in place it should not be happening. They need safety from not just alcohol and drug use but also all sorts of abuse. That would be one area where there is a massive resource gap.

There is some good work being done up here, such as the Warmun program. I think the alcohol and drug agencies work very well together on the whole. We all have pretty good communication networks with each other. We know each other very well. I know the Fitzroy women and what they are doing and I know the staff at Jungarni Jutiya in Halls Creek and what they are doing. We have a memorandum of understanding with Ngnowar Aerwah. We help train their staff. I have seen some programs come and go. The reason they fall down is generally that they are in non-government organisations that do not have the governance and accountability processes to really sustain and run a program. They do not understand what the best practices are; they are sort of feeling their way in the dark. They are told to ask the state government and to get into a MOU with it, the implication being that they can tap into our expertise, but we are already flat out dealing with the client groups that we have got. There is some good work being done, but I could name three Kununurra programs alone that have fallen down because they have been in non-government organisations and they have lacked the governance ability to get up and running.

The CHAIRMAN: David, could you provide for the record an overview of the Kununurra ambulance service?

Mr Williams: Kununurra's ambulance service is run by St John Ambulance, so it is a volunteer-based system. It has one community paramedic who was appointed about two years ago. That has made a significant difference to volunteer numbers; it really improved the quality of the training to the volunteers and stuff like that and increased the number of volunteers, which was excellent. We

gave them some land a few years back on which they have recently built their new facility, just next to the hospital. More recently we have secured some funding to upgrade seven ambulances across the Kimberley and have given them funding for another community paramedic, which is meant to assist with Wyndham which has a bit more trouble in getting volunteers and stuff like that. As opposed to Halls Creek, the hospital runs the ambulance service there because they cannot get volunteers. We effectively have an extra orderly and a bit of a nurse who goes out on all ambulance calls.

The CHAIRMAN: Like at Fitzroy.

Mr Williams: The same as Fitzroy and Derby.

The CHAIRMAN: Erik, could you tell us about the GP services in Kununurra?

Dr Beltz: There are the hospital GPs, some GP obstetricians and we of course have a 24-hour ED. There is both specialities and theatre. That is the primary task for the hospital and then we do a GP service. Because of a lack of staff, the GP service is suffering most of the time.

The CHAIRMAN: Is there a GP service in the town, or does the hospital run it?

Dr Beltz: There is a private GP.

The CHAIRMAN: One?

Dr Beltz: At the moment there are two. They are flat out—fully booked. The community would like to have a GP service run next to the hospital. We want to provide it but of course at the moment we are limited in what we can provide because the core business of the hospital takes priority. A lot of people come to the hospital who could have been seen by GPs.

Mr Williams: OVAHS has GPs?

Dr Beltz. OVAHS has Aboriginal GP services. The number they have is a bit erratic, but at the moment they have three GPs with a registrar. They have a vision of four permanent GP doctors but it is not always there and there is a lot of turnover.

Mr I.C. BLAYNEY: Do they take non-Aboriginal patients?

Dr Beltz: Yes, they take anybody who comes in.

Mr I.C. BLAYNEY: I assume that they bulk-bill.

Dr Beltz: Yes.

Ms Winsor: We just finished an east Kimberley integrated primary health care plan. I think the final changes were made to it today, so it is now finished. When I send my transcript to you I will attach that.

The CHAIRMAN: Thank you; we will accept that.

Ms Winsor: That talks about GP services and the demand for GPs. Kununurra can easily cope with another GP and would still be very busy. We are looking at the model of GP services to go into the new big facility that is being built under the east Kimberley project—the integrated primary health care facility. We will see how we can support private general practice to go in there. That is a work in progress. The plan has just been finished; I just have to send it off to the area before it can be endorsed. It is a nice piece of work.

The CHAIRMAN: I thank you all 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 these corrections and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points, please include a

supplementary submission for the committee's consideration when you return your corrected transcript. Thank you all again for coming in today.

Hearing concluded at 4.12 pm