



AHCWA 2011 STATE SECTOR CONFERENCE REPORT

FROM THE RENDEZVOUS HOTEL WITH
FACILITATOR ERNIE DINGO

12 & 13 APRIL 2011

The Aboriginal Community Controlled Health Service Sector's State Annual Conference for 2011 was held over two days again this year and this is a detailed report on all the scheduled events on the program. It captures the discussions from the floor after presenter sessions and presents the main messages from each Conference Day.

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INTRODUCTION TO OUR 2011 STATE SECTOR CONFERENCE REPORT

The AHCWA team was privileged to be the organisers once again for our annual State Sector Conference which was held at the Rendezvous Hotel on Scarborough Beach, Perth on the 12 & 13 April.

The program for the two day event covered as many current items as possible. It was pleasing to have the Hon Ken Wyatt address us as one of our excellent keynote speakers in the first session on Day One. The Director General of the WA Department of Health Kim Snowball also addressed the Conference in the opening Keynote Address session along with two of our own senior leaders Vicki O'Donnell and Glenda Humes.

We were also extremely pleased to have the Hon Helen Morton in her new capacity as Minister for Mental Health along with Mr Eddie Bartnik who heads up the Mental Health Commission.

Both Ken and Helen have a long association with our sector and our annual state conferences and it was great to host them this year in their new roles in the Australian and Western Australian Parliaments. It was the first time that Helen Morton has addressed our State Sector Conference since her recent appointment as the state Minister for Mental Health.

The Hon Warren Snowden was a key speaker on Day Two of the Conference.

This year's Conference showcased the value of the event for getting so many leaders from our sector into a setting where they can hear from and interact with elected officials, senior public servants and other influential and knowledgeable people.

One of the main messages from the Conference was the quality and strength of the leadership and expertise from within our own sector. It was resolved that next year's Conference program would create even more opportunities for our own leaders and experts to present, to participate and to stimulate important debates.

This year's Conference was facilitated by Ernie Dingo and the organisation and support effort leading up to and throughout the event was provided by the AHCWA work team. Their dedicated efforts were acknowledged by Chairman Vicki O'Donnell.

The Aboriginal Community Controlled Health Organisation sector in Western Australia acknowledge and appreciate the financial support made available OATSIH and OXFAM which makes this important annual event possible.

ABOUT THIS REPORT

This report follows the Conference program. There were sixteen speakers on the Day One program and sixteen on Day Two. Many of the speakers used extensive power point presentations which contained a great deal of statistical information in graphs and charts.

In order to keep this report to a manageable size, not all of the power point material has been included. For many of the reports where the speaker used power point slides simply to summarise points in text form the most salient information has already been incorporated into this report mostly in arrow point or list/summary form and with minimal editing.

Where a particular speaker had a power point presentation containing statistical/graphic material not integrated into this report, this is noted at the commencement of those summary reports.

Readers interested in viewing any of the speaker's power point presentations can access these by going to the AHCWA website (ahcwa.org.au) and click on the 'Conference Presentations' link.

Most of the speaker presentations were followed by a session enabling the participants to engage directly with the speakers. Notes recorded from these sessions are transcribed in this report with minimal editing at the end of each session. If there are no participant discussion notes at the end of a session, this is because there were no comments or questions raised by participants at the conclusion of that particular presentation session.

CONFERENCE DAY ONE

MORNING SESSION

The Conference Facilitator Ernie Dingo welcomed the participants and introduced the Welcome to Country presenters Ms Marie Taylor and the Balga High School Aboriginal Dancers.

WELCOME TO COUNTRY

Marie is an Elder Nyoongar woman.

In her address to the Conference, she shared an old dreamtime story about when the sky was so close to the earth and there was no room for the people. The light was shut out so there was only limitation and darkness. The people had to find their way and collect their food without being able to see so everything was done with their hands working in the dark. There was no light and no warmth.

The magpie Kulbardi decided they needed to try and raise the sky to make more room. So the people worked together and lifted the sky to make room. And as they all lifted the sky upward to make room, it split open, showing the first sunlight and making the magpies sing because of the light.

The darkness broke into fragments and drifted away as clouds. Ever since that time, magpies have been singing to greet the sun as it rises in the mornings.

Then Marie spoke in Language for the welcome. She translated this to mean that:

“The custodians of the land greet you and welcome you here to this South West land. This is the Cockatoo dreaming land and the people who went before us lived on this land, camped on it and walked all over this ground. Today we share our land with you and we welcome strangers from everywhere in the world to this place of ours.”

In Language again, Marie asked the bad spirits to leave and the good ones to come. She explained that in leaving a bunch of gum leaves behind her, the meaning is that she has ‘not come in anger today, but to make you welcome and safe.

Marie closed with the moving words:

“Until we meet again, when clouds billow on our country and in the words of our beautiful song:

***We are one and we are many
And from all the lands on earth we come
We share a dream and sing with one voice
I am
You are
We are Australian”.***

To the sound of a lone Didgeridoo, the talented young Aboriginal people moved around the tables telling their stories about bush animals in the most time honoured way.....through music and dance.

KEYNOTE SPEAKER SESSION

The Hon Ken Wyatt, AM, MP – Member for Hasluck. Speaking about the impact of National Health Reform on the Aboriginal Community Controlled Health Organisation sector, strategic approaches and opportunities.

Mr Wyatt acknowledged Marie's presentation and all those who came before and will come in future. He kicked off by noting the great topic for his talk.

He shared with participants that as he was preparing his thoughts for this address, what came to mind was from so many years ago. He recalled back to when the "*grandmother of the Aboriginal Medical Service movement*" in Redfern NSW was first established. And that made him remember a little known secret - that Derbarl Yerrigan had been shaping up as an AMS a long time before that right here in WA.

Ken reflected on the AMS development journey over more than thirty years and acknowledged the progress and difference the sector has been able to make. He said the main message is that reform processes leading to innovation must be based on strong and reflective study of things that have worked superbly well.

Aboriginal Medical Services have been forming and shaping so they influence community health and extend outcomes through strong advocacy, influencing policy decision making and providing services which people are have a lot of confidence in and therefore feel safe in using them.

Ken described the AMS movement as being:

"born three decades ago, but a bit like a child who is still growing to reach its full potential. The sector is still adding more layers, depth, expansion, expertise and leadership through the workforce, influencing choices and forging important linkages. And there is still so much more left to do."

Ken commented on his view that health legislation in the Parliament recently demonstrated areas where there is still much more to do. He said it points to areas where we are successful and also to the things which still need to be put in place where more support and resourcing are required.

New equipment and technologies should be extended so even remote Aboriginal people can enjoy the benefits they bring. This is a big challenge, but a necessary next step.

Another challenge he noted is in the area of human resources. New and different skills are needed and the ageing of the workforce across Australia is a big issue. On this issue, Ken noted that for the Aboriginal population, the greatest asset is Aboriginal youth who are still growing and being developed.

Just prior to attending the Conference Ken shared with participants that he had just had a somewhat surreal experience at an early morning function with "*40 WA captains of industry – talking about workforce shortages and skills needed for the major industry players in WA.*"

This speaks of great future opportunities for Aboriginal youth to grow and be trained and nurtured into a multitude of career pathways in response to this very obvious need coming from big industry in the country.

There is so much growth in the global economy as countries with huge populations develop strongly. Many major industry players in Health and other domains are taking on very global portfolios and Ken gave the Ramsay Health Care company as an example. Ramsay owns hospitals in several countries including Australia. They operate outside governments and have become a powerful and influential Health employer on the world stage. And they are hungry for skilled workers.

On the subject of Medicare Locals, Ken commented that some of the major players had noted to him that *“the AMS have not approached us.”*

His response has been that they need to link with ACCHS and that the sector already has well established and highly functional vehicles through which this is possible. He said he cautions that the standard industry approaches to new policy initiatives tend to overlook the social justice aspects and strategic opportunities to connect with well established operators and advocates in the Aboriginal health sector as a whole, or in the regions.

Ken stated strongly that in his view, the ACCHO sector must be positioned to be influencing future decisions and the shape the reforms ultimately take. The next two decades will, in his view, be crucial in development of reform in health opportunities.

He said that we must retain Aboriginal Health resources so we can continue to do those creative ‘outside the square’ innovations our sector has become so good at because of who you are and the way you work.

He acknowledged Kim Snowball and Nicole O’Keefe for their strong commitments to partnering, getting things to happen, connecting with the sector and making things possible.

His main message was that the influence from the ACCHO sector must be strong. He put the Aboriginal population within the wider Australian population into perspective and reflected that it was such a very small percentage that Aboriginal people could almost be ‘case managed’. On this basis, he argued that it should be that hard to make a big difference to people’s health and well being.

He encouraged participants and the ACCHOs to seize opportunities to be innovative, to push boundaries and to remain alert to the fact that:

“You are a very sizeable lobby, with a significant capacity to influence decisions and outcomes. Be pathfinders on the issues and solutions underlying the determinants of health for Aboriginal people. You are well placed to use your vision and to bring into effect your goals and objectives.”

In closing, Ken advised that people had said to him prior to the last Federal election that as a State, WA was not ready for an Aboriginal person to be in a Federal Parliamentary seat. But in spite of this outlook, he said that he knew what had to be done. He had a clear vision and worked with his support workers right through the campaign and was encouraged because he knew in his heart that he is part of a forty thousand year old living culture.

He said that what made him so proud after reaching the goal of being elected to represent his electorate was how it was such a good thing to be standing as an equal amongst other politicians in the House when he first entered the Parliament.

He wished participants well in their endeavours and gave his commitment to advocate for the things Aboriginal people need as the oldest living nation to improve outcomes for health and well being and to make sure we can all grasp the opportunities for the coming decade in particular.

He encouraged people that when they reflect back ten years from now, they must know that *“we achieved some big things.”* One particular outcome he said he would be hoping for would be that there will be many more Aboriginal CEOs, professionals and politicians in and outside of government in major positions of leadership and influence. He personally would like to see an Aboriginal Director General of the WA Department of Health based 100% on competitive merit as one of those key achievements.

Ms Vicki O’Donnell, AHCWA Chairman, CEO Derby Aboriginal Health Service, CEO Jurrugk Aboriginal Health Service. Responding on behalf of the Aboriginal Community Controlled Health Organisation sector.

Vicki acknowledged the Nyoongar people and called for one minute of silence to acknowledge the wonderful people who have been before us and remember those who were dear to us that we have lost recently.

Vicki reflected back on the time when the COAG reforms and funding were going to be rolled out across Australia. As a major health sector in WA, we decided that this time we weren’t just going to let the money sit in the middle so all the various health organisations could compete and fight over it. Instead, we decided to be leaders and to take a different approach through working as partners with the government and other non government service providers and agencies.

Considering what has been achieved because of that decision, Vicki said that our sector in WA is entitled to feel very proud. WA has been the only state in Australia to not only adopt this approach, but to actually make it work. Because of the commitment and effort from all of the major stakeholders, there was none of the typical outcomes we had been used to seeing in the past. Vicki recalled times when everyone spent their time *“fighting over a dollar, ending up with two cents each and nobody ever getting enough to achieve anything lasting out of it.”*

Vicki expressed her congratulations to all who were involved in this real breakthrough here in our state. She said it had been the first time she can recall where Aboriginal leaders were given the opportunity to participate as equals and at all levels with Commonwealth and the state health departments.

“Finally, some clear footprints have been laid down and now there are very well trodden pathways forged during the journey together as the community controlled and government health sectors”.

Looking out to the future, Vicki said her sights were on:

- How the Office of Aboriginal Health (within the WA Department of Health) develops under its new leadership and how our sector can continue to partner with them;

- Justice system priority issues and our need to influence this area of government policy decision making; and
- Other areas of state government policy such as housing and Aboriginal Affairs.

In response to the Hon Ken Wyatt's reference to the ACCHO sector being thirty years into its developmental journey yet still growing to its full potential, Vicki noted that:

“We helped this baby grow and we are going to nurture it over the next few years so it keeps growing up even stronger. If it means we have to drive things hard, ruffle some feathers and make changes so people think outside the square, then so be it.”

She made a special acknowledgement to each of the many Aboriginal Community Controlled Health Services who are members which AHCWA service. They are right across the state and many of them operate in very remote community settings.

As one of the biggest providers of services and employment for Aboriginal people in the health domain we look forward to further opportunities to work in collaboration with the Commonwealth and the State as partners. Our shared goals are for equal health status for Aboriginal people and the development of the workforce and health servicing capacity are the goals that bring us together.

Ms Glenda Humes, Deputy Chair NACCHO. Speaking on the national position and approach to the Medicare Locals and the health reform agenda.

Glenda acknowledged the welcome to country and the traditional owners of the land and conveyed greetings from the people from the western districts of Victoria where she came from before she came to WA.

NACCHO represents s 152 Aboriginal Community Controlled Health Services across the whole of Australia. It is an independent health authority working with and as advocates for the state Affiliates and Members to represent a national position on issues of concern to our sector and to build a health future for our people.

NACCHO also has a lead role in monitoring and evaluation of policies and programs for Aboriginal health improvement.

Glenda said that she intended to talk about what she believes is the 'missing piece' in our efforts to reform the way we advance our people's health. She also said that she intended to share NACCHO's views on the primary health care reforms and Medicare Locals.

Glenda presented an update of the NACCHO work agenda which is summarised below:

Better access to medicines – The Section 100 program for remote communities has made a huge difference. NACCHO is currently involved in a review of the support allowance;

The QUMAX program (Quality Use of Medicines Maximised in Aboriginal Communities) in regional and urban communities has made similar advances. This is a program NACCHO administers jointly with the

Pharmacy Guild. A recent independent review of the QUMAX has been completed and is due to be released in the very near future. The initiative looks set to receive a glowing endorsement. The services which use QUMAX know that there is a massive workload involved in transitioning to the latest QUMAX model with new work plans being submitted and reviewed as part of the new pharmacy agreement and the practice incentives payments scheme;

A sophisticated communications network developed by NACCHO to support QUMAX reporting is being rolled out. This NACCHO Communications Network (NCN) offers huge benefits to a range of program areas across services for easy communication, access to common documents and retention of the corporate history of many key projects. The accreditation project officers are the most advanced in their use of the NCN;

Developing national key performance indicators for the sector with input from Members, Affiliates, the Public Health Medical Officers network and OATSIH. These indicators will function as a quality assurance and improvement mechanism for services;

Workforce - the rollout of many positions through the COAG reforms, new training initiatives and award modernisation;

Facilitated the formation of the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA). This is an important step leading to the national registration and recognition of Aboriginal Health Workers as professionals leading the way in 'Closing the Gap' initiatives;

Aboriginal Health Workers specialising in Ear Health have had training organised by NACCHO in March and last October in 2010. These were part of the rollout of new ear health diagnostic equipment to services and new training aids;

Developing a national cultural safety training database of accredited courses. It will allow our services and outside agencies to find the nearest suitable cultural safety training in their area;

Updated male health policy was endorsed at the last AGM and a national committee is being formed to take this area forward;

Active in the area of reproductive health, sexually transmitted infections and alcohol and other drugs with a special focus on ensuring we develop and support the workforce in these areas;

Currently coordinating the massive task of updating NACCHO's national guide to a preventative health assessment in Aboriginal and Torres Strait Islander people. This is in conjunction with the Royal Australian College of GPs. It is available to all services and GPs online with the updated version to be available next year;

Actively engaged in appraising the OATSIH web based reporting tools for services involved in the Healthy for Life program and establishing appropriate business rules.

There are also some particular initiatives NACCHO are involved in so they are fine tuned and properly developed for the Members and Affiliates. These are:

- Practice Nurse incentives;
- Good Medicines Better Health program;
- eHealth Records;
- Telehealth MBS payments for online consultations;
- New draft Cardio Vascular Guidelines;
- Recommendations for the special PBS drugs list for Aboriginal peoples.

In the research arena, NACCHO is a partner with the Kirby Institute (formerly NCHECR) looking into sexually transmitted and blood borne viral infections.

On the subject of Medicare Locals, these were announced last May (2010) as part of the Federal Government's Budget. The policy grew out of the primary health care reforms recommended by the Rudd Government's National Health and Hospital Reform Commission initiative.

It seems like a long time ago that Mr Rudd's catch cry was to '*stop the blame game*' in health policy in Australia. There was to be an end to the confusing divisions of responsibility in health between federal and state governments.

The Reform Commission said the Federal government should be responsible to finance the entire public health system in Australia and take over the functions the states and territories currently have responsibility for and control over. With a transition to the Commonwealth taking full responsibility for funding primary health care, we do not know what will happen to the state funding arrangements and the associated services and care models.

The new local coordinating mechanisms for this change were to be 'primary health care organisations' which have since been named as Medicare Locals.

It was obvious to our sector when the government announced the Medicare Locals plan that there was no concept of how Aboriginal health and the Aboriginal Community Controlled Health Organisation sector might fit in with the new structure.

Our sector has always emphasized building services from local communities, local structures and local solutions in primary health care.

The government based the super clinics on our sector's model of comprehensive primary health care.

We can also say that we always knew the importance of local knowledge. Our sector's services serve communities with different needs and dynamics, so each has its own local solutions to the primary health care reform agenda and the Medicare Local model best suited for particular communities.

With Western Australia staying out of national reform developments last year due to the standoff over GST revenues, it made responding to the challenge of the Medicare Locals model even more difficult for us in this state.

At the national level last year, NACCHO convened a meeting with Affiliates to establish basic principles for our relationship to the Medicare Locals.

These included that:

- NACCHO representation on the committee overseeing the implementation of the mainstream Medicare Locals is essential to ensure our sector's interests are respected;
- We have the option, according to locally determined needs, of establishing specific Aboriginal primary health care organisations in urban, regional and remote areas;
- Their responsibilities might include regional planning and development, quality improvement, regulation and compliance, performance management and identification of areas of 'market failure and addressing service gaps;
- That all levels of our sector will work to strengthen networks and relationships so we are actively engaged in the health reform process.

Our influence on the transition arrangements to Medicare Locals has had some spinoffs.

As part of the 'intention to apply' process for organisations wanting to become a Medicare Local, the support of our services has to be sought.

Each of NACCHO's state Affiliates is determining their own approach to their involvement in the establishment of Medicare Locals according to their needs.

By way of an example, the Queensland Aboriginal and Island Health Council (or QAIHC) has a statewide approach as to where Medicare Local applicants are expected to align with a set of principles. This includes:

- Adherence to the principles of Aboriginal Community Controlled Health Services models;
- QAIHC as the lead agency negotiating on the sector's behalf with applicants;
- Representation of QAIHC members on the Medicare Locals governance board;
- Development of performance indicators and accountability measures to be negotiated with QAIHC member services.

This is one part of QAIHC's strategy to establish new regional primary health care organisations along the lines of its Institute for Urban Indigenous Health in South East Queensland.

The sector needs to be involved in the Medicare Locals process and vigilant to ensure that applicants respect the interests of our communities.

Mr Kim Snowball, Director General, WA Department of Health. Speaking on "Making health for Aboriginal people everyone's business".

Kim acknowledged the welcome to country and the sector. He expressed his appreciation for the privilege and opportunity to be a keynote speaker at this year's State Sector Conference.

Kim introduced his talk about the commitments he has asked the Department of Health to make to Aboriginal health. He noted that the job of the Director General is very a tough one, but in spite of this he has made the commitment to also improving Aboriginal health whilst he is in the job.

He said he wants the ACCHO sector to partner with the Department of Health strongly. He acknowledged that they (the Department) don't always get it right and offered that he is up for hearing about what we don't do well so he can try to bring about improvements.

He showed a slide with a graph on life expectancy for Aboriginal and non Aboriginal people which demonstrated what the 'Close the Gap' agenda is all about – life expectancy and quality of life. He said that he believed there are some good signs with some trends moving in the right direction for Aboriginal infants. But he also said that there is so much more to do to get the health status for all Aboriginal people onto an equal level with other Australians.

Kim said he believes that the data prove that we are all doing some things right. But he also said we must keep monitoring progress and above all we must be prepared to change and do things differently to keep getting better results.

Kim reconfirmed his and the WA Department of Health's Commitment to Aboriginal health improvement and offered that:

- Aboriginal Health is now fully integrated in WA health strategic intentions framework;
- The Office of Aboriginal Health is undergoing a re-building program;
- The Department will be strengthening partnerships with the ACCHO sector;
- They are committed to building a strong Aboriginal workforce across the Department;
- The Department will develop its learning about Aboriginal culture;
- Implementing COAG is a priority; and
- Reporting and monitoring systems are a high priority.

In terms of the rebuilding of the Office of Aboriginal Health, new Director Jenni Collard's performance agreement is to develop the new agenda, new direction and strength.

Kim noted that the WA Premier won't sign up to policy initiatives which affect the health of Aboriginal people unless Minister Kim Hames and the he as the Department's Director General are satisfied that the health interests of Aboriginal people will be well served. He said that he would be looking to the ACCHO sector for counsel on what is best for Aboriginal health interests.

He said that there will be times when we must be prepared to stand together and push back and say:

"This is what will work for WA and this in the way we intend to do it."

On the issue of partnerships, Kim shared his own view that one of the great strengths is that there is some forgiveness, some room to help each other to keep trying to be better to get it right.

He has performance agreements with all of the Departmental executives and they are each tasked to take a personal leadership role in improving Aboriginal employment outcomes.

In reference to the nine Aboriginal health plans, Kim showed an information slide which outlined that:

- The Planning Forums are the gatekeepers for regional services and programs and said that these are the most important connecting device we have together;
- Over 160 service proposals were received for COAG reform initiatives;
- There is a budget of \$145.8 million and 227 positions have been funded in the health sector for COAG services to Aboriginal people;
- Around 180 positions are dedicated to serving Aboriginal people; and
- Initiatives like the Aboriginal Liaison Officer Program have established 42 new funded positions.

In summary Kim finished his keynote address by reiterating that:

- The WA Department of Health will keep working with Aboriginal Community Controlled Health Services;
- They will re-build a strong and re-focused Office of Aboriginal Health;
- Major national and state health reforms are underway;
- Local solutions for local issues are the best way to go;
- His department is committed to partnership arrangements with the sector; and
- There must be shared roles and responsibilities.

In closing Kim acknowledged the Hon Ken Wyatt's contributions and achievements in pulling together a strongly representative Western Australian position in the new Parliament and that he also shared the view that it is not fair and not reasonable to leave Aboriginal health outcomes to Aboriginal people alone.

He said:

"We must work together with you."

Participant Discussions/Questions:

A participant from the Heart Foundation sought affirmation that other NGOs working in the Aboriginal health arena would be recognised as part of the broader health sector as well.

A participant from the Broome Regional Aboriginal Medical Service posed a question about sitting fees for ACCHS board members using OATSIH core funding. Nicole O'Keefe, State Manager Department of Health and Ageing/OATSIH responded that sitting fees for board members are not encompassed within the funding agreements at the present time. She also offered that there is a plan for wider consultation on the issue and that there will be an opportunity for this to be discussed in context with new funding agreements.

Another participant expressed the view that in terms of the Medicare Locals initiative, the "horse had bolted" and that she believes that anything to do with Aboriginal health should be influenced from within the sector. In her view, it must be recognised officially that the ACCHO sector is the major delivery mechanism and is the best in terms of the right cultural approach.

She lamented that the mainstream is still have the controlling influence over Aboriginal health and that policy is still coming from the 'white man'. She said they should not be happy about prison health, or maternal and child health. She is of the view that the biggest factor causing the health gap is a white organisation trying to control Aboriginal health programs. She challenged that:

“If you are both dinkum – and you have said some good words – lets consolidate our position on Aboriginal health and write it into legislation. If this doesn’t happen, we will continue to be ‘a program’ and we should be fundamentally much more than that”.

The Hon Ken Wyatt responded:

- No government has legislated any mandatory solution about Aboriginal health in legislation in the history of Australia;
- We must read policy documents and analyse them – engage with the key players, negotiate, advocate and influence;
- There is no scope for legislating mandatory measures like employee quotas – this is not an approach any government would seriously consider;
- We must keep learning more about health policy and taking opportunities to leverage our position.

Kim Snowball responded:

- Whether or not you are a fan of Medicare Locals you can’t fight it;
- What we can do is partner strongly to make sure it rolls out how we want and need it to in WA.

There was a response from the floor to the question from the Heart Foundation about general NGO participation in Aboriginal health funding initiatives. The position was summarised as follows:

- The concept behind the Regional Aboriginal Health Planning Forum movement allows for this. It doesn’t matter what organisation you are. The model brings everyone together who provides services for Aboriginal people, so get involved at this level because this is where the decisions are being made; and
- The ACCHS are driving the Forums and we must make sure all organisations get linked in so they can be part of it.

Another response to the remarks about the Medicare Local issue is summarised below:

- The ACCHO sector sent a letter to Minister Nicola Roxon clearly stating that we as a sector do not support the initiative the way it is going;
- The Barnett government has not signed the National Funding Agreement;
- There has been no consultation or opportunities for proper discussions. So we are not supporting any Medicare Local in WA;
- We have then had the Assistant Secretary from the Department of Health and Ageing in Canberra making some statements and this has created an opportunity for our sector to discuss our position together on Thursday in the second session of our Sector Planning Day with the DoHA;
- On Friday, we will then have the opportunity to put our position strongly forward in a session with the GP Networks and to hear directly from them as well;

- Friday will be an opportunity for good debate from and with our WA sector and to try and negotiate a way forward which we can be an equal partner in.

Chris Pickett, CEO Pilbara Health Network, Director of the WA GP Network and a member of the National Transition Advisory Committee for the new Medicare Locals. Speaking on health reform, Medicare Locals, working with ACCHS and opportunities for the ACCHO sector.

Chris began his presentation by recapping on the history leading up to the primary health care reforms and the Medicare Locals initiative in particular. In 2007 the Rudd Government's National Health Reform initiative was launched and the National Health and Hospitals Reform Commission (NHHRC) was established in February 2008. The Interim Report for public consultation was released in February 2009 and the final report, called '*A Healthier Future for All Australians*' was published in June that same year.

A National Preventative Health Strategy was developed, titled '*Australia – the Healthiest Country by 2020*' followed by discussions and agreements formed under COAG in 2010 and 2011. The National Primary Health Strategy followed and outlined four directions for change:

Key Priority Area One – Improved access to health care and reduced inequality;

Key Priority Area Two – Better management of chronic disease;

Key Priority Area Three – Increasing the focus on prevention; and

Key Priority Area Four – Improving the quality, safety, performance and accountability of primary health services.

The Federal Budget in 2010 stated that there was to be a single funder of primary health care in Australia (the Australian Government), a new National Health and Hospitals Network, Medicare Locals would be established from the existing GP Networks - completing the transition by July 2012 with the first fifteen to be operational from July 2011.

Over the past eighteen months there has been a great deal of 'argy/bargy' between the state Premiers and the Australian Government over details. WA in particular refused to sign into the reforms and their issues were not around content from a health perspective but rather disagreement about the loss of big shares of GST revenues from the state.

By February 2011, WA had agreed to participate in the reforms at a COAG meeting.

There have been extensive consultations with government about the functions of the Medicare Locals. There has been detailed work completed on boundary mapping to determine the number, size, and population coverage of the Medicare Locals.

Initial calls for Expressions of Interest went out in December 2010. Fifty eight proposals were lodged by 113 GP Networks across Australia, indicating that there were many mergers of current GP Networks envisaged.

Fully detailed proposals were then sought from the GP Networks who submitted EOIs in March 2011 and the closing date was earlier this month on 5 April. Announcement of the first fifteen Medicare Locals is expected in May this year with the commitment to commence them operating from 1 July 2011.

What problems are the National Health and Hospitals Reform Commission trying to address?

- A declining workforce;
- Increasing burden of chronic disease;
- Inequality of access to health care and outcomes;
- Divided responsibilities and inefficiencies, eg ending the 'blame game';
- A complex and hard to navigate health system; and
- A predominant focus on acute care and the hospital service model.

The primary focus of the Commission is to develop a National Health and Hospitals Network with close links to new Primary Health Care Organisations (now called Medicare Locals) built from the GP Networks.

Medicare Local Boundaries in WA

As at December 2010, there are to be six Medicare Locals in WA – four in the metropolitan area and two in the country. Here Chris expressed his personal view that local population health service models were preferable to the past history of trying to use a 'one size fits all approach'.

The specific expectations of Medicare Locals are to:

- Develop regional health plans and models of care for communities;
- Allocate funding and ensure the delivery of comprehensive health services for their populations;
- Address service gaps;
- Support the broad health workforce;
- Work with the Local Hospital Networks on patient pathways out of hospitals; and
- Support community and provider engagement.

It was also noted that in some instances the Medicare Locals will deliver programs that promote health and prevent illness through direct service provision.

In terms of opportunities under the Medicare Locals, Chris outlined the goal of a 'true population health planning approach' which would:

- Involve local communities in the planning process;
- Shift away from 'one size fits all thinking; and
- Recognise differences in access to health services, disease burden, population demographics, remoteness, infrastructure and workforce;
- Focus on 'Local Solutions to Local Problems' – more primary health care models to address health promotion and illness prevention, better coordination, less duplication and waste and involving all delivery agencies in planning and providing solutions.

Chris presented his own ideas for opportunities he could see specifically for the ACCHO sector. He outlined the following key points:

- Involvement in Medicare Local governance;
- Building on the work done through the Regional Aboriginal Health Planning Forums;
- Expansion of the ACCHO sector service model of primary health care to the broader sector;
- Better understanding at the local level of the needs and challenges facing communities;
- Working in partnership to improve health workforce development outcomes for local primary health care.

He noted that the government had directed that there was to be a skills based board for Medicare Locals as opposed to a membership made up of representatives of certain sectors and interest groups.

He acknowledged that he was personally aware that there are strong views within the ACCHO sector and he expressed his appreciation of the value of the service models and the Regional Aboriginal Health Planning Forums.

He also made the point that the current GP Networks, which are to be defunded once the new Medicare Locals are operational, deliver tens of thousands of episodes of primary health care to clients and that in many areas they are the only providers for local communities. The GP Networks are particularly concerned to ensure that this service capacity is not lost in the transition processes.

Participant Discussions/Questions:

A participant from the sector asked about where we can get very specific information about the Medicare Local model intentions.

Chris advised that some information is available from the website but the policy has been developed 'on the run'. There are big political imperatives behind the roll out and this has made it difficult to engage in consultations.

The participant asked how they proposed to mainstream culturally appropriate Aboriginal services into the model.

Chris said that there aren't any Medicare Locals in place at the moment, but it is intended that the constitution will include Aboriginal interests. Also, training and cultural security will need to be an element so Medicare Local funded services are required to comply with standards.

Sector participants stated that we don't see how a Medicare Local – a GP driven model - can hope to emulate what the ACCHS do. Sure, they can get cultural security training but that doesn't make them right for connecting with local communities in the way than our sector services do.

Chris reiterated that consultation in WA has been difficult. The window for submissions was very limited because WA has not been signed up to the reform agreement with the Australian Government.

A participant from 'GPs Down South' asked for clarification about the concerns that Medicare Locals would have a GP focus and asked "what are your views"?

A sector participant responded by saying that the sector is focused around collaborative working arrangements with other health providers. The Regional Aboriginal Health Planning Forum mechanism works really well. You can get some focus on best outcomes and shared agreements for roles and responsibilities, service models and funding distribution.

Sector participants also offered to Chris that you can ensure Aboriginal participation will be part of the deal. But nothing in the package refers to Aboriginal people or services. AHCWA and individual ACCHS have written and received no reply. There has been no engagement at all – we can't just sit back and take the word of governments and other individuals no matter how genuine they intend to be. How can you make any assertions when the people owning and driving the Medicare Local model have said nothing?

Chris responded to this by saying that he was not the Commonwealth. He couldn't speak for them and that these are the sorts of questions they need to put directly to them. He offered that in his own personal view that it was plain to see that the Aboriginal health sector is crucial and that any decisions about the way it will work in WA must to be based on evidence of engagement with as well as agreement from the sector. He said for example that there could be an Aboriginal person on the board and an Aboriginal health subcommittee built into the governance model, although he reiterated that as he understood it, board membership was not supposed to be about representing and lobbying for sectors.

Sector participants put the view that we operate a social model for health. We are concerned that Medicare Locals will be based on a disease model. What are your comments on this?

Chris said he was aware that GPs are always accused of being too much focused on a disease model and he thought this was a fair enough criticism in past. But he also said that this is changing now. He said Medicare Locals will work in partnership with ACCHS to ensure the social model of health continues to develop and that the determinants of health are also addressed through the strategies and decisions taken.

Sector participants said that we need to understand what the governance model looks like. Our sector needs to influence things like who is on the board and how governance will work and this is going to be the subject of robust discussions on Friday.

Another concern was expressed from the sector, that community services are not well staffed and often don't cater for the needs. So the question was posed as to where are the GPs to service these remote communities need and how would these be assured through the Medicare Local model.

Chris offered here that maybe things in this respect will get a bit better under this new Medicare Local policy. Perhaps there will be ways to better reach people in need and to increase services and opportunities. But he also said that this point is really talking about whether or not there is enough primary health care funding made available to the Medicare Locals. That is in fact a government decision regardless of the Medicare Local or any other model for that matter. The Medicare Locals will not be the vehicles for independently deciding what level of overall government investment will be in place for primary health care. He said it was his understanding that the new model is intended to be a more effective vehicle for getting whatever funds the Australian Government wants to put into primary health care allocated and services planned and delivered in an integrated way.

More clarification about this point was sought from participants.

Chris expanded on this issue as best he could, and said he understood Medicare Locals will be the vehicle through which the Australian Government will distribute primary health care funding for its various policies and programs. He gave the example of new flexible care packages. In future the funds across Australia will be distributed through the network of Medicare Locals. So in effect, it won't be the Medicare Locals taking over the decision making about flexible care package programs and funding. Rather, they will be responsible to allocate those funds within the areas they work for and will need to ensure the needs are understood, that there are local plans in place and that there are well coordinated service models in place.

The view was stated by a sector participant that funding for Aboriginal health could be 'open slather' under the Medicare Local arrangements.

Here again Chris referred back to his own views on the opportunities he envisaged would be available for the ACCHO sector as part of these reforms.

Professor Gavin Mooney. Speaking about Medicare Locals and the National Funding Formula.

Professor Mooney started off his address by pointing out that there is no National Funding Formula.

With respect to the Medicare Locals model, he said he believed that we have a good opportunity to improve primary health care and specifically Aboriginal health in this country which is very exciting.

He said that we know the broader determinants of health are so important but it is unfortunate that the Medicare Local model isn't going to deal specifically with that. He was clear that his own views are in contrast with those expressed through Chris Pickett's presentation. He specifically intended to focus on the funding formula issues because they are so important in his opinion.

He also flagged his intention to talk about institutional racism.

He referred to a poem which was in his power point slides, which he wrote as an 'Ode to Medicare Locals':

*Medicare Locals are creating big Divisions
We long for some unifying and healing decisions
Where are the social determinants of health?
(They appear to be secret – to be processed by stealth?)*

*GPs seemingly are to hold all the power;
(The others excluded must really be sour!)
The community controlled sector? Missing from here
Oops.....forgotten..... (Why can't black fellas just disappear?)*

*We need radical thinking, leaders charismatic
Revolutionary strategies, truly dramatic!
Bold, inspiring, healthful new visions
Else, what do we get? Just bigger Divisions.*

Professor Mooney declared that his main focus is to discover on what basis/criteria primary health care funding will be determined to be distributed through the Medicare Locals.

In terms of 'What We Do Know', Professor Mooney outlined that there is:

- \$477 million over 4 years to establish the Medicare Locals;
- A total of \$171 million per year of core funding;
- Distribution of funding between the Medicare Locals will use a national funding formula based upon rurality, socio economic and ATSI status.

The GP Divisions Formula:

Is largely population based, is weighted for socio economic, rural/remoteness and Aboriginality factors. It has a weighting for Aboriginality of 2.9.

The Medicare Local Formula:

The Australian GP Network advised that Access Economics were engaged to advise on the formula. Professor Mooney shared that his main concern with this is that Access Economics *"have a tendency to provide the outcome their client wants"*. This is a worry in his opinion.

He then made specific references to Minister Roxon's speech at the Australian GP Network National Forum held in Perth on 4 November 2010. He quoted several sections of her speech and the following are transcribed directly from his power point slides:

"Different parts of Australia have different populations, health needs and health services, and it will be important for the funding to individual Medicare Locals to take this into account."

"My Department is engaging professional economic consultants to develop a funding formula that will enable funding for Medicare Locals to be fairly distributed, taking into account the needs of different parts of Australia."

*"The consultants will consider whether and how factors such as population, socio-economic status, rurality and indigenous-status should be taken into account in distributing funding **fairly**."*

*"Once the consultants have completed their analysis, the **Government will consult with the AGPN before finalising the funding formula.**"*

Professor Mooney shared that he was left wondering what Minister Roxon meant when she said *"fairly"*. He also referred to the aspect of the Minister consulting with the AGPN before finalising the funding formula was *"the crunch"* in his own view.

In his view, a big problem with funding formula development is that they don't recognise the actual cost, or benefits of culturally secure primary health care. One study undertaken by colleagues at Curtin University demonstrated that cultural security alone bought with it at least a 50% cost increase for services to clients.

Another study by Mooney and Henry modeled the cost weighting for cultural security in Aboriginal health settings at a factor of 5 times and he expressed the view that this number would be even higher allowing for remoteness and for relatively higher numbers of Aboriginal people within a local population.

He then shared an outline of a conversation he had with an official from the DoHA Primary and Ambulatory Care Division in Canberra. In essence, he said he had been advised the following in summary as taken from his power point slide:

- The funding formula is still under wraps but is an urgent priority;
- It is being devised by financial experts;
- The DoHA won't be going out to consultation on the formula;
- But the Minister might.....

The other issue Professor Mooney wished to focus on in his presentation was about institutional racism. He reported that he had written a published article on this subject in the Medical Journal of Australia and has also addressed the issue in a previous AHCWA State Sector Conference.

He advised that he has encountered institutional racism again in the work he has undertaken for AHCWA on the Medicare Local reforms. It is, in his view *"alive and well in the Department of Health and Ageing, with Minister Roxon and in the Australian GP Network."*

Professor Mooney talked about his experiences facilitating 'Citizen Juries'. These are where they get together a totally random selection of people, give them good information about health outcomes and ask them to think about and express what they see as the priority health issues for investment and effort

All ten of the Juries wanted greater equity in Australian health care and the first priority listed was Aboriginal health. This outcome is all the more astounding because the Juries have all been mostly made up of non Aboriginal people. So there is a good indication of what well informed people think are the priorities. Yet, there is this problem of racism from within governments and their institutions.

Professor Mooney concluded his address to the Conference with a statement on a power point slide entitled 'SHOCKING'. It says:

"I want to go on record to state how appalled I have been at the way in which the most disadvantaged section of the Australian population – that is Aboriginal people - and that section of the population who are most dependent on primary health care – again Aboriginal people – have been denied their rights to be heard in the biggest shake up in decades in Australian Primary Health Care".

He called upon the sector with his advice that:

- This issue of funding matters;
- They should question DoHA and the Minister 'QUICKLY' on what is happening on the formula and who is to be consulted on its contents;
- They try to get some work done on it quickly BEFORE the formula is finalised;
- This will be the best way to influence what will go in the formula; and
- They should work to get recognition of the need for funding to be allocated to cultural security.

Participant Discussion/Questions:

Discussion from sector participants declared the following concerns: If the formula is based on population, we will be at the bottom of the scale, but if it is based on health needs we will be at top. So what will it be based on? This is one of the most important issues for us to influence. It is a 'back to front approach' - Canberra to us. We need to talk so it goes back to Canberra. They should be finding out what it actually costs ACCHS to provide specific services. The sooner the government understands this, the better.

Professor Mooney responded – the probability is that an Aboriginal person walking through the door will cost a lot more to care for than a non Aboriginal person. We must bring decision makers back constantly to what we all are trying to achieve: closing the health status gap. A fair and decent deal is essential and it dictates the funding should enable the necessary care to be provided for them.

From Derby AHS – our message is that we Kimberley mob need more action to be taken quickly. Could Nicole O'Keefe approach Andrew Tongue's office and ask him what can be done for us through the funding formula. I would like this question to be put to Nicole O'Keefe.

The Tripartite Forum meeting is in June and the theme is Health. We would like to ask Nicole to give an answer to the previous question so it is on the agenda and goes to Canberra.

Chris Pickett offered that the funding formula process has been a concern to GP Divisions for many years. It has never really been understood and there is no doubt in anyone's mind that remote people are disadvantaged. But he also noted that what is being talked about is really a small part of what the Medicare Local policy is about. The funding being discussed is core funding for Medicare Local operations across Australia. It is not in fact the funding for services and programs. It is important to get the core funding right but it is only really the organisation administration overhead. The real effort is to ensure we get access to the bigger primary health care bucket of funding.

Professor Mooney responded by saying "yes and no." He also said:

- *"I think we will see a precedent of what will happen - funding wise - from there on. What we have seen in term of GP services and Aboriginal health is most inequitable. For example, if GP s receive a 'tick in the box' for doing some cultural security training they get extra payments. But in fact it only requires one GP to line up and undergo a training session. We need to address this sort of nonsense.*
- *I spoke to AGPN and told them they were racist. I know there are some fabulous GPs, but the institution has essentially ignored Aboriginal people and equity.*
- *The statement by Minister Roxon is completely ignoring the Aboriginal voice and equity interests.*
- *We will not have another chance in the next few decades to inform good reform in primary health care. If we all get it wrong it will take decades to fix. What we get may destroy Aboriginal health services. It is a real threat".*

The question was posed about the Medicare Local policy being based on a model used in the United Kingdom.

Professor Mooney stated that he did not see a parallel between primary health care for Aboriginal people in Australia with the UK situation and that the systems are very different.

A participant commented that a speaker visiting from the UK at a recent event said that the Australian government was going down the wrong track if it was set on copying models from the UK because they had been a disaster which required government intervention to fix up.

It was noted that the UK reforms mostly involved the hospital sector and that the primary health care model was very different to the one in Australia. It was also offered that there is more alignment between the Australian health reform and models in New Zealand.

In terms of the institutional racism matter, one participant noted that Aboriginal people are not even recognised as a race in the Australian Constitution. She said “We are too placid, doing what we are told and staying in our place”.

Professor Mooney responded that he wasn't prepared for a broader constitutional discussion, but reflected back again on what has come through the many Citizen Juries he has facilitated. These results tell us that ordinary people from the community are very concerned once they are helped to get a much clearer understand of the issues. Ordinary Australians, given good information are concerned about Aboriginal health inequality, they are very compassionate and they want something done about it by our governments.

Facilitator Ernie Dingo wrapped up the session and shared a comment of his own about what memories the word ‘formula’ stirred up in his mind. He reflected that when he and his mates were school kids they were given formula in a tin which they were made to take. They hated it, but they stirred it up and swallowed it. “From what I have been listening to today, it sounds like not much has changed about ‘formula!’”

Glenda Humes, Deputy Chair NACCHO. Speaking on the National Aboriginal & Torres Strait Islander Health Authority Campaign.

Glenda outlined the developments to date for a new National Aboriginal Health Authority. Summary points from her presentation are presented below:

The work of the Authority is to be guided by the following principles:

- Equitable access to Community Controlled and comprehensive Primary Health Care for Aboriginal and Torres Strait Islander peoples that delivers better health outcomes;
- Recognition and reinforcement of a human rights based approach consistent with Australia's signed commitments to UN declarations;
- Recognition of Aboriginal Community Controlled Health Services (ACCHS) as a leading model of successful comprehensive Primary Health Care;
- Decisions are driven by evidence of effective and comprehensive Primary Health Care; and
- Recognition and reinforcement of a commitment to Reconciliation across the nation

Main functions

Policy and planning:

- To lead development of a National Aboriginal Health Policy;
- To lead development of a National Aboriginal Health Strategic Plan utilising available evidence.

Make funding recommendations to COAG based on performance outcomes; and
Accountability for expenditure and reporting to COAG.

Structure

Be administered by a skills-based board of Aboriginal & Torres Strait Islander peoples;
Be a member of the COAG Ministerial Council on Health and report directly to COAG; and
Be a Statutory Authority of the Commonwealth, to be operated as a Government Business Division.

Benefits

Delivering better health outcomes for Aboriginal peoples and closing the gap on life expectancy;
Continuity over a long period of time & successive governments;
Direct monitoring & measurement of outcomes, including targets set in the “Close the Gap” health agenda, enabling readjustment of programs and priorities;
Capitalise on the reform agenda;
Continuity of the ‘Close the Gap’ health agenda after the first round of funding is finished; and
Behavioural change in the administration of health services across the country.

Key Questions to be Addressed

Where does NACCHO fit with this proposed new structure?
What does it mean for each AMS?
What does this mean for particular States and Territories?
How do we decide who are the Board members of the Authority?
Which existing bodies or departmental units might be absorbed into the National Authority?

Engagement and Advocacy

Building support from other Aboriginal health stakeholders on the concept of the National Authority;
Building support from other mainstream health organisations;
Engaging with media, including Aboriginal media and key commentators to win endorsement;
Building endorsement of the plan with state and territory governments;
Building awareness and understanding with health bureaucracies at both state and federal levels and expanding on the concept from their input; and
Building political support at federal level across the political spectrum.

Strategies

- **National Advocacy Day: Tuesday 31st May 2011**
 - A coordinated program across the country of meetings/presentations to state and territory Premiers and Ministers as well as the Prime Minister, Opposition and the Greens/Independents.. Every Affiliate to be involved.
- **National Aboriginal & Torres Strait Islander Health Symposium: 11th & 12 August 2011**

- Bringing all key health organisations, advocates, academics and other peak bodies together to discuss the concept of a National Aboriginal Health Authority to develop a structural model of the proposed Authority; outlining divisions, tasks and processes; for formal submission to federal, state and territory governments by end of August.

Glenda concluded her presentation by reminding participants what NACCHO stands for. It is:

'A living embodiment of the aspirations of Aboriginal communities and their struggles for self-determination'.

Jenni Collard, Director, Office of Aboriginal Health (WA Department of Health). Speaking on the new direction for the Office of Aboriginal Health, its roles and responsibilities.

Jenni has been in her new role as Director for the Office of Aboriginal Health for nine weeks. She shared with participants that she has been given a very specific brief by the Director General of the Department to strengthen the Office. It is now a small operation and as such said that she has been giving a great deal of thought as to how the new look Office of Aboriginal Health can make an impact.

Jenni acknowledged the strength AHCWA and its members throughout the sector bring to the Aboriginal health domain in WA.

She made a particular point that many people think Aboriginal health is about Aboriginal Health Worker services. Her view is that the Office of Aboriginal Health needs to work with and through the entire system and she believes this aligns with the Directors Generals' own message that Aboriginal health is about making it 'everyone's business'.

Jenni said that she doesn't really see a WA Aboriginal health strategy as being separate from any other strategies or areas of government activity. Rather, the Office of Aboriginal Health will build on what everyone is doing to articulate a clear strategy which has all the major players on the one page. In effect, every strategy needs to deal with Aboriginal health and well being as needed.

She stated that she gave a great deal of thought to things which Professor Mooney addressed in his earlier talk about institutional racism. She believes this is an issue and that it falls to the Office to focus on Aboriginal health business through a cultural lens – especially in terms of policies, practices and procedures.

Jenni has a goal to get Aboriginal leaders into the senior ranks in health system and wants the Office to impact significantly on this particular objective.

In summary, the priorities she has identified in terms of the New Way Forward for the Office of Aboriginal Health are:

- Re-building Aboriginal leadership within WA Health;
- Monitoring and accountability within the WA health system;
- Building the capacity of the system;
- Seeking out national opportunities.

She has already started the process of refreshing the Office; strengthening relationships with the Aboriginal Community Controlled Health Organisation sector, the Department of Health and Ageing, other State Government agencies; and looking to build linkages across the Tasman.

The vision for the Office is firstly to work to get the bottom up/top down efforts within the WA Department of Health, the Commonwealth department and the community sector aligned.

Monitoring the system is a role for the Office of Aboriginal Health and Jenni outlined their intentions to put a 'cultural lens' on policy and practices, to bring together reporting, monitor progress on specific commitments and look to measure outcomes on gaps and trends.

Building and learning is another major focus for the Office and the targets are for a better Aboriginal workforce, cultural learning and Aboriginal leadership.

In terms of seeking out opportunities, Jenni outlined the approach is to connect with current and potential policy commitments and initiatives, to get integration of reporting for commonwealth and state commitments, keep linkages with other jurisdictions and build national alliances.

Participant Discussions/Questions:

A participant reflected that back in the old days the remote communities had services that they don't have anymore because there is no money for them. He said he wants to see more education and training for younger people and that he is also worried about old people taking medicines properly. He said they don't understand English or about taking medicine on certain days and that these problems are because they don't have the services they used to get.

Jenni acknowledged that this was a real problem and that she would do her best to influence change.

Another participant recalled that the Office of Aboriginal Health was once a funding body and that the funding responsibility had been shifted to the WA Country Health Service. He posed the question about what that shift of function means for the Office.

Jenni responded that Kim Snowball had asked her to speak to as many people as possible about the best role for the Office in the future.

The participant suggested training and workforce development was an important area needing strong leadership and action. Some ACCHS run Registered Training Organisations and have tried to find a recurrent source of funding to get business continuity. It had not been possible to get any traction as yet on this issue and he said they would like to see Office join with the sector to try and address this matter. They need a reliable and secure funding stream to keep the vitally important training effort going.

Another question put to Jenni about workforce was asking if there was an Aboriginal employment policy in place in the Department of Health and around the health system in WA. It was also stated that the public system should look to how the ACCHS achieve good Aboriginal employment levels.

In response, Jenni advised that there is a policy that Aboriginal employment targets are applied within the Department of Health.

Another question was what funding does the Office of Aboriginal Health give to ACCHS?

Jenni outlined again that the Office no longer has a funds allocation function as this has been transferred to the WA Country Health Service and that this has created the opportunity to refresh the future roles and responsibilities for the Office.

Jenni took the opportunity to acknowledge she was new to the job and that she found it difficult to address all the questions in any great detail today. However, she wanted people to understand that she was pleased to be given the opportunity to come and talk about some ideas for the Office today and that she is really keen to listen to everyone and take on board ideas and priorities for her Office to work on.

AFTERNOON SESSION

Two concurrent sessions were conducted in the afternoon session on Day One, covering Research and Workforce themes. These sessions were designed so that several speakers could give a brief overview of their area of work relevant to either topic and to engage as a group with participants in discussion.

Breakout Session One – Research

Mandy Wilson and Jocelyn Jones from Curtin University on Social and Cultural Resilience of Aboriginal Mothers in Prison (SCREAM)

The SCREAM research project is being conducted across two hubs, one in WA and one in NSW. It has been funded for four years by the NH&MRC. The project recognises that Aboriginal imprisonment in Australia is shaped by unique cultural, historical and political circumstances.

The focus is on the health and well-being of Aboriginal mothers in prison in WA and NSW.

Why Do This Project?

Australian Aboriginal women are the fastest growing group within the Australian prison population; These women suffer multiple disadvantages and face race, gender and health discrimination; and

“The number of Indigenous women in prison has increased by 343% since the 1991 Royal Commission into Aboriginal Deaths in Custody despite its principle that **‘imprisonment should be utilised only as a sanction of last resort’**” (NIDAC 2009).

And if you need any further convincing:

Female Aboriginal prisoners experience significantly higher levels of mental health issues than non-Aboriginal women and are more likely than Aboriginal males to die prematurely after release (AIC 2010);

80% of Indigenous female prisoners are mothers (Behrendt, Cunneen and Liebesman 2009); and It is estimated that 20% of Indigenous children aged between 0-16 years in NSW have experienced parental incarceration (Quilty & Butler 2006).

The aims of the study:

Involving a broad range of stakeholders throughout the research process, the study aims to find out more about:

- The health and emotional well-being of these women;
- The health services that are available and what services they access while in prison; and
- Whether the women perceive these services as appropriate for their needs.

We also aim to identify:

Attributes of culturally safe models of health care for Aboriginal women in prison; and

Pathways for the transition of culturally safe health care into the community.

How it is being done:

Prisons in NSW (Berrima, Emu Plains, Grafton and Silverwater Correctional Centres) and WA (Boronia, Bandyup, Broome, Eastern Goldfields, Greenough and Roebourne Prisons);

An audit of the prison medical notes of Aboriginal women;

Narrative data will be collected through talking with Aboriginal women in prison;

Narrative data will be collected through talking with prison health, mental health, Aboriginal liaison and other correctional personnel; and

Focus group interviews will be conducted with key stakeholders from data collected, develop a tool that seeks to encapsulate the SEWB of these women.

Why we are here today:

Our study SCREAM wants to find out how the imprisonment of Aboriginal mothers is impacting on them, their children, their families, communities and community organisations:

- To be able to do this we need to speak to the experts who know this story; and
- We recognise that those experts are the mothers, families, children, communities and your organisations.

Mandy and Jocelyn concluded their research project overview by offering that today is a first step that we are taking in the project to let you know who we are, what the project aims to do, and simply get the message out. We'd like to hear what you have to say.

If you would like to speak to us further at a later date here are our contact details:

Mandy Wilson

Jocelyn Jones

mandy.wilson@curtin.edu.au

j.jones@curtin.edu.au

9266 1625

9266 1616

Participant Discussion/Questions:

What do you have in place for young Aboriginal women in juvenile detention centers?

It is a lot harder in juvenile prisons to get into the main projects and look at issues. We will look at different options to manage this.

How do you manage the smooth transition of prisoners from Bandyup to Boronia and how it affects women with children?

Currently the project has not looked at this.

How do you manage the health and development progress of the child in prison?

This is not within the scope of the project at the current time.

What is the age group of pregnant women in prison?

18 years and onwards. We don't have an age stipulation for the project. Younger girls aged below 18 years are in juvenile prisons settings and our research doesn't encompass this group.

About the social and emotional wellbeing of mother and family: a small baby or child is not allowed into prison and fostering out the children into families could have detrimental effects on the mother and the child in the long term. What are the thoughts on this?

You have raised a very good question on this issue. We will look into that but it is not on the radar at the current time.

Paul Higginbotham, CEO Telethon Speech and Hearing on the 'Ear Bus Program'

The Telethon Speech & Hearing operates 3 mobile children's ear clinics – The EarBus: Screens at schools with significant cohorts of Indigenous children; EarBus #1 and #3 go to Primary Schools in the Metropolitan area and Ear Bus #2 covers parts of the South West (based in Bunbury); The screens are for middle ear health and some basic hearing screening.

The Program:

- Ear health screening is carried out by the EarBus team;
- GP follow up is arranged within 2 weeks;
- ENT clinics are run monthly at local hospitals; and
- Surgery is scheduled on approximately a quarterly basis.

The screeners carry out a battery of tests. These are:

- Otoscopy;
- Tympanometry;
- Audiometry (thresholds screening);
- Otoacoustic emission screening (transient evoked); and
- Behavioural observation audiometry screening.

Screening Outcomes

Students are screened and given one of three results:

- PASS – results within normal range and no further action;
- REVIEW NEXT VISIT – some results outside normal expected range, mild or temporary abnormality suspected; or
- REFER TO GP – results in both ears show concerning ear health or one ear with discharge. Perforation or foreign object suspected.

Client Management

- Students who PASS are not seen again until the next initial round of screening;
- Students for REVIEW are screened again in approximately 10 weeks when the bus returns to their school; and
- Students for REFERRAL TO GP have their results given to a Derbarl Yerrigan doctor for further investigation.

Beyond Screening – the GP Bus

- The GP Bus run by Derbarl Yerrigan Health Service (GP, nurse and Indigenous Outreach Worker);
- This Bus visits the schools towards the end of the EarBus visit to follow up on the children referred;
- GPs identify those who need ENT review/ referral; and
- Children who need surgical intervention are then prioritized for treatment.

GP Treatment

- The GPs prescribe medication where appropriate;
- Refer cases onto ENT team for review as needed;
- GPs liaise closely with the school and the AIEOs to ensure prescription medication is purchased, stored and administered for the full course of antibiotics; and
- The GP Bus is a parental option. Families who wish to access their own GP or visit their local Aboriginal Medical Service for primary care are encouraged to do so.

ENT Specialist Services

- Developed treatment protocols and management strategies – documented in the Aboriginal Ear Health Manual;
- Professor Coates is the ENT referral point for the GP Bus;
- ENT Clinics are held monthly at Swan District Hospital in Midland and Bunbury Regional Hospital in the SW;
- Swan District Hospital provides theatre facilities, anaesthetists, full audiology work up, post-operative pre-discharge care and patient handling; and
- Schools organize central transport pick up and drop off, parent information and education and continuing surveillance and supervision.

There are several project partners and these are listed below:

Variety WA
Clinical Professor Harvey Coates
Telethon Speech & Hearing Centre for Children WA – the Earbus
Derbarl Yerrigan Health Service – the GP Bus
Swan Education District
Office of Aboriginal Health
Swan District Hospital
Bunbury Education District
SWAMS
Bunbury Regional Hospital
Ngala
WA Institute for Deaf Education
Australian Hearing

Research recommendations were summarised:

1. Improve access to Maternal and Child Health Services, particularly later child health visits;
2. Offer families cost free, community-based financial counseling;
3. Improve food security and support healthy eating;
4. Support mothers in establishing and sustaining breastfeeding;
5. Offer families cost-free, community-based support to deal with stress;
6. Implement and continue initiatives to prevent family stress;
7. Provide cost-free, community-based support to give up smoking;
8. Community-based support to establish and maintain housing security;
9. Support Koori childcare centres and playgroups with access to adequate hygiene facilities and infection control;
10. Continue community-based Koori playgroups, childcare centres and health services as important sources of social support.

-Koori Kids' Ears and Health – 2006 report from VicHealth p. 13

Paul's power point presentation presented some data tables showing statistical outcomes and other project details and readers are referred to this for detail. He closed his presentation by adding:

"...changing ear health outcomes for indigenous Australians is an ambitious and difficult challenge. But by working persistently and intelligently as technical experts in partnership with indigenous communities we CAN effect real and enduring change".

Participant Discussion/Questions:

How are teachers and prison officers involved?

Some teachers are engaged in professional development on ear health within education districts. There is a program called 'Do you hear what I hear?' This is patchy and there are not enough resources. There is increasing awareness amongst school principals and it is necessary to keep persisting until message is out.

How does 'Do you hear what I hear?' work?

It worked well with Aboriginal Health Workers. They have an understanding the issues with hearing amongst young Aboriginal children and the effects on learning difficulties and behavior of children. With the School Health nurses, referrals and flyers handed out, but they are never followed up.

Aboriginal Elders have lived with the problem all of their lives.

There was not enough research back then.

Anna Leditschke and Matt Cleary from Health Workforce Australia on 'Scoping Health Worker Practice'

Anna and Matt provided information about Health Workforce Australia and what it does. In summary, it is a Commonwealth statutory authority established in January 2010 through a COAG National Partnership Agreement (NPA).

It is responsible to report to the Australian Health Ministers Conference (AHMC) and is governed by a Board of Directors. It is a national agency that operates across both the health and education sectors, across public and non-government sectors.

The aim of the project is to identify how the Aboriginal and Torres Strait Islander Health Worker workforce can be strengthened to deliver care in response to the known burden and distribution of disease in the Aboriginal and Torres Strait Islander population.

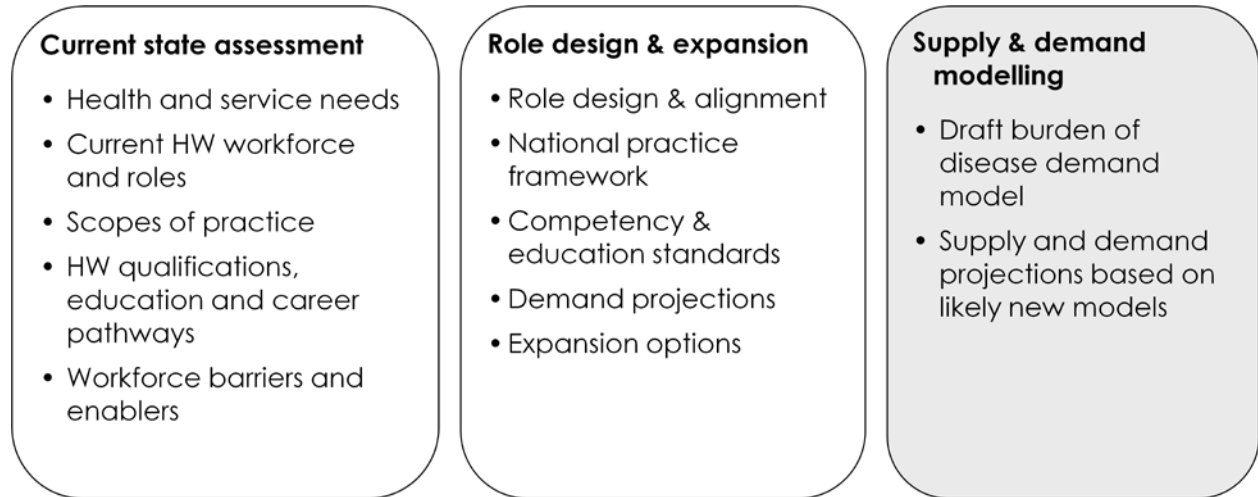
The project will develop a national picture of the Aboriginal and Torres Strait Islander Health Worker workforce including information such as location, roles, skills, qualifications and the interface between Aboriginal and Torres Strait Islander Health Workers and other sections of the health workforce.

It is to be used to provide a national understanding of Health Worker roles and scope of practice, inform the development of national standards and improve the range of career pathways and interactions with other health professionals.

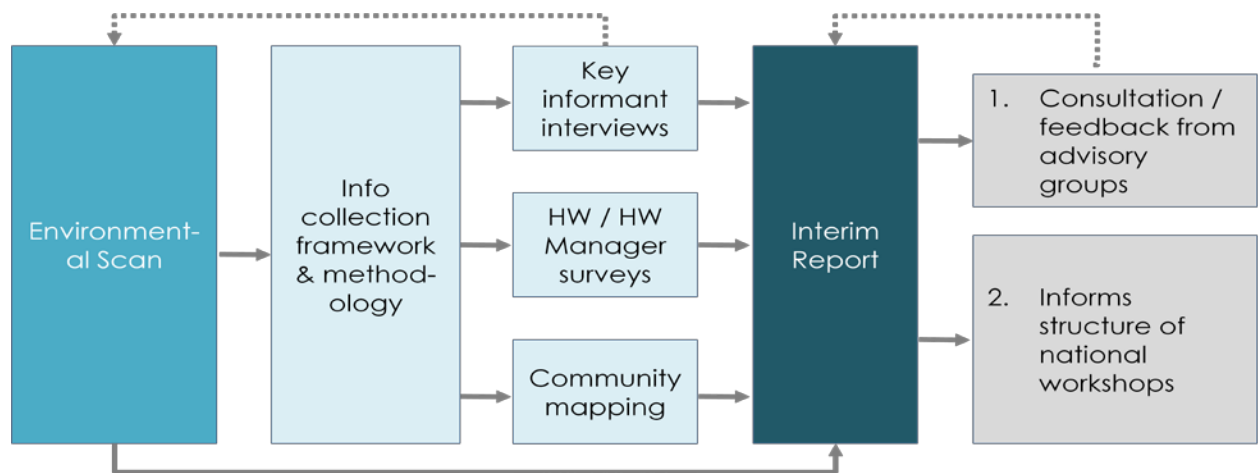
Relationship to the National Registration and Accreditation Scheme

- The Project will gather a body of evidence and provide key information for consideration to inform the developmental work of the National Registration and Accreditation Scheme (NRAS) in the lead up to the registration of appropriately qualified *Aboriginal and Torres Strait Islander Health Practitioners* on 1 July 2012; and
-
- All decisions on NRAS will be made by the Health Ministers and the Registration Board.

There are three phases of the project, outlined in the slide below.



Phase One Methodology



We have spoken to thirteen mainstream and ACCHO sector services in Perth and the regions.

The Interim Report provides:

- Analysis of the data and information gathered throughout Phase One from
 - surveys (quantitative)
 - consultation (qualitative)
- Provides us with
 - baseline workforce information
 - Possible opportunities for action

The existing Aboriginal Health Worker workforce is estimated to include between 1007 (Australian Bureau of Statistics, 2006b) and 1600 (ATSIHWGG 2009) Health Workers.

- 17% of the Aboriginal and Torres Strait Islander health workforce are Health Workers;
- 48% of Health Workers in remote areas service 24% of the Aboriginal and Torres Strait Islander population;
- The average weekly income ranging from \$363/week to \$900/week; and
- Only about 30% of the Health Worker workforce is male.

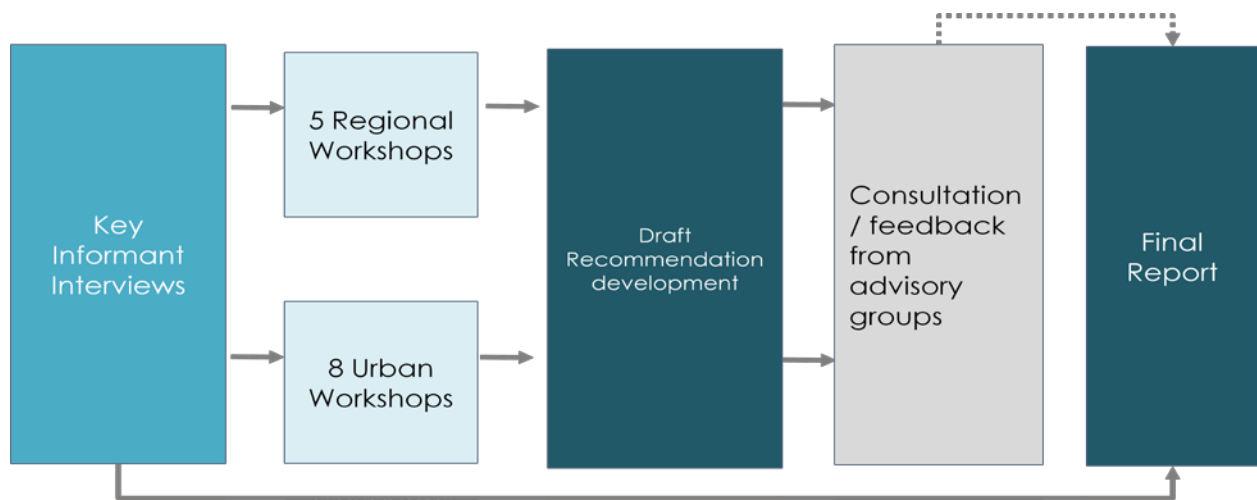
There is a working definition of an Aboriginal Health Worker. An Aboriginal and Torres Strait Islander Health Worker is a person who:

1. Identifies as being of Aboriginal and/or Torres Strait Islander descent;
2. Holds an Aboriginal and Torres Strait Islander Primary Health Care qualification; and
3. Adopts a culturally safe and holistic approach to health care

The 3 underlying themes emerging from analysis:

1. Enabling Health Workers in the workplace;
2. Recruitment and retention of workers; and
3. Systemic issues.

The next steps: Phase Two Methodology



There will be a series of workshop locations across Australia in eight capital cities and regional centres in Alice Springs, Broome, Townsville, Mildura and Thursday Island.

Anna and Matt outlined how interested stakeholders can participate and this is summarised below:

- Go to www.hwa.gov.au/atsihw to have your say on our forum
- Attend a National Workshop, planned for
 - Broome in May 2011
 - Perth in June 2011
- More info about the workshops will be available on our website in May 2011

Participants were invited to establish contact with either Anna or Matt using the following contact details:

Anna Leditschke

Senior Project Officer, Workforce Innovation and Reform

Health Workforce Australia

Phone 1800 707 351

Mob 0404 003 795

Email anna.leditschke@hwa.gov.au

Participant Discussion/Questions:

Definition of Aboriginal Health workers without qualifications: where do they fit in?

The working definition is for Phase One of this project and unqualified health workers could still participate. The majority are qualified. Currently there are advisory groups helping to craft better health worker definitions. They are still focused on the pay rates for Aboriginal Health Workers.

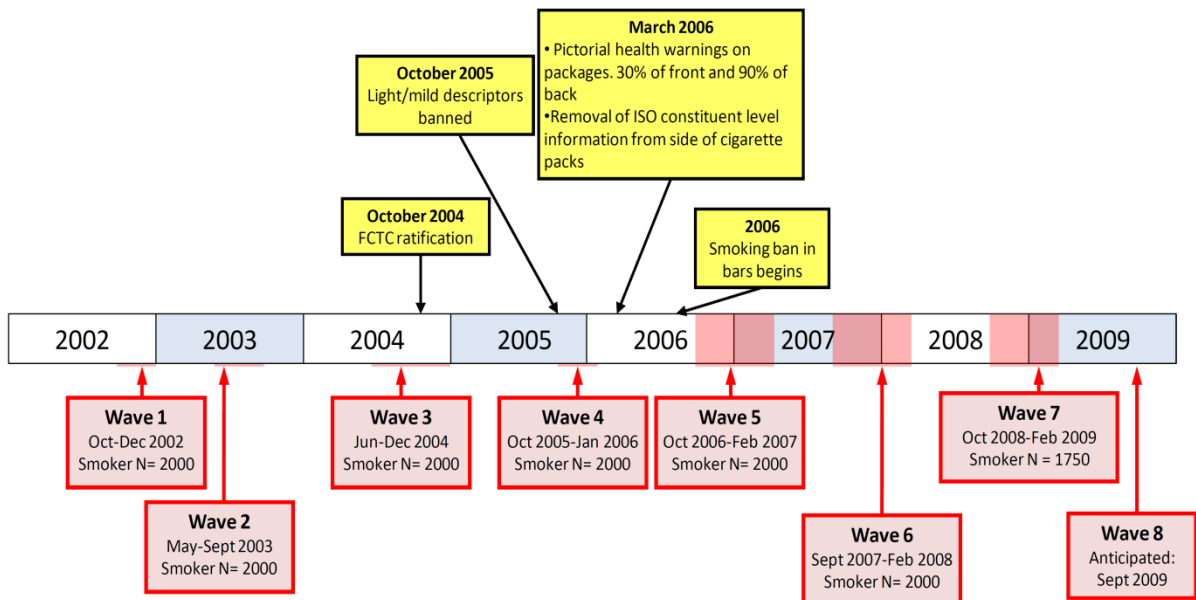
Where are the health workers going – medicine/nursing?

This is still being researched.

Anna Nicholson from the Menzies School of Health Research on ‘Talking About the Smokes’.

AUSTRALIA

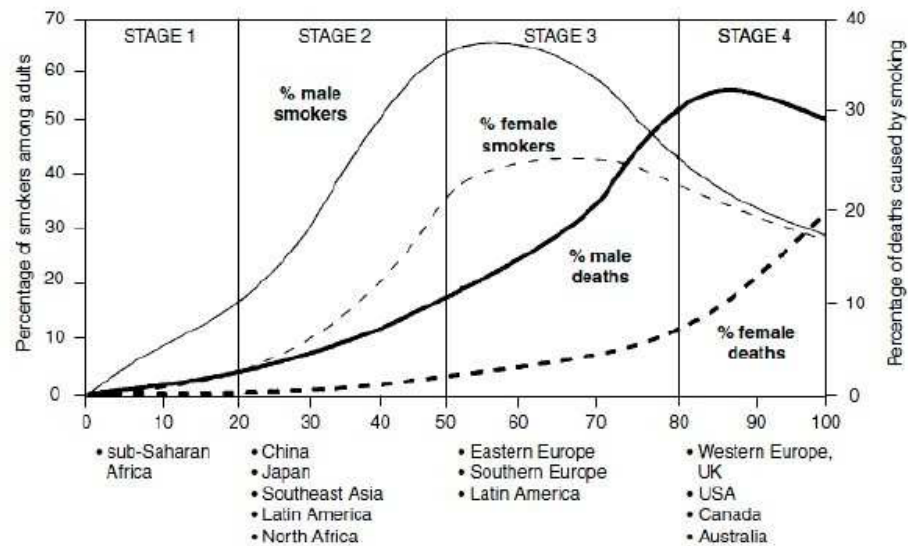
Timeline of Tobacco Control Policies and ITC Surveys



Survey Mode: Telephone (CATI), Web (CAWI)
Respondent Types: Smoker



The International Smoking Epidemic is demonstrated in the graph below.



Source: Lopez AD, Collishaw NE, and Pihla T. (1994). A descriptive model of the cigarette epidemic in developed countries. *Tobacco Control* 3: 242-247. Reproduced by permission of BMJ Publishing Group.

What is 'Talking About Smokes'?

It is a national research project which aims to find out what is working in the area of Aboriginal and Torres Strait Islander tobacco control. The project is linked to the International Tobacco Control (ITC) Policy Evaluation Project which is being run in 20 countries worldwide.

Who is Overseeing the Project?

There is a partnership involving many organisations. The project is lead by the Menzies team and there is membership by NACCHO and Affiliates, the Centre for Excellence in Indigenous Tobacco Control (CEITC) and the Victorian Cancer Council. NACCHO and Menzies signed a Memorandum of Understanding which guides the project's various processes.

It is funded by the Department of Health and Ageing.

For your health service to be involved in the research project, it would involve a local research assistant meeting with various people to gather information into an interview/survey instrument and also a follow up survey about a year later. There are four parts to the research process.

1. The first part is interviewing ATSI tobacco users;
2. Secondly, we would interview ATSI people who do not use tobacco;
3. Next we would survey some of your workers; and
4. Finally we would talk with a nominee from within your health service who can advise us about tobacco control activities taking place in your communities.

Training will be provided for people taking on the roles as Local Research Assistants and there is a financial support mechanism to reimburse participating ACCHS for direct costs.

Where information is obtained for reporting purposes from local ACCHS the authorization of the CEO will be sought for anything which identifies that service area.

Local survey participants (not including your employees) will be given a \$20.00 fee to compensate them for the time given for the interviewing.

Local results will be provided back to the participating ACCHS.

This project is important because the rate of tobacco use amongst ATSI peoples is 47% higher than for the general population and it contributes to around one sixth of the health status gap problems being experienced. It causes around 20% of ATSI deaths and we still don't really understand how to reduce tobacco use effectively. The project is trying to find the best answers so there can be as much investment and effort as possible put into things most likely to work.

Participants were invited to contact the project through:

Anna Nicholson, Project Manager
Telephone 08 89228412
Anna.Nicholson@menzies.edu.au

Participant Discussion/Questions:

This program is tobacco focused only. What about people who smoke marijuana?

We only have funding from the national tobacco project. Funding from the Department of Health & Aging is still being finalized.

Breakout Session Two – Workforce

Dr Tim Leahy, A/Professor Clive Walley and Dr Shirley Godwin from the University of Notre Dame on 'More Home Grown Doctors'.

“A medical career is an achievable objective for Aboriginal people.”

Clive Walley kicked off the session, reflecting on his long association with Aboriginal health and recalled a time in 1994 when he worked in the Office of Aboriginal Health when they had \$30,000 to invest in a QUIT program. Looking at the smoking problem in the Aboriginal community at the present time, he expressed the view that programs like these didn't seem to have achieved much good.

Clive then shared his experience along with a few other colleagues when they first went into tertiary studies at ECU. They felt that they were getting a clear signal that “Aboriginal people were not ready for tertiary studies”.

After a long career, Clive has been able to take what he has learned and experienced into the Notre Dame initiative which is all about supporting Aboriginal students to achieve the goal of a career in medicine.

Dr Tim Leahy works two days each week in at the Notre Dame University and he talked about the aims to attract and support Aboriginal medical students and helping to make them feel secure and safe during their student years.

At the present time, there are around 150 Aboriginal doctors in Australia and a further 150 doing undergraduate medical studies.

The Notre Dame University is committed to incorporating Aboriginal studies into their medical course curriculum. The distinction was made that at Notre Dame, the bureaucracy is much thinner and it is very accessible for academic staff to directly approach the 'brass' and make propositions to them. Not only this, but the likelihood of worthwhile ideas being accepted and agreed was much higher, meaning that staff are able to get things to happen 'on the ground' fairly quickly. This was noted as a refreshing change.

Tim left a very strong message with participants:

"It is so much more effective to have students work in Aboriginal Community Controlled Health Services. The idea is to get these young people to have very positive experiences during their undergraduate years in the hopes that they will chose to work back in these services and towns once they graduate. The evidence shows that people will return to places where they experienced something very special".

He said this is a major benefit for the ACCHS to captalise upon – work on giving them a really amazing experience while they are on placement with you so you have good prospects of getting them to come and work for you in the future.

He called upon ACCHS to consider cadetships providing support and holiday employment for students working in partnership with the University. Matching actual and deeply valued experiences with the core curriculum learning material has a very profound impact on where these students will take up work when they are ready as graduates. He asked that services who have these students to call on he and Clive and offered to do everything they could to help them make the student's experience the best it can be.

Tim and Clive invited sector services to help encourage and support students. They also invited the sector to help inform and work with them on forthcoming Clinical Governance arrangements. In particular Tim advised that there was still some research funding available for Clinical Governance projects in the ACCHO sector and asked that if any services wanted to undertake research that they contact him.

LeAnne Smith, senior officer from WAGPET on the 'First Wave Indigenous Health Training Program'.

LeAnne described for the audience how a 'coalition of interest' had been developing since 2009 and WAGPET have been actively marketing to get medical practitioners into General Practice.

They are working on program development and have some good things happening in the short to medium terms and keen to make sure there is a good long term outcome as well.

Scholarships are effective mechanisms to spark interest in placements. In a pilot program they received 55 Expressions of Interest for only 3 places, so they were heartened at how well students had responded.

The selection panel had a hard job choosing from so many applicants for only 3 places.

WAGPET has many accredited practices participating who already have registrars and who are keen and willing to provide help with support and training.

In terms of the spirit of the theme of 'A New Decade – New Opportunities, LeAnne remarked that students report that their placements have been wonderful and that there are good indicators coming in with great feedback from students.

Presence of a registrar has value and there is good engagement from the services to keep students supported. Feedback from the services is also really good. They say their experiences are very good and the students help to add capacity for the practice.

Gerard McKelvie and Cheryl Davis from Charles Stuart University 'Djirruwang Program'

The program is based at Wagga Wagga, which is half way between Melbourne and Sydney and provided an excellent location.

Gerard and Cheryl presented an outline of an outreach Registered Nurse training program for WA which is an extension of the Djirruwang program to meet health needs of Aboriginal communities.

The training for nurses is in the special field of Aboriginal mental health and it articulates with other courses, such as the Social and Emotional Wellbeing training available at Broome campus.

Some of the graduates are already streaming into senior positions within mental health services in both management and clinical coordination roles in mainstream and the ACCHO sectors.

Gerard advised about a preceptor training course, which has not been done before. He said "we must ensure the students really get the learning they need through experiences and skills development".

This training through Charles Sturt University is the only one available in WA for Registered Nurses which link practice and theory together. The clinical placements provide the skills development and additional learning to match the theory component.

The timing for this formal training and qualification outcome for Aboriginal nurses is good because professional pay rates at much higher levels are not far away. Therefore the job and remuneration opportunities will be very good and should work to attract and retain the trained workforce. Nurses will need the formal qualifications to access the jobs and the income levels.

Participant Discussion/Questions:

A participant stated that "before the whitefellas came we had our own doctors and nurses to fix the people."

Gerard responded that they did understand this was the case but also had to accept that it is not there anymore and that we now need to get the Aboriginal nurses and doctors educated with formal qualifications so they can do this work and be well paid.

Cheryl also offered that these trainees will be formally qualified but will also have their knowledge of culture and traditional healing enhanced. They will be able to provide mainstream and traditional health care in an integrated way so their value will be exceptional.

Christine Smart and Anne Wilson. Speaking on the Aboriginal Child Health Project and professional workforce development opportunities.

A COAG state funded initiative is funding two positions with a small operating budget for four years. The main aim is to improve child health for 0 – 5 year olds through developing skills in the Aboriginal health sector in child health.

There is no Aboriginal child health course available in existing health worker education for child health. Through the project, short courses are being offered to help improve knowledge and skills. Funding is available to help with travel and accommodation costs for services that send participants to learn the skills.

The project is running four day courses in June and again in August during 2011. They are considering learning from the Kruske work and developing a WA specific course.

The second training initiative is for Aboriginal Health Workers and it offers a professional development opportunity through a 2.5 day course. They will be inviting services to contact the project team and discuss taking up training opportunities.

Participant Discussion/Questions:

From a participant from Yura Yungi AMA was “will you come out to us?”

Christine and Anne responded that they would be very interested in doing that and asked that he contact them to discuss how they can make this happen.

Another participant commented that all the Aboriginal Health Workers in her area are female. She said that she herself is a nurse and that when she started working in the field 20 years ago they had resources to go into the schools and attend to children with problems. Now the Aboriginal Health Workers haven’t been able to get proper training in child health and we would like to take up opportunity to get them skilled up.

Again, the response was “great – please contact us and we could look at bringing some training out to Kalgoorlie to help your staff develop more”.

A question from Marwankarra – are you going to extend into schools?

No, we are focused on 0-5 year old children. Our goal is specifically to impact positively on child health outcomes before kids get to school.

It was also noted that child health checking on school kids in the school environment appears to be raising some ethical/policy issues. Eg doing urinalysis and possibly needing parent consent is a concern to the Education Department.

Matthew from Yura Yungi again – have you thought about educating 11 – 12 year old kids in school about child health? They have younger children in their families and will also become parents themselves so why not educate this group of kids so they can apply their knowledge in their own environments for themselves, families and people around them?

“Good idea and thanks. Our project goes over four years and we certainly see ourselves doing some things we haven’t thought of at this stage. This is the value of talking to people like yourselves and we are very keen to hear your ideas and look at developing some responses to them during our project. So thank you and please keep talking to us about this one”.

Day One of the Conference concluded at this point.

CONFERENCE DAY TWO

MORNING SESSION

The Hon Helen Morton, MLC and Minister for Mental Health

The Hon Helen Morton opened her talk saying that she wanted to focus at the present time on the WA Mental Health state funding (\$22 million) opportunity, the rollout of Suicide Prevention strategies and important future directions for Mental Health in WA.

She gave a short briefing on some of the challenges the Mental Health Commission are currently working on.

There has been a lot of association with the SEWB effort in the Aboriginal health sector and she acknowledged that there are many issues to address within the Aboriginal mental health area.

The Minister stated that she did not believe that traditional mental health services are working well for Aboriginal people and that it was her strong conviction that the new Mental Health Commission arrangements will make a difference.

She said that establishing the Commission was a crucial reform element within mental health to enable new developments and improvements to be properly led by an organisation dedicated solely to mental health.

She described a similar strategy being used thirty years ago when the disability services portfolio was re-structured out of mainstream health and set up in a similar model. She believes that the current Disability Services Commission is an outstanding success in the Australian environment which had developed over the last twenty years.

The Minister also pointed out the new Mental Health Commissioner Eddie Bartnik was a part of the effort which achieved that outcome in the Disability Service Commission and this was one of the reasons she believes they are fortunate to have him on board to lead achievements within the mental health domain.

She reaffirmed that the Mental Health Commission is now completely separate from the Department of Health, which is now the provider of public mental health services and not responsible for mental health funding allocations, policy, planning and associated decision making. The funding for mental health is no longer appropriated from the Treasury to the Department of Health. Rather, it now goes from Treasury directly through the new Minister for Mental Health and to the Mental Health Commission.

As such, the Commission now has both the mandate and control over the resources to lead improvements in mental health in WA.

The Commission is fully responsible for mental health strategic planning, positioning of the mental health services industry, reducing the stigma still associated with mental illness and stewardship of reforms. The Commission will interact with service providers in all sectors, the community and other government departments which provide services for people with a mental illness.

The Minister stated her view that only by working together can we hope to get maximum support for Aboriginal people and their families suffering with a mental illness and to try and reduce the tragedy of suicide. She said she was looking for world class mental health commissioning.

The ACCHO sector is seen by the Commission as local leaders in mental health reforms for Aboriginal people.

The Commission will be working with all stakeholders in every service delivery sector to establish a full understanding of needs and how best to respond to them. They envisaged working with partnerships which will be developed through planning and service commissioning processes.

The community sector is very well placed to deliver mental health services for Aboriginal people. The government understands that the sector is flexible, responsive, socially innovative and offers the attraction of much less bureaucratic complexity.

In terms of a social innovations program, the Commission is developing new ways to deliver services through the community sector.

WACOS have given their support for this approach and have said that the proportion of the health budget being allocated for mental health must go from the current 6% to 12% in the future. Helen shared with participants that it was her view that it could go even further than this.

She said that the primary focus and aims of reforms are to make sure there is more comprehensive and person focused support available for mental illness sufferers and carers for housing, maintenance of relationships and employment. She intends to ensure there is a much more connected system which functions for the benefit of service users regardless of who funds and provides services, where people live and what the particular mental health issues are.

She said she is calling on all partners involved in mental health services to get together to share the common goals, to help ensure there is a balanced approach to investment in early intervention, acute care, recovery and services for elderly people with mental illness.

She also acknowledged that over time there will be occasions when providers will be decommissioned and funds redirected. She said that the government expects this outcome as a key part of the reform process and that indeed, taxpayers and consumers also expect that there will have to be some changes. Therefore, there is likely to be some controversy from time to time.

The actual process of decommissioning will require careful intention. There will need to be evidence based business cases, an improved quality focus and consideration of the broader social and economic impact of changes on the mental health system as a whole.

In terms of Aboriginal people working in areas of SEWB, all the evidence indicates that Aboriginal people experience higher rates of illness than their non Aboriginal counterparts. Research also shows Aboriginal people have less access to services for many reasons.

The Minister concluded her talk by saying that she wished she could tell the Conference that the new Mental Health Commission could change the situation facing Aboriginal mental illness sufferers and their carers and communities overnight but we know that's not possible. However, she said that they have identified priorities and set in place the long term objectives.

By way of a pledge to Aboriginal communities, the Minister will ensure they have a greater say in mental health service decisions for their communities. She asked for continuing advice, support and help from the sector to make these reforms work.

Mr Eddie Bartnik, Commissioner, Mental Health Commission

Eddie Bartnik addressed the Conference directly following on from Minister Helen Morton.

He reiterated the Commission's objectives in relation to SEWB work in Aboriginal communities in WA and said they are clear that mainstream services are not meeting needs.

As the Commissioner responsible, he said that he accepts this fact and undertakes to try and turn that around. He promised to do everything in his power to make a positive difference in mental illness services for Aboriginal communities.

How was he going to do this? Eddie offered that the Commission is seven months into its new existence and effectively still getting to grips with the situation and priorities.

The Commission has been given the clearest possible mandate in WA. The key value is that the mental health system will be based on the needs of the people, their families and communities.

Eddie said that he wants the Commission to work in partnership with a whole range of services to build really comprehensive systems of support for people. He said he intended to shift funding out into community settings and also has commenced the process of increasing the direct involvement of individuals and families in the planning.

The Commission is currently in the process of setting up a new Mental Health Advisory Council and will ensure there is very strong Aboriginal participation within this important and influential body.

They are also reviewing staffing levels, values and essential skills for the new commissioning work. They are actively out and about talking to a lot of people, listening carefully and building relationships.

He said he really wants to try and lead a very positive conversation about the future of mental health developments in WA. He is acutely aware that a great deal of stigma about mental illness still exists and that this is in fact a significant issue in and of itself. There are very negative attitudes and a good deal of fear about mental illness.

He commented on a mental health promotion event held last year in the Pilbara and that it had been especially notable that people were generally taking care to avoid the mental health stall set up in the mall of the local shopping centre.

From a 'Purchasing Intentions' perspective, Eddie clarified that at this point in time about 85% of mental health services funding is locked into the public health system and that the Minister will be releasing a new mental health policy and a 10 year strategic plan.

He advised that there are twelve major reform areas and it will be essential to engage the whole community. The strategic work will provide a good framework. The principles underpinning our work are that we want:

- Mental health clients treated with respect and dignity at all times;
- A shift away from provider/patient traditional relationships; and
- A move to more partnership based relationships with the people who are served.

Programs which the Commission are currently working on:

- COAG statewide specialised Aboriginal mental health services (\$45m over 4 years);
- This will increase the number of staff from 21.5 to more than 80 positions;
- The main aim is to improve mental health and wellbeing by taking a whole of family and community approach;
- Building a sustainable Aboriginal workforce involved in mental health services provision;
- A policy and training unit for the metropolitan strategy and staff recruitment is underway now.

For the Suicide Prevention Strategy, Eddie advised that the Federal government have increased funding to \$30million over four years for the 'One Life Strategy'.

He said that the Commission is working with communities using a bottom up approach to develop action plans and then will work with a broad range of agencies to develop approximately fifty community action plans.

The Emergency Suicide Response team is currently working with Kimberley stakeholders and Eddie reported that it is very pleasing that so many major stakeholders have joined up with this work effort and shown a strong and shared commitment to getting the best outcomes together. He advised that all

communities wanting to develop a suicide community action plan can contact the One Life Helpline and request assistance.

The Commission is also working to bring into effect some relocation assistance to help people maintain family contact through rooming in arrangements.

Discharge planning is being developed to help people stuck in hospital to get back home with adequate support.

In closing, Eddie stated that this shakeup in the mental health system in WA is the biggest reform we have ever had. He expressed his appreciation for the ACCHO sector and called for their strong participation, feedback and evaluation of the various strategies. Above all, he reaffirmed his need for support and partnerships with the sector.

Participant Discussions/Questions:

A participant posed some issues concerning redress for traumatized people from the Stolen Generation. Is there a program to deal with this? It seems like program goal posts get shifted and this just increases distress. How can these people still suffering be left out on a limb? How serious are you going to be about tackling the emotional suffering of these badly affected people?

The Minister responded to this by saying

“Let there be no mistake about the seriousness of our intent. In terms of the Stolen Generation, I am very clear about the way redress WA took place, the expectations established, the claims procedures and the way funds were allocated. I can say that if there are still vulnerable people, I will be glad to pass this onto the Minister with specific responsibility for that portfolio and help to ensure some resources are allocated to address their needs”.

Eddie Bartnik also offered that the Commonwealth and the State are working together on new and better ideas. For example, some communities have been talking about a healing centre model as opposed to a clinical treatment model. He said that the Mental Health Commission would be very happy to go with innovative strategies such as this in the future.

Another participant asked about the lack of support back at the community level for mental illness patients and for their families who find it really difficult to deal with mentally ill relatives. The question was also asked about whether or not the Commission would be working with the prisons system because a lot of Aboriginal people with mental illness are caught up inside prisons. It was proposed that the families will always take them back but that there is almost no support. For this reason, before long the mentally ill end up back in prison or being shipped out to Graylands again. There seems to be no real communication between departments either.

Eddie Bartnik responded to this discussion and offered that part of the problem is that too much money is locked within the acute care system and there has been a significant under investment in non acute treatment options. This also has contributed to the problem of there not being enough service, support or problem solving capacity out at community level for the kinds of support you are talking about. He stated that we really need a completely different way of thinking about problems and finding the best solutions must start at the person, family and community level. In terms of how we package and better

balance services and support systems around individual, family and community needs, we are currently bringing some serious work in 'cross departmental' models along. They are being properly costed and we will be putting investment into this model in future through our commissioning processes.

Another participant noted that under COAG much of funding is in the state sector. The Minister said she wanted to see investment in the community sector as well and that they are very interested to hear more about this approach.

Eddie Bartnik also responded to this discussion. There are two funding programs: one is \$22 million to go into the ACCHO sector. Approximately the same amount will also go into the public sector. The SEWB approach is a distinct aspect and we are learning and thinking a lot more about this. What has been done has been done in terms of the past, but we are very open to rethinking approaches for the future.

A participant queried if the individual client package model allowed for a 'halfway house' arrangement for some patients.

Eddie responded and said that in other states, they have built a more comprehensive step down infrastructure. He said that in WA we want to have a really good look at this approach too. He acknowledged that in WA, resources such as these have been badly underdone and for this reason, clients and their families are virtually 'stuck' with old and largely acute care based models. He said that we must stay focused on getting people into their own homes, so we need to be really careful we don't create the half way house idea as a default permanent home. But having said that as just a precaution, he was still of the view that models like the halfway house option are an important component in a better overall system.

A participant expressed that view that mental health is far too important an issue for us to spend so little time on it with the Minister and Mental Health Commissioner in such a short session.

Expanding on this, it was also declared that:

"We have no community and after hours care and no housing support systems. We need to really work on how all these problems are going to be addressed.

We need a full day to thoroughly workshop on just this issue alone.

We talked about this last year and still haven't allowed enough time. We've all come from far away and quite different environments and needs. The families are there around the clock every day and it often ends up that the Police have the last say about what has to be done with individuals when things have gotten out of hand due to lack of mental health services.

We have no secure wards in country hospitals so people get put into straight jackets and shipped to Perth. They often have to just wander around the streets like lost dogs because there is nobody who will or even can help them because they are so very difficult to deal with.

There is a failure here and it is not by the families. It is by the government.

Stop sweeping this under the carpet. Half of the stuff you are talking about is not enough for people who come from everywhere and they have almost nothing".

There was an enormous round of applause from the Conference in response to these strong and impassioned sentiments expressed on behalf of Aboriginal families at this point.

The Minister responded to this and acknowledged the issues are all correct. She expressed her regrets that she was unable to stay longer as the Parliament is sitting today.

She provided an assurance that there will be many other opportunities for her and Eddie Bartnik to spend time with the sector and that she was very anxious to make sure this does occur. She said she has had people report these exact issues to her many times over the last several years and it for this very reason she has pushed so hard to get these reforms into place so they can start doing something about it.

She also said that these are obviously huge issues and there is going to have to be a significant support system and structures developed. She said she also hoped people will understand that decades of neglect cannot be fixed over night. She said she dearly wished she could fix it all right now, but said that she felt very sorry that the reality is that no one could and that it will take time.

The Minister did invite the sector to stay strong in their voices about these issues and asked them to make sure you keep saying these messages about the truth of what is really going on and:

“Keep us on our toes”.

Eddie Bartnik also offered that they are looking for very big changes in the way the system treats the patients, families and communities. He reiterated that it is going to take time to get the shift we want because aside from anything else, it needed to have an equally big change in people’s thinking about mental illness treatment and management.

The same participant demanded that the Minister and Commissioner instruct the department to get this action happening right now. She said:

“We will be burying big numbers of these people while we wait for you to sort things out”.

Another participant stood and with enormous sadness shared with the Conference that there had been another suicide last night in a remote Kimberley community. Conference participants were devastated by this awful news.

The Minister said that she had been advised about this terrible tragedy and that it is another sad example of why so much needs to be done. She expressed her sincere sorrow for this tragic loss of another young Aboriginal life and that it deepened her personal conviction that they must do everything in their power to bring about changes and improvements in the chronically neglected WA mental health system.

A final plea was presented by another participant who said:

“This is such a big issue. Please can we be given an opportunity to meet again and soon with the Minister and the Commissioner?”

AHCWA Chairman Vicki O'Donnell noted that there is an upcoming Mental Health Conference in Newman and Eddie also offered that he is completely open to discussing an opportunity to get together soon anywhere in the state.

The session was concluded as time ran short and the presenters had to leave to attend other commitments. There was a groundswell of support from the entire Conference to:

- ***Create an urgent opportunity to get back together with a lot more time to develop strategies and an action agenda for this issue. Participants expressed in very clear terms that they want to get concrete strategies developed, to have the time and resources to do this and to engage in a spirit of urgency for action with the Minister for Mental Health and the Mental Health Commissioner.***

Graeme Cooper, CEO OVAHS on the OVAHS Mental Health Hub Model.

Graeme Cooper kicked off this session and acknowledged that what OVAHS are doing is a good start to getting Aboriginal people taking some control and doing something without waiting for others to do it for them.

He reflect on the Hon Ken Wyatt's comments about Derbarl Yerigan being in the wings, and therefore older than Redfern. So in effect, the AMS movement has been around for the better part of about forty years.

As our sector has been around for so long proving primary health care, Graeme expressed his own view that it stands to reason we should be leading on mental health service action for the Aboriginal communities we serve.

In 2007, OVAHS initiated a Social Support Unit. The service is committed to a co- morbidity approach and as such deals with everything the client needs – be it chronic disease and other substance abuse complications and the like.

Mental illness and suicide rates are much higher and we have heard today that they are real and that they are officially acknowledged. We are also dealing with a huge burden of social problems mixed in with the mental illness issues.

Our unit at OVAHS works in response to people, families and agencies concerned about people and their mental and emotional health and well being. A family member can say "we are concerned about so and so" and one of our people will go out and see that person. We will go around to the house and keep on going to find where people are. We don't just leave a calling card and leave it to them. We persist.

We do refer clients to mental health professionals and the doctors. But we are a truly community service and we can do so much more than the narrow diagnosis and treatment aspects provided by mainstream services by working in very different ways at the person, community and families levels.

One of the very distinguishing features of our services is that we do go out and collect people and help them with transport to access the services.

Objectives

- Increase local drug and alcohol/ mental health counseling services;
- Workforce development;
- Ensure cultural security/integrity;
- Greater access for clients;
- Flexible services that can adapt to individual needs;
- Services in an holistic model ;
- Comprehensive address to AOD/ Mental Health/ Healthy Lifestyle issues;
- Provide comprehensive physical health checks, specifically in the areas of:
 - Men's health;
 - Women's health;
 - Child health;
 - Chronic disease.
- Better coordination with local / regional providers; and
- The Headspace East Kimberley youth mental health trainer/ coordinator post to be based eventually with OVAHS.

Aboriginal people are in desperate need of mental health services. There is so much about our services which offer a whole model already in place. We don't need to wait while the new Mental Health Commission takes years to learn how to do it best. To the contrary, they need to plug into what we are already doing right now.

At OVAHS we want to employ more mental health nurses, develop Aboriginal mental health students and add a full time psychologist.

We employ more Aboriginal people than just about anyone else in our sector. We know how to do this and how to look after them and develop them.

Almost forty years of 'know-how' in primary health care for people with many and complex morbidities. So we aren't stuck with traditional disease based service and professional territorial models and we use our deep connections into the community.

Yes, there are going to be issues with some of the service models in the ACCHSs. Clinical governance is obviously one of them. However, these issues can be addressed. When ACCHS started out they surely made some mistakes. But we have developed and we can work with supporting expertise we have in KAMSC, AHCWA and in partnership with WACHS and others to learn and develop good clinical governance systems.

We have proven our model works and it is helping people right now. OVAHS started off with only 3 staff in our service. We now have sixty employees and we just keep growing, adapting and improving.

Kim Snowball said yesterday that no one sector or model can provide all the answers. This is true, but:

"If we can work together on a level playing field with the experience and knowledge we have and to have this truly respected, there is no limit to what we can achieve".

Alisha Roberts – Yorgum and Margaret Quartermaine, Director (Marr Mooditj) Workforce Support Unit

Participants were given a summary presentation which outlined how the 2007 evaluation of the Bringing Them Home (BTH) and Indigenous Mental Health programs identified the needs for ESWB workforce development and support.

The objective is to create and sustain an effective and sustainable ESWB workforce.

The role of the Marr Mooditj Workforce Support Unit is to monitor and coordinate professional support and training for OATSIH funded workers. WA has two units in Carnarvon and Albany.

The Unit provides training to meet the mandatory requirements for BTH home competencies and qualifications. The Unit focuses on caring for the staff while they care for the people.

In a Questionnaire based survey of twelve agencies in WA, a huge majority of staff said they were unsupported in their roles and were experiencing a number of difficult issues.

The RTO's conduct annual training needs analyses and deliver recognised training to qualification levels set out in the relevant manuals. It was noted that there is no manual for substance abuse workers.

The Unit holds two workforce regional forums each year and these provide a chance for the OATSIH funded SEWB workers to attend and network together. They can share stories about their work in their own communities.

Margaret talked about the training needs analysis work and the Training Pathways. She explained that Marr Mooditj is only playing a small part in the training and that they are working along with other RTO's on supporting SEWB training.

Margaret advised that they were approached by OATSIH about their involvement in training in the area. There are still a few things being worked out and at this stage there are no clear guidelines.

Marr Mooditj has submitted a funding application along with other RTO's and we envisage working very much together.

She said that today she wanted to show participants the pathways and how people will have various options. These are all detailed in Margaret's power point presentation which is available on the AHCWA website.

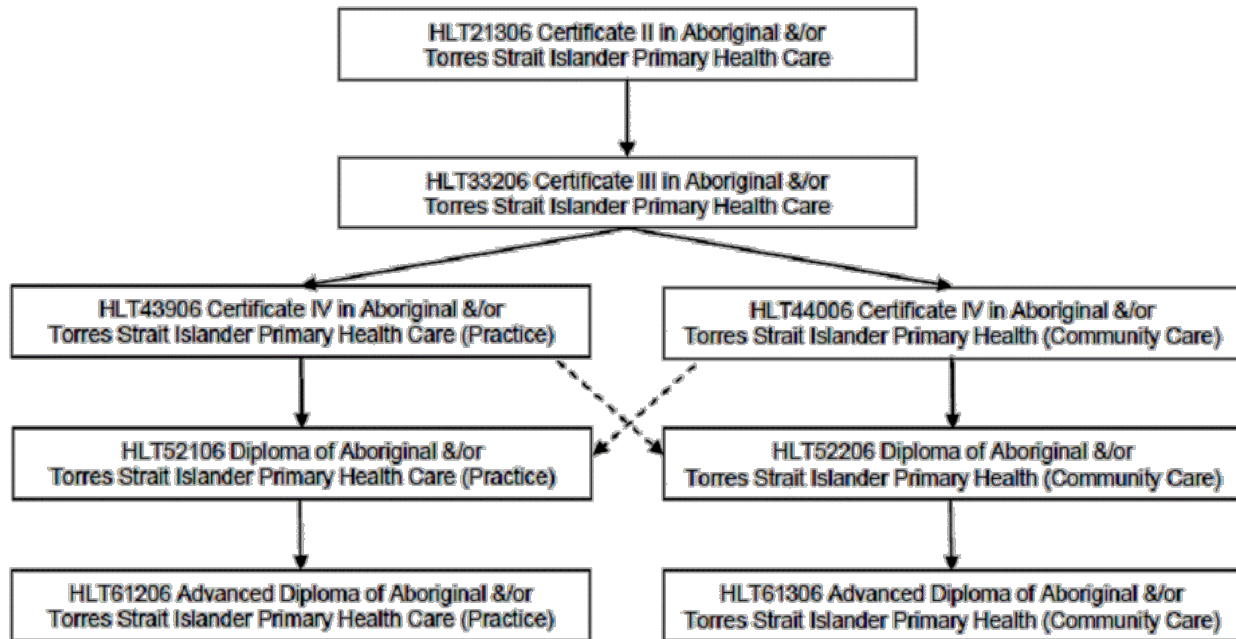
All workers in various SEWB roles funded by OATISH will need to undergo appropriate training.

Some groups of units don't lead to a qualification but students can select them if they wish. The package can be accessed to cover the essential competencies for undertaking certain aspects of SEWB work.

Marr Mooditj will link with KAMSC and BEGA RTO's on training strategies to get the best coverage of the state. DAO also have an RTO. The idea is that together we can put out a good training program and deliver the outcomes the sector and the workforce need.

We will be doing training needs analyses, also identifying existing knowledge and qualifications. There will be a mechanism for Recognition of Prior Learning and the ability to address specific knowledge gaps. We will design a training plan for the worker, work out details with the employer and inform OATSIH so they know who needs particular types of training and what the costs are going to involve.

The Training Pathways slide is shown below.



Wayne Flugge, WANADA programs

Wayne Flugge outlined that WANADA is the peak body for the NGO alcohol and drug sector since 1984. It is independent, it is a not-for-profit organisation and governed by a board. It operates from Perth. There are about one hundred and forty agencies in WA and ninety are members of WANADA.

Within this membership base, twenty nine members are Aboriginal service agencies.

The membership also covers a diverse range of agencies servicing in the residential and non residential settings providing counseling. There are also ACCHS and other NGOs in metropolitan and rural/remote areas.

WANADA has a team of five Aboriginal workers.

Wayne outlined a summary of the service and support programs provided for members from WANADA and these are summarised below.

AHCWA/WANADA Accreditation Support Partnership

Through the Establishing Quality Health Services (EQHS) Accreditation Support Program, the AHCWA/WANADA Accreditation Support partnership primary objective is to assist four agencies to implement quality improvement practices. The ultimate aim is achieving accreditation in line with Australian Health Accreditation Standards. To date, one agency (Jungarni Jutiya) has achieved accreditation and the other three (Ngnowar Aerwah, Milliya Rumurra and AADS) are all expected to be accreditation ready by end of August if not before.

Accreditation Framework Standards

For the past six years, WANADA has been implementing a model of Continuous Quality Improvement (CQI) to assist program and service development to better meet the needs of consumers and improve outcomes;

The Quality Framework (QF) was specifically designed for AOD services in the Western Australian context through extensive consultation with consumers, service providers and a broad range of other stakeholders;

The QF is now being transformed into the Accreditation Framework. We will be conducting several consultation sessions in WA during May on the interpretive guide and would welcome any interest from all agencies here today to be part of that process;

There is also an opportunity for further partnership work as the Accreditation Standards are implemented;

The whole standard is about cultural security in the way the agency delivers health services to Indigenous people;

AHCWA is an RTO and we would very much like AHCWA to deliver any training around cultural security which agencies will be required to undertake to meet cultural security requirements to satisfy accreditation auditors.

Quality Framework Peer Review/Accreditation Framework Standards Peer Review

The QF Peer Review was a threefold support process which firstly assesses the agency's progress in implementing the Framework (set of best practice principles);

It then assists the agency to identify ways to further progress implementation of the Framework;

Finally it works with the agency to identify impediments to further implementation of best practice in the AOD sector;

The Peer Review process will continue with the implementation of the Accreditation Framework standards;

AOD services participating in the Peer Review will be fully supported by WANADA and the review agency (Institute for Healthy Communities Australia (IHCA) to achieve accreditation.

Aboriginal Network

In 2006, WANADA began work to establish a network for Aboriginal Alcohol and other Drug workers or workers associated within the sector from both non-government and government agencies in the metropolitan area;

The Network gives Aboriginal workers the opportunity to come together for peer support, information and resource sharing and to provide ongoing links which provide better support in the future;

The network is now managed by Tina Hayden. Anyone interested in finding out more about the network can talk with Tina.

Consumer Health Project

Masters students of Nutrition are working with AOD residential services and residents to develop diet-nutrition education and research projects as identified by the agency to support a sustainable capacity building approach to better meet the general health needs of AOD service clients.

Child Care Access Program

The Child Care Access Program makes it easier for people to attend AOD counseling and treatment by covering the cost of childcare during session times. WANADA covers the cost of that childcare session.

Interpreter Access Program

The Interpreter Access Program covers interpreter costs for AOD member agency clients to help improve access to agencies by people experiencing cultural and linguistic barriers (including people with English as a second language and people who are deaf and hard of hearing).

Wayne concluded his session by requesting feedback and provided his contact details which are shown here:

Contact Details

Wayne Flugge
Aboriginal Services Manager
wayne.flugge@wanada.org.au

Tina Hayden
Aboriginal Network Project Officer
tina.hayden@wanada.org.au

Sasha Casey, Drug and Alcohol Office. Speaking on the key Aboriginal Advisory Group for Fetal Alcohol spectrum Disorder.

Sasha gave a presentation describing the Strong Spirit Strong Future project which has been funded through COAG for a four year period.

This project is not diagnostic in nature and does not work directly with people affected with FASD. The Project targets Aboriginal girls, women, their partners and their families to increase awareness of FASD and the impact of drinking alcohol in pregnancy on unborn babies.

They also encourage the screening of all women and girls of child-bearing age and the provision of support and assistance to women wanting to stop using alcohol due to concerns about pregnancy and the affect of FASD on children.

There are other FASD related projects and these were summarised for Conference participants. They are detailed below:

- The FASD Model of Care (Health Network);
- The Marulu Liliwan Project through the University of Sydney at Fitzroy Crossing;
- The National Drug Research Institute (NDRI) National Resource Development project;
- Telethon Institute of Child Health Research (TICHR), Alcohol and Pregnancy project;
- The Ord Valley Aboriginal Health Service (OVAHS) FASD project;
- The Department for Communities FASD Network; and
- The Pilbara Aboriginal Alcohol and Drug Program (PADAP) – Alcohol and Pregnancy project.

The Project works with culturally secure resources, summarised here:

- Resources to support health promotion, education and clinical work;
- Develop set of generic evidence-based resources;
- Modify or change resources to reflect local Aboriginal community needs.

In terms of community awareness, the issues were summarised by Sasha as follows:

- Three are low levels of knowledge and a lot of confusion;
- Women are increasingly drinking at risky levels and research suggests a lack of awareness of harm to unborn;
- Pregnancy is often unplanned;
- Awareness raising needs to be culturally secure both local and state wide and campaigns needs to target the key people who need the information and help to act on prevention;
- Messages which strengthen Aboriginal systems of care, control and responsibility will work better.

At the professional workforce level, the issues are that:

- Professionals are unsure about how to engage alcohol using pregnant clients;
- There needs to be a consistent message - NHMRC guidelines;
- Brief intervention skills and AOD knowledge is needed; and
- They need to be able to source support for alcohol using clients in treatment.

The Advisory Groups objectives are to:

- Ensure that the project principles underpin all elements of program development and delivery;
- Ensure culturally secure content expertise and oversight;
- Foster collaboration and linkages between this Project, Aboriginal communities, the drug and alcohol sector, primary health care, community controlled service providers and other strategic partners; and
- Promote awareness of FASD and this Project

What We Do Know:

- Alcohol is a teratogen. It is a drug that is toxic to the developing fetus;
- Alcohol may cause miscarriage, deformities, growth deficiencies, and functional deficits to the fetus;
- Alcohol passes through the mother's bloodstream and crosses the placenta to enter the bloodstream of the fetus;
- Alcohol concentration of circulating blood will be the same for the mother and the fetus.

Several factors can influence the development of a fetus that is exposed to alcohol:

- Dose of alcohol;
- Pattern of alcohol consumption;
- When the mother drank alcohol during the pregnancy (timing);
- Biological factors of the mother and fetus;
- Nutrition;
- Metabolism.

FASD is an umbrella term to describe the adverse effects of alcohol exposure on the developing fetus. These effects include physical, mental, behavioural and learning disabilities.

The disorder encompasses:

- Fetal Alcohol Syndrome (facial features);
- Partial Fetal Alcohol Syndrome;
- Alcohol Related Neuro-developmental Disorders; and
- Alcohol Related Birth Defects.

The estimated prevalence of FASD is:

- 0.02/1000 births for non-Aboriginal children;
- 2.76/1000 births for Aboriginal children;
- The difference is thought to reflect socio-cultural variables e.g. SES, poor nutrition, and drinking patterns.

NHMRC Guideline Four states that maternal alcohol consumption can harm the developing fetus or breastfeeding baby, that it is harmful for women who are pregnant or planning pregnancy and that avoiding the drinking of alcohol is the safest option.

Also, for women who are breastfeeding, not drinking is the safest option.

Alcohol consumption in pregnancy of non Indigenous West Australian women (n=4839):

- 46.7% of women had not planned their pregnancy;
- 58.7% drank alcohol in a least one trimester of pregnancy;
- 14.8% drank outside the (2001) Australian guidelines;
- 4.3% consumed five or more drinks on a typical occasion in a least one trimester;
- Aboriginal women are less likely to consume alcohol than other Australian women. Those that do consume are more likely to do so at hazardous levels;
- In a statewide study (n=5289) 22.8% of Aboriginal mothers reported drinking during pregnancy

The WA FASD Prevention Aboriginal Consultation Forum 2010

- Held 12 November, 2010;
- Forum Report soon to be available on the DAO website;
- Senior Aboriginal professionals and community members from throughout the state were invited to attend the forum;
- Well attended (including 60 people from across WA).

Key workshop consultation themes included:

- Current community knowledge explored
- Prevention approaches and messages targeting women, men and youth
- Workforce development and training needs.

Where to Next?

- Complete consultation;
- Determine key messages;
- Campaign development;
- Resource development to support campaign and workforce;
- Development of workforce training package.

Participant Discussion/Questions:

A participant asked if it was known how much funding goes into FASD compared to smoking and the expressed the view that it should be a lot more given the potential for so much lifelong damage right from pre-birth.

Dr Simon Towler, Chief Medical Officer, WA Department of Health. Speaking on the WA Primary Health Care Strategy.

Dr Towler reflected on the Reid Reform report which stated back in 2004 that:

“Incremental reform is not good enough”.

He acknowledged that the reform of hospitals has not been good enough and that the primary health care reforms are an essential part of the strategic action plan.

For his overview of the WA Primary Health Care Strategy, Dr Towler used a comprehensive power point slide presentation containing a great deal of valuable information and graphs. Only summary information is presented in this report and those interested in viewing his entire presentation may obtain access to it on the AHCWA website.

He summarised the key drivers of health reform as access barriers to services and the growing burden of chronic disease and population aging.

There are also cost inefficiencies and the all too well known ‘blame games’ added to the escalating cost of new technologies which is seemingly never ending.

The National Health and Hospital Reform Commission principles are:

- People and family centered services;
- Equity;
- Shared responsibility;
- Strengthening prevention and wellness;
- Comprehensive approaches;
- Value for money;
- Providing for future generations;
- Recognising that broader environmental influences that shape our health.

The Australian Primary Health Care Research Institute defines primary health care as:

“Socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors.”

Dr Towler outlined how the WA Primary Health Strategy aligns with COAG and the Commonwealth government health reforms. Specifically in the areas of:

- Regional integration;
- Information technology and eHealth;
- Skilled workforce;
- Infrastructure; and
- Financing and system performance.

There is a clearly documented case nationally and internationally supporting the need for changes to the way services are funded, delivered and linked together.

There is national and international recognition of the urgent need to develop new service delivery models to respond to the growing disease burden associated with chronic health conditions (which contribute 70% of the burden of disease in Australia).

Furthermore, there is a growing awareness that hospitalisation for people with chronic diseases may be inappropriate and that primary care teams could better manage these patients.

Jeff Richardson, an economist from Monash University (2004) argues that Australia uses hospital services intensively compared to other countries with older populations.[1]

Malcolm (1994):

“The overriding problem of hospitals, as organisational entities, is that they fragment the continuum of care, the delivery of integrated services which should be inclusive of both hospital as well as community-based care”.

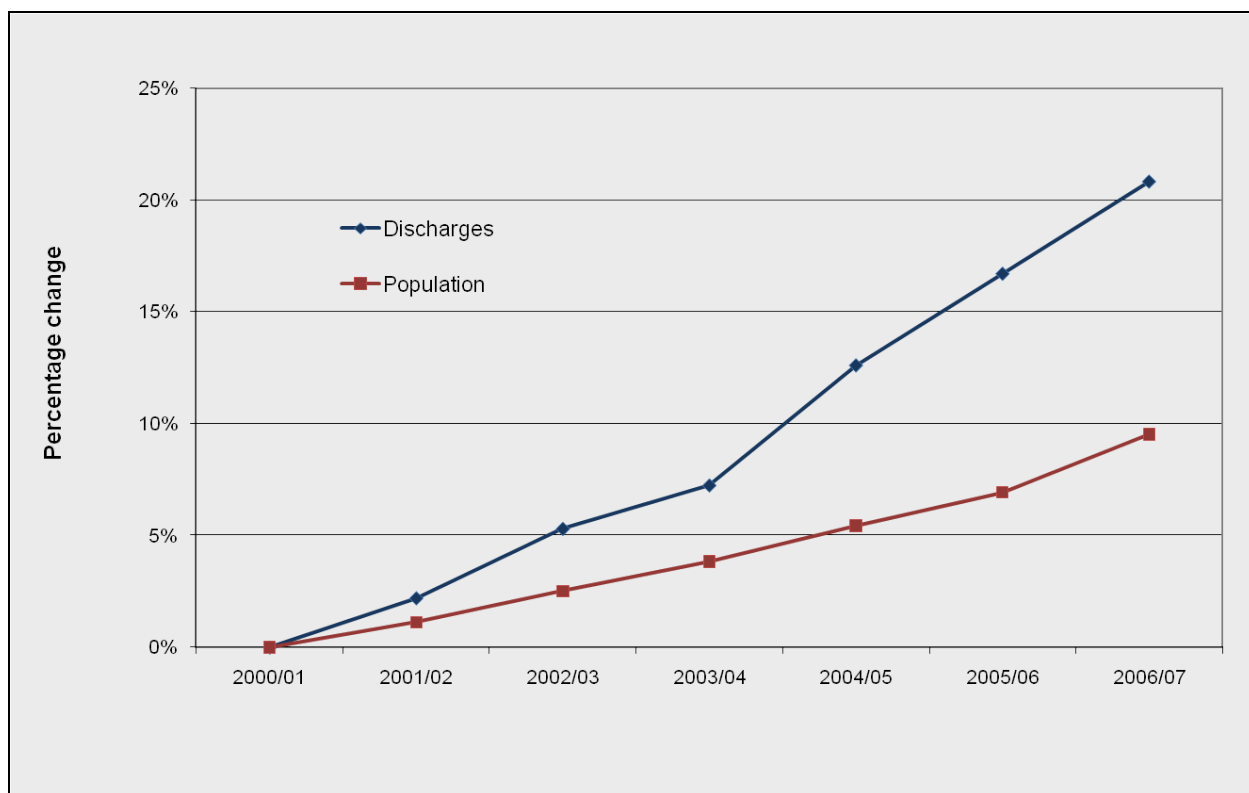
Dr Towler outlined the following issues as being central to the business of Health:

- Providing health care;
- Supporting policy and economic review;
- Logistic development;
- Fostering innovation in management;
- Working with providers on new service models;
- Direct patient support;
- Improving clinician performance.

The graph on the following page clearly demonstrates the steep upward trend in hospital discharges relative to population growth.

This gives evidence to the statement that WA is a ‘hospital intensive’ health system.

The over reliance on hospitals is far greater than in many other states and developed countries with similarly ageing populations and perhaps reflects the lack of a well organised, accessible and properly coordinated primary health care system.



Evidence-based medicine has been defined as the integration of best research evidence with clinical expertise and patient values.

There is no doubting the evidence supporting a strong case for health care system reform in WA when we consider a range of other health outcomes which are summarised below (please refer to Dr Towlers' full presentation for detailed data graphs):

Older people receiving a voluntary health assessment in 2005/06 in WA were 17% and Australia wide it was 22%.

People with diabetes mellitus who received an annual cycle of care with a GP in 2005/6 in WA were 17% and Australia wide was also 22%.

Older Indigenous people who received an annual health assessment in 2009/10 in WA was better than the national average.

Hospital separations for preventable conditions in 2006/7 in WA for Indigenous people was 42/1000 people and for non Indigenous people was 14/1000 people.

Daily smoking rates in WA for Indigenous people were 40% and for non Indigenous people were 18% in 2007/8.

Harmful alcohol intake for the Indigenous population in WA was 16% at risk people in 2004/5.

Mortality rates for the WA population in 2004 - 2008 were 6%, the same as all other states with the exception of Tasmania and the NT which were higher.

Indigenous mortality rate for WA in the same year range as above was 17/1000 people which is the highest in Australia.

Mortality rates on Indigenous to non Indigenous populations were 3.6 times higher in WA for Indigenous people and higher than in the NT. For endocrine disease it was 9.3 times higher, for digestive disorders it was 7.1 time higher and for kidney disease it was 6.8 times higher for Indigenous people in 2004 – 2008.

Potentially avoidable deaths in WA were 4 times higher for Indigenous people than for non Indigenous people.

The proportion of live infants born with a low birth weight in WA in 2008 was 18% for Indigenous babies and 4% for non Indigenous babies.

As compelling as the case for change in the WA health system is, there is clearly a great deal of resistance to change. This isn't isolated only to Australia or WA. This quote from a UK based health reform proposal deals with essentially the same underlying resistances in the professional medical system as we have here in WA.

“The whole approach of this review has been to develop clinical support for our proposals. But it is easy to support principles for London, harder to support change in the hospital or locale where you work. Many clinicians understandably fear that change will affect their job satisfaction, their autonomy, and their clinical reputation. To confront and assuage these fears, NHS London needs to indentify clinical champions to make the case for change.....”

What Now for the WA Primary Health Care Strategy?

- Targeted consultation;
- Building regional and local focus;
- Linking to other key activities;
- Where does health promotion fit?
- Aboriginal workforce priorities;
- Collaborative models;
- Pre-hospital service reforms;
- COAG and Medicare Locals.

Participant Discussions/Questions:

Primary health care consultations have a mechanism which closes out with a last ditch opportunity for consultation with clinicians. This opens up an avenue for the traditional and change resistant doctor sector to have the last say and override input from sectors like ours. What are your views on this?

Dr Towler responded to this, reaffirming his commitment to listening. He said that they know changes need to be made and also know the traditional sector/s will be nervous and quite loud in their

oppositions. Nevertheless, he said it will be necessary for changes to be made if there is going to be different results from what we have been seeing.

A participant stated that our sector must take responsibility for the poor mortality rates in WA and asked if Dr Towler agreed with that.

He said that he is always mindful of the sector's struggle to attract and retain doctors in the face of the much higher pay rates the public system is able to offer. He said that this leaves the ACCHO sector barely able to compete in the workforce market.

Another participant said that in terms of consultation, it is understood that the DoH has a cultural respect framework. If followed it would have included the Aboriginal community to comply with the impact statement framework. The State Health Executive Forum checks this off, so is this policy working?

Dr Towler responded by saying that the policy is alive but may not always work as well as it needs to. He offered that the translation of these framework policies into practice within a very big system is challenging and they don't always get it right. Consultation processes are not easy.

He said that the intentions are right, but our practice is less than ideal and he acknowledged they hadn't got this one entirely correct. We are committed but we find it hard. He asked to be able to put a challenge back to the sector because we struggle. Please help us to develop a legitimate model of continuous partnership through ongoing participation.

A WACHS representative spoke at this point and offered that they see the primary health strategy as very high level priority and are committed to regional planning with partners to bring about changes though regional plans developed in consultation.

A participant queried why the data Dr Towler was presenting was three years out of date at least and was concerned this would be out dated now? It was also pointed out the Minister for Health Dr Hames gave a commitment three years ago to develop a working party with people working on it, even at NACCHO level. The system is now resorting to bringing doctors in from other countries and cultures and yet Aboriginal people aren't even in the constitution of this country. So in effect, these people can claim to be Indigenous!

Dr Towler declined to get into the constitutional issues. Regards the data, it is the most recently published official health data in Australia. He remarked that it takes a long time to clean and present full sets of data. This is the most contemporary data we have and although it goes back to 2005 to some extent, we can very much rely on the trends.

It was pointed out by another participant that data from the ACCHS are not included and if it was, the graphs would look different. Why don't you engage with AMS to include our data as well?

Dr Towler encouraged the sector to discuss this in more detail. Any ideas to improve data collection would be well supported. As a great deal of the data are Medicare data, to this extent for GP services the ACCHS data would be included. Also the hospital, mortality data sources and midwives notifications on birth weights do include Aboriginal people. These are not data sources the ACCHS could contribute to.

It was pointed out by the same participant that we have special services in cities and large regional centres so we need to make sure these get out to the people where they are. We now need to talk about how we take services out to the people and not about bringing them in. We should be:

“Delivering the services to the people, not delivering the people to the services”.

Dr Towler agreed strongly with this position. He said there needs to be a network of specialists prepared to go out to where people are. We know there is so much undiagnosed burden of disease out there.

Des Martin offered that to capture Sandy’s point about data, AHCWA signed an agreement with WACHS to collect and share data together and look at how we can use these data for planning, developing strategies, evaluation and better reporting. There are jointly owned data arrangements in place.

Simon said he was aware of this and thought it was a big step forward. In terms of getting specialist medical services out to where the people are, he countered by saying that they can’t make specialists go to places they don’t want to go.

It was put to Dr Towler that:

“Your system seems to be able to make us jump through hoops so why can’t you get them to do the same?”

Dr Towler said that he sees our point, but that the department simply has no mechanism to instruct doctors what to do in this country.

He offered that the Conference might be interested to know what the public system is paying for medical coverage by specialist doctors in many country hospital Emergency Departments. The going rate is now up to \$3000 per day. And yet we still have a few specialists willing to get out there and do bulk billing to help get their services more accessible to people who need them the most.

Sandy Davis stated that if the mining companies were paying the basic wage, they wouldn’t have too many people working for them? He said that if we are dinkum about getting health professionals out to where they are needed, they need to be paid and set up. It costs a huge amount of money but we have to ask *“are we serious or do we just want to try and do it on the cheap”?* He said that if we don’t address health issues of people in rural and remote Australia, we will never close the gap. There will be a lot of financial pain – there will only be gain if governments are prepared to wear some short term pain.

Dr Towler said he agreed, but also countered that it isn’t just about money. The real issues are the need to change the basic culture within medicine in Australia. Unfortunately and for various reasons, the Australian health system is centered almost entirely on doctors who are for all intents and purposes in private businesses they own. They are not employees with a boss and for this reason, they cannot be told or forced to anything they don’t want to do.

The Hon Warren Snowden, Federal Minister for Aboriginal Affairs.

The Minister said that his first task was to congratulate Vicki O'Donnell for making the WA Women's Hall of Fame. He acknowledged that the participants all know Vicki well and that he knows her less well. He said that knowing her even to the extent that he does, he is quite glad they are mates!

He wanted to especially acknowledge her work in Derby and said that he believed this a great example of what a well led ACCHS can do working at the community level.

He shared his own view with the Conference that the ACCHS are in fact really good cross community service models and would work for everyone, not just for Aboriginal people.

We all know there are ACCHS with difficulties, but the good ones are absolutely fantastic.

Leadership is a key and essential ingredient, so congratulations to Vicki for a great job in leadership.

The Minister said that he also wished to acknowledge Nicole O'Keefe and the great job she does at the state level. We are very well served by the people who work for us in the Commonwealth and particularly fortunate to have Nicole on our team here in WA.

He said that chronic disease issues are right at the forefront of our minds. 50% of GP consults are for chronic conditions and smoking accounts for 20% of all Aboriginal deaths.

The Minister said that he felt very strongly that we have to do a lot more about preventing chronic illness and lowering the smoking rates. We know this is exceedingly difficult in remote Aboriginal communities.

50% tobacco consumption rates in Aboriginal communities and 16% for general population is, he said, just too high.

He commented that after the WW11, the smoking rates amongst adult males was 80% and that this had been reduced through public health measures.

We know if family members smoke, that kids will smoke.

One major thing we can all do to close the gap is to stop people smoking in the first place and get as many of the smokers as possible to quit smoking.

For this reason, COAG funding has gone into many new positions in Aboriginal services to help achieve a better level of tobacco control.

The Minister said that he has also been very actively promoting the Get Active/Eat Good Tucker/Live Longer initiative. He said there are four very simple messages to get out to people and if we can get people to put these measures in place in their daily lives, it will make a huge difference in helping to close the health gap. This particular campaign provided \$21.3m program over four years and is funding community initiatives to raise awareness and encourage healthy living.

The Minister said that this stuff is common sense. It is not medical, complex or hand work. It is simple, plain common sense and unless people make a conscious decision to live healthy, we will keep doing the primary health care interventions but we won't really be able to make a big enough difference in terms of measurable health benefits.

In terms of the Health Reforms the Minister said that he was concerned that for some reason people have got a message that because of Medicare Locals the Commonwealth government won't be funding the ACCHS directly anymore.

He said he wanted to make it known that the government will definitely continue to finance the ACCHS directly and through a quite separate funding program than the one for the Medicare Locals.

He said:

“Let there be no doubt and I will say this once and for all: let there be no confusion or distortions or communication mix ups, the new reforms are to provide opportunities for ACCHS and not threats. There is no threat to the funding of ACCHS at all”.

The National Indigenous Quality Council (NIQC) is an element of the new national ATSI health plan. The Minister said he has been having meetings with 'Close the Gap' groups and there have been discussions about how we can communicate better with the ACCHs sector. This will be the vehicle for NACCHO and health professional organisations to work through this framework and the Minister said he believed it would get us a comprehensive outcome.

The final matter the Minister addressed was the OPAL fuel initiative.

He said that there has been great success and expressed his thanks to BP who are now rolling out low aromatic fuel to remote Aboriginal communities. The impact has been up to a 94% reduction in petrol sniffing. One hundred and ten sites around Australia will be rolled out in May 2011 and will continue after this so that all communities with petrol sniffing problems have access to this new fuel technology.

He said Opal Fuel is made in Kwinana. It is transported to South Australia then trucked into WA through a special distribution network. It requires unique transport and storage arrangements.

The Minister said that there had been a bit of white anting behaviour by some fuel outlets which he said has been disappointing but was happy to say this is generally being dealt with successfully now.

He said the scientific evidence demonstrates Opal fuel is as good as, if not better than ordinary fuel and that they are doing some things to prove that and address the myth that Opal fuel is substandard and not good for car and boat engines.

He offered sincere congratulations to BP. A trial shipment is going to Canada for testing with Canadian indigenous Indian people. He also offered his appreciation to Opposition Leader Tony Abbot for his initial efforts in kicking off the vision of this fuel to prevent sniffing behaviour. Well done to BP for taking the initiative. Their investment in the R&D would hopefully lead to a good global market for the product which would benefit the company in the longer term.

A representative from BP followed the Minister after his talk and gave a brief overview of the Opal fuel product.

She said BP introduced it in 2005 as a practical response to petrol sniffing.

As the sole supplier of Opal, she said the company is very proud to be able to make a real contribution to reducing the damage caused to young Aboriginal people by sniffing aromatic petrol fuels. Production has increased at Kwinana and is now projected to reach thirty million litres this year which will be a thirty fold increase in production since 2005.

The five years of initial R&D investment by BP also involved technical support, talking with communities and testing the product. Opal meets all the requirements of the standard quality fuel but with low levels of aromatic and delivers a comparable performance to 91 Octane standard unleaded petrol.

OPAL is shown by research to be remarkably successful.

The company modified Opal to bring the product up to a much higher and comparable standard so it will work well and cleanly in engines designed to run on standard unleaded. The new formulation actually removes 20% of deposits left by standard fuel. It is cleaner and doesn't need aftermarket additives. It is still low in aromatics. The improved product has been manufactured since 2010 and is now being made available throughout the distribution chain, including the Goldfields.

The transition at outlets to pure new Opal depends upon the rate of consumption out of their holding tanks. In reality, in low consumption areas it may take a few tank refills before it becomes fully Opal and low aromatic fuel at the outlet.

It isn't suitable for cars designed to run on Octane 95 fuels.

The great benefit for engines designed for 91 Octane fuel is that it actually prevents new sooty deposits left behind by standard fuel and in addition to this, it gradually cleans up existing build up accumulated whilst the engine was running on normal 91 Octane petrol.

Opal is quite OK to use in small engines, including two and four stroke boat engines. Opal has exactly the same storage requirements as for 91 octane unleaded petrol.

AFTERNOON SESSION

Anne-Marie McHugh, A/Statewide Coordinator, Aboriginal Maternity Services Support Unit (AMSSU). Barbara Henry, A/Manager, Aboriginal Maternity Services Support Unit (AMSSU). Speaking on the AMSSU Strategic Plan.

Overview of the AMSSU:

- Funding for the Unit is through COAG, Element Two, Indigenous Early Childhood Development (IECD). \$3.28 million has been funded through until June 2014;
- Seven new positions have been created, including a Statewide Coordinator, Manager, Clinical Midwifery Consultant, Medical Officer, Researcher and an Administrative Assistant;
- Four of the positions are designated as 50d positions;
- The Statewide Coordinator position is a joint appointment with AHCWA; and
- Engagement with services is via Regional Planning Forum process, through direct local service provider requests and by way of community forums.

The Strategic Purpose of the Unit:

- Capacity and sustainability, supporting others to achieve their service goals for Aboriginal clients; and
- Improving the cultural performance of WNHS/KEMH .

The Goals are to improve health outcomes for Aboriginal women and families by:

- Encouraging improved access to antenatal, postnatal care and early access to child health services;
- Ensuring client needs are identified and met;
- Improving the cultural competence of the workforce;
- Encouraging and supporting improved service delivery;
- Supporting full partnership and collaboration in the identification ,design and implementation of services to the target group;
- Encouraging and supporting an holistic approach to maternity services provided to Aboriginal women;
- Ensuring continuous evaluation and monitoring of services and programs;
- Facilitating the use of economic evaluations in maternal and child health programs and services;
- Ensuring the design and direction of service delivery is in line with evidence; and
- Working in partnership with stakeholders and service providers.

The Strategic Direction for the Unit

The unit's role is to support services. It is intended to provide/support and/or facilitate:

- Evidence based clinical advice;
- Research;
- Information;
- Linkages; and

- Professional Development.

In the WA context:

An estimated 3.4% of the total population in WA identifies as Aboriginal. In WA in 2007, 5.9% of mothers were of Aboriginal or Torres Strait Islander descent compared with the national average of 3.8%;

Compared with non-Aboriginal mothers, the stillbirth rate was double in Aboriginal mothers, the neonatal death rate three-fold higher and the post-neonatal rate six-fold higher;

Aboriginal women living in regional WA have the highest rates of infant and maternal and health problems.

Modifiable factors are sustained and early access to culturally appropriate antenatal care, smoking cessation support, substance misuse support and improved sexual and reproductive health .

WA Frameworks and Work to Date:

Maternity Services Framework goal one Improving Health Outcomes for Aboriginal Women
<http://www.healthnetworks.health.wa.gov.au/projects/matservices.cfm>

Strengths and Needs Analysis of Maternal and Child Health and Model of Care for Maternal and Child Health available at <http://www.ichr.uwa.edu.au/accare/reports>

Strength and Needs Analysis Recommendations

Clinical Governance framework for Maternal and Child Health:

- Models of Care-Maternal and Child Health, Guidelines, standards of care inclusive of continuous quality improvement and action research at local level to inform this process;
- Infrastructure- dedicated clinic space, funding, communication and IT;
- Partnerships-for integration and referral ;
- Workforce –training and development;
- Health Promotion;
- Joint role between the AHCWA and WNHS to progress the recommendations of Strengths and Needs and communicate Model of care.

The model of care was informed by the ACCHS for the ACCHS in response to the Strengths and Needs Analysis.

Model of Care for Maternal and Child Health

- The broad objective of developing an integrated model of care is to ensure people get the right care, at the right time, by the right person and in the right place (Queensland Health, 2000; WA Health Networks); and
- An integrated quality model of care is one which considers all the factors that affect maternal and child health and wellbeing and considers these when planning a continuum of care from preconception through to early child hood.

Closing the Gap Targets

- Halve the gap in mortality rates for Indigenous children under five within a decade;
- Halve the gap for Indigenous students in reading, writing and numeracy within a decade;
- All Indigenous four year olds have access to quality early childhood education within five years, including Indigenous children living in remote areas.

To contact the Unit, Anne-Marie provided contact details and these are provided below:
Aboriginal Maternity Services Support Unit
amssu@health.wa.gov.au

Danny Brown, CEO of Mawarnkarra Aboriginal Health Service in Roebourne. Speaking on the benefits of COAG

Danny got his Mawarnkarra team up on stage to show that it really is a team effort in their health service.

He showed a video clip of an advertisement they had done to promote a working career in their health services to the local/regional job market.

They were able to do this using COAG funding. The advertisement was made to be shown on GWN TV.

Danni enthusiastically acknowledged the enormous contribution to Aboriginal health within the sector by the “old mob”. He said he was in awe of champion leaders like Sandy Davis, Margaret Colbung, Maxine Armstrong, Lorraine Whitby, Philip Matsumoto and Gloria Khan.

And he also acknowledged the “new mob” who are making a massive mark on the ACCHO sector leadership. People like Vicki O’Donnell on the AHCWA board, Pilbara Representatives like Aunty Geni Smith and many others.

Danni said that in Mawarnkarra they have got quite a few young people in their health service which he notes was a wonderful asset for the community. He said some of them are so young and so new that they say to him “Danni, what is COAG”?

He talked generally about the COAG objectives and the many benefits for the sector through being able to do so much more. Not only that, the process has created partnerships that didn’t exist before and even more is able to be achieved because of this.

Danni impressed Conference participants enormously with his sheer energy and his positive and excited outlook on the future for Aboriginal health and the leadership that is coming through from the younger generation of developing talent within the community controlled sector.

He introduced his staff as a team and said that without them, they would get nothing done.

In closing he outlined a few of the functions they had been able to establish through the COAG funding. He said that for example, they have a patient journey worker and a patient transport officer. He said these initiatives through COAG were crucial and making so much difference to their work in the

community. They also have a trainee Aboriginal Health Worker who is being developed to focus on the child health program.

**Nola Taylor, Coordinator for Aboriginal Health, South Metropolitan Public Health Unit.
Speaking on the benefits of COAG**

Nola Taylor introduced Charlie Kickett who she had invited to come along today to talk about the benefits of the COAG reforms from the perspective of an Aboriginal service client and contributor on a local health action team.

Charlie and his wife Helen are residents of the Kwinana/Rockingham area and have been there for over thirty years. They have seen many changes take place during that time.

Charlie has held many positions in the community, from working in the welfare arena to policing before he retired. Both Helen and Charlie have committed to supporting the ongoing needs of the Aboriginal community for primary health care, education and well being. They provide support to help the council to meet the community needs. They are members of the Aboriginal Health Action group for the district which works with the South Metropolitan Public Health Unit.

Charlie addressed the Conference and said he was borrowing a line from Big Kev on TV in saying "I am excited about what is happening!" He said he and his wife Helen believe that the COAG reforms are the best thing done so far because of the funding made available at the community level to improve health for Aboriginal people.

He noted that from the start when COAG action first happened that there are many more good things happening in the community due to so many different programs. He said he didn't bring a big list like Danni Brown, but said they also have some of the same sorts of things occurring as well.

Charlie said that he remembers the old people with sickness like diabetes, heart disease and high blood pressure and recalls many of them dying. This left him with a lot of fear about the horrible things some people have go wrong with their health which caused so much death and suffering.

He said he was very shocked when he found that he himself had diabetes and that he knew that for him this was caused from *"too much going to fast food joints"*.

He shared with the Conference that he was afraid when he was told about having Diabetes, and that he sat down and cried. He was frightened because he thought that was going to be the end and that his life was finished. He believed he was going to die just like the old people.

He said he didn't know at the time that it was possible to manage diabetes and learn how to live with it and not die from it.

Charlie said that his people in the local area have a say in what goes on from the community level. The Health people talk with us before they go ahead and put in programs and that this is so important because *"we Aboriginal people vote with our feet"*.

If the people don't understand what programs are in place and the reasons for them, they won't or can't use the services properly and these programs are out there on their own doing not much good for anyone.

He said that on the other hand, if they do things the way we know the people will like, there will be great benefits. Our people appreciate being given a say in things and to have our voices listened to. And the people have more trust in things that they know have been done by talking and listening to Aboriginal ideas.

Charlie said that Aboriginal people have a very clear idea about what is wrong, why some things don't work and the things that will work best. For this reason, he believes that things will work better when the government gives the people as say in the way things are done.

He said "I just want to tell you that great things are happening because of all this work. People are attending doctors and taking part in many programs now and the health benefits are very good".

Charlie confessed that he used to always think twice about going to the doctor because he worried about how much it would cost and if he would have enough money.

Now, because of some of the programs and services provided through COAG, the people know they can get medical care and that they don't have to be worried that they may not have enough money on them to pay the bills. This is why, he says that he feels so excited about what is being achieved through the COAG reforms.

Mr Sandy Davies, Chairman of Geraldton Regional Aboriginal Medical Service and Chair of the Yamitji Regional Planning Forum. Speaking on the benefits of COAG and the Regional Aboriginal Health Planning Forum approach.

Sandy commenced his talk by firstly acknowledging the sadness of today because of another tragic loss of life through the suicide which happened in Kimberley yesterday. He reflected that it was yet another sad day for Aboriginal people and that it was even sadder because there will probably be a few more lives lost in this way before we rectify things.

On another note, Sandy reflected about how Governments come along and do their reviews of various programs. He said they take a look to see if they can find something that isn't working and occasionally they will just wipe things out across the board. For this reason, he cautioned the Conference participants to bear this in mind with programs that they believe are important and doing a good job.

By way of an example Sandy offered that there had previously been thirty seven Local Justice Reference Groups and ten Regional Local Justice Forums in WA and that because some were found not to be working, the whole lot got abolished by the government.

He repeated his key message here with particular reference for the Regional Aboriginal Health Planning Forums:

"Make sure they are all working really well so the government can't find any reasons to come along and abolish them."

He advised participants to bring together all the service providers and to make sure the members focus on the older programs as well as the newer initiatives. He said, aim to get rid of things like duplication, things that are not working well enough and try to reinvent them into programs that work better.

A couple of great things to reflect upon:

One is the 'True Health True Culture' initiative which is run jointly by the Carnarvon Aboriginal Medical Service and the local Carnarvon District Hospital. They won an award for this program; and

The other one is that we have the first Aboriginal person to be appointed to a senior position in WACHS in our region. Jasmine Gregory has just been appointed as the Regional Aboriginal Health coordinator.

Sandy then reflected that when we talk about cultural security, we start thinking back to our own culture. But we also need to keep in our minds that one of the components of cultural security we don't see enough action on is making sure we have Aboriginal people employed in the government sector in senior management and decision making roles.

These are just two examples of the good things happening now through COAG and the Regional Aboriginal Health Planning Forum approach. We could only have dreamed of these outcomes in the past and now we are seeing more and more examples and breakthroughs.

In our Forum, we have every health provider imaginable around the table. We also have other agencies involved who are not health providers but who have indirect involvement in developing initiatives. A good example is the Mid West Development Commission. It was through this connection that we got funds to help us get the Mt Magnet health centre developed.

The thing to always bear in mind is 'who can contribute'. This is question you need to keep asking yourselves.

Sandy also offered that in his view, the current Minister for Health Dr Kim Hames is the best the state has had so far. He also said that he had known the current Director General Kim Snowball for a long time and had great respect for him. He said that if it had not been for Kim's efforts when he was in charge of SJOG Hospital in Geraldton they would never have gotten their foot through that doorway. He said he believed that Kim Snowball was one of the most pro Aboriginal people he had ever known.

"If we can't close the gap while we have Kim Snowball and Kim Hames in charge, we never will".

Again, here Sandy reminded participants that there are two major things they need to focus on:

1. They need to make sure all of our Regional Planning Forums are operating as they should. He said they need '*to be, and be seen to be*' a highly functional system and it is up to us to make every one of them work; and

2. They need to make sure everyone in their Forum and in the health services are thinking constantly about closing the health status gap and keep making Aboriginal health everybody's business.

In closing, Sandy said he had been reflecting back on Minister Snowden's comments about smoking amongst Aboriginal people. He recalls the days when the government thought it was okay that all those old people got paid for their labour with jam, flour, tea and tobacco.

He said if the people couldn't or didn't like to smoke it, they learned to chew it because it had to be of some use to them because that was how they got paid.

Sandy said he was only a kid back in those days but he remembers so much of it well. He said he was struck by the irony of how it was back in those days when getting paid with tobacco instead of money was a policy supported by government. And yet here, now, we have a Minister of the government standing up and telling us that tobacco use is "our problem and people should just stop using it".

Mr Kevin Green, Paul M. Taylor and Co. Speaking on Governance: an auditor's perspective.

Kevin summarised the key elements of corporate governance for participants. These are listed below:

- Compliance with laws, regulations, standards and best practice guidelines;
- Matters reserved for the board – the roles of the Chairman and other members;
- Adding value;
- Delegation of authority (not accountability);
- Ethical and responsible decision making;
- Respecting the rights of its members;
- Risk recognition and management: financial, administration and records, audit, CEO performance evaluation and fair remuneration for employees.

Aboriginal Community Controlled Health Services are incorporated under Acts which provide the legal framework:

- The Corporations Action 2001; or
- The Corporations (Aboriginal and Torres Strait Islanders – CATSI) Act, 2006.

Kevin then talked briefly about six major focus areas of board accountability and the relevant sections in either Act which provide the specific legal construct for each. These are summarised in the table below:

ACCOUNTABILITY ELEMENT	ACT /SECTION		KEY POINTS
	CORP ACT	CATSI ACT	
Care & Diligence	180	265-1	Decision making in good faith for the corporation; without personal interest and being properly informed.
Good Faith	181	265-5	Honest intentions and best interests of the corporation.
Use of Position	182	265-10	No improper use of position to gain an advantage for self or someone else to the detriment of the corporation.
Use of Information	183	265-15	No improper use of information for personal gain or to detriment of the corporation
Duty of Disclosure - Material Personal Interest	191	268-1	Interests, rights or privileges must be disclosed when they relate to the corporation.
Insolvent Trading	347A	531-1	Review the corporation's solvency on a regular basis and ensure it remains solvent at all times.

Solvency means that:

'There are reasonable grounds to believe that the corporation will be able to pay its debts as and when they become due and payable'.

Kevin discussed some indicators that board members need to be aware of as they could indicate risks to solvency and should trigger inquiry/investigation. These are listed below:

- Recurring operating losses month after month;

- Poor cash flow;
- Absence of cash flow forecasts;
- No business plan;
- Incomplete financial records;
- Disorganised internal accounting/administration;
- Increasing debt;
- Problems collecting debtors;
- Unpaid creditors and/or increasing trend for creditors to be paid outside the usual terms (> 90 days);
- Letters from creditor solicitors, payment demands/summonses and judgments issued against the corporation;
- COD terms only demands by suppliers;
- Post-dated cheques being issued;
- Dishonoured cheques;
- Overdue taxes, unpaid GST and increasing superannuation liabilities;
- Loss of management personnel;
- Increasing complaints from suppliers.

Kevin then offered participants some simple measures they can use themselves to assess whether or not their corporations are 'going concerns'.

The first one is assessment of the Working Capital. The formula is quick and easy:

Working Capital = Current Assets - Current Liabilities

An example is in the table below:

CURRENT ASSETS	100,000
LESS CURRENT LIABILITIES	50,000
WORKING CAPITAL =	50,000

Another simple but effective measure is the Liquidity Ratio. The formula is:

Liquidity Ration = Cash/Current Liabilities (the answer should be great than (>) 1.

An example is in the table below:

CASH	70,000
CURRENT LIABILITIES	50,000
LIQUIDITY RATIO =	1.4

The Consequences of Insolvent Trading

A board director must take reasonable steps to keep informed about the corporation's financial position.

Civil penalties of up to \$200,000 can apply if it is proven that the director did not take reasonable steps. In such cases, it isn't necessary to prove that a director/s intended to be dishonest. Rather, it is simply a

case of establishing that they did not take reasonable steps to keep themselves properly informed of the actual situation. Essentially, this means that:

“Not knowing, is not automatically an acceptable excuse”.

It is also possible for a board director/s to be sued by creditors (suppliers of goods or services who owe you money).

If dishonesty is involved and proven (meaning that there was an actual dishonest intention to do the wrong thing) there can be criminal consequences (charges, penalties etc).

System of Review

Organisations should have systems in place to ensure that there are regular and robust reviews of the major accountability areas of the board.

At a minimum, there should be:

- Established annual budgets and cash flow projections;
- Regular and detailed reviews of financial performance compared with budgets;
- Variances should be analysed;
- Forward outcomes should be projected and the underlying assumptions assessed;
- Review of the internal controls. For this, the board should ensure that there is:
 - Segregation of duties – good administration risk minimisation to break jobs up. For example, different staff are responsible for purchasing and for paying invoiced (removes temptation);
 - All transactions are properly authorised;
 - Documentation and records are adequate – no payments are made without an invoice;
 - Good physical control of the organisation’s assets – mobile assets in particular;
 - Independent checks on the reliability of accounting information and the overall efficiency of the organisation.

Kevin closed his session by also advising that it is a good idea for boards to have a properly functioning audit committee in place.

He also recommended boards take opportunities to source ongoing education and that they focus on ensuring that directors understand how to interpret balance sheets and the associated financial statements.

He encouraged boards to utilise the auditors and accounting experts they have available to them and to take up opportunities to undergo refresher/continuous governance education.

Participant Discussion/Questions:

A participant asked about situations where Aboriginal Elders do paid consulting work for ACCHS. They fill in a statutory declaration so we don't have to withhold 48.6% of their payment. Is this OK?

In response, Kevin clarified that if the individual does not have an ABN, it is acceptable that they receive one off payments on this basis.

Another participant talked about issues years ago from ATSI days where previous directors/boards did knowingly trade when they were insolvent. She said some of these people not only got away with it but they continue on other boards and give other people a bad name. She said they should be removed or ineligible.

In response, Kevin offered that he cannot speak about ATSI or the historical issues. But he did stress that the important thing aside from any of these issues from the past is that people on boards at the present time learn and take steps to ensure they are doing the right thing and protecting themselves appropriately. For example, he recommends that directors take care not to become 'compliant' with others. If you disagree with something then you should request that your disagreement be recorded in the minutes. This can be done politely and respectfully and is how boards regularly do their business.

He reminded participants here that a board can '***delegate responsibility but cannot ever delegate accountability***'.

Ms Glenda Humes, CEO South West Aboriginal Medical Service. Speaking on Governance: From the organisational perspective.

Glenda opened her address by describing good governance in terms of how public institutions conduct affairs and manage public money. She said it is:

"A process of decision making and decision implementation".

Glenda then sought by show of hands the numbers of participants who have done some governance training. She then asked for a show of hands amongst the CEOs who had undertaken governance training.

It was demonstrated by the show of hands that quite a lot of the directors had done training.

Glenda described herself, as a former lawyer and that she had very much enjoyed the study of corporate law. She said this had given her a love of governance and a great respect for it.

She described the somewhat different system they have structured for governance in SWAMS, which she said was designed for a region with a major city in addition to a number of much smaller towns within the catchment area they serve.

The AMS has a wide regional service area and so they have a Ward system for the board. There are six Wards and eight directors. Directors are elected locally by their own Ward constituents. Bunbury has three directors and the others have one elected director for each Ward.

Glenda said that there had been some questioning as to whether Bunbury should have more Ward directors representing its interests. There was a good deal of board discussion about it and there were some suggestions to take away one of the other Wards and give it to Bunbury.

The board as a whole debated this and the majority voted in favour of this not happening.

To further demonstrate the governance process at work, Glenda also shared with participants that there had been a resolution passed at the last AGM that the board would create two additional director positions. These are to be 'selected directors' and not elected like the Ward representatives and they will be chosen specifically for the particular skills they can offer.

Glenda then sought a show of hands from participants who have served on boards at times when there have been difficult problems confronting them. Almost all the directors amongst the participants raised their hands, indicating that most boards encounter problems at some time.

Glenda offered that in her own area last year there had been an issue which ended up being about having to manage inappropriate interference in an operational matter by a director. This amounted to incorrect use of position and confidential information. It was quite a serious governance issue and in this particular instance, the board had to take quite firm action.

She commended the board, who she said showed courage and leadership. They knew the right thing had to be done and they stuck to their position knowing not everyone would be happy. They also made sure the decisions were transparent.

It was very challenging for them, even to the extent that a vote of no confidence was moved against the board at a big community meeting. In the end, a community elected individual was terminated from the board, but it was extremely difficult for some directors as they worked through the backlash.

This affected the board significantly and there were even some resignations. But the final result was that the board became more stable. Glenda said the board is now a very 'thoughtful and wise' group.

There are elections later this year when the whole board stands down in October. The board also had the death of a member to deal with. Glenda said she observed how this had brought them much closer together and this had made them even more effective in their stewardship of SWAMS.

Glenda acknowledged that she was speaking about sensitive information, but she clarified that she had been given the authority by the board chairman to tell this much of their 'story' in the spirit of highlighting some of the challenges boards face. They also wanted to share what they had been through and what they had learned along the way. There is a very strong belief within the SWAMS board about the important role the boards can play for the whole of the community.

This value is even greater when you get board members who are there for the right reasons.

Equally so, it can be incredibly difficult when people get onto boards for the 'wrong reasons'.

In SWAMS, Glenda said that they changed the rules governing who could be on the board. This involved not just the Ward system, but also applies now to rules about family relationships.

The board has set out to get a very good cross section of the community within their membership. They are also concerned to good gender and age balance and they have deliberately made the shift away from the risks of being a 'family centric' board.

Glenda's message for CEOs who play a lead role in communities and with boards was that they need to know their constitutions *'inside and out'*. She advised that they take the constitution to every meeting so it sits close by on the table and is actively used as the framework it is.

The CEO, in her view, also needs to know a lot about governance. The CEO must be able to advise the board on governance matters very reliably. The strength of boards correlated to some extent with the strength of their chief employee and most senior and influential staff.

Glenda said she has seen organisations really struggling and talked about instances where the clinic services generally work quite well and often in spite of, rather than because of, the quality of executive management and governance by the board

Participant Discussion/Questions:

A participant talked about problems being experienced within boards which can get 'ugly' For example, you might have a director or a manager breaching conduct, abusing powers and the like.

In response, Glenda stressed that there needed to be very clear distinctions between the roles and responsibilities of board directors and management staff. There must be good separation of powers. She pointed out that a strong CEO will occasionally have an argument or a debate with a board around certain things and that this is a very good quality in the main. Boards also should take care not to interfere with day to day management. For example, members of the SWAMS board have a discipline now about how to deal with operational issues they might become aware of. A director will not go to any staff member for example or try to sort things out at a management level. They will come through her as the CEO and she said that it is her job to follow through with the management action and to advise the board on the outcome of the matter.

If things are uncertain or there is disagreement, it must be sorted out in the boardroom.

Glenda suggested that there should be a clear charter for each board, quality orientation and training for directors. She said there should be a lot of assistance for new directors.

Another participant put the position that on many ACCHS boards, directors are elderly and not educated in finance or other corporate accountability matters. At times they don't really even understand the process. The speaker said that it can be:

"Quite frustrating at times for them and us. These directors often get tired and bored and they don't make decisions".

But on the other hand, the speaker said that Elders are so important in their own right because of who they are and the cultural wisdom they possess. However, the reality is that if or when a board is made up almost entirely of people who are both Elders and quite elderly, it can be unworkable.

Glenda acknowledged that these things do happen and need to be dealt with. She said it takes care and time to sort out and that the CEO needs the skills to find a way to both assist and get value from a board like this.

An effective CEO will work with the board before and between meetings through processes approved by the board so the administration processes and decisions are not held up or overly dominating or frustrating board meeting times.

Another participant also cautioned everyone to remember that ACCHS are run by Aboriginal people, for Aboriginal people and that this should always be the central principle. The quality of the relationship between the chairman and the CEO is crucial. It is up to us as a sector to bring the young ones – like Danni Brown and his young team from Mawarnkarra – along and encourage and nurture them.

Lisa Bastian and Jude Bevan, Sexual Health and Blood Borne Virus Program, Communicable Disease Control Directorate. Speaking on the Hepatitis C implementation plan and the Hepatitis B National Strategy WA implementation plan.

The presenters commenced their presentation with some statistical information:

The rate of newly acquired Hepatitis B in WA in 2010 was the highest in Australia and 36% higher than the national rate;

The rate of newly acquired Hepatitis C in WA in 2010 was the second highest in Australia and 80% higher than the national rate;

From the perspective of trends within these rates over the last five years, both Hepatitis B and C are trending down;

The rates are generally higher for Indigenous people than for non Indigenous people and this was exceptionally the case for Hepatitis C notifications in the metropolitan area in 2010;

Hepatitis C notifications in the Indigenous population aged 20 – 24 years in the metropolitan area in 2010 was markedly higher than all other aged groups, although the rates for Indigenous people across all the affected age groups was generally higher;

Hepatitis B notifications in WA in 2010 were 6% from Aboriginal people and the rates for Aboriginal people fluctuated considerably over the period from 2001 to 2010. The ratio of Aboriginal to non Aboriginal notifications was 1.7: 1; and

Hepatitis C notifications in WA in 2010 were 13% from Aboriginal people and the rates for Aboriginal people also fluctuated across the ten year period. The ratio of Aboriginal to non Aboriginal notifications was 9.7: 1.

Hepatitis B Vaccine Coverage

- Universal hepatitis B vaccination at birth commenced in Australia in 2000;
- The current schedule for hepatitis B vaccine:
 - Birth, 2 months, 4 months, 6/12 months;
 - Catch-up program for adolescents.
- For those aged 24-27 months, rates of vaccine coverage are comparable for Aboriginal and non-Aboriginal infants;

- Decline in prevalence of markers of hepatitis B infection and carriage in Aboriginal and Torres Strait Islander children since the introduction of vaccine.

Strategic Context – National Strategies

- Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013;
- National Hepatitis B Strategy 2010-2013;
- Third National Hepatitis C Strategy 2010-2013
- Sixth National HIV Strategy 2010-2013.

Third National Aboriginal and Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy 2010 – 2013

- The goals of the Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013 are to:
 - to reduce the transmission of, and morbidity and mortality caused by, STIs and BBVs;
 - to minimise the personal and social impact of these infections.

WA Hepatitis B and C Implementation Plans - Consultation

- Draft plans and questionnaire – distributed widely by email;
- Sent to 180 individuals;
- Consultation meeting;
- Currently – sign off on Memorandum of Understanding by key stakeholders.

Priority Populations Hepatitis B

- Draft plans and questionnaire – distributed widely by email;
- Sent to 180 individuals;
- Consultation meeting;
- Currently – sign off on Memorandum of Understanding by key stakeholders.

Priority Populations Hepatitis C

- People with hepatitis C;
- People who inject drugs ;
- Aboriginal people ;
- People in custodial settings;
- People from culturally and linguistically diverse backgrounds;
- People with hepatitis C with co-morbidities.

Priority Action Areas

- The priority issues of the Plan include:
 - primary prevention for priority populations
 - secondary prevention and early detection

- disease management and tertiary prevention
- workforce development
- Monitoring and evaluation
 - WAISHAC
 - WACBVSS

Role of the Sexual Health Blood Borne Virus Program

- Implementation of plans at state-wide level in partnership with key stakeholders;
- Funding;
 - Health promotion and prevention activities;
 - Education and workforce development.
- Support state-wide campaigns (Hepatitis WA);
- Vaccination program;
- Coordination of state-wide needle and syringe program.

Resources

- Vaccines
- Health promotion resources and hardware;
- Assistance with establishing/maintaining needle and syringe programs;
- Workforce development grant and bursaries <http://www.public.health.wa.gov.au/>
- Hepatitis B and C on-line education program <http://hepatitis.ecu.edu.au/>
- DAO - Blood-borne Virus Capacity Building Project;
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Participant Discussion/Questions:

A question was posed about the prison population.

In response, the presenters said the models elsewhere have been successful in prisons when using needles exchange mechanisms to prevent spread of BBV. So far in Australia no jurisdiction has been willing to pilot it but a private prison in Canberra is looking at it.

Pat Mason and Susan Murphy, Manager Aboriginal Justice Program, Department of the Attorney General, Policy and Aboriginal Services Directorate. Speaking about the Aboriginal Justice Program: The role within the justice system and partnerships with Aboriginal Community Controlled Health Services.

The Aboriginal Justice Agreement between Justice and related State Government Agencies and organisations representing Aboriginal people as signed March 2004 and expired March 2009.

The Aboriginal Justice Agreement was an engagement program that replaced the Aboriginal Justice Council which wound up in 2002.

It was established to address the over representation of Aboriginal people in the justice system, both as perpetrators and victims.

There were twenty four local and ten regional forums culminating with a State Congress and the initiative was commenced in 2003. It was funded in July 2006 as an initiative following the Mahoney Inquiry (2005) with \$10.8m over four years funding provided (averaging \$2.7m per year).

Although strongly focussed on justice issues, it has not overlooked the link between unhealthy lifestyles and mental health and the ascension to offending and high levels of victimisation.

Aboriginal Justice Agreement Evaluation

- Internal audit (KPMG) March 2008;
- Monitoring and evaluation framework agreed, March 2008;
- Process evaluation, November 2008;
- Impact evaluation completed in late 2010.

Key findings:

- Failed to work on an established baseline;
- Failed to engage government agencies;
- Failed to achieve results in community development.

After the Evaluation

- Greater scrutiny of data;
- Strong direction from the government;
- Four areas for attention:
 - Drivers licences
 - Fines Enforcement
 - Young Offenders
 - Family and Domestic Violence
- Strategic approach based on consolidated data from across government:
 - Police
 - Transport
 - Courts

- Health
- Child protection and
- Community

New Directions

- Change from Aboriginal Justice Agreement to Aboriginal Justice Program:
 - Work strategically with targeted regional communities to facilitate measurable improvements in these 4 key areas.
- Outcomes from the program scheduled to be assessed in four years;
- Enhance the successful open day concept where multiple agencies collaborate on addressing community problems.

Opportunities for Improvement

- Three tiered partnerships across the human services organisations:
 - Executive – Aboriginal Affairs Co-ordinating Committee;
 - Regional Executive – Human services managers;
 - Local – Managers and field staff.
- Aimed at a collaborative and strategic approach to solutions across the state.

Partnerships

Engaging and working with health agencies – government and NGOs to:

- Focus on mental health with prisoners;
- Reduce the high levels of victims of trauma from assaults and sexual abuse;
- Identify the gaps – share information.

Aboriginal Justice Program Expertise

- Research specific to Indigenous disadvantage;
- Capacity to engage Aboriginal people;
- Legislative reform;
- Project management;
- Working collaboratively with others.

Pat Mason is the co chair for local regional and state levels and has a background in health.

She explained that she got out of Department of Health because she knew that she could be a much stronger voice for what is needed.

Pat offered that the program in WA is the only Aboriginal justice community approach that works bottom up from grass roots level.

She said that looking at 'hot spots' which can be clearly seen in 2010 Police data showed interesting information. Offences against others were at very high rates in Laverton, Wiluna, Halls Creek, Meekatharra, the Lands areas, Magnet, Mullewa, Wyndham, Derby and Sandstone.

The data also show the highest violent crimes by rates at the present time.

She said that in her mind the issues are linked and that we need to be developing strategies for how we plan to improve health and well being and lower violence and Aboriginal offending, incarceration and victimhood.

The presenters invited discussion with the participants at the conclusion of their formal presentation.

Participant Discussions/Questions:

A participant asked if data are available on offenders by region, district or even town levels.

Susan responded that the website is a rich data source of easily available and current data which is updated every Friday.

Danny Brown pointed out to the presenters that COAG gives us an opportunity to work together between Justice and Health.

Clarification was sought from Susan that the ACCHS would be contacted so they are aware when her team are visiting the area.

Susan confirmed that they would certainly ensure this happened.

The questioner also asked about the role of the Aboriginal Liaison Officers who are employed in the court system.

Susan explained that they are there to help people going through the courts or into prison. She said that the decision to establish these positions came out of the report. But she acknowledged that there aren't enough of them and that they sometimes find themselves having to act a bit like 'default lawyers'

There was a question also about the circuit magistrates who go around the northwest, and it was confirmed that the ALOs accompany them.

The questioner pointed out that the community needs to be given this information so they can have a better understanding of the roles.

Susan responded that she wasn't from the court system so couldn't speak for them. She suggested that if there were community needs for information about how the court operate their support systems it might be helpful to approach them directly.

A participant asked specifically for information about what is being done to deal with the criminally insane who are incarcerated at the governor's pleasure?

The presenters were unable to answer this question.

A participant from the Kalgoorlie area inquired as to whether or not Susan or her team would agree to come to the community to discuss ways these issues might be addressed.

Susan agreed she would be pleased to do this.

Another person explained that they had written away for a birth certificate but couldn't get one. They then had to wait until next time the courts have an amnesty process for people born during the time when birth certificates were not routinely issued for all Aboriginal people. Otherwise, the person explained, the process for getting a birth certificate can cost a lot of money.

It was pointed out that the Registrar should go out to the regions and ensure birth registration is more accessible to the affected Aboriginal people. The date of the next amnesty was not known to the presenters or participants but Susan offered to find out and let people know.

There was a question about where the Aboriginal Justice Program fits with the Royal Commission on Deaths in Custody and it was also noted that this issue had been 'quiet' for some time.

The presenters stated that they were uncertain about this aspect at the current time.

A participant from Fitzroy Crossing offered that she would be very happy to see the Program team visit their area to talk to them about people going to prison who might have FASD. The Justice system don't recognise FASD. The participant, Maureen Carter also offered that she went to Canada in February this year and that seven judges talked with the tour group. They advised that they have specific programs to deal with people affected by FASD who go through the courts/justice system.

Susan responded by saying that the FASD issue does concern the Aboriginal Justice Program team and that they would be pleased to follow up on this invitation.

There was a question about Aboriginal Sentencing Courts.

Susan advised that there is one operating in Kalgoorlie and that it is under evaluation at the present time. She agreed to provide information about this as soon as possible.

A participant from Broome (BRAMS CEO Chips Bin Kali) suggested that the team visit Broome if and when they do make a visit to Fitzroy Crossing to speak with their medical team about the new legislation on Cannabis. The team agreed to this also.

A participant from Kununurra noted that FASD hasn't been accepted as a diagnosis or a disability. He asked if it was necessary for this to be addressed before the Court system is asked to recognise it as a factor in dealing with offenders before the courts. It was also noted that this could impact on pensions and other eligibility domains.

Pat Mason responded to this discussion and offered that people affected by FASD may require specialised counsel and legal advocacy in the same way as individuals with other intellectual disabilities.

The Fitzroy participant stated she believed two things need to happen;

- Increased awareness. On this aspect, she reported that a FASD research study will be getting underway and that there had been a 97% consent rate from local people wishing to participate in the study; and
- Development of a diagnostic tool.

A request was put to AHCWA CEO Des Martin asking if they would try and find out information about the Canada model on behalf of the sector. Des agreed it is a really important issue but also expressed concern that the AHCWA team may not have the specific expertise in this area and would need input from a suitable person/s from the services. He said he felt it could be done as a coordinated approach.

The CEO from Mawarnkarra in Roebourne (Danni Brown) contributed to the discussion and offered that in his local role, he wears 'two hats' and the other one is to do with the justice area. He said that he agreed there are a lot of issues to work through. But he also felt strongly that we have before us some real opportunities to make new breakthroughs. The linkages are strong now between the community and government sectors and partnerships are critical for getting anything done. He said he was reminded of the theme for this Conference which is 'New Decade/New Opportunities'.

Susan agreed and responded also that "Nelson Mandela said change will only happen if many come together".

A representative from OXFAM reminded participants that they have a research unit and offered an opportunity for people to talk about research ideas in FASD.

CLOSING THE CONFERENCE

Ms Vicki O'Donnell, Aboriginal Health Council of WA Chairman addressed the participants for the closing session.

She took this opportunity to present the key messages from the two day conference program. These are listed below.

Main Messages from Day One:

Aboriginal Medical Service development has been taking place over a 30 year timeframe so far – what a huge difference you have made in that time!

The sector is still in the process of growing and reaching its full potential.

Aboriginal youth area the most valuable asset we have for the future and what we do in the next two decades will impact on them one way or another.

The current health reforms are the biggest shakeup of primary health care policy in Australia in most of our lifetimes.

It is quite likely that we won't get another chance at such fundamental health reform for a very long time and we will be living with the results of the current reform for decades.

It is vitally important that we are a major participant in the reforms and that we work on trying to get it right.

Our sector in WA is a proven leader in partnering. No other state has achieved what we did in the COAG rollout through working in partnership with others at the local, regional and state levels.

We must leverage this success as the primary health care reforms take shape.

We are a big lobby and at our most powerful when we speak and act together.

We are well positioned to push the boundaries for the sake of Aboriginal people getting the best possible results from the big shakeup of the health system.

Main Messages from Day Two:

The Conference called very loudly for at least a full day to workshop with the Mental Health Commission on mental health strategies and the potential role for the community controlled sector. Their key message was that much more time is needed.

The Mental Health Commission has a few new wheels to invent but the Aboriginal primary health care wheel was invented more than three decades ago – so this is one wheel nobody needs to wait around for someone to ‘re-invent. The sector is ready, willing and able to start work on better mental health servicing for Aboriginal people right now.

The reality backdrop for the WA Primary Health Strategy: the seventeen times higher Aboriginal mortality rate in WA and the worst health status gap in Australia. Dr Simon Towler said:

- *you can’t keep doing the same thing and expecting a different result; and*
- *We can’t direct or force private GPs and specialists to go where they don’t want to go.*

Therefore, our sector MUST be a major player in primary health care reform. If we are not, how will it be possible for anything to change?

Minister Snowden’s message:

“Let there be no confusion, distortion or miscommunication about the Medicare Locals health reform. This reform is about opportunities to improve primary health care and is not about being a threat. I want to dispel the myth that somehow ACCHS are going to be defunded. That isn’t going to happen – ACCHS will continue to be funded out of a separate ‘bucket’ of funding”.

Mawarnkarra rocks! Danny and his young team are living proof of the leadership the sector has coming through the younger generations.

The Conferences also heard about a sad loss of life in the Kimberley and one of the senior leaders made the comment “another sad day and there will no doubt be a few more sad days before things are rectified”

Work hard on making your Regional Planning Forums work well. They are the most important vehicle for getting things done in partnership with others.

Good governance is care and diligence centered in the principles of “Services for Aboriginal people controlled by Aboriginal community people”.

Government Policy can be ‘funny’:

- *Once it was a policy acceptable to government for Aboriginal workers to be paid using tobacco as a substitute for money; but*
- *Now, government policy is against smoking!*

In closing, Vicki undertook that the sector, through AHCWA will follow up on the priorities which spring out of these observations about what was discussed over the last two days.

She also advised that discussions are going on with OATSIH with a view to two conferences each year.

She agreed that a yearly conference and planning workshop opportunity is not enough and doesn't allow time to get into the highest priority matters in any depth.

She wants to see a lot more opportunity for all the members and the sector as a whole to develop side sessions/meeting and workshops. A good example would have been for a day to have been available to spend working with the Mental Health Commission.

Vicki expressed her appreciation to all the participants for coming together and participating so actively in the discussions on the issues and with the various presenters this year.

She also thanked the AHCWA team for their great work in putting the program together and supporting so well.

For next year, she called for a program which would also allow more opportunities for participants to hear from the experts and leaders we have in our very own sector.

2011 STATE SECTOR CONFERENCE CLOSED