Better Practice
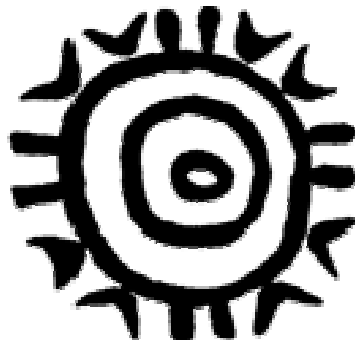# for Child Health Service Delivery
to
Queensland Indigenous
Communities

FINAL REPORT
February 2002

Indigenous Health Program

THE UNIVERSITY
OF QUEENSLAND

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Better Practices for Child Health Service Delivery to Indigenous Communities

Executive Summary

This project examines the healthcare of indigenous children 0 to 5 from a functional or "process" perspective. It highlights practical barriers to care, relationships between service providers and services, and success factors drawn from three well-regarded, best practice programs and projects, some aspects of which are supported by scientific evidence.

Improving the health of Indigenous peoples (particularly in rural and remote communities) must be underpinned by a multi-dimensional approach which targets improving socio-economic status, environmental health and basic community infrastructure such as housing, sanitation, water and electricity. This is a systemic response to the adverse affects of social determinants of health. Within the health sector direct responses to need can also help to mitigate the effects of these social determinants, at an individual, family and community level. Improving the capacity of health services to respond to the cultural security and health needs of Aboriginal and Torres Strait Islander clients is an important complimentary step towards achieving better health outcomes. A holistic approach to health, one which recognizes the interconnectedness of physical, emotional, mental and spiritual health across individuals, families and communities is an essential part of improving outcomes. A holistic approach to Indigenous health compliments the strategic focus on greater integration, seamless health services and continuum of care. (Barton R, 1999).

Early childhood is an important period of growth and development that has its own health problems and influences a range of adult health outcomes. As such, the 0-5 year age group is the target for this project. Health issues for Queensland Indigenous children aged 0-5 include a high incidence of low birth weight, sudden infant death, nutritional problems, chest, ear and gastrointestinal infections, injury, abuse and neglect. Infection, injury and abuse continue to be problems in the school age period. Children are the most vulnerable members of families and the most dependent on effective family functioning, and the effects of family breakdown have a direct impact on child health. Early family relationships and experiences in the young school age period build resilience and wellbeing in preparation for later childhood and youth, where currently increased rates of mental illness, suicide and violence manifest. The multifactorial problems of indigenous families, and specifically children, require a range of intervention strategies implemented concurrently.

Experience has shown that Indigenous children and their parents are under-represented in most mainstream health promotion and early intervention programs. It is clear that a special approach, indeed special programs, are required to reach this target group. We describe a group of successful projects, and recognize certain principles and similarities in implementation that can be applied with the aim of improving practice for this specific target group.

The models of service delivery we advocate include:
1.   public health approaches to raising local community awareness of health information, eg the SIDS/ Babyhelp project which could be applied to a number of issues, for example breastfeeding promotion, knowledge of appropriate weaning diet, early care of teeth and the need to eliminate cigarette smoke from the household as a means of asthma prevention – interventions shaped by Indigenous people themselves.
2.   family level intervention to integrate a range of services in the primary care/ social support setting, tailoring intervention to individual child and family needs as in Family CARE. This model could be applied to a wider range of families in a variety of geographical settings, modified to target the whole antenatal period in continuity with later care in the first year of life. The key integrator of delivery is the Indigenous Health Worker, well supported by a multidisciplinary team;
3.   specialised care of individuals with chronic disease using an integrated package of services organized by local services and community (on the basis of expert advice), sometimes in collaboration with external specialists, as in the Torres Strait Respiratory Project. This could be applied to developmental disability and a number of medical conditions.

Through consultations with service providers and managers, and an analysis of the Indigenous Health Paediatric Respiratory Outreach Program, the Family CARE Program and the Babyhelp and SIDS projects, 14 critical success factors evident in service delivery have been identified.

1. **Community consultation** before and during the life of the project/service;
2. **Community involvement** in the delivery of the project/service;
3. **Empowerment of clients and community service providers** within the project/service via embeddedness in a community development model;
4. **Documentation of the context and monitoring of progress** of the project/service;
5. **Appropriate research** which contributes to scientific and community understanding of the health problem and advances knowledge of intervention effectiveness;
6. **Targeted enhancement of workforce development** and community skills in relation to program delivery;
7. **Development of culturally secure resources** in collaboration with communities;
8. **Culturally secure and locally appropriate service provision** guided by local area input
9. **Continuity of Care** across health service levels
10. **Role delineation within multi-disciplinary teams**
11. **Integration of services** across health sectors
12. **A holistic approach**
13. **A Population health approach** to health education and preventive care
14. **Partnerships** developed between health services and other providers with communities

These success factors are described in chapter 6, which provides practical detail of features identified in successful experiences. The success factors have also contributed to the development of a proposed model of service delivery which aims to improve the health of Indigenous children aged 0-5 years through integrated health care which supports and empowers families.

Better Practices for Child Health Service Delivery to Indigenous Communities

Acknowledgements

Note on Terminology

The term "Indigenous" is used to refer to Aboriginal and Torres Strait Islander peoples throughout this document.

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1. Introduction

1.1 Policy Overview

In addressing the health status of Indigenous Australians, the 1989 National Aboriginal Health Strategy, although not fully implemented, was an innovative and highly valued director of health advancement. Further developing the principles outlined within the original document, the recent Draft National Aboriginal and Torres Strait Islander Health Strategy has incorporated the structural changes which have taken place since 1989. The principles identified within the recent draft strategy are:

1. **Cultural security:** ensuring that the legitimate cultural rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected.
2. **Improving the health of Aboriginal and Torres Strait Islander individuals, families and communities** as a core responsibility and a high priority for the whole of the health sector.
3. **A holistic approach** to health issues including physical, spiritual, cultural, emotional and social well-being, community capacity and governance.
4. **Community control** of primary health care services as a preferred method of service delivery.
5. **Working together** with other government, non-government and private organisations and within and outside the health sector to improve the broader determinants of health.
6. **Localised decision making** that responds to the needs and priorities set by local Aboriginal and Torres Strait Islander communities.
7. **Promoting good health and preventing illness as a core activity** for health services.
8. **Building the capacity of health services and communities** to respond to health needs and to take more responsibility for health outcomes.
9. **Accountability** for health outcomes to Aboriginal and Torres Strait Islander communities and governments.

The Commonwealth's commitment to addressing the disparities that exist between Indigenous and non-Indigenous Australians is evident within the National Aboriginal and Torres Strait Islander Health Targets, and the Framework Agreements. Within Queensland, Indigenous health has been identified as Queensland Health's number one priority, and as such a committed response has been shown to reducing the burden of illness. The document Meeting the Challenge (Queensland Health, 2000), indicates Queensland Health's commitment to reaching the National Aboriginal and Torres Strait Islander Health Targets by 2007. In particular, Meeting the Challenge provides examples of improving access to health services; community development and capacity building; integration and joint planning; integrated workforce strategies; improving data; and moving towards best practice. While the national targets span the life cycle, they also recognize the relationship between child and adult health, a relationship that in recent years has been well documented. Seven of the sixteen targets specifically focus on children aged 0-5 years, these being:

2 years: 95% hepatitis B full immunization (children aged 2-6 years)
3 years: 85% immunization rate
10 years: 50% reduction in stillbirth death rates
10 years: 50% reduction in infant mortality rates
10 years: reduction in age-standardised, all causes mortality rates
10 years: 20% reduction in age-standardised death rates
10 years: 50% reduction in injury mortality rate

In addressing Indigenous health, the Queensland government have recently taken a more collaborative and cost-effective approach, engaging across sectors government and non-government organizations which impact on health (i.e. education, employment, housing and welfare groups). The building of functional relationships between sectors within Queensland. The "partnerships" strategy is identifiable through regional planning which has been undertaken to develop the Queensland Framework for Action in Aboriginal and Torres Strait

Islander Health (Queensland Aboriginal and Torres Strait Islander Health Partnership, 1999). This framework highlights ten of the thirty-nine ATSIC regional areas within Queensland, as action areas to target to improve health outcomes on the basis of need demonstrated by demographics and current health data. The Framework identifies seven key objectives, these being improving access to health services; community development and capacity building; integration and joint planning; integrated health workforce strategy; improving data; best practice; and improving partnership building capacity. Regional profiles have been developed on the regional action areas, with specific objectives being targeted accordingly.

Maternal and child health is a designated priority within the Queensland Framework, with factors such as the rate of hospitalisation for pregnancy and childbirth, the rate of low birth weight, pre-term birth and maternal age, used to determine the regional ranking. According to the identified regional areas, the actions regarding maternal and child health are as follows:

Central Highlands - expansion of community midwifery program
Cook - upskilling workforce in regards to maternal and child health
Far South West - address maternal, child health and parenting issues
Gulf - collaborative approach in regard to the community midwifery program
Mount Isa - address needs of pregnant women who have experienced violence
Near South West - upskilling workforce in regards to maternal and child health
South Burnett - development of birthing services at Cherbourg; upskilling workforce in regards to maternal and child health
Torres - establish an outreach midwifery/ antenatal service; upskilling workforce in regard to maternal and child health

Design and delivery of health programs and services within Queensland should seek to incorporate the objectives and actions of the Framework Agreements. In operationalising programs, the principles of the Aboriginal and Torres Strait Islander Health Policy (Queensland Health, 1994) apply:

Community control of primary health care services;
Participation;
Culturally appropriate service provision;
Needs based criteria for service provision and resource allocation;
Workforce planning and development;
Information, monitoring and evaluation; and
Across government approach to the provision of key social and infrastructure services to the Aboriginal and Torres Strait Islander population.

In implementing these principles within health services, a number of practical elements must be identified within programs. Such elements include staff/ personnel; support; training; health promotion materials; appointments; referrals; networks; follow-up; community acceptance; information systems; method of service integration; and transportation. To function, barriers within programs should be recognised during the developmental phase. They can be either **professional barriers** (i.e. territorial barriers - how to facilitate regional ownership?); **geographical barriers**; or **resource barriers**.

1.2   Indigenous Child Health Status – Context and Indicators

The Northern Territory and Western Australia have provided leadership in establishing data on various health issues of Indigenous populations, and useful age-related data can be accessed regarding respiratory infections, injury and disability

Indigenous people have poorer health than the rest of the Australian community as a whole. The most striking differential is found in adults in the prime of their parental and working lives, aged 35 to 44, where mortality is 5.8 times for males and 5.5 times for females than that of the general population (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2001). Programs to address the major contributors to mortality of cardiovascular disease, respiratory disease, injury and diabetes via adult lifestyle change promotion,

improved health care access, improved medical management and immunisation have been established at a national level. In competition with adult programs, many Indigenous child health programs have been de-prioritised in recent years. This has occurred in association with falling infant mortality. Infant Mortality Rate (IMR) for Indigenous children in the Northern Territory in the 1960s was reported as around 150 per 1,000 live births. This fell to around 25 per 1,000 in the 80s (Thomson N, 1991). In 1994 to 96 the rate was still 18.6, still much higher than for non-Indigenous Australian infants (Stanley F,2001).

The health status of Australian Indigenous children continues to be of concern. **Mortality** in Indigenous children and young people is higher than the norm. This is demonstrated by a rate ratio in comparison with the Australian general community for the 1997-99 period of 2.7 times for males and 2.6 times for females aged under one year, 2.1 for males and 2.3 for females aged from 1 to 4 years, 2.6 for males and 3.2 for females aged 5 to 14 years and 2.9 times for males and females at ages 15 to 24 years (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2001). Poor health status and large differentials are also reflected in an increased **rate of hospital admission** throughout childhood (approximately twice the general community rate nationally, but much higher in some local areas). Hospital morbidity rates must be interpreted cautiously – they reflect met need and the location of service providers, among other things.

Increased morbidity is seen in the primary care setting, for which there is limited published data available. The National Aboriginal and Torres Strait Islander Survey (NATSIS), ABS 1996, found parents reported 42% of Indigenous children 0 to 4 years were ill in the two weeks prior to the survey, most commonly due to respiratory and skin or subcutaneous diseases. For children 0 to 14 years, Asthma was the most commonly reported long term problem, followed by hearing, skin and chest problems. This data source gives little indication of the unmet need in the primary care sector. Important problems of young children usually managed largely in the primary care setting include **chronic middle ear infection** and **skin infection.** These infections are recognised internationally as dependent on the adequacy of environmental infrastructure in a community (American Public Health Association, 1989). Middle ear disease in early life leads to speech delay and poor school progress. Skin infection, particularly prevalent in remote communities and often secondary to scabies infestation, may lead to acute renal failure in an outbreak situation, and is now suggested to be a factor contributing to renal failure in adult life (Hoy W, 2001).

The mortality rates of under fives alone indicate that the child health situation warrants continuing monitoring, investment and program development, and prevention and early intervention in a well supported primary care setting. In this way lifestyle modification and increased health service usage may produce the most gain available within the health sector.

One element in the health picture stands out as essential to health gain for both children and adults. Indigenous women have a higher level of morbidity and lifestyle risk factors in pregnancy (eg smoking rates of 50% in Cape York women prior to delivery and 46% in women completing the 1995 National Health Survey of urban and large rural area dwellers), resulting in more prevalent **perinatal mortality** (20.7 per 1000 births, compared with a rate of 9.8 in the general community) and a higher rate of **low birth weight** (13% compared with 6%) (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2001). Low birth weight in the past has been consistently high in remote communities, for example in Cape York a rate of 20% has remained unchanged for many years (Humphrey M). **Prematurity** is a major contributing factor to low birth weight, increasingly recognised as Indigenous women's access to ultrasound examination during pregnancy increases. The health of pregnant women and the effectiveness of pregnancy care influences birth outcomes, young child health and later health in adulthood. Recent research describing the "metabolic syndrome" and its origin in foetal life brings new focus to the health and care of pregnant women and prevention of low birth weight as a means of decreasing cardiovascular disease and diabetes (Day P, Sullivan EA and Lancaster P, 1999). NAHS also recommended retaining a continuum of care in maternal and child health, an approach, which is both functional in health organisational terms and more culturally sensitive.

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Low birth weight increases the vulnerability of children to illness in the perinatal period and in early childhood, particularly during the first year. For example, low iron stores are a feature of prematurity. Early deficiency of iron or other micronutrients may lead to increased susceptibility to infections and growth impairment, which particularly in a remote setting may eventually result in failure to thrive via an infection/malnutrition downward spiral. Overcrowding and inadequacy of washing facilities and sewage disposal greatly magnify the exposure of infants to gastrointestinal, respiratory and skin infection. Small babies are more likely to suffer severe dehydration when they develop a diarrhoeal illness.

Indigenous child health status is influenced by individual, family and community factors, and as such health issues should be understood from an epidemiological, social, cultural and environmental perspective. The ABS June 2000 population projection is approximately 420,000 Indigenous Australians living in the country, 11% of Torres Strait Islander origin. Twenty eight percent reside in Queensland. A much younger age distribution is identified in the Indigenous community than in the general community with fifteen percent aged 0 to 4 years, forty percent of the total under 15 years of age, and a further 20% aged between 15 and 24 years. The burden of care carried by young and older healthy adults is therefore great compared with their non-Indigenous counterparts, most caring for more children and more chronically ill adults.

The recent ABS report entitled "The Health of Aboriginal Australians" give a clear national picture of social and environmental disadvantage - these adults are called upon to do more with less, and children bear the consequences in terms of fewer resources to maintain health. This young population has relatively low levels of education (11% adults vs 31% with post secondary qualification), high unemployment (23% vs 9% in 1996) and low family income. The median weekly income for Indigenous adult women ($190) was substantially less that the non Indigenous ($224). That for Indigenous males ($189) was substantially less than the general community of males ($415).

Household size is high (average 3.7 people vs 2.7 in the general population). 6.6% of Indigenous people live in households of 10 or more (vs 0.14 of general community). Home ownership rates are low (31% vs 71%), most people depending on public or community housing. A higher proportion of families are single parent households, usually headed by women. Increases in social security benefits since 1986 may have improved the position of single parents with one child, but large families are more difficult to support adequately.

One quarter of Indigenous Australians identified by the 1996 census live in non-urban areas. Those in remote areas have higher food costs and more need for expensive transport. Housing and environmental infrastructure (basic water supply, sewerage and garbage disposal) is often lacking. There is relatively limited access to education and health care. There is a particular concentration of adverse birth outcomes in remote areas for many reasons, with suboptimal maternal nutrition, both during and prior to pregnancy, and with an increased incidence of maternal infections. Urinary infection and sexually transmitted infections are more prevalent in remote pregnant women, where antenatal care may be accessed less frequently. Foetal alcohol syndrome, particularly in mild form, is increasingly being recognised in Indigenous babies. The more severe forms occur largely in remote areas where there is a higher than average alcohol intake in many pregnant women. Low birth weight and early growth failure are prevalent in Aboriginal communities, while children in the Torres Strait Islands on average demonstrate birth weights and early growth similar to that of the general community (Vlack, 1992). Recurrent infections, including otitis media, are main concerns for under 5s across all remote communities.

Three quarters of the Indigenous population are reported to live in urban areas. While environmental infrastructure and the quality of housing and food access is better in urban areas, overcrowding still occurs. Access to services is limited by virtue of social and cultural isolation. Urban indigenous children clearly have a high incidence of prematurity (Craig E, 2000) have lower breastfeeding rates and more dental problems than the general community (Hayman N, 2000)

The National Nutrition Survey (1995) pointed to nutritional problems in urban as well as rural/remote locations. **Growth failure in infants** and young children is the prevalent problem in remote areas, usually with onset in the latter half of infancy and associated with under-nutrition, and sometimes associated with iron and other micronutrient deficiencies. Later childhood and adult obesity are more prevalent than the norm in both remote and urban areas.

Childhood obesity is known to increase the likelihood of adult obesity, an increasingly common problem in all communities which directly increases the risk and severity of diabetes and ischaemic heart disease.

Immunisation rates also show differences between urban and remote areas, low coverage being a particular problem of urban areas in most situations (Hanna et al, 1994)

Amongst Australian children there is a rising incidence of motor disability including cerebral palsy as younger and smaller babies increasingly survive neonatal intensive care (Stanley F, Blair E et al, 2000). Although information is scarce, it appears that major disability is more common in remote area children. This is most likely due to the concentration of low birth weight, severe foetal alcohol syndrome and a higher incidence of neurological infection. Children with **major disability** in remote areas have a substantial problem of access to appropriate specialist services and specialised supportive care.

1.3   Intervention

Effective intervention in child health has the potential to confer long term benefit through improved physical functional capacity and emotional resilience leading to improved school performance, increased employability, career development and positive family relationships, which are valuable long term, downstream benefits.

Some health outcome improvements might also be achieved within a timeframe of years. Family intervention has gained general acceptance in Australia as a strategy for supporting children – for example the NSW "Families First" initiative and WA's "Building Blocks". Programs that build on individual, family and community capacity have been recommended by the Draft National Aboriginal Health Strategy (National Aboriginal and Torres Strait Islander Health Council, 2000).

The positive benefit of involving Indigenous people at all stages of a project or program has been our experience and is reflected in Queensland Health projects, eg as documented by S. Angus, who produced a "principles of best practice" document on the basis of experience in cervical screening program development, and most clearly by Maureen Kirk in her work on breast screening programs for indigenous women in urban, rural and remote settings. A similar approach to community based research, i.e. involvement at every stage, has worked well in our experience and is also reflected by others, eg as documented by the Bibbulung Gnardeep longitudinal child health project in Perth. We see the two (service development and research) as going hand-in-hand, and the community involvement aspect effectively addressable as a process issue independent of personalities driving projects.

1.4   Evaluation

Health outcomes should be monitored in community programs, but the interpretation of current health statistics, data over time and comparing communities is fraught with difficulty.

- Indigenous mortality and hospital admission data in Queensland is of limited value at present, in part due to ethnicity not being included on death records until 1996, and incomplete identification of indigenous status on hospital admission. Pertinent comments on the quality of Queensland Indigenous health data are contained in EHIB's paper on "Community Health Planning Resource Information, February 1999". Indigenous Health Program research has documented interpersonal factors impacting on accuracy of data recording in hospitals. A compounding issue in regard to newborns is that those with an

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indigenous father and non-indigenous mother are automatically excluded from recognition in the birth hospital.

- Local figures will be the most relevant in understanding factors relevant to a local area and program, particularly in Queensland where the social and physical environments are diverse, however the small numbers involved often preclude generalisation of results.

Hospital admission data is likely to be a poor indicator of morbidity, reflecting in part current service access and the physical location of health service providers. In relation to children, the conditions on which we focus are handled largely outside the hospital admission process. For example, the impact and management of impact and management of disability is poorly quantified and resource intensive in the community sector, and service access improvement is essential to addressing inequity.

- The relationship between health intervention and health outcome in this particular situation is complex. For example, a number of undocumented social and economic variables influence the child nutrition situation in remote communities in ways we are unable to quantify at present, and health services are largely unable to control. A summary (Warchivker I, 2000) of "reasons why children may not be growing well in the community as presented to the researcher by Aboriginal people" illustrates this well:

Social	Economic	Education	Organisation	Medical
Gambling	Poverty	Lack of knowledge about solid food	Food availability	Inability to breastfeed
Too many social responsibilities	Inability to plan spending	Lack of knowledge about malnutrition and hospitalisation	Lack of hardware – cooking and storage facilities	Inability of child to take certain food
Lack of relationship support	Access to affordable food		Lack of breakfast provision	Prolonged episodes of diarrhoea
Maternal malnutrition	Maternal malnutrition			Lack of nutrients
Cultural beliefs	Gambling affects income distribution			Maternal malnutrition

Interventions appropriate to the above would include increasing family income, decreasing the cost of food and improving housing in cooperation with the community as well as helping the community build capacity to deal with gambling, promote budgeting and provide social support. Health education and increased access to primary care are essential elements, but their ability to tip the balance will be determined by the potency of the additional influences. Were alcohol widely abused in the community, its impact would be felt in addition to the above factors and warrant specific interventions in the interest of child growth.

An example of a primary care centred program for Indigenous Australian pregnant women and mothers with young children which specifically uses community capacity building is the **Strong Women, Strong Babies, Strong Culture program (SWSBSC).** This program has been implemented and formally evaluated in areas of the Northern Territory and Western Australia. This is the most rigorously evaluated indigenous child health program of recent years in the literature.

An evaluation of 3 NT pilot communities for the period 1990-96 (Mackerras D, 1998), with an intervention number of 246 infants, showed a decline in the prevalence of low birth

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weight (19.8% to 11.3%) in comparison with a lesser decline in other similar communities in the top end of NT, and a rise in mean birth weight 79g more than in the other communities. Record review in the pilot communities indicated that women engaged earlier with antenatal care and an increased number of genital infections were treated. In this program "Strong Women Workers" are recruited in the community to support pregnant women, promoting healthy lifestyle and antenatal care attendance and follow up of health problems, and promoting cultural practices. The community steers the program. There is an element of general community mobilisation and interest in pregnant women's welfare. This has been extended to include aspects of young child nutrition and environmental and general health promotion. The community capacity building element was thought to be the feature of SWSBSC that made it stand apart from other projects and conferred success in influencing health. The health services of these communities also introduced urinary PCR testing for genital infection during the study period.

An evaluation of outcomes in five northwest WA communities after 14 months of operation, with an intervention number of 63 children and with detailed monitoring of individuals, showed no change in the prevalence of low birth weight, but an increase in average growth of full term infants after the age of six months. Premature infants, a large proportion of the total, did not improve their growth rates, and the authors recommended a future focus on prevention of prematurity. In this project both SWSBSC program in the community and health service periodic nutritional assessment and counselling of pregnant women and mothers of infants and young children were implemented. The outcomes were compared with outcomes in the same communities for the previous five years. It could be argued that the intervention period was too short for health improvement to be demonstrated, given the diffuse community impact of capacity building.

1.5   Project Overview

A number of Queensland projects have proven to be successful in operational terms. These include the Indigenous Health Paediatric Respiratory Outreach Program, the Family CARE Program and the Babyhelp and SIDS projects. The principles and elements of the delivery of these services have resulted in models of service delivery which have been successful in the participating communities.

The project aims to:

(1)   Document the existing delivery models, and the relationship of the models to local service providers, the Indigenous community, and workforce development strategies. The report would document processes for measuring health outcomes, and levels of community satisfaction, as well as the knowledge changes that occur as a result of education and health promotion initiatives.

(2)   Produce a detailed plan for an integrated model of paediatric care to be implemented in a variety of Indigenous health settings, including urban community-controlled and Queensland Health settings, as well as rural and remote communities. The plan will include a coordinated program of neonatal, respiratory, growth and development clinical services, as well as community based home care programs. It will also include the implementation of the Health Worker training package in child health, and address the appropriate health promotion approaches.

In documenting models of Indigenous child health service delivery, the project team have focused on the 0-5 year age group, and therefore the following documentation of programs/services and consultations is heavily focused on this area.

1.5.1 Project Management Committee and Personnel

A/PROF CINDY SHANNON (PROJECT MANAGER)

Director, Indigenous Health Division
University of Queensland

Dr Susan Vlack (Project Coordinator)

PUBLIC HEALTH PHYSICIAN AND SENIOR LECTURER

Indigenous Health Program

Dr Kenneth Armstrong (Advisor)   Prof Paul Colditz (Advisor)
Director   Director
Family CARE Program   Perinatal Research Centre

Dr Paul Woodgate (Advisor)   Dr Brent Masters (Advisor)
Mater Mother's Hospital   Department of Respiratory Medicine
Royal Children's Hospital

Ms Louise Hooper (Project Officer)
Senior Research Assistant and Associate Lecturer
Indigenous Health Program

1.5.2 Methodology

The original three-month timeframe identified to complete the project was extended to allow for sufficient consultations to be held with a number of service managers and providers, exploring their knowledge, attitudes and experiences in the delivery of services to Indigenous communities. While the consultations explored service delivery in general, there was a specific focus on service for Indigenous children aged 0-5 years. Progression of the project is outlined in Table 1.

Table 1 - Project Operations to November 2001

Activity	Strategy	Outcome	Time Frame	Person Responsible
1. Project Management Procedures	1.1 Employment of project personnel 1.2 Meeting of project management committee and personnel	- 2 Project Officers employed - Development of a meeting schedule for project management committee and personnel - Development of a plan of data collection.	Oct. 2000-March 2001	• Project Manager, Project Coordinator • • Project management committee and personnel •
2. Literature review	2.1 Review of relevant literature and reports relating to service delivery in Indigenous communities.	- Background information established relating to models of health service delivery to Indigenous communities	Nov 2000-March 2001	• Project Coordinator
3. Documentation of existing models	Identify principles and elements of service delivery Development of interview questions Interview project personnel in regards to project operations (specialist, home visiting and health education projects)	- Interview guideline established for Cairns case study and consultations with service providers - Identification of key principles and elements of health service delivery within the existing projects - Documentation of the principles and elements of service delivery for three projects which include a specialist service, a home visiting service and a health education program	Nov 2000-March 2001	• Project Coordinator, Project Officer
4. Consult with Cairns Family CARE Program Training Participants	4.1 Discuss and identify the principles and elements of successful service delivery 4.2 Following circulation of a draft consultation report, coordinate a feedback workshop	- Consultation report to inform service delivery of the Family CARE Program and define a model of service delivery that focuses on young Indigenous children - Feedback obtained from participants of the Cairns Family CARE Training	Dec. 2000-May 2001	• Project Coordinator, Project Officer
5. Consultations with Key Stakeholders in Indigenous Health	5.1 Identification of key stakeholders within State and Commonwealth health services 5.2 Contact and recruitment of key stakeholders in the consultation process	- Consultations undertaken with State and Commonwealth Health service providers - Feedback obtained from consultation participants	May 2001-Sept. 2001	• Project Manager, Project Coordinator, Project Officer

Activity	Strategy	Outcome	Time Frame	Person Responsible
	5.3 Undertake consultations with key stakeholders regarding principles and elements of health service delivery 5.4 Provide ongoing provision for feedback			
6. Analysis and interpretation of consultations	6.1 Transcriptions of consultations with key stakeholders 6.2 Draft transcriptions forwarded to key stakeholders for feedback 6.3 Thematic analysis of consultations	- Endorsed consultations included in final report - Identification of key principles and elements necessary in the delivery of child health services to Indigenous communities - Report which summaries the consultations	May 2001-Sept. 2001	• Project Officer
7. Report	7.1 Meet with Queensland Health to discuss progress of the project 7.2 Draft report devised and circulated to project management committee for feedback 7.3 Feedback workshop held with Queensland Health, OATSIH and other service providers to discuss outcomes of the project and issues associated with workforce development and models of care in the implementation of such a program 7.4 Incorporation of feedback in final report which documents the models and a proposed model of service delivery	- Meeting held with Queensland Health - Feedback obtained from project management committee and service providers - Workshop held with Queensland Health, OATSIH and other service providers - Final report endorsed by project management committee and submitted to Queensland Health - Proposed model of service delivery to be piloted in a Queensland Indigenous community	August 2001-Nov. 2001	• Project Manager, Project Coordinator, Project Officer

2   A Specialist Service – Indigenous Health Paediatric Respiratory Outreach Program

2.1   Rationale

For Aboriginal and Torres Strait Islander people respiratory disease is a major cause of excess death (observed deaths in relation to expected deaths based on all Australian age, sex, & cause specific rates). For Indigenous males the proportion of excess is 13.4% and for Indigenous females it is 15.8%. Respiratory disease is the fourth highest cause of death for Indigenous people, both males and females (ABS 1999).

The National Aboriginal Health Strategy (NAHS) (1989) identified chronic obstructive lung disease (COLD), asthma and pneumonia as priority health problems. To address these issues specific strategies included:

Ensuring access to comprehensive, culturally appropriate community-controlled primary health care for all Aboriginal people
To develop culturally appropriate patient education programs which would emphasize the skills necessary for asthmatic crisis prevention and management
Access to basic respiratory function testing
Health service provision that ensures access to appropriate immunisation for all children, and access to early diagnosis and treatment for respiratory disease.

The Torres Strait Framework for Action agreement (2000) is a detailed document that outlines how to address the priority areas identified in the Torres Strait Health Strategy (1993). A major goal in the framework for action is to:

Improve access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs.

One of the specific actions to meet this goal is to enhance resources to the Child Health and Respiratory program to improve service delivery to outer islands.

Towards the end stage of the project's development the Commonwealth and State governments created a new initiative to improve specialist service delivery to Indigenous communities. This presented the perfect opportunity to gain funding to implement the project. A proposal was developed to meet the requirements of the new initiative and was successful in gaining funding for two consecutive years pending successful progress of the project.

The project was completed in 2000 and a formal independent evaluation undertaken.

2.2   Program establishment

The program provided comprehensive assistance and care for respiratory illness in combination with patient and service provider education. The Commonwealth Government, through the Office for the Aboriginal and Torres Strait Islanders Health (OATSIH), Queensland Health and the Sisters of Mercy at the Mater Hospital, jointly funded the Indigenous Health Respiratory Outreach Program for two years from July 1998. The program provided sub-specialist outreach services to Indigenous communities in the Torres Strait and NYP Health District and the Mt Isa Health District of Queensland. It was delivered through collaboration between the Department of Respiratory Medicine at the Mater Children's Hospital, the Indigenous Health Program (IHP) at the University of Queensland and the Queensland Institute of Medical Research (QIMR)

The service proved to have a very high level of community acceptability in the Torres Strait. It produced reliable data on asthma prevalence in the Torres Strait community, and led to the development of a high quality program which has been adapted to other Indigenous contexts and has improved the management of asthma in the primary setting by demonstrating and educating about best practice in relation to treatment and utilization of medication.

2.3   Service delivery

The Indigenous Health Paediatric Respiratory Outreach Program endeavoured to develop a model for chronic disease management in Indigenous communities. Specifically, the aims of the project were to:

Reduce paediatric respiratory disease morbidity and mortality within the Aboriginal and Torres Strait Islander population using a culturally acceptable and sensitive model of prevention and care, in collaboration with local health care workers and community leaders; and
Assess the value of this model whereby ongoing evaluation and scientific investigation are used to inform local communities, policy decisions, funding and research priorities. Over time these aims became more process driven. The aims of the program as reported in progress reports and the evaluation brief were:
Provide specialized paediatric respiratory medicine to Indigenous communities;
Provide local Health Workers, community members, local health professionals, and other interested persons with educational resources and programs to improve knowledge and awareness about prevention, diagnosis, treatment and the management of paediatric respiratory problems; and
Provide wider community and participating communities with the resources and benefits of scientifically conducted research.

The project was established following the prevalence of respiratory illness among the Indigenous population and initiatives of the Commonwealth and State government to improve specialist service delivery to Indigenous communities.

The Program was delivered in the Torres Strait and Northern Peninsula Area and North-West Queensland Indigenous communities. Implementation of the program incorporated three components:

- Clinical service delivery
- Education
- Research

2.4   Clinical service delivery

The clinical component of the service focused on patient treatment, management, screening and prevention of respiratory illness, therefore incorporating elements of primary health care. In particular, the focus on screening and prevention identified risk factors and undertook patient referral.

The program team visited on a six monthly basis. The core team consisted of two respiratory paediatricians, two respiratory nurses and a physiotherapist. Children were booked for 45-minute consultations with the respiratory paediatrician. Following this the respiratory nurse and Indigenous Health Worker (IHW) speak with the mother about the nature of the child's illness and ongoing management. Advice and support was given by the physiotherapist where necessary.

2.5   Education

Implementation of the outreach service delivery model incorporated an emphasis on education that is associated with the clinical service delivery. Education delivered focused on patient, carer and community information. Specifically, education was directed to patients, carers, Health Workers and other health professionals.

As well as "one on one" apprenticeship training for IHWs as part of the clinics the program also provided structured learning opportunities through tutorials and lectures. A number of training packages have also been developed.

2.6   Research

There were two main focuses of research. The clinical data base that has been delivered for all patients seen in the clinics and an asthma prevalence study in the Torres Strait and Northern York Peninsula (NYP) Health District.

In order to have a greater understanding of respiratory illness within the Torres Strait, data collected during the service included epidemiological, social, cultural and environmental factors. In regards to analysing the outreach service, data collected related to economic, health and educational outcomes. The gather and analysis of such data enabled the identification of health education to be delivered, particularly to patients.

2.7   Features of the model

Some of the program's major achievements included:

- Delivering clinical services with continuity of staff to six sites (Thursday Island, Badu Island, Mornington Island, Doomadgee, Mt Isa and Bamaga) over nine trips
- Seen 517 patients during 40 clinic days
- Developed a model of care that empowers IHWs and parents through the consultation process
- Provided a wide range of educational activities including "one on one" teaching, tutorials and lectures, debriefings after clinic visits and development of IHW training packages.
- Modelling best practice in conducting the "Short Wind" prevalence study and in the feed back to the community
- Results of the prevalence study leading to a re-assessment of the rates of asthma in remote Indigenous communities
- Established comprehensive patient data bases that can be used for research and evaluation purposes
- Provided detailed documentation of project activities through reports on specific aspects of the program
- Developed a constructive working relationship with health managers in the Torres and the Tropical Public Health Unit in Cairns.

It was not possible to identify child or community health/treatment outcomes. There was no formal evaluation of educational activities.

2.8   Principles

2.8.1 Community consultation

In order to understand local service delivery issues and relationships between service providers, community consultation was a key principle of the service. As the primary project team was based in Brisbane, consultation with participating communities mainly consisted of written correspondence. Telephone discussions and community visits were also integral to the development and progression of the service. In particular consultation was undertaken with community and local councils, health centres, and other health and community organizations. Consultation focused on support for the service, implementation of the service, appropriateness of the research tool used for the asthma prevalence study, methods of raising community awareness and mechanisms for feedback of information. The development of such mechanisms to consult with the community enabled ongoing advice and communication.

2.8.2 Community participation

Community participation particularly occurred in the early stages of developing the model and in the completion of a prevalence study.

2.8.3 Culturally appropriate service provision

Culturally appropriate service provision occurred through Health Worker involvement and a sensitivity to local cultural and language issues.

2.8.4 Workforce development

Health Workers were involved in on-the-job training in the clinical services and were provided with professional development opportunities with local health staff.

2.9   Elements

2.9.1 Referrals and follow-up

In the Torres Strait, local Health Workers referred patients. Referral was initially based on local knowledge of asthma or respiratory disease, however referrals increased following the completion of the prevalence study. By providing local Health Workers with the ability to refer patients, local medical officers were absent from the clinical process. The local doctors were also informed of visits by the respiratory clinic and encouraged to refer patients. Conscious efforts to interact with local medical officers were made by the project doctors.

When following up patients, on most occasions respiratory specialists would inform local Health Workers of patients to be followed-up.

In the Torres Strait most parents were contacted prior to or during the week of the respiratory clinic. Initial contact was by telephone or identification in the community. Following this an appointment card was mailed or

hand delivered to patients. It was not unusual for parents to be contacted one or two days prior to their child seeing the respiratory clinic.

The involvement of Health Workers in the referral process had a number of outcomes:

During initial visits many asthmatic children and children with other respiratory problems were referred to the clinic. However as the two years progressed less children were newly presenting with respiratory illness. The LMOs were isolated from the project in the beginning making the bridge to repair an effortful task Empowered and gave ownership of clinic to local Health Workers

2.9.2 Appointments
Waiting times
In general clients would access the respiratory clinic in groups rather than at their individual designated appointment time. In instances such as these, client waiting times would be 30-40 minutes. Geographical location impacted on client waiting times. In the Torres region, where attendance to the clinic was higher than other geographical locations, waiting times would be increased, particularly if an unscheduled client was seen or clients turned up outside of their scheduled appointment time. However, while the longest waiting time would have been 1 hour, the majority of patients in all areas did not have to wait long before their consultation.

2.9.3 Duration of consultation
Patients who had not previously been to the respiratory clinic usually required a 45-minute consultation which included patient history, thorough medical examination, and one-to-one patient/carer education, if necessary. The duration of the consultation was the same as that given in the major urban hospital. Follow-up patients generally require thirty minutes consultation which allowed for basic measurements to be taken and recorded, a consultation with the respiratory specialist and reinforcement of respiratory education.

2.9.4 Transportation
Private transport is the main mode of transport used to get to the clinic for an appointment, with other modes including bus, taxi and walking. The Health Workers knew which families had difficulty getting to clinics and provided transportation. Although one of the clinics had a driver, this service was not used by the Health Workers for the respiratory clinic.

2.9.5 Community acceptance and support
The IHPROP was well accepted by IHWs and parents. Attendance rates, particularly in the Torres NYP Health District are reported to be very high (over 90% of children booked).

Unfortunately there is no data on the levels or reason for satisfaction with the service delivery model. It seems likely that the strong emphasis on the empowerment of IHWs and parents is appreciated by those involved and spread quickly through the community. The time spent with each child (45 minutes for the initial consultation) could also be seen as reinforcing the view that the IHPROP is interested in building relationships and listening to what people have to say.

The service was also successful as it strengthened local health services within the Torres Strait. Essentially the service complemented what was currently available rather than being an alternative or competing service.

2.10   Barriers
Barriers that emerged from the evaluation affecting the management of the program consisted of:
- Sub-speciality services are not a replacement for primary health care services and over the next phase of the program it will be important to ensure that the service provided is enhancing local health services rather than replacing them.
- It is not clear if the program has been able to strengthen continuity of care and management between visits
- There is some concern that the program was based on the types of problems than have been seen in the sub-specialty clinics and that these may not reflect the most important (or poorly managed) health problems in the District, such as lower respiratory tract infections.

2.11 Professional Support

The project was administered by the Mater Children's Hospital and a small project management team met regularly. Necessary equipment that was taken into the field included spirometers and specialist personnel (eg respiratory physiotherapist) supported the project.

An issue brought forward in a consultation for this project was that one of the regional paediatric services did not support the project. The representative considered that the funds expended on the clinical service would have been better utilised by the local unit to enhance its general paediatric visiting service.

2.12 Training

The program had a clear focus on developing the understanding and capacity of IHWs and mothers/carers to manage respiratory illness. In its two years of operation the IHPROP undertook "one on one" education with IHWs, ran tutorials and workshops, debriefed clinicians on cases seen in the clinics and developed a number of specific programs.

The IHPROP made concerted efforts to incorporate a training component into all of its activities. The program delivered programs to different levels of health workers and in a number of different ways (based on cases, theoretical discussion and individual case management) which will have increased its effectiveness.

2.13 Information systems

All patients details were stored in the excel computer program. Information collected during consultations included social history, past medical history, immunization status, examination (i.e. height and weight), knowledge of respiratory drugs, medications in the last 12 months, functional severity score, delivery technique, investigations, summary and treatment. Following consultations the respiratory team participated in debriefing and data sheets were forwarded to each Health Worker participating in the clinic3.

2.14 Further development suggested

Development of a more co-ordinated system which will involve development of:

- clinical guidelines for the long term management of respiratory illness
- care plans for patients with poorly controlled asthma
- case conferences
- communication strategies
- compatible information systems

3. A Home Visiting Service - Family CARE Program (FCP)

3.1 Rationale for the service and service delivery

The Family CARE Program aims to support vulnerable families through the antenatal period and first year of a newborns life, by developing a trusting relationship, parent empowerment, anticipatory guidance, celebration of success and promotion of well baby health care and attachment of families to available community resources. This is achieved by way of a multidisciplinary team operating predominantly within the family home. The primary health worker visits the mother once prenatally, with 16 visits occurring postnatally from one week to 12 months of age. The primary Health Worker case conferences with other team members on a regular basis and introduces them to the family as required. In this way the program offers a service which promotes infant, parent, family and community resilience.

The Program is based on defined referral criteria. Referral to the FCP is determined by the presence of at least one of the following:
- Violent partnership
- Depression – current or history
- Financial stress

These criteria are predictors of poorer outcomes in children.

The Program is currently being run in a number of Health Service Districts – Cairns, Sunshine Coast, Logan-Beaudesert, West Moreton and Gold Coast. Outcomes of the Program have been effective promotion of infant immunization and SIDS prevention practices, and a high satisfaction with the service among mothers (Child & Youth Health Unit, Queensland Health, 2001).

3.2 Program Establishment

The Cairns population has a relatively high proportion of Indigenous people, being 8.4% of the general population (Australian Bureau of Statistics, 2001). Family CARE operates as a general community program with a number of special features in consideration of Indigenous family involvement. Prior to implementation of the Family CARE Program within Cairns, little structure existed to support high risk families in the health system.

In establishing the FCP for Indigenous families, principles of formation included:
Community and local service provider consultation
Involvement of Indigenous community
Empowerment at management level
Adequate monitoring and data collection
Workforce development

3.3 Community consultation, involvement of Indigenous community, empowerment at management level

The process of consultation was to identify practical issues in delivering services specifically to Indigenous communities.

When implementing the FCP in Cairns, initial consultation was undertaken by the project manager with Cairns District Management. Following this, a one week consultation was organized involving key Indigenous players and the main Indigenous health care providers in Cairns (i.e. Health Workers and nurses). The one week consultation involved a public meeting which was open to everyone. Management of the local consultation was organized by the Senior Paediatrician at the Cairns Base Hospital. Although the consultation was well represented and included management of the WuChopperen Medical Service, the only group not represented was Health Workers at WuChopperen.

Through consultation the Program suggested that the Cairns groups develop a Steering Committee. The Steering Committee, involved a wide representation from the Cairns community and included Indigenous service providers. Steering committee consulted with Apunipima (Cape York Health Council) and WuChopperen (Cairns-based community controlled health service).

The Steering Committee formed the Implementation Committee which served as a "hands on" group discussing the procedures of implementing the FCP in the Cairns community.

The FCP discussed with services the stages of implementation of the program. In each of the Districts, there have been powerful advocates for the FCP. In Cairns these included:
Director of Nursing at Cairns Base Hospital
Senior Paediatrician, Ross Messer
Director of Community Health

Other advocates have included:
Division of General Practice – steering committee, invited to meetings, each of the divisions have provided a member for steering committte
Public Health Physician – promotion of immunization

3.4   Adequate monitoring and data collection
Monitoring and evaluation of the child is undertaken on 16 separate occasions from prenatal to 12 months postnatal. Enrolment is undertaken at the first antenatal visit, with nurses visiting mothers prior to delivery.

Sustainability of the Program is determined by the ability to produce data.

As outlined in the Family CARE Manual Home Visiting Guide, expected health outcomes are:

General Focus	Specific Focus	Outcome
Child health and well-being	SIDS prevention	Sound knowledge of SIDS risk factors Appropriate SIDS prevention behaviour
	Vaccine preventable disease	Sound knowledge of the immunization regime Full immunization of the infant at 6 months
Parent/family functioning	Maternal distress/depression	Early recognition of caregivers with signs of postnatal depression and timely referral to appropriate services Lower levels of distress/depression among families participating in the Family CARE Program
	Social connectedness	Social trust A primary health care provider for every family
	Attachment and quality home life for the infant	Securely attached infants Optimal cognitive development among infants through nurturance and developmentally appropriate stimulation Client satisfaction with the quality of service provided by the home visitor

Monitoring and evaluation is systematic and uses a number of instruments including (Queensland Health, 2000):
The Brisbane Evaluation of Needs Questionnaire*
The Edinburgh Postnatal Depression Scale*
The Infant/Toddler Home Inventory
The Australian Development Screening Checklist (ADSC)
The Social Provisions Scale*
The Modified Parent Satisfaction Questionnaire 1B*
* indicates that the instrument is self-administered

These instruments are administered at various stages throughout the Family CARE Program visitation schedule, with the earliest introduction of the instruments being at the first or second visit. Some of these instruments are self-administered. The complexity of some of the english language used, was considered inappropriate for Indigenous families, and the forms are currently being revised for this purpose.

From use of these instruments and other procedures, monitoring and evaluation aims to:
Provide individual client information that assists in guiding clinical activity
Provide progressive information about the Program's effects within and across Disricts
• Provide progressive information about quality of practice
Enable Queensland Health to monitor/assess the efficacy of the Program
Guide decision-making about wider Program implementation
(Queensland Health, 2000)

3.5   Workforce development

Health Workers, nurses and other personnel are involved in training which focuses on:

- Dealing with family violence
- Dealing with child abuse and neglect
- Promoting maternal-infant attachment
- Normal infant behaviour
- Interdisciplinary team work
- Professional boundaries
- Counselling skills
- Case conferencing
- Dealing with maternal and paternal mood disorders

The FCP provides direction for organisations and clients involved in the Program. There are a number of underlying principles in the delivery of the FCP.

- *Fairness and equity* – in the delivery of services
- *Trust* - The importance of developing a trusting relationship with the family. This is considered to be the first necessary step of the Program
- *Empowerment* – of families
- *The early attachment relationship* - The Program has adopted a strong focus on the importance of developing a secure attachment, particularly in the early years of life due to the lifetime outcomes on brain development impacted in the early years
- *Social connectedness* - The ability to facilitate families to access services and groups available in their community. The Program also provides a forum for groups of mothers to form. Essentially, similar groups of mothers are brought together thus facilitating their feeling of belonging to a group (i.e. discussion group). Primary health visitors organise the development of groups to discuss an area of interest.
- *Anticipatory guidance* - The FCP recognizes that infants go through predictable phases of development (i.e. waking up at night). When parents are aware of the phases of development, issues are easier to handle.
- *Preventive public health* – SIDS prevention, immunisation, breastfeeding, accident prevention and infant development
- *Safety* – of the infant, mother and home visitor

3.6   Elements

3.6.1 Monitoring and evaluation

Statewide, over 600 families are enrolled in the Program, and patient satisfaction sheets indicate that satisfaction of the clientele is high.

Immunisation of children involved in the Program is between 95-100%, and mothers are encouraged to attend clinics, rather than immunizing children at home.

Half of the mothers enrolled in the Program smoke cigarettes. The FCP promotes exclusion of smoking inside of the house, and mothers have been identified to be making positive decisions about smoking outside of the household.

3.6.2 Referrals

Clients are referred by midwives antenatally, and among others, child health workers, Indigenous Health Workers, GP's, mental health and alcohol and drug services refer clients both antenatally and postnatally to the Program according to the presence of one of the following criteria:

- Violent partnership
- Depression – current or history
- Financial stress

3.6.3 Community acceptance and support

The FCP has enjoyed widespread community acceptance and support. It is recognized by the Health Districts as an integral part of the community health program. It has also enjoyed unqualified support from outside of health and in particular from the Dept of Families, Education Queensland, Justice Dept, local, state and federal members of Parliament.

3.6.4 Networking

The focus of groups of professionals on individual checks has led to the development of close links between antenatal, community, mental health, General Practice, domestic violence resources, alcohol and drugs, Indigenous health, and other services. This is one of the key and important qualitative outcomes which will be formally evaluated in the new year.

3.6.5 Information

The information on outcomes is collected centrally by Queensland Health using the SPSS-X package. This information is then returned to Districts on a monthly basis providing raw and comparative data to assist local decision making and management processes.

3.6.6 Staff

To implement the program Queensland Health provided cohditional funding to allow employment of child health nurses, Indigenous Health Workers, early intervention specialists, administration staff as well as infrastructure costs.

3.6.7 Resources

The FCP has been successful within Cairns as it provides permanent resources and has established groups. Administration support and infrastructure costs (eg phones, cars, computers0 are provided by Queensland Health.

In particular, resources include:
- Training package
- Stickers and pamphlets
- Birthday cards (for infants)
- Posters
- Reward certificates (for parents)

3.7   Barriers

A barrier to the implementation of the FCP in Cairns, has been the low level of involvement of the Community Controlled Health Service. When approached by the FCP, the particular service indicated that as funds were currently being sought to expand its own "Social Health Service" which provides individual and family counselling, it would not be appropriate to also implement the FCP. While the service did not implement the FCP, their attendance at the Cairns training session indicated that inclusion of services in training and other operations of the FCP, is important for community acceptance of the program and is possibly one step to involvement of the service in the FCP at a later date.

WuChopperen were invited to be a member of the Steering Committee. Although Health Workers from WuChopperen were not involved in the consultation, a number of Health Workers attended the FCP training.

Tensions between State and Commonwealth health services was a barrier noted during consultations. Again, the Family CARE Training workshop proved to be a successful forum for overcoming such tensions, as representation from both State and Commonwealth health services was good.

The delivery of the FCP has identified that cooperation between workers and organisations on the ground is needed for the success of the Program.

3.8   Training package

The training package, titled "The Family CARE Home Visiting Guide", is delivered to staff of hospital-based services, community-based services, mental health services, the Department of Family Services and Education, most of whom provide representation at the training. The FCP recognize the importance of ensuring that training is delivered to a number of health and other professionals thereby providing the opportunity for various organisations who work with families to link together. Such delivery promotes integration of services by focusing on one program. Case-conferencing maintains integration of services.

Trainees have provided positive feedback to the training with 96% of staff perceiving the training to be useful and well presented (Child & Youth Health Unit, Queensland Health, 2001).

3.9   Follow-up training

Follow-up training for those delivering the FCP will occur in November 2001. Again, wide involvement of health and others will be encouraged. A Train the Trainers package has been developed and training in each of the current districts and the eleven new districts to deliver the FCP in 2002 will be trained.

3.10   Variations

There are a number of variations between implementing the FCP in Cairns as opposed to other locations. In Cairns, variations include:

- High proportion of Indigenous population in Cairns compared to other locations
- Indigenous Health Workers were incorporated into training
- Wide array of expertise involved in the training – Health Workers to Director of Community Health Services
- The Program offered in Cairns was more flexible in order to accommodate the expertise involved
- The training in Cairns incorporated trainee-identification of a number of issues related to child health (i.e. difficult behaviour)
- Cairns has an increased number of Health Workers compared with Brisbane

The variations experienced in Cairns identified that training needed to be flexible and there was a specific need to develop an Indigenous training package.

3.11   Further development suggested

From current operations, the Program has identified two areas of expansion – training and the development of a service that targets all Indigenous mothers based on identification of additional health issues within the community. The current trial of an Indigenous FCP in Brisbane would suggest that this is possible.

The Program has identified that to successfully implement the FCP in the Indigenous community, funding needs to be sought to develop a specific Indigenous training package. The developed training package would differ from the current training package, and would focus more on the primary health care issues (i.e. immunization, breastfeeding, SIDS), in addition to social and emotional issues. Modification of the current training package would include targeting skills of Indigenous Health Workers.

Funds would also need to be sought for the development of culturally appropriate monitoring and evaluation tools. Current assessment tools have involved a lot of time to fill out. In identifying appropriate monitoring tools to be used by Health Workers, in Brisbane it was found that having an individual read out and tick boxes was effective, however this process was very time consuming and not an adequate ongoing solution.

The training package would also include a position description for Indigenous Health Workers. This need has arisen due to a perception that Health Workers don't have skills which are vital to the Program (i.e. weights, breastfeeding, identification of lactation, heights).

3.12 Possibilities for an integrated service that targets all Indigenous mothers

The Brisbane-based study identified a higher level of social, psychological and other risk factors in the Indigenous population than the control group of a randomized controlled trial targeting families with high level risk. The level of risk factors warrant a service that targets all Indigenous mothers. Within the Brisbane community, the benefits of the FCP in influencing positive practices were noted. While on initial visits Indigenous mothers may not have undertaken health promoting practices outlined in the FCP, discussion of these practices with staff of the FCP encouraged incorporation of the practices and at subsequent visits, mothers were identified to be undertaking the specific practice/s. While this identified the importance of providing education to mothers, education specific for the Indigenous community would include addressing antenatal issues (i.e nutrition, alcohol and drug use). Education directed to mothers of the FCP could also deliver the developed Babyhelp and SIDS resources through the Program.

4. Establishing a Health Education Program - Babyhelp and SIDS

4.1 Service delivery

The aim of the Babyhelp project was to improve knowledge of the signs of childhood illness and to provide carers with knowledge of when to seek medical attention. The aim of the SIDS project was to convey the public health message about 'Reducing the Risks of SIDS'. In response to the aims, the objectives of each project were as follows:

Babyhelp project objectives:
- Review parents' current access to informational and promotional resources
- Describe current knowledge of childhood illness and practices of parents
- Identification of parents most in need of information, education and communication (IEC) material
- Develop a culturally appropriate resource to improve knowledge of the signs of childhood illness suitable for urban, rural and remote Indigenous settings.

SIDS project objectives:
- To elicit knowledge, attitudes and practices for SIDS risk factors in an Indigenous population
- Develop a resource package for an Indigenous population to convey the public health message about 'Reducing the Risks of SIDS'
- Make the resource package readily adaptable for other Indigenous communities and the dissemination of other public health information

4.2 Number of Participants

The projects were undertaken in urban, rural and remote Indigenous communities in Queensland. At the time of data collection, the collective number of Indigenous children aged 0-2 years in the participating communities was 1000 (Queensland Health, 2001). A total number of two hundred and forty-four (244) questionnaires were undertaken within the participating communities with carers of Indigenous children aged 0-2 years.

4.3 Rationale for the Project

While the Babyhelp project was informed by the community-identified need for a resource to identify severity of illness in children, and the rates of morbidity as a possible result of late presentation at medical services, the SIDS project was informed from the high rates of SIDS in the Indigenous community. At commencement of the SIDS project, Queensland had not identified an Indigenous rate of SIDS as ethnicity was not included on death certificates until 1996, however rates identified from studies undertaken in South Australia, Western Australia and the Northern Territory indicated that the rate was about 4 to 6 times greater in the Indigenous population.

The participating communities highlighted the desire for the Babyhelp project through a project previously undertaken by the Indigenous Health Program in collaboration with the Mater Hospital. The previous project titled "Babycheck", piloted the UK developed Babycheck resource among Indigenous Queensland communities. The resource was designed to assist parents in identifying serious illness in children aged 0-1 years through the scoring of 19 signs and symptoms. Indigenous communities involved in the piloting identified that although they desired such a tool, the Babycheck resource was not appropriate for their communities. Two years following the piloting of "Babycheck", the Babyhelp project commenced. Essentially, the aim of the project was to devise a resource to identify severity of illness in Indigenous children aged 0-2 years. Those communities who participated in the piloting of "Babycheck" were willing to be involved in the Babyhelp project. Discussions with participating communities also elicited the involvement of the SIDS project which aimed to develop an Indigenous resource to convey the public health message about "Reducing the Risks of SIDS".

4.4 Principles

As both the Babyhelp and SIDS project related to parenting of Indigenous children aged 0-2 years, consultation, data collection and resource development were undertaken concurrently. The underlying principles of both projects were:
- community consultation
- community participation
- the development of culturally appropriate health resources
- research

4.5   Community consultation (community and stakeholder issues)

Following identification and clarification of the areas to be targeted, engagement of communities involved written correspondence and discussions (meetings and telephone discussions) with the primary project team (Chief Investigators and Research Assistant). Service providers engaged in this included District Coordinators, Chief Executive Officers, Directors of Nursing, Child Health Nurses, Health Workers, other health service personnel, non-health service personnel (i.e. preschool teachers), and Aboriginal and Torres Strait Islander Elders.

To ensure that the participating communities and primary project staff had a common understanding of the research process, communities were required to forward documentation of project support. Issues outlined in correspondence detailing conditions of support included confidentiality, acknowledgement and ethical clearance.

Community consultation throughout all phases of the project was necessary to provide participating communities with information regarding progress of the project. In particular consultation during data collection, analysis and resource development included:

Data collection (focus groups and questionnaires)
- Written correspondence, meetings and telephone discussions with health service personnel
- development and distribution of a flyer throughout health services informing community members of the project and their involvement
- development of an information sheet for focus group participants
- piloting of questionnaires with health service providers and community members
- training of community members to assist with data collection

Data analysis and resource development
- Telephone discussions and correspondence to communities outlining the status of the project
- Piloting of resources in communities
- Feedback report and presentation.

Ongoing community participation
Participating communities were provided with the opportunity to participate in data collection, either exclusively or in collaboration with the project team. Prior to data collection, one community had experienced SIDS deaths. While the community expressed that they wished to proceed with the project due to the need for preventive Indigenous SIDS resources, due to the sensitivities that existed, the community chose to exclusively collect data. This required that the Research Assistant provide training to identified community members, thereby enabling a transfer of skills from project staff to community members.

Urban Indigenous communities also participated in the piloting of resources developed from data analysis. Such participation elicited appropriate terminology and the usefulness of the resources.

4.6   Development of culturally appropriate resources

By obtaining community knowledge, attitudes and practices in regards to childhood illness and SIDS, resources could be developed that would be specific to the knowledge base of the participating communities, and recognize current attitudes and practices among the population. Lessons learnt from the previous Babycheck project identified that although carers indicated that they wanted a resource to assist in recognition of illness in children, the developed Babycheck resource was inappropriate as it failed to incorporate the current knowledge, attitudes and practices of carers, particularly carers of Aboriginal and Torres Strait Islander children.

4.7   Elements

The project identified a number of elements that informed the successful development and delivery of the projects. Essentially, these elements included culturally appropriate provision, staff/personnel, training, community acceptance and support, networking and information systems.

4.7.1 Culturally appropriate provision

The projects have aimed to ensure that delivery is undertaken in a culturally appropriate manner. This has involved engaging with communities in a longer than anticipated consultation process, thus building on past developed relationships and ensuring that all stakeholders are aware of the research processes. A longer time frame was also noted when undertaking data collection. This resulted following SIDS deaths within a participating community, therefore the community chose to be trained in data collection, thereby responding to the sensitivities present within the community, and providing community members with the option to be involved in the process.

The resources have been developed according to how Indigenous community members would like to receive health information. Terminology, images and general appropriateness of the resource were piloted within communities.

4.7.2 Staff/ Personnel

The project is managed by an internal group of staff of the Indigenous Health Program and Perinatal Research Centre, University of Queensland. Day to day project operations are undertaken by a Research Assistant, with support and guidance being provided by 3 project managers.

Other key stakeholders in the projects include the Indigenous Health Program, Inala Community Health Centre; SIDS Queensland; Brisbane North Health District; Queensland Council of Obstetric Paediatric Morbidity and Mortality; Tropical Health Program, University of Queensland; and the Brisbane North District, Queensland Health. While some of the individuals who were on the original proposal of the project have since left the positions they held in their respective organizations, the role of the key stakeholders in the projects was to provide support whenever necessary.

4.7.3 Training

As focus groups and questionnaires were the method used to gather data, community members and other personnel employed on the project were provided with appropriate training. In the instance of training community members, training was held within the particular community, thereby providing community members with access to the training. Focus group and questionnaire training were each held over one half day, with follow-up training being provided if necessary.

4.7.4 Community acceptance and support

The Babyhelp and SIDS projects have been accepted and supported by participating communities. While written documentation supporting the projects have been provided by communities, verbal support has been provided by community members, Council of Elders, health service providers, preschools, and other service providers.

4.7.5 Networking

The primary project team (internal project group) identified that there was little available knowledge about various program/services and other operations currently taking place in Queensland in regards to Aboriginal and Torres Strait Islander child health. In response, the project team developed the Aboriginal and Torres Strait Islander Child Health in Queensland newsletter, which serves as a networking mechanism for individuals and organizations that have an interest in Aboriginal and Torres Strait Islander child health. Initiated towards the end of 1998, the success of the quarterly newsletter is evident in the increasing distribution and recipient feedback.

4.7.6 Information systems

Information systems used in the course of the projects included research material (i.e. data) and contact details. Data collected has been stored in lockable filing cabinets and saved on the School of Population Health's (University of Queensland) network server. The contact details of individuals and organizations directly or indirectly associated with the project, as well as recipients of the Aboriginal and Torres Strait Islander Child Health in Queensland newsletter, is adequately maintained by the Research Assistant.

4.8 Barriers

The expectation to devise resources within a short timeframe, thereby limiting the consultation phase with communities, has implied that the development of the resources exceeded the proposed timeframe. Due to the sensitivity of SIDS within a participating community, data collection within this community implied that data entry and subsequently analysis and resource development was longer than anticipated.

The geography of the communities and the resources provided implied that travel to rural communities was limited, therefore consultation mainly consisted of telephone conversations.

4.9 Further developments recommended

Certain resources or campaigns could be developed in a broad generic format for local modification, with local community and expert health professional advice to maintain content. The BabyHelp resource for example, lends itself to this treatment. This approach is used widely in World Health Organisation child health programs, for example "Integrated Management of Childhood Illness", materials for which are available on the World Health Organisation website, (WHO 2001).

5.   Working in the Field with Indigenous Families: A Case Study in Cairns

5.1   Background

40 members of Indigenous Health organisations and service providers from the Cairns Family Care team and other services met to discuss ways of dealing with the important and common issues in health service provision to Indigenous families. The workshop was followed by a series of individual interviews to allow further exploration of the identified themes. The purpose was twofold, to inform service delivery practice within the Family Care Program and to provide information for this "Better Practices" project.

Workshop participants came from Apunipima Cape York Health Council, Wu Chopperen Health Service, Wu Chopperen Social Health Program, University of Queensland Health Equality Unit, University of Queensland Indigenous Health Program, Cairns Base Hospital, Community Health Services in Cairns and Mossman and the Family Care Training Team based in Brisbane (Appendix 3). Participants included Family CARE Training participants, Health Workers and district managers.

Discussion focused on Indigenous family characteristics including child raising styles and the influence of history, environment and society on families. **The participants recognised "gaps in family experience" as the situation which most affected family functioning in the target group for the Family Care Program.** The implications of family functioning for health workers and the models of service delivery in this context were further discussed. Primarily, the need for a holistic approach was emphasised by participants, and the need for services to work in cooperation rather than to duplicate or overlap. The community worker who provides individual care was seen by participants also as promoter of community development and health advocate. On a broader level, the idea of "partnership" in working with Indigenous families and organisations was discussed.

The most important strategies to promote change were seen to be family empowerment, the engagement of young people and effective use of health promotion. A record of the discussions and interviews is provided (Appendices 4 and 5) This record contains a wealth of information and useful advice for program development in the local area, and demonstrates the wide range of resources available within the health sector for the support of families.

Included is a statement prepared by Ms Leanne Knowles, Wu Chopperen Social Health Program, for training of Family CARE workers of the Community Health Service. It crystalised the holistic approach of an experienced Indigenous counselor who had "walked in the shoes" of her clients.

Succeeding the workshop, a feedback workshop was organized by Yvonne Cadet-James and Deanne Minniecon. This workshop provided participants of the case study the opportunity to modify and provide additional comments to data gathered. Themes discussed at the workshop included the need for support groups, collaborations/ partnerships between service providers, accommodation for young women, and promotion of services and health resources.

5.2   "Working with Indigenous People" (Leanne Knowles, WuChopperen Social Health Program)

5.2.1 Points to remember

Having read through the Family CARE training manual, there are a few points which relate to Indigenous clients that I would like to share. I believe this program, and you workers, have an opportunity to make a difference to many lives, and I would like to state from the outset that I wish you well. When you connect with Indigenous families, expect to laugh and have some fun.

5.2.2 Historical implications – Intervention VS Interference

You may be the latest in a long line of people who have intervened/interfered in the lives of Aboriginal people or Torres Strait Islander peoples. This intervention in the past has had lasting impact on our Indigenous families, and for this reason, you may have to work harder to earn our trust. In accessing mainstream services, our mob have had very valid reasons for **NOT** trusting outsiders. You may at first be perceived as just another government worker sent to keep an eye on our mob.

5.2.3 Dealing with oppressed peoples

Internalisation of the dominant discourse

Many Indigenous people have taken on board the false messages we have been fed by society through the media and other sources, e.g., doing well at school is for white kids, black kids are hard-heads, family violence, grog, drugs etc are "Murri way". You can assist your clients by:

Tapping into cultural connections – do they know their clan/tribal/language group? Reconnect with the strength of Indigenous family structure.

Imagining life for Murri families before the European invasion – e.g., if violence etc were "Murri way" there would not have been anyone here when Cook arrived.

5.2.4 Multiplicity & complexity of social ills

Many of our families with which you connect will most likely be enmeshed in many of the social circumstances mentioned in the paragraph on 'Fairness and Equity'. Be aware of the stressors impacting in the families you visit.

5.2.5 Making connections

Of all the worker qualities required for making 'workable' connections, the following are imperative.

Genuineness and honesty

Avoid the social work nod and the extra loud voice. Celebrate successes, but don't go overboard in the way that you do it. You might praise the caregiver through the baby, e.g., your mum proper know how to feed you; you're growing stronger every day. There must be congruence between your words and your actions; you will be 'sussed' out pretty rapidly if you do not mean what you say, or your body language denotes a different meaning to what you say.

Humour

Laughter has been one of our mechanisms for survival. We don't take ourselves too seriously, and most of us use laughter to rise above the daily grind. If you can inject a dose of humour at every home visit, you'll do your clients and yourself a great service.

Self-Awareness

As stated in the counselling sheets, do not impose your values onto clients. To avoid this means that you as workers should be aware of your own little prejudices and preferences. Spend time deciding whether these are based in the personal or cultural perspectives. Casualness – like the story of the Nunga family in South Australia, be aware of personal values, hang-ups, and don't impose these on the families with whom you work. Our Indigenous families have had our fill of other people determining what's best for us. All the literature supports self-determination as a lynchpin for improvement in Indigenous health.

Communication Skills

Be aware of non-verbals – don't drown people in words. Be honest if you are experiencing difficulty in understanding accents and language. Learn as much of the family language as you can. Interaction between caregiver and baby may include a fair amount of non-verbal communication. Communication is not just about words.

There are no hard and fast rules in dealing with Indigenous peoples, especially since we are not a homogeneous mob. The above can be taken as a general guide.

5.3   Consultation synthesis:

5.3.1 Families

Many children in Indigenous families experience a warm, positive, extensively supportive environment. There are many examples of "formidable women", tirelessly working for home, family and community cited. Leaders of both genders are now prominent in the media of North Queensland, viewed particularly in this context as of value to young people in their search for role models, in the development of self esteem.

Babies are regarded as the core of family life, and traditions passed on to do with birthing and child rearing are important to most people. Some have entrenched family values that may be quite different to those of the wider

community, and of service providers. There are differences in culture and tradition between Aboriginal people and Torres Strait Islander people, and these should be acknowledged. There may be differences in family structure, i.e. people other than the parent (eg Aunt, Grandmother) may be of more significance in a child's life. Men in the family may not see child care as their role, consider it the domain of women, and some might be particularly uncomfortable in handling female children.

The history of adversity, with family separation from traditional lands, traditional culture, community and from each other, capped by the removal of children, has lead to family breakdown and "gaps in family experience" of surviving families. Suicide, substance abuse, domestic violence, and child abuse including sexual abuse are seen to be a consequence of this family breakdown, fueled further by the continuing pressure of inadequate income, unemployment and discrimination. Men in the family are seen as the key to turning this situation about, to reversing the trend of violence, so that affected families can heal, become re-established. Changes may take a generation or more.

Children who grew up in an institution or in a broken family sometimes missed out on experiencing mother love, and on the demonstration of parenting skills. They may not understand how different one child is from another, and how different approaches can best fit different situations. Their health and sex education was given by schools, if at all. The lack of information being passed down particularly affected boys, who generally find it difficult to talk about sex and parenting matters. These children are now parents.

Health education and knowledge of body systems is seen to be limited within many families. This is particularly recognised by Indigenous workers who take the time and effort to establish the level of understanding of their clients in regard to health problems of concern.

In regard to health matters, what affects a family member affects the whole family, and emotional or social concerns may dominate. In fact, within the community network, grief and loss of any member affects all. Every family has been touched by suicide of its young members. Self mutilation occurs in young people. Physical care priorities are by comparison low.

The family environment for many is extremely stressful, with a very low income and many demands on resources. Housing may be overcrowded, with inadequate bathing and washing facilities and no resources to maintain them. There may be no car in the household, and no suitable public transport. Remote families are particularly affected, with added difficulties in adequately disposing of rubbish and controlling animals, and the need to leave the community for many types of medical care. However, many urban families are also under housing stress. It would be not unusual to find 15 or more people living in a two bedroom apartment in Cairns. Many of the adult members of the family have chronic diseases that increase their own health care needs and limit their options for employment and for other family support roles. A Health Worker has described this as "too many issues in one house". Even so, the most disadvantaged parents will strive to improve the care of their children, given support and encouragement. Healthy children are seen as a better future.

5.3.2 Healthworkers

A worker coming into a family with the aim of promoting supportive care must be mindful of the above. Comprehensive cross-cultural training is available. The local history of separation and grief is set down in many documents, but most health workers are not familiar with these or do not understand the significance of this history in the day-to-day functioning of families. Indigenous workers may have first hand experience of these issues, and may act as a team resource but will also be subject to extra tensions of social obligation and in some situations, unresolved personal grief. A two-way exchange of knowledge, expertise and support should occur between Indigenous and non-Indigenous team members.

Cultural and local sensitivities, for example tribal boundaries, avoidant relationships, should be respected. These are particularly important in regard to household visits. There is a local etiquette for this situation that is different from that of the general community. Entry to the house, or in particular sleeping areas, may not be appropriate.

Consistency of staffing and the capacity for long term work with a family are regarded as important by workers.

Flexibility is an important attribute of workers and of programs to meet family needs. Rigid maintenance of appointment schedules within and outside the household are seen as a barrier. A change in plans should be able to be incorporated when a new family need arises.

Good communication at all levels is paramount. A gulf between doctors and their patients in terms of communication is described, but this may also apply to other health professionals. Often the resources provided for the general community on health issues do not use appropriate language nor focus on the Indigenous context. Communication and trust between team members should be fostered by clear role definitions and expectations. Communication with other services should be characterised by workable and timely referral procedures which minimise the duplication of effort by the client while preserving client confidentiality.

Maintenance of confidentiality is a major concern of families.

Indigenous Health Workers see themselves as the most appropriate front line visitor. They seek a more active clinical role in the family support process, eg independently weighing and measuring children. Health Worker training is required here.

Worker skill is required to deal with the social and emotional issues as they present themselves, and this training is desired but not currently easily available. The Family Care training partly addresses this need. There is an expectation of both families and team members that Indigenous workers handle social and emotional issues, reliant as they are on effective communication and understanding.

Strategies for dealing with intoxicated clients are a concern of all workers in the home visit context.

Workers require knowledge of welfare issues and avenues for contact with welfare agencies. Access to pensions etc, which may be hampered by family mobility, are often an immediate concern in the household.

The strength of teams and the function of debriefing are seen as important to worker effectiveness and role sustainability.

Workers strongly saw their role as including community advocacy and community development.

5.3.3 Healthcare delivery models

It is important that service development is based on Indigenous perspectives and practices, that in working with Indigenous communities a holistic model of health, not a disease-focused model, is the starting point.

Community consultation is essential at the outset and throughout the life of a project or program. It should be based on recognition of current initiatives (eg Queensland Framework for action in Aboriginal and Torres Strait Islander Health). Local sensitivities are important – eg Apunipima workers discussed the readiness of Cape York women to publicly act on domestic violence within families, but not to address issues to do with child sexual abuse in the same way. It should involve leaders acknowledged by the local community, employ consultation processes endorsed by community groups, assign real responsibilities and deliver real outcomes consequent to consultation. Impatience with "consultation after consultation and no change" was expressed by participants.

Adequate information needs to be transmitted to community groups about health concerns and the progress of programs. Also more health promotional resources and promotion of available services and programs needs to be incorporated into delivery models.

The funding base for a program should be sufficiently large to be effective and of a long term nature to enable outcomes to be realised.

Both young women and young men need to be targeted by family enhancing programs. These two groups are likely to require different approaches. Appropriate primary school based health education was thought to be essential. School based interventions could include Indigenous Health Workers, elders groups, womens groups and mens groups. Life skills and cultural awareness should be incorporated and built upon through later human relations and health education. Strategies of intensive one-to one education and support of young antenates through pregnancy to early days of breast feeding were emphasised, as were group based strategies for young men

in the community. The value of intensive work in prisons was highlighted. Availability of both young male and young female workers was seen to be a major advantage. In addition, the linking of young women with older women and of young men with older men required facilitation to promote the handing down of both traditional and "Western" knowledge.

A lack of adequate mental health services, particularly in remote areas, was seen as a major contributor to family stress.

Support and specialist services need, particularly in remote areas, to be grounded within the primary health care service to maintain continuity for the patient and foster their long term engagement. There was a cited need for support groups for carers of children. Young women are too depressed to notice their children are sick. This results in the children suffering. Although these women are hurting, they are not talking to anyone about their problems, and are gambling and drinking. These women cannot get out on their own. Often they do not have employment, have only a small amount of social security money and usually have no partner. In response to the pressures experienced by young mothers, there is a need for the provision of support accommodation. Examples highlighted were a hostel for high school students who are pregnant and kicked out of their homes. Young mothers would be able to access services and programs through this accommodation and also receive necessary support.

A support group also needs to be established for grandmothers and aunts who provide care for children.

There is a need for childcare for women attending clinics or programs/classes (eg, child care during antenatal classes or clinic checks etc).

5.3.4   Network of Resources
Services need to work together to address identified gaps, and social and environmental issues (eg, Wuchopperen, Qld Health, Manoora Renewal Project etc).

Indigenous community groups help build self esteem through knowledge of culture and community involvement. An example is AASPA committees which support Indigenous students in schools. There are many other groups organised around housing, welfare etc which also foster culture, respect and community care.

Elders have many leadership functions.

Younger successful people, eg sports stars, can be role models for young people and commonly promote a healthy lifestyle.

Churches and Pastors can both lead and support.

Community agencies include Warringu Womens Shelter, Mookai Rosie Bi Bayan House for remote are women and families, Yuddika Child Care Agency (linked with Family Services), Shelter, Housing and Action in Cairns (SHAC), Community Information Referral Centre, Youthlink, Emergency Housing Referral Service (Dept of Housing)

Media Agencies – K41G, Bama Bippera, BRACCS, CAAMA, JJJ promotes youth issues.

Health Groups include the Community Health Service (including the Family Care Team),Wu Chopperen Health Service, Wuchopperen Social Health Program, the Community Mental Health Service, Project 300 (institutionalisation and mental illness), the Blue Nurses, General Practitioners. Links between these services include a fortnightly advisory committee on rural and remote issues, and a weekly paediatric meeting at Cairns Base Hospital which focuses on integrated case management.

Apunipima Cape York Health Council provides a focus for consultation and planning, and also runs some projects, eg Domestic Violence Project.

Cairns District Health Service has an Indigenous Community Reference Group, and there are two Indigenous representatives on the District Health Service Research Ethics Committee

Cairns TAFE provides Health Worker training and the universities provide training and research relevant to communities (eg Komla Tsey's Family Wellbeing Index). The Indigenous Education and Training Network links trainers with district health services and other health organisations around the state.

Queensland Health Indigenous Health Policy Unit provides direction particularly on workforce issues within the District and State Health Service.

The Queensland Aboriginal and Torres Strait Islander Health Partnership consists of representatives from the Commonwealth Department of Health and Aged Care, the Queensland State Department of Health, the Queensland Aboriginal and Islander Health Forum (QAIHF) and the Aboriginal and Torres Strait Islander Commission (ATSIC). The partnership has undertaken joint, needs based planning processes to improve health outcomes for Aboriginal and Torres Strait Islander peoples. The assessment of need has taken in Maternal and Child Health indicators, Social and Emotional Wellbeing indicators and other important indicators, region by region to prioritise health spending.

5.3.5 Direct involvement maintains the focus
Family Care team members made it clear that the core activity of home visiting and support must be maintained as a discrete program, requiring specific funding. The strength of their position in the network comes from their continuing and direct involvement with the families in greatest need.

(See documentation of the workshop in appendices)

6 Operational considerations – Views of Service Providers and Managers

6.1 Introduction

Consultations were also undertaken with service providers and managers, focusing on their experiences in delivering services to the community, and principles and elements necessary for effective outcomes. Consultations were held with:

- Adrian Carson, Principal Indigenous Health Coordinator, Central Zone
- Stella Taylor-Johnson, Principal Indigenous Health Coordinator, Southern Zone
- Cleveland Fagan, Principal Indigenous Health Coordinator, Northern Zone
- Mick Adams, CEO, Queensland Aboriginal and Islander Health Forum
- Amy Lester and Ellen McDonald, CEO and RN, Bidgerdii Health Service, Rockhampton
- Andrea Kerslake, Kambu Medical Service, Ipswich
- Tom Kairupan, Project Officer, Aboriginal and Torres Strait Islander Health Alliance
- Dr Beres Wenck, Chair, Aboriginal and Torres Strait Islander Health Alliance
- Dr Paul Torzillo

A copy of the interviews is located in Appendix 7.

The model of service delivery we propose is based on both program experience as documented and the advice gained from this series of consultations with Service Providers and Managers. Development of a model of service delivery addressing child health in Indigenous communities needs to recognise and respect the differences that exist between communities. Essentially a generic model which details and outlines the principles and elements of service delivery that can be adapted by communities is viewed as best practice.

6.2 Principles of service delivery

The principles of the Aboriginal and Torres Strait Islander Health Policy (Queensland Health, 1994), underpin each of the Queensland Health zones strategies in improving health outcomes. (Refer to Chapter 1 – Policy Overview for list of principles).

Across Queensland, these principles were acknowledged by service providers to be essential in the delivery of services. However, one Zone did indicate that successful delivery of health services and reaching identified targets involves focusing on some of these principles and achieving outcomes, rather than attempting to address all principles with fewer outcomes. The principles currently being targeted by this particular Zone were workforce planning and development; culturally appropriate health service provision; and an across government approach. While all principles were identified as being integral and related, these principles in particular were closely related. Increasing the Indigenous workforce would improve access to health services by the Indigenous population, and partnerships with the Indigenous community would evolve.

When delivering services, it is important to adopt a content-based, rather than a process-based approach. A content-based approach is more beneficial as it promotes discussion on what service is being delivered, who is delivering the service, sustainability and general content of the service. Incorporation of a specialist service, will require this approach, identifying the big needs within the community.

6.3 Priority areas throughout Queensland

6.3.1 Service planning priorities

The Southern, Central and Northern Zones have been in the process of developing Operational Services Manuals for each Zone. The Manuals outline existing operational arrangements and possibilities for enhancement of these services.

As outlined in the Partnerships Agreement, Commonwealth money is prioritised against 10 communities of interest. Prioritisation against these communities of interest which have undertaken, or are currently undertaking regional planning, fails to recognise other communities which have a high concentration of Indigenous people and health needs. Subsequently, those communities which aren't identified as communities of interest are not a high priority in accessing Commonwealth funds into Queensland. Partnership Agreements also fail to identify processes involved in service delivery such as cultural barriers, protocols and confidentiality.

Regional planning by communities of interest seeks to identify how Queensland Health, community-controlled organisations and other organizations can deliver community-identified services and programs. Following endorsement by the Partnership, the developed plans are forwarded to OATSIH to be considered for program funding to implement the strategies identified. An example of consultation involved in regional planning can be identified in the Central Highlands region. When undertaking planning, the AMS recruited a consultant, and was involved in a number of consultations with individuals and organisations in the region. Service providers and community members were consulted separately, with service provider representation including the Queensland Health District Manager, Director of Nursing, Duaringa Shire Council, Anglicare and Domestic Violence Program. The doctor within the region was absent during consultations.

Health Action Groups are not in all Indigenous communities or districts with a high Indigenous population, therefore in some communities which are supportive of the groups, these are trying to be established. The Health Action Groups will focus on improving indigenous health in conjunction with Queensland Health.

At a State level, it appears that the focus on various health issues (i.e. hearing health) has resulted from competition between State and Commonwealth Health services. Identification of health issues and successful delivery of services and programs however, needs to involve planning beyond this and involve communities. Planning also needs to identify mechanisms by which State and Commonwealth Health services can work together, as both services would encounter the same or similar service delivery issues.

It is acknowledged that relationships between different organisations are difficult to build, however in overcoming this barrier one Zone had adopted a Memorandum of Understanding between State and Commonwealth health services and the Division of General Practitioners. A community-controlled service provider was also currently in the process of negotiating a Memorandum of Understanding (MOU) with the local Queensland Health provider. Through the development of the MOU, resources (i.e. staff) and the delivery of programs and services could be coordinated, enabling utilisation of services across the board, as currently there is a duplication of services. The MOU would also assist in negating criticisms received by the community-controlled health service from Queensland Health staff in regards to the operations of particular programs and services.

The recently developed Aboriginal and Torres Strait Islander Health Alliance aims to improve Aboriginal and Torres Strait Islander health through a coordinated approach. The Alliance is identifying methods by which the Division of General Practitioners can work with Aboriginal Medical Services. Comprehensive care of Indigenous clients is currently under utilized, therefore increased coordination would provide the opportunity for a comprehensive care plan being developed for Indigenous clients. Coordinated care items are currently not efficiently utilized, therefore a focus on establishing care plans is needed. Awareness of the care plans could generate money for AMS.

6.4 Specialist services

The success of visiting specialists is determined by how the specialist service are integrated with local primary health care services. While specialist services have been identified to have a "fly in, fly out" approach, it is important that the service identified and builds skills within the community. In regards to training of staff within the community, using a content-based approach will establish the level of skill currently within the community, and identify the best provider to deliver the training.

Specialist services tend to have a consumer-end focus, therefore it is important provide an accessible service, thereby reducing clients having to travel for specialist attention. Therefore, services should be delivered according to what is available within regions, and what services are needed. They would be integrated where needed and be available at the local level.

An example of how a specialist service could be sustained within a community was provided. As indicated, if a community wants to look at a particular disease or group of problems, a short-term program with specific objectives might be appropriate. Super-specialist visits for a couple of years might provide research data or training that could be sustained by existing services within the community.

The time taken to access specialist services was indicated to be a lengthy process. In the instance of an ENT specialist in an urban location, the waiting time was approximately 3-6 months.

Specialist services currently travel to Cape communities every 6-8 weeks, with a child and women's health specialist service travelling to communities from Cairns. In urban areas, community-controlled services were identified as delivering a lot of clinical, preventative and specialist clinics, with Queensland Health delivering preventive services. When accessing specialist services in Cairns, remote community members access community-controlled rather than accessing the 24hour medical service or Cairns Base Hospital. It is therefore important that linkages between service providers are developed (i.e. Townsville Synergy).

6.5   Partnerships

Partnerships between State, Commonwealth and community-based groups were identified as mechanisms to coordinate delivery of services. In particular, the Townsville Synergy was indicated as a proactive collaboration of services including AMS, Queensland Health and other related organisations to address the duplication of services provided to communities, and to provide a collaborative approach on improving indigenous health. Another example of organisations working in partnership was indicated by an AMS, which regularly participated in case-conferencing to establish a greater understanding of the health issue, management of the issue and therefore avoidance of service replication between organisations involved in the management of the case.

The establishment of partnerships between health and community-based organisations incorporates a broader focus of health, inclusive of medical and social issues that impact on the health of Indigenous communities. While historically organisations may have feared partnerships due to the belief of being overtaken, today partnerships have been recognised as necessary elements that assist in the sustainability of programs, ensuring productivity and positive outcomes.

6.6   Data Collection
6.6.1 Baseline data

Indigenous identification on health records has been a problem in gaining adequate knowledge of the scope of health problems. In some Health Service Districts, Indigenous identification has been reported to be as low as 30%, compared to approximately 80% within the Northern Zone. While there is a particular need to ask clients whether they identify as Indigenous, there is also a need to address the system in which data is collected. Currently data is collected from hospital and health services, of which a lot is paper based.

Improvement in data collection will enable funds to be more readily sought and to identify health needs.

6.6.2 Monitoring

FERRET has been trialled and evaluated in the Torres, with results of the evaluation indicating the appropriateness and suitability of the system to be implemented across the Cape, Cairns and Mt Isa districts. Information generated from the system will provide a measurement of what impact the Chronic Disease Strategy has had on the chronic disease problem in communities.

6.6.3 Patient Recall Systems

An evaluation of a patient recall system similar to the Chronic Disease Strategy, however focused on diabetes in the Torres, identified a reasonably large decline of diabetes compared to patients who were not involved in the patient recall system.

As community members may only access doctors when they are unwell, the patient recall system is useful in developing a plan which outlines when clients should visit service providers for monitoring of their health problem.

6.7   Funding

In regards to delivering specialist services, while Commonwealth money may be available, as Aboriginal communities need long-term strategies for service delivery, incorporating the specialist service with the general service currently within/servicing the community would provide a more sustainable service.

In consideration of the expected outcomes and aims of the Aboriginal and Torres Strait Islander Health Alliance, funds to deliver proposed services/ programs may be obtained through the Division of General Practitioners. Funding is available every three years, coinciding with the development of business plans within the Division.

6.8   Workforce

6.8.2 Recruitment of Indigenous People
Although it is anticipated that the ratio of Queensland Health Workers to the Indigenous population be at 1:150, when compared to the Northern and Southern Zones, the workforce within the Central Zone is limited.

A particular challenge in the recruitment of Indigenous people in Queensland Health will be to increase the recruitment of Indigenous people into mainstream Queensland Health positions. A strategy to address this will be to encourage Indigenous people to apply for mainstream positions.

Increasing the Indigenous workforce within Queensland Health, has highlighted the need to build alliances between Queensland Health, Education Queensland, and other sectors. Such alliance serve to increase community and individual interest about employment in the health sector.

While it is important to focus on Indigenous recruitment, there is also a need to focus on retention of Indigenous staff.

6.8.2 The role of Health Workers
The role of Queensland Health Workers is clinical and preventive. When delivering preventive programs, services and information, it is important that Health Workers access the community and discuss various health issues. A mechanism of accessing the community may be through schools. An example of this has been identified in the Cape, where Health Workers have directed preventive work to schools, thus linking the Indigenous Workforce Strategy and part of the implementation of the Enhanced Model of Primary Health Care.

The roles of Health Workers within Australia vary enormously. While some Workers may be very skilled and able to manage health centres, others may have fewer skills, therefore creating difficulties in delivering services. Within the past 30 years, it had been identified that having a Health Worker involved in delivering health care did not necessarily modify or improve the health situation.

While there has been success in having specialist Health Worker roles, the reality of having positions within rural and remote communities is limited, due to the size of the workforce within these areas. Rather than creating a specialist Health Worker position, the current workforce and health needs within the region should be identified. While a needs analysis may warrant a specialist position, it may be more appropriate to employ a generalist Health Worker whose role would encompass a number of roles.

Health Workers are employed in a number of health programs including antenatal and postnatal, nutrition, eye health and hearing programs. Most health services aim to have a mutli-skilled workforce, with some services rotating staff between programs. Difficulties in locating and attracting staff who are trained in maternal and child health are barriers indicated when delivering maternal and child health services. Although Health Workers acquire antenatal skills at training facilities, few receive training in child health skills. Therefore, in providing appropriate delivery of health services to communities, the Indigenous health workforce needs to focus on recruitment and training. Intensive resources such as training, technology to allow communication and appropriate pay scales would enable long-term support of Health Workers.

6.8.3 Professional Development of Indigenous Health Workers
Through increasing the Indigenous workforce, the professional development of the current health workforce also needs to be created and sustained. The number of expectations and demands placed upon Health Workers within communities also warrants the need to ensure a focus on the current skills and issues of the workforce.

The level of training received by Health Workers, whether at a certificate or diploma level, has resulted in inequity between Health Workers and other health professionals. While Health Workers provide the link between doctors, nurses, other health professionals and the Indigenous community, Health Workers are not currently recognised and respected for their ability to effectively deliver health information to community members in a culturally appropriate manner. The clinical experience of doctors, nurses and other health professionals compared to Health Workers, further creates inequity. In addressing such workforce barriers, inequities between doctors, nurses and Health Workers concerning entitlements such as leave, study and housing needs to be addressed.

Non-recognition and respect by other health professionals towards Health Worker training leads to misconceptions about Health Workers in the delivery of services, and the feeling by Health Workers that they're employed in 'token' positions. Primarily, addressing of these issues involves the establishment of clear role statements for health professionals involved in the delivery of services. Health Worker role statements would recognise the skills of Health Workers, including linkages within the Indigenous community and knowledge of Indigenous culture. Subsequently, Health Workers would be able to provide non-Indigenous health professionals with education about appropriate methods of service delivery to Indigenous clients. Role statements would also provide the forum for the recognition that Health Workers and other health professionals are constantly learning from each other and their environment.

While services identify and support Health Workers in maintaining an appropriate level of training, health services have experienced frustrations with training. In particular it was identified that staff may leave a service after receiving training, as a result of pursuing other positions that are able to provide a larger salary and other incentives. Other frustrations are a result of Health Workers being unable to undertake various procedures acquired during training (i.e. immunisations).

Block release and workplace training were indicated as the most appropriate and accessible methods of delivering training materials to Health Workers. The block release mode, enables workers to reinforce theory received during training into practice in a clinical setting. While most staff have young children, creating difficulties in accessing training facilities situated in other geographical locations for 2-3 week periods, the incorporation of block release for one week periods, enables staff to go to other locations, meet with other Health Workers and discuss various work methods whiled also remaining employed.

While training received in the workplace doesn't provide the opportunities for Health Workers to network with other workers, classes do not impact on the household environment of Health Workers, particularly where children are concerned.

6.8.4 Cross-cultural training

While cross-cultural training has been incorporated into the health workforce, it is important that education about Indigenous culture is delivered to individuals prior to entry into the health workforce. The most appropriate method of delivering cross-cultural training would be through medical schools and other health training facilities. This training should be reinforced in the workplace.

6.9   Current Programs

While the Zones identified few programs and services which target Indigenous child health, programs identified include:

- Kambu Antenatal and Postnatal Program – the antenatal and postnatal program was developed from the identification that community women were not accessing hospital antenatal services. The program can be delivered in the home or clinic and provides women with one-on-one education about their pregnancy and child rearing (i.e. breastfeeding), addressing issues antenatally until two years postnatal. The program responds to client needs, and can be delivered to women as needed (i.e. once per week or once per month). Kambu refer women to the program following confirmation of a pregnancy at the clinic, or through a shared-care role established with the hospital, which enables identification of mothers following delivery. The program does not target women who attend antenatal classes, as these women are identified as having greater knowledge about pregnancy and child rearing. Of mothers referred to the program antenatally, the program encourages mothers to have at least one scan.
- Nutrition program – Provided by Kambu, the nutrition program focuses on children aged 2-5 years, and therefore follows the antenatal and postnatal program. The program incorporates growth and development screening and aims to create awareness that as development changes may be different in the Indigenous population, there may be a need to create awareness of what is appropriate growth and development in Indigenous children.
- Hearing program (baby vigilance) –Kambu acknowledges that health issues need to be addressed at a young age, especially before children commence school. Hearing screening is undertaken every 6 months, however, if concerns are identified or if a child has had an ear infection, screening will be undertaken every 3 months or as required. It is important to initiate hearing screening prior to children commencing school. The transient nature of the Indigenous community results in some children not obtaining standard hearing screening received in grades one and six.
- An ear/hearing health program which targets Indigenous children aged 0-5 years is being provided within the Central Zone.

- Immunisation programs – have been identified to involve a number of service providers including Queensland Health, community health, Aboriginal Health and St Vincent's. In particular as some community members don't access doctors for immunisation, the involvement of Health Workers has resulted in a higher immunisation rate.
- Koomara Family Care Group – independent community-based group that incorporates family support and school programs and focuses on early intervention for hearing and speech problems
- Jagera Jarjums
- River of Life - a recent strategy of the Apunipma Cape York Health Council that is being rolled out in the Cape, the program targets school children and mothers with children. The family is indicated as the role model within the program, and aims to change family behaviour by providing information on a number of areas including nutrition, exercise, drugs and alcohol. Queensland Health is identifying how the program will link into the Enhanced Model of Primary Health Care/ Chronic Disease Strategy.

6.10   The role of family and empowerment of mothers

Family were indicated as an integral component in the development, implementation and evaluation of programs and services. Representing an important component of Indigenous communities, family need to be included in the target group of programs and services, and health promotion needs to be delivered within the family context.

In traditional Indigenous society, the roles of males and females in the upbringing of children was clearly indicated. The extended family assisted in child rearing, with aunts and uncles providing care alongside mothers and fathers of children. Such child rearing practices involving the extended family are also present in modern Indigenous society, with family providing support and help with the upbringing of children. The family involvement in child rearing, needs to be acknowledged when addressing health issues. Rather than focusing on child rearing provided by mothers and fathers health programs also need to recognise the positive and supportive environment provided by aunts, uncles and other family members. Incorporation of this focus would allow a two-way learning process, whereby health services and families would provide each other with information about the presenting health issue.

It has been identified that the parental influence when rearing children can encourage health promoting or health hindering practices in children. An example of influences can be identified in children who are raised in a domestic violence situation. As children are exposed to health hindering practices, the child may mirror these practices in later life, therefore adapting to the environment.

In the current Indigenous community, males and females as young as 12 years of age have become parents. As the age of these new parents has limited their ability to effectively acquire roles of responsibility, it has been identified that such roles needs to be restored. As young parents may live apart, with the mother providing immediate care for the child, it is important that fathers are incorporated into the child rearing process. Although the age of the father may limit his ability to be able to provide financial support, his ability to provide emotional support to the mother and child will enable positive parenting roles to be passed on to the child. While in the past expectant fathers have not been involved in antenatal classes, an emerging area has been the inclusion of males in classes, and the importance of establishing preparation classes for males to become fathers.

The empowerment of mothers was indicated as an important catalyst in the advancement of child health, particularly for mothers to access health services and hospitals and discuss the health of their child with health professionals. Empowerment of mothers would result following the delivery of information to mothers regarding the health of their child, thus increasing their confidence levels. While it was recognised that mothers need to receive health information, they all need to be included in the consultation process, providing valuable information on the health of their child.

In advancing towards empowerment of mothers, there needs to be an understanding of what information is currently being delivered and what procedures are undertaken. This would enable identification of what information needs to be delivered to mothers about their child's health and procedures being undertaken.

The process of information delivery to mothers needs to incorporate the reality of social situations (eg financial). Recognition of health influences within the community would promote empowerment as it would provide mothers with reassurance of her parenting practices.

6.11   Establishment of Local Programs

Local activity within communities, districts or regions needs to be identified, supported and built on when developing and implementing programs. Programs also need to incorporate workforce of the particular area and Indigenous culture. An example of the failure to incorporate Indigenous culture is identified in the Triple P Program. While the program is recognised as a good program, the relevance to Indigenous mothers is unknown. Historical events (i.e. removal of children) has resulted in some mothers having feelings of fear and shame of doctors and nurses entering their home. Some mothers also have fears of health professionals saying that they're not adequately looking after their child. It is therefore important to recognise that as parenting is not the sole problem in Indigenous families, being a wonderful parent may not be the main priority for Indigenous mothers.

Involvement of communities in consultation when establishing programs, will incorporate community-identified priority areas, thereby identifying the level of need for the development of a particular program. Community consultation is necessary, as in most instances failure of programs will be identified by community members, rather than health service and program staff. If identified by the community as useful, Aboriginal and Torres Strait Islander Health Forums and Health Action Groups are appropriate forums to ensure that community members are represented and involved in the decision-making processes regarding the planning, development and provision of services to their communities. These forums also provide services with a forum of individuals to directly consult with.

So that programs can adequately be implemented, the workforce of the community, district or region needs to be reviewed.

6.12   Delivering services

Enhanced Model of Primary Health Care/ Chronic Disease Strategy

An Enhanced Model of Primary Health Care has been developed in the Northern Zone, for the Cairns, Cape, Torres and Mt Isa Districts. The strategy is part of an enhanced model of primary health care. There are 3 components of the model, these being:

Identification of health needs - work in conjunction with communities to identify health needs. Identification can possibly be undertaken through regional planning, Health Action Groups or other health related planning which has been undertaken in the community

Workforce and information systems – ensuring there are adequate Indigenous staff. This component of the model is linked to workforce policy and training. In developing and maintaining this component, it has been important to set national standards with which to work by, particularly is working in a clinical setting. The technology used in the delivery of the model incorporated a computer and/or paper based patient recall system for identification of people with chronic diseases.

Evidence-based programs to measure health outcomes such as the Chronic Disease Strategy.

The components of the Chronic Disease Strategy are as follows:

- Education/promotion – consulting with adults and others about sexual health, mental health, alcohol and drugs, and other programs. It has been more appropriate for community organisations to deliver prevention programs.
- Early detection – Health Workers undertake opportunistic screening during visits, even though they may not be clinically focused (i.e. family and social issues). During the consultation, the Health Worker may provide brief intervention, and if a chronic disease is identified, referrals are made to the appropriate specialist service (i.e. ENT, eye health, child health, women's health).
- Management – monitor health issue to halt progression. A health management plan is established for the client, to ensure that the health problem doesn't worsen. Monitoring and management of the problem will eventually reduce the burden of care on hospitals.

6.13   Evaluation of Programs

Sentinel site evaluations were identified. The example provided stated that there might be a small number of Indigenous communities where particular work is being undertaken, enabling information to be collected from the site. Collection of the data would be practical rather than ideological, and could include information collected by service providers within the site which looks at changes within illness patterns. Evaluation such as this would address the small size of the communities, the short timeframe and the methodology used.

While indicators generated from hospitals are useful for statewide evaluations, the time needed for programs to positively generate change can be great, therefore a strong focus on these may not be worthwhile.

Evaluations of programs over the past 50-60 years have generated understanding of what factors of health care delivery are successful (i.e. programs which focus on growth and immunization, and providing accessible, 24 hour services). Rather than implementing established resource-consuming programs, it was identified that the challenge in service delivery will be delivering the basic components in a competent manner.

6.14   Barriers to service delivery
A number of barriers were identified in regard to the delivery of services. These barriers ranged from management level to program delivery in general and specifically targeting Indigenous child health.

6.14.1 Management
Service planning

There is a tendency to build up expectations of what is possible within the community, however the health service/s may not be able to deliver the particular program/service. It is therefore important to identify who has the responsibility for aspects of the program/service.

6.14.2 Workforce
The number of Health Workers in comparison to the Indigenous population creates barriers in appropriate delivery of services. The salary level of Health Workers also creates barriers. While the role of Health Workers in the delivery of services is equally as important as doctors and nurses, it is recognised that Health Workers receive minimal salaries compared to these and other health professions. Training facilities are usually located in larger geographical locations (i.e. Brisbane, Cairns, Townsville), creating difficulties when accessing the training. A number of Health Workers have young children, and as training may be for one or two weeks at a time, Health Workers find difficulties leaving their family for periods of time.

6.14.3 Resources
The geographical location of communities in the Northern Zone creates resource barriers. The cost of travelling within the Zone and the time taken to travel are primary resource problems. Coupled with this is the difficulty of attracting quality staff to various locations and employment positions in rural and remote areas.

The financial resources health services are supplied with, does not enable a sufficient workforce to be employed to respond to health issues within the community.

6.14.4 Discrimination
Community members and Health Workers have indicated discrimination by other health professionals. Discrimination towards community members creates barriers when accessing services, and it has been recognised that community members may access health professionals in other geographical locations, rather than local health professionals. Discrimination towards Health Workers by other health professionals impacts on the ability of Health Workers to effectively deliver health care to the community.

6.14.5 Transport
Transportation to access services, particularly in rural and remote communities, is a problem associated with geography and social disadvantage.

6.14.6 Geography
While the Southern Zone did not experience geographical barriers as readily as the Central and Northern Zones, geography did impact on the delivery of services. Identified geographical issues across all Zones related to the allocation of resources and the access to specialist services. In addressing these barriers, partnerships between organisations such as the Royal Flying Doctor Service and the Department of Families, are vital to overcoming the emergent problems.

Remoteness of communities creates barriers when developing a workforce. While the remoteness of communities creates difficulties in getting Health Workers and other health professionals to various locations and positions, it also creates difficulties in attracting quality staff. The main barrier focuses on the lack of incentives. In addressing this problem, it is important to seek and support community members who have a vested interest to stay in their community, to acquire appropriate skills to work in their community.

6.14.7 Ethnicity

Ethnicity posed problems when delivering services, resulting from non-Indigenous identification of partners of Indigenous clients and their ability to access services specifically targeting the Indigenous community. Future programs may therefore need to incorporate household dynamic issues (i.e. composition).

6.14.8 Gender

Gender of health professionals has been indicated as a barrier to community members accessing services. As identified in the consultations, women expressed dislike at accessing a male doctor, indicating preference for a female doctor.

6.14.9 Community knowledge

Community knowledge of the programs and services being provided creates barriers.

6.14.10 Program delivery (specific to child health services)

- Appropriate services – there is a lack of appropriate services which address family issues
- Geography – The geographical location of communities creates isolation.
- Mental health – there is no focus on particular issues
- Incorporation of families - Current drug and alcohol services are not designed for families
- Coordination of services - Services aren't properly coordinated
- Medical/Individual focus - Environment not fixed – only for individual, rather than holistic approach
- Bulk billing - General practitioners (GP's) not bulk billing, therefore Indigenous community members may use accident and emergency. Alternately, some community members are noted to not go to some GP's who do bulk bill if they are unfriendly
- Men need to be involved in the delivery of health services.
- Research - Research around models of service is lacking.
- Priorities - Priorities need to be clear. By initially integrating services on a small scale, services will eventually become implemented on a holistic scale.

7. Predominant Themes arising from services/programs and consultations

7.1   Success Factors

There were 14 critical success factors identified across programs and in keeping with service provider and manager knowledge and experience (refer to Table 2).

1. Community consultation before and during the life of the program/service;
    - Engagement of community with project – beginning the cycle
    - Relevance and appropriateness of service, methodology and communication methods
2. Community involvement in the delivery of the program/service;
    - Local acceptance of service/ program by local community and service providers
    - Increase of community actively using the health system to meet needs – gaining information and obtaining services
    - Improves sustainability
3. Empowerment of clients and community service providers within the program/service via embeddedness in community development model;
    - Ensures community controls the project – ownership of project
    - Strengthening of community development processes
    - Acknowledges and enhances local health knowledge
    - Building capacity to explore need and undertake new projects
4. Effectively documenting the context and monitoring progress of the program/service;
    - Effective recall
    - Comparable to other programs
    - Identification of appropriate service delivery
    - Provides feedback for community
5. Research which contributes to scientific and community understanding of the health problem and advances knowledge of intervention effectiveness;
    - Understanding of the health issue
    - Baseline data
    - Comparable to other programs
    - Evaluation which is nationally relevant
6. Targeted enhancement of workforce development and community skills in relation to program delivery;
    - Transfer of skills from health professionals (and other trainers) to personnel (i.e health workers and community members)
    - Acquired skills transferable to other components of service delivery and community activities
    - Skills compatible with background protocols
7. Development of culturally secure resources;
    - Community acceptance and utilization of developed resources
    - Awareness of health issues raised within the community
8. Culturally secure and locally appropriate service provision;
    - Utilisation of service
    - Sustainability of service within the community
    - Developed model of local community service provision
9. Continuity of Care
    - Sustained follow-up of chronic conditions
    - Effective utilization of available resources
    - Effective and efficient referral process
10. Role delineation with multi-disciplinary teams improves team functioning
11. Integration of services in the current method of service delivery to ensure sustainability and access to a wide range of services
    - Content-based approach
    - Primary health care focus
12. Wholistic approach ensures that client needs are addressed
    - Client focus in regards to service delivery
    - Individual issues can be addressed within the service
13. Population health approach
    - Community focus in regards to service delivery

14. Partnerships developed with health services and other providers within communities
    - Advocacy of health influencing factors within communities
    - Effective utilization of resources
    - Wider target of community members

The appendices provide further detail about the strategies utilised in programs, and barriers to care to be addressed as providers see them. Documenting these projects in this way allows future program planners access to the detail and practical features of these successful experiences.

Among those elements of child health services identified from programs and consultations, the predominant elements which emerged were the need for partnerships; the need to provide clear and supported roles for Health Workers; provide accessible training; integrate programs and services at the local level; deliver information through families and empower mothers. A content-based approach, would identify the degree to which these elements exist within communities, and identify areas of need. A content-based approach would also provide a clear understanding of the health issues to be targeted. A model for integrating services for children 0 to 5 years is proposed arising from the study and in view of health priorities evidenced by current health outcomes.

Table 2 – Critical success factors evident in a specialist service, home visiting program and health promotion project with various Queensland Indigenous communities

SUCCESS FACTORS	Respiratory (specialist)	Family CARE Program (home visiting)	SIDS/ Babyhelp (health promotion/ education)
1.Community consultation	• Undertaken with community and local councils, health centres, health and community organizations • Various methods of consultation – written, verbal and community visits • Undertaken throughout various phases of the service • Understanding of current service delivery issues and relationships • Community involved in discussions relating to implementation of the service	• Undertaken with key Indigenous stakeholders and health care providers	• Undertaken with key health and community stakeholders • Various methods of consultation – written, verbal and community visits • Undertaken throughout various phases of the project
2.Community involvement in processes	• Health Workers recruited patients • Health Workers provided follow-up • Health Workers involved in transportation • Community involved in discussions relating to implementation of the service • High attendance rates • Strengthening of local health services	• Development of a steering committee including local service providers and community • Development of an implementation committee	• Communities members participated in data collection • Community members trained in research methods • Documentation of community support • Community involved in discussions relating to implementation of the project
3.Empowerment	• Community members provided with education of respiratory illness • Community service providers involved in consultations and implementation • Strengthening of local information systems • Two-way learning • Community support • Feedback of project data to community	• Mothers had increased knowledge of healthy behaviour • Community service providers involved in consultation and implementation • Recognising carer and family strengths • Community support • Feedback of project data to service providers	• Community empowered through identification of how messages should be conveyed • Training of community members • Development of resources in response to community-identified need • Community support • Feedback of project data to community
4.Monitoring and data collection	• Asthma prevalence study • Patient details collected, stored and	• Clear guidelines established on data to collect at each home visit	• Collected data enabled the development of resources appropriate to community

SUCCESS FACTORS	Respiratory (specialist)	Family CARE Program (home visiting)	SIDS/ Babyhelp (health promotion/ education)
	analysed • Details of clients utilized to enable timely recall • Indicators – economic, health outcomes, educational outcomes • Understanding the problem from an epidemiological, social, cultural and environmental perspective	• Monitoring and evaluation in line with National and International criteria • Patient satisfaction sheets	knowledge, attitudes and practices •
5.Research	• Asthma prevalence study • Education and research integrated • Communication and data collection informed and improved by health workers knowledge of local community	• Analysis of collected data • Communication and data collection informed and improved by health workers knowledge of local community	• Analysis of collected data • Developing resources for the target population based on identified knowledge, attitudes and practices identified in survey. • Communication and data collection informed and improved by health workers knowledge of local community
6.Workforce development	• Health Workers trained in diagnosis, treatment and management of respiratory illness • On-site training • Articulation with local workforce development plans	• Health Workers, nurses and other personnel involved in training • Training manual provided • Training incorporated trainee-identified issues • Flexible training	• Community members trained in research methods
7.Development of culturally secure resources	• Community awareness exercise – local newspapers and radio •		• Community awareness raising materials developed and distributed throughout communities • Culturally appropriate resources developed in response to the identification of community knowledge, attitude and practices, and how community members would like to receive messages.
8.Culturally and locally appropriate service provision	• No waiting times • Health Workers involved in service, particularly referral and consultations	• Home visiting service • Health Workers involved in service • Service informed and improved by	• The project was delivered through consultation with key health and community stakeholders.

SUCCESS FACTORS	Respiratory (specialist)	Family CARE Program (home visiting)	SIDS/ Babyhelp (health promotion/ education)
	• Outer islands visited • Transportation provided • High attendance rates • Strengthening of local health services • Service informed and improved by health workers knowledge of local community	health workers knowledge of local community	• Data collected at times appropriate to the community • Service informed and improved by health workers knowledge of local community
9.Continuity of Care	• Communication pathways between specialists, doctors and health workers established • Regular follow-up reduces hospital admissions	• Having sustained care between antenatal and postnatal period • Developed referral process across services	• Dissemination of Babyhelp resource will include all service providers within communities
10.Role delineation with multi-disciplinary teams	• Establishing health worker as key family educators and points of referral to medical services	• Sharing of roles lead to request for role clarification and specific health worker training	• N/a
11.Integration of services	• Specialist service delivered in primary care setting and engaging local health workers	• Integrated with community health multi-disciplinary teams, GPs and other professionals • Case-conferencing with other care providers	• Dissemination via established networks and service delivery points within communities •
12.Holistic approach	•	• Integration of social issues • Focus on family rather than child	• Package of information for mothers and carers of young babies encompasses SIDS prevention and illness recognition, accompanying Personal Health Record in response to need identified in Babycheck project
13.Population health approach	• Screening/ case finding to identify level of community need for the service	• Identified strategy of recruiting at risk families to the program	• Provided appropriate resources to address population level problems
14.Partnerships		• Partnership within community developed through clinical networks	• Long standing relationships developed with participating communities involved with other projects

8. Recommendations

In undertaking this project, it was anticipated that the project could inform both research and the delivery of paediatric care in Indigenous communities in Queensland generally, including sub-specialist areas such as neonatal, growth and development, behavioural and respiratory medicine. It would also be able to provide educational opportunities for Health Workers. From the programs and consultations, the identified success factors have led to a model of service delivery modifiable to urban, rural and remote Indigenous communities. It is proposed that the model be piloted within an Indigenous community.

8.1 Preliminary proposal:
8.1.1 Project Title

"Bridging the gap in service delivery to Indigenous children aged 0-5 years"

We propose that our project group work with a district or zone, in cooperation with eg an Indigenous Zonal Coordinator, district manager and local public health unit staff to set up implementation of the model in a pilot area.

8.1.2 Project Management Team from UQ:
A/Prof Cindy Shannon
Dr Susan Vlack
Dr Kenneth Armstrong
Prof Paul Colditz
Dr Paul Woodgate

8.1.3 Aim and Objectives
To improve the health of Indigenous children aged 0-5 years through integrated health care which supports and empowers families.
- Establish a local forum for children's health issues
- Engage current service providers
- Establish partnerships between service providers and community organizations
- Build on current service delivery by establishing and supporting specialist Indigenous Health Worker positions in Maternal and Child Health in organizational locations best able to utilize and support the workers
- Increase access to services by presenting identifiable, culturally appropriate services with specific care objectives for Indigenous children
- Provide appropriate and empowering health education resources to families in relation to children 0-5 years
- Monitor healthy processes and health outcomes in children 0-5 years
- Feedback evaluation of processes and outcomes to managers and childrens' issues forum for the purpose of quality improvement

8.1.4 Timeframe
In recognition of the uniqueness of each Indigenous community, a timeframe has not been indicated. The model is designed to be modifiable to communities, therefore there is a particular focus on the elements and principles of the service delivery, rather than the timeframe taken in each phase. As an example, it is recognized that while some communities may have established partnerships, other communities may need to establish these, thus requiring a longer timeframe. The timeframe for the proposed model would be established following consultation with the participating community and service providers.

The project is divided into three phases.

Phase 1 – Developing partnerships and networks
Partnerships and networks would be established through mapping service providers within the community, and consulting with these and community members.

Phase 2 – Integrating the service
Following planning with community members and service providers, the proposed service would be integrated into existing service delivery with the community. The service would position the Health Worker in a specialist role. Integration of the service would also focus on community access to the service, delivering educational resources, and using appropriate performance indicator to monitor performance.

Phase 3 – Feedback
A workshop and detailed report will provide feedback to the key stakeholders.

8.1.5 Expected Outcomes
- Establishment of a specialized Health Worker role and training in maternal and child health.
- Community engagement in the decision-making process
- Integration of activity of a range of service providers in the delivery of primary and specialist care and health promotion.
- Implementation of a success-based model of Indigenous child health service delivery modifiable to a range of Indigenous settings
- Evaluation of the service undertaken with and by the Indigenous community, thereby ensuring community participation, ownership, and cultural appropriateness is maintained.
- Fostering of research about the health service delivery process.

8.1.6 Child health problems/outcomes
Child health problems which might be scrutinised in planning and monitoring could include some or all of these:

Low birthweight
Perinatal mortality
Prematurity
Growth failure in 0 to 2 year olds
Developmental disability
Acute and chronic middle ear disease
Skin infection
Severe gastroenteritis
Severe respiratory infection
Vaccine preventable infections
Non-accidental injury
Accidental injury

This project addressed several priority strategies and outcome areas in relation to Indigenous children contained in Queensland Child Health Policy 2001 – 2006. Note that legislative approaches, facilitation of child care provider policy, school curriculum development, initiation of outbreak response and establishment of hospital based and specialist protocols and clinical pathways are not specifically addressed. We regard these as general community strategies pertaining to all children.

Specific indigenous child initiatives to build on general community strategies have been concentrated as follows (refer to QH policy document, table of priority strategies and outcomes):

ANTENATAL – PERINATAL

Most strategies are incorporated, utilising home visiting and community linkage approach to encompass pregnancy and the perinatal period, and utilising adapted risk assessment and monitoring tools currently being developed in the "Indigenous Family CARE Evaluation Project". Service providers, with expert assistance, would work with local womens' groups to produce appropriate community information packages. The community intrface is strengthened by improved access to secondary and tertiary health services for the target group

INFANCY – TODDLERHOOD 0 - 2 YEARS

Most strategies are incorporated. Home visiting programs would work with Child Health Nurses, General Practitioners and specialised services to address priority outcomes via locally based approaches which may be generalisable in the future. Preventive care, early intervention and specialised support for low incidence conditions are incorporated.

TODDLER – PRESCHOOL 2 – 5 YEARS

Most strategies are incorporated, relying on health service utilisation by parents except where specific conditions are being followed up. Family empowerment in the health service setting should result in improved utilisation of services for toddlers, the established contact activity being immunisation. Outcome measurement relies largely on accessible external reporting. Of particular interest is a referral pathway between child health and mental health services, both child and adult, in relation to Indigenous families, which could be further developed at a local level. A north Queensland initiative involving several of the Better Practice Project Team members is beginning to address this issue at a program level (See "Mental Health Service Delivery Models for Indigenous Children and Families living in Far North Queensland" project currently under development.)

A summary of project activities and deliverables of the proposed model is identified in Table 3.

8.1.7 Summary of appropriate indicators derived from the model

1. Process indicators marking progress of implementation:
- List of organisations involved
- Report of community issues, priorities and target groups
- List of service providers and referral process
- Detailed report of workshop
- Synthesis of a report from phases 1 and 2
- Circulation of report.
- Workshop/s undertaken.
- Report outlining recommendations for service development
- Position description for Health Workers established
- Number of education and training programs delivered. Process of delivery of training
- Team meetings occurring
- Training updates
- Tracking of the impact and changing role within the workplace
- Parent has increased understanding of chronic conditions of child
- Adequacy of feedback to primary health care team
- Mothers have increased knowledge of chronic condition
- Modes of communication
- Feedback from patients about marketing strategies used
- Modes of communication
- Feedback from community about media strategy
- Number of local resources developed

- Number of group-based activities
- Community feedback about group-based activities
- Growth surveys in remote areas
- Development of protocols
- Progress reports distributed
- Number of workshops and meetings held
- Community representation
- Community feedback obtained

2. Health Service delivery indicators:
- Number of public sector occasions of service (screenings, specialist referrals, delivery of health information or resources)
- General practice visits for identified conditions.
- Number of promotional events, and episodes of desired media exposure
- Client satisfaction with particular service
- Increase in client usage of a service
- Completeness of follow-up
- Immunisation rates
- Continuing engagement of vulnerable families
- Utilisation of identified specialist clinic by Indigenous families

3. Health Behaviour Indicators:
- Behavioural risk during pregnancy
   (smoking, excessive consumption of alcohol, no antenatal care)
- Immunisation rates
- Breastfeeding rates
- Parents empowered (eg actively identify problems and seek care)
- Parents have improved confidence in managing condition
- Change in parent knowledge, attitudes, practices (eg change to health seeking behaviour and preventive care, via home visiting and centre based contacts)

4. Health Outcome Indicators:
- Hospital based monitoring of low birth weight, perinatal mortality, prematurity
- Incidence and progress of health conditions in the community, eg
   - Preventable problems during pregnancy
     (eg anaemia, sexually transmissible infection)
   - Post natal depression in mothers
   - Growth parameters of children
   - Developmental disability
   - Acute and chronic middle ear disease
   - Skin infection
   - Vaccine preventable infection
   - Other notifiable infections
   - Non-accidental injury
   - Accidental injury
- Hospitalization rates for identified conditions as appropriate to mix of programs selected
   - gastroenteritis
   - asthma
   - pneumonia
- Preventable infant and child mortality including SIDS

Note that the measured incidence of several of these conditions would be expected to rise with implementation of measurement and increased earlier identification of health problems.

8.1.8 Project Plan

Goal

To improve the health of Indigenous children aged 0-5 years through integrated health care which supports and empowers families.

Table 3 – Project Activities and Deliverables

Objective	Strategies	Personnel	Indicators	Timeframe
1. Establish a local forum for children's health issues	*Mapping might include Health Action Group, other forums developed by Indigenous zonal coordinators, and community organizations such as women's groups, men's groups, community elders and, preschool* Facilitate a community workshop to identify local community issues and priorities for families, and definition of target groups	Indigenous District Coordinator Health Worker Indigenous District Coordinator	List of organisations involved Report of community issues, priorities and target groups	1 month
2. Engage current service providers	Mapping currently available services and referral processes Facilitate a workshop to identify gaps in service delivery within the community and identify the potential for improving linkages	Indigenous District Coordinator Or other relevant health district staff	List of service providers and referral process Detailed report	1 month
3. Establish partnerships between service providers and community organizations	Devise and circulate a report to managers of services and community organisations outlining recommendations from phases 1 and 2. Facilitate workshop/s between managers of services and community organisations to establish mechanisms to work in partnership (eg Townsville Synergy, Rockhampton area MOU between district and community-controlled service)	Indigenous District Coordinator Indigenous District Coordinator Indigenous Zonal Coordinator CEO of community-controlled health service	Synthesis of a report from phases 1 and 2. Circulation of report. Workshop/s undertaken. Report outlining recommendations for service development	
4. Build on current service delivery by establishing specialist Indigenous Health Worker positions in Maternal and Child Health in organisational locations best able to	Establish the role of Health Workers in the development, implementation and evaluation of programs and services e.g. health promotion, home visiting, primary care and specialist liaison Deliver education and training program to Health Workers when needed (see attached draft outline of objectives for training)	Manager of health service Indigenous District Coordinator Trainers	Position description established Number of education and training programs delivered. Process of delivery of training	

Objective	Strategies	Personnel	Indicators	Timeframe
utilise and support the workers	Ongoing support for Health Worker	Trainers	Training updates	
	Development of team structure	Manager of health service	Team meetings occurring	
		Manager of health service	Tracking of the impact and changing role within the workplace	
	Evaluation survey of Health Workers trained		Training impact on workplace; adequacy of training; satisfaction levels; appropriateness	
5. Increase access to services by presenting identifiable, culturally appropriate services with specific care objectives for Indigenous children	Home visiting service –primarily delivered by Health Worker (preventive care in the antenatal period and infancy)	Health Worker and primary care or community health team	Number of home visits Evaluation of visits (Immunisation rates, breastfeeding rates, incidence of postnatal depression etc) Client satisfaction Mothers empowered Increase in client usage of support service	
	Formal community screening and referral (eg otitis media in preschools)	Health Workers Community organisations	Number of screenings Referrals accepted Client satisfaction	
	Facilitation of opportunistic screening in other health settings (home visiting, primary care clinics)	Health Worker Other health professionals (GP, early childhood nurse etc)	Utilisation of identified service Completeness of follow-up Client satisfaction	
	Primary Care Children's clinic (immunisation, early detection of chronic illness care, support and monitoring of vulnerable children)*	Health Worker Other health professionals (GP, early childhood nurse etc)	Utilisation of identified clinic Completeness of follow-up Increased understanding of chronic conditions of child Client satisfaction Immunisation rates Growth parameters of children Incidence and progress of health	

Objective	Strategies	Personnel	Indicators	Timeframe
			condition Specialist referrals accepted Continuing engagement of vulnerable families	
	Specialized paediatric clinic in community–based service, suggest general paediatrician with specialised visitors if determined/agreed, eg ENT or respiratory	Health Worker Paediatrician Visiting specialists	Utilisation of identified clinic by Indigenous families Completeness of follow-up Adequacy of feedback to primary health care team Change in incidence of condition being screened Mothers empowered Mothers have increased knowledge of chronic condition Improved confidence in managing condition	
	Marketing strategy for the group of services targeting the Indigenous community (eg promotion of health services).	Health Promotion officer Community organisations Media groups (BRACCS)	Modes of communication Frequency of delivery of information Feedback from patients	
6. Provide appropriate and empowering health education resources to families in relation to children 0 to 5 years	Distribution of established resources through services: Babyhelp and SIDS, immunization, growth and development, child-raising, injury prevention, oral health	Health Workers	Number of resources delivered Evaluate change in knowledge, attitudes, practices (eg change to health seeking behaviour and preventive care, via home visiting program and centre based contacts)	
	Media strategy as identified by the community (eg complementary to established resources)	Public Health Unit	Modes of communication Frequency of delivery of information Feedback from community	
	Local development of a resource where	Health Workers	Number of local resources developed	

Objective	Strategies	Personnel	Indicators	Timeframe
	appropriate (eg oral health)	Health Promotion officer		
	Group-based activities where appropriate (eg parent groups at day care)	Health Workers Community organisations	Number of group-based activities Community feedback	
	Integrating delivery of information at local community events	Health Workers Community organisations	Number of promotional events, and episodes of desired media exposure List of promotional events	
7. Monitor healthy processes and health outcomes in children 0 to 5 years	Increased immunisation coverage	Public Health Units	Immunization rates	
	Comprehensive reporting of program process and health outcome indicators In comparison with population indicators (may involve collation of cross sectoral data eg from Family services re child protection)	District Manager Health Workers	Growth surveys in remote areas Evaluate the knowledge, attitudes and practices in regards to help seeking behaviours, preventive health care (i.e. SIDS) and service delivery.	
	**DM to have formal accountability for service via service contract or MOU with indigenous organisation Empower families to access health services	Health services Specialist health services	Utilisation rates of health services Utilisation rates of identified specialist services Completeness of follow-up	
	Increased utilisation of health services by target group Increased utilisation of specialist services Define management protocols for common and identified conditions	Primary care team and paediatrician	Development of protocols Hospitalization rates for identified conditions as appropriate to mix of programs selected General practice visits for identified conditions.	

Objective	Strategies	Personnel	Indicators	Timeframe
8. Feedback evaluation of processes and outcomes to managers and the children's issues forum for the purpose of quality improvement	Distribute progress reports to key stakeholders Undertake community consultation	District Manager Health Workers	Progress reports distributed Number of workshops and meetings held Community representation Community feedback obtained	

These activities will be undertaken if community planning has not focused on child health delivery

*point of family based intervention – strong links and referral path to Indigenous counselling services and mainstream counselling services (family violence, drug and alcohol etc) should be developed and maintained for the group of services

** this is a previously little utilised strategy, which is in keeping with the direction of current policy and management developments
Note that some districts have locally developed strategic plans, which incorporate child health strategies and indicators (eg North Burnett District) so that local plans to collect the relevant information may already be in place.

8.1.9 Maternal and Child Health Worker Training

The breadth and specifics of training would be modified in accordance with the role description developed by the health service in the proposed project. Queensland Health specialist Health Worker competencies (level 004 – 006) would be incorporated and assessed in the workplace. Training would need to be flexibly delivered to suit a currently employed workforce.

Basic training objectives to consider:

Maternal Health

Know and understand:

The risks of pregnancy
Issues related to family violence and an approach supportive to women and children
Health promotion before and after pregnancy, the importance of good nutrition and healthy lifestyle
The essential elements of good antenatal care, and issues related to women
Accessing antenatal care in the first trimester of pregnancy
Principles of management of diabetes and hypertension in pregnancy
The requirements for a safe delivery
Principles for managing obstetric emergencies
Care of the post-natal woman
Methods of fertility control
Aboriginal and Torres Strait Islander peoples' attitudes to birthing and the interface with current obstetric management

Be able to provide:

Health advice to women before planning a pregnancy
1. Counselling for pregnant women on the value of antenatal care
Support and referral in dealing with family violence
A routine antenatal consultation (history and examination)
Assistance with an unexpected normal vaginal delivery
Assistance to resuscitate an infant at birth
Recommendations to mothers about post-natal care
Advice about the advantages and disadvantages of contraception

Child Health

Know and understand:

Issues surrounding the high frequency of low birth weight in Aboriginal and Torres Strait Island communities, the contribution premature birth makes, and common conditions of infancy which impact significantly on future wellbeing and are amenable to prevention eg. Maternal hepatitis B, vaccine preventable diseases of childhood, Sudden Infant Death Syndrome etc.
The complex social issues resulting in excess morbidity and mortality of Aboriginal and Torres Strait Island children and differential diagnoses and initial community management of common health problems in children
Environmental factors contributing to the high incidence of infectious disease among Aboriginal and Torres Strait Island children, in particular invasive bacterial diseases such as meningitis, urinary tract infection, skin infection.
Factors that lead gastrointestinal infections and infestations, strategies for prevention eg breastfeeding, food safety, environmental and hygiene issues

The impact of respiratory tract disease in Aboriginal and Torres Strait Island communities, causative factors (microbial and environmental), prevention and treatment measures

Causes and prevention of middle ear disease in Indigenous Communities and the different measures involved in diagnosis and treatment

Normal child growth and development, infant to adolescent, the domains of development (for example as applied to developmental screening), and appreciation of the needs of young people in the primary health care setting

Behavioral programs for parenting support

Issues surrounding injury to children, both accidental and non-accidental (including Legal implications of referral for non-accidental injury), and injury prevention approaches

Be able to provide:

1. General history taking and physical assessment of the neonate
2. Basic assessment of a child presenting with acute illness, including history taking and
3. examination
4. Assessment and initial community management of children presenting with fever
5. Assessment and community management of dehydration
6. Clinical assessment of the respiratory system, and recognition of pneumonia and
7. asthma in children
8. Otoscopy and tympanometry
9. Body measurement and plotting and interpretation of growth charts
10. Referral of children at risk

9. Appendices

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9.2   Abbreviations

AMS   Aboriginal Medical Service
CARE   Community-based Assistance Resourcing and Education
Dept   Department
ENT   Ear, nose and throat
FCP   Family CARE Program
GP   General Practitioner
Hep   Hepatitis
MOU   Memorandum of Understanding
NAHS   National Aboriginal Health Strategy
OATSIH   Office of Aboriginal and Torres Strait Islander Health
SIDS   Sudden Infant Death Syndrome
TAFE   Technical and Further Education

9.3 Indigenous Family Service Provision Workshop Participants in Cairns
(See also Section 5)

9.3.1 Participants for Indigenous Health Session
Smithfield Community Health
Cairns
7th December 2000

NAME	JOB	CONTACT DETAILS
Micheline Batcheler	CNC, Edmonton Community Health	PO Box 483, Edmonton, Cairns. Ph – 4045 9900
Sue Muirhead	CN, Westcourt Community Health	1
Sean Booth	CN, Westcourt Community Health	1
Caroline Harvey	SMO, Cairns Community Health	PO Box 483, Edmonton 4869. Ph – 4045 9900
Donna Legge	FCS	189 Royal Street, East Perth 6004. email – donnal@fcs.wa.gov.au
Lynne Thomson	Nurse, Smithfield Community Health	2
Olive Tau Davius	Health Worker, Westcourt Community Health	1
Carmel Doolan	CNC	2. Ph – 4038 9900
Denise Parsons	EMS - Midwife	PO Box 217, Edmonton
Leanne Knowles	Counsellor, WuChopperen	PO Box 878M, Manunda
Ada Tillett	Liaison Officer	Cairns Base Hospital, PO Box 902
Lynn Butterss	Child Health	Mossman MPHF, Hospital Street, Mossman Qld 4873
Tracey Watts	Generlaist	3
Gwen Kemp	Child Health	2
Lorraine Moore	Child health	3
Sue Crocker	Nurse Educator/RN	8 Aplin St, Cairns, 4970
Dee Wallis	MWHN	193–197 Lake St, Cairns. Ph – 4050 8155
Mary Boyd	Health Worker	193-197 Lake Street, Cairns
Jenny Cory	Social Worker	3
Jane Gryg	EMS Midwife	Maternity, Cairns Base Hospital
Jennifer Smith	Director, Child Advocacy Service	Community Child Health, RCH & HSD, PO Box 1507, Fortitude Valley 4006
Lesley Leece	Senior Project Officer, Child Advocacy Service	PO Box 1507, Fortitude Valley 4006
Marilyn Chew	Nursing Director, Riverton Early Parenting Centre	PO Box 333, Clayfield 4011
Sue Rath	Nurse/Midwife Educator	4
Trish Fagan	W/H P/M	PO Box 5100, Cairns 4870. Ph – 4050 8166
Lenore Mills	HW	1
Maud Donas	HW	10 Dunbulan Rd, Smithfield. Ph – 4038 9900
Sharyll Ellington	HW	Mossman Community Health
Kath Wheeler	CNE Neonates/Paeds	4
Helen Myles	Project Officer	Apunipima Cape York Health Council, PO Box 2797, Cairns. Ph – 4051 7450
Carol Fyfe	Admin	Apunipima Cape York Health Council, PO Box 2797, Cairns. Ph – 4051 7450

Sylvia Solomon	Health Worker	3
Susan Wason	Health Worker	Smithfield Community Health, C/-PO Kuranda 4872. Ph – 0408 712 324
Anne Gray	Health Worker	1
Doni Tonkin	Social Worker	1
Marg Metcalfe	Nurse	3
Wendy Sexton	Indigenous Coordinator	Cairns District Health Service, PO Box 902, Cairns 4870. Ph – 4050 6897. Fax – 4050 6663
Aileen Addo	DHW	1
Simon Bridge	Doctor	WuChopperen. Ph – 4080 1800?
Mary Whiteside	Project Officer	Uni of Qld. Ph – 408/50 3646

1 – Westcourt Community Health, 277 Mulgrave Road, PO Box 398W, Westcourt Qld 4870

2 – Smithfield Community Health, PO Box 1010, Smithfield Qld 4878

3 – Edmonton Community Health, PO Box 483, Edmonton Qld 4869

4 – Cairns Base Hospital, PO Box 902, Cairns Qld 4870

9.3.2 Minutes from the Indigenous Health Session, Family Care Program Training Workshop, Cairns
Smithfield Community Health
7thDecember 2000

Ken Armstrong introduced the Better Practices project. Ken outlined that the reason for the discussion was to outline how to make the process of working with Indigenous families better.

Sue Vlack introduced the Better Practices project as a process of consulting with health service providers to gain their opinions. A copy of letters were forwarded to members of the group, detailing the projects.

Participants were made aware that the consultation would be documented, with information being forwarded to participants for further comment.

A contact list was distributed to outline who attended the session. Details included name, occupation, contact and interest in receiving the Child Health Newsletter. Louise Hooper described the development and purpose of the Child Health Newsletter.

Sue asked the group to discuss issues in regards to the provision of services to the Indigenous population. Issues raised were:
- Non-Indigenous staff being an outsider – interfering in business, high staff turnover, continual changes/programs, not in community long enough, "your business is health business not family business", minimal trust. Need to have a process of consultation to ensure community idea. Has to be concept of community development
- Access – transport
- Confidentiality
- Overcrowding – too many issues in one house. Babies and grandparents can be in one house and the health worker may need to care for both. Visiting extended family, not just one consumer on home visits.
- Finance
- Housing
- Social - history of social issues – substance abuse, child abuse, domestic violence, parenting skills
- Environmental
- Different family structure
- Finance and housing affects the health of children
- No food in household
- Referral between agencies
- Home visit by service provider may not be appropriate as the family may have different priorities to that of the service provider, therefore health services must be flexible
- Expectation of health workers outside of role – not trained
- Insufficient training and support, difficulty keeping motivated
- Entrenched family values
- Team work/ debriefing
- Intolerance to cultural issues – ie funerals
- Time and appointments
- Gender – mens and womens business – there is a gap as the female workforce don't talk about women's business with men (and vice versa). "Screaming" for a male health worker
- Not motivated unless life threatening
- Individuals won't present if it isn't a priority – doctor hasn't told patient the condition. Problems with communication include lack of general knowledge by the patient.

Methods of conveying messages include pictures as these aren't as complicated as words. Models convey messages. The Indigenous population is visual.
- Also need in FCP – literature for FCP
- Men – community based program – important to also attract men whilst in prison as they are off the grog

The question was asked "Do Indigenous men want to be involved in child raising?" Group stated that dads are not always around and it is more appropriate to focus on the female. Involvement of spouse

- Band aid intervention going from crisis to crisis. Lack of resources for prevention
- In Cairns a mens group is available which can be utilised, however there is a need to utilize young men more
- Education should be directed to young women as they appear to not be accessing services.
- Different approach for younger and older women
- Postnatal care should be offered to everyone and therefore avoid stereotyping certain individuals

Donna Legge from Western Australia explained the Building Blocks Program. The Indigenous community have a range of services delivered at different times (both metropolitan and country).

Specific programs

Sue asked to group what issues they would like to discuss in small groups. Due to the size of the group, it would be necessary to have six groups, therefore issues to be discussed were:
1. Engaging young people
2. Communication
3. Linkages
4. Environmental and social
5. Gaps in family experience
6. Health promotion – including all health areas (mental etc)

While formulating the above issues, the group also discussed a number of other issues:
Parenting skills – mothers not around their mother, therefore resulting in gaps in family experience.
- Disciplinary model
- Health education
- Transient community – mobile families
- Differences between Aboriginal and Torres Strait Islanders should be acknowledged
- Staff retention – to develop trust and respect
- Consumers get sick of repeating problems
- Family Care Program is based on Western child rearing and doesn't include Indigenous perspectives and practices.

In response to the six highlighted issues, groups were asked to report the following:
Sue discussed the issue as outlined on the overhead:
- List what works well now
- List which new ways you see of dealing with the issue that would be helpful
- Consider – community involvement; health promotion; service provision, staffing, training; communication; referrals, networks

The group was asked to form small groups, upon which five groups emerged. The issue of linkages was not discussed. Group discussion was held for about 30 minutes. There was a high level of interaction between all groups, with all groups having a range of expertise and experience.

FEEDBACK

1.   Gaps in Family Experience

- PPP – Parenting/house mothers group
- Lack of role models/modeling – didn't see mothers
- No nurturing experience/motherly love – ostracized through jail and hospitals
- Lifestyle skills
- Appropriate services
- Limited opportunities to be around babies
- Loss of culture, love, family, belonging led to self mutilation/mental health
- Strong senior womens programs
- Prolonged counseling – hard road
- Appropriate venue
- Refer appropriately
- Name/term "family care" implies family services
- Baby clinics – no appointments, drop in
- Passed on traditions re: babies family life core
- More flexible hours/ groups after 5pm
- Appointments – days later (weeks)
- Linking – camps – groups
- Permanent staff (longer)

2.   Health Promotion

What works well now

- Vaccination/immunization – i.e. HepB, hospital – pre-discharge, F/U at home, Centrelink payment
- Baby clinics – baby info, books/literature, WuChopperen – kiddies clinic
- School education – in some schools e.g. sexual health, HRE (high schools)
- Community-based support groups e.g. Yarrabah Men's Group – "working with community to leave skills there", community develop their own priority
- Action groups e.g. Kuranda Action Group
- WuChopperen bus/transport

New ways that would be helpful

- Provide transport – access to services
- Good rapport/trust between non-Indigenous and Indigenous health workers/professionals (equal partnership)
- One to one education e.g. between mum/grandmothers, family members and service providers e.g. SS Milk
- To make "both parties" (family and worker) feel comfortable e.g. empowering, access to non-Indigenous agencies, mothers group
- To teach new skills – HOW? Stop staff rotation, link 'problem' family to 'good' family, utilize expertise in Indigenous families
- Encourage/support school home programs e.g. Gordonvale Heights. Health workers involvement. Not only mother craft but life skills
- Encourage Indigenous dads in parenting skills
- Learning should be fun

3. Engaging Young People

- Target schools with elders, men's groups, women's groups, lifestyle skills, cultural awareness
- Youth Link
- WuChopperen
- Healthy Lifestyle chats
- Role models within community e.g. basketballers and footballers
- Sports (groups/training) – may lead to further opportunistic teaching/training and more people starting programs
- Crocestedford – substance abuse education etc
- Indigenous community groups – building self esteem, cultural activities, targeting parents i.e. Headstart
- ASPA – parenting groups, public speaking, skilling
- Universities/ colleges
- Needs to be budgeting changes to trial different strategies
- 'Back to school' programs for early leavers
- The younger we engage the better
- Amalgamate service to be more productive
- Target individuals on an ongoing basis
- Employ appropriate staff for communities, hospitals, centers – to build trust/ rapport with youth
- Encourage youth to be employed or strive for community work i.e. health workers, registered nurses, doctors
- Youth media – K41G, bamabippera, braccs, caarma, JJJ – promoting youth health issues

4. Social and environmental issues

Issues include overcrowding, hygiene, water supply, illiteracy, rubbish disposal, sewerage, transport, financial, substance abuse, animals, housing, employment, lack of education, discrimiation or racisim

What works well now

- Education – talking and seeing, demonstrations (models and video), books and posters, sit and explain (therefore give education)
- Contact other agencies – emergency housing referral, Dept of Housing (help with filling in paper work), bond loans
- Have the skill to help with financial counseling and refers on to social worker, clinic, LifeLine, youth link
- Get community involved through health action groups i.e. Kuranda Health Action Group
- Call on Elders and Pastor (church)
- Take in the whole situation – not just mother and child
- Take your time, wait for them to raise an issue
- Discrimination occurs even among Indigenous population and we need to be aware of it

New ways of dealing with social and environmental issues

- Music/tapes to hand out
- Arrange respite for older family members
- More community awareness and development
- We have obligation to make leaders and community groups aware of situations
- More home visits, mums don't like visiting clinics
- Be flexible – catch them down the street or CDEP, not on pension day
- Use CDEP to help control dog problem and round up to worm, wash, desexing etc

<u>**Never**</u>
- Talk to them when they are drunk
- Never interfere when they are having an argument
- Never over step your mark when walking into their home
- Always have respect
- Visit on pension day – out shopping

5.   Communication
<u>**What works well**</u>
- Health worker and client
- Ongoing education for school children
- Ongoing education for all care providers

<u>**Helpful ways of dealing with issues**</u>
- Encouraging self-empowerment
- Cultural education for both
- Consistency of staff
- Time/timing
- Topic of interest
- Alternative therapeutic mediums
- Continuity
- Culturally appropriate education aids (visual)
- Humour
- Involvement of influential members with community – role models
- Responsibility
- Acknowledge differences
- Showing interest i.e. community events
- Venue
- Acceptance of others values
- Queensland Health infrastructure
- Education of public i.e. roles

Helen Myles from Apunipima Cape York Health Council presented the domestic violence initiative. Project team members are Helen, Daphne Naden and Caroline. The project has been funded for 3yrs (2 ½ years have been completed) to develop a model to address domestic violence. The reason behind the successful tender was that domestic violence had been indicated as a priority area. The model can be illustrated as:

Family Violence

Regional Service Providers (IFAG) – discuss coordination of services (18 months operation) Meet monthly Self evaluation	Community women	Local service providers Health clinic School Police (different for each community)
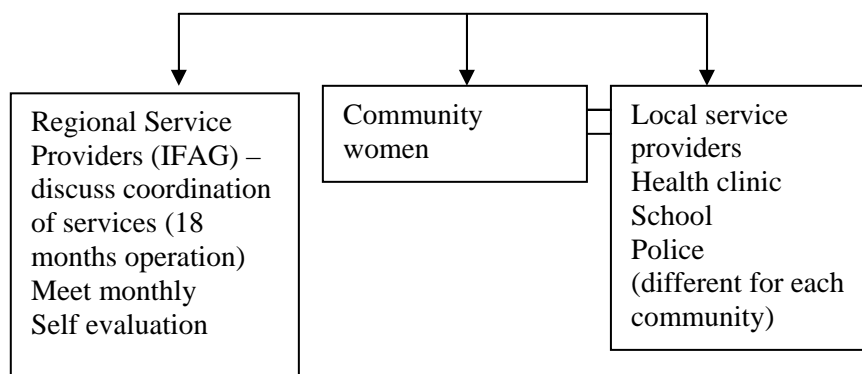
The initiative only goes to communities where the project has been invited. The project often hears that women want to be involved. The term 'family violence' refers to domestic violence, sexual assault and child abuse, however the community have indicated that they are not ready to address sexual assault or child abuse.

Sue Vlack gave an overview of WuChopperen's Social Health Program in Leanne's absence. Simon also provided information on the program. The program incorporates mental illness and social justice.

COMMENTS
Indigenous definition of health underpins the issues.

9.3.3 Dr Ross Messer (Workshop follow-up interview 8th December 2001, Cairns)

Structure of services
Agreement with community for the service, sustainability within the current health service.
Provision of services that work in with other services currently in the community.
When funding for programs runs out, somebody (usually District) has to adopt the program.

Issues
Health service providers need to be aware of day-to-day operations within communities.
Issues need to be identified by the community.

Need for ENT specialist, as no current service available in Cairns. Ear service needs to be based in Cairns and incorporate frequent visits. There is a problem with fly in, fly out operations as this process postpones services being based in Cairns and it doesn't incorporate a comprehensive service (primary care)

Things that make a difference
Doctor in community and health workers being given proper responsibility and not treated inappropriately by nursing staff.

Training
Health Workers need to be trained properly. Skills needed by health workers for child services include communication and basic clinical skills. A Health Worker is in a difficult position where faced with a situation of child sexual abuse, for example, where social pressure not to notify may be very great.

Family Care Program
FCP is a good service.

Wording of FCP needs to be addressed, as current wording of the program ('family care') raises community feeling in regard to Family Services Dept, associated with removal of children.

Concerns about security of funding – partial funding and regions need to pick up funding. Unless fully funded, FCP will dissolve.

Educational component needed for health staff in region when delivering services. When delivering services, need to know how to go into the community. There is some uncertainty as to what this entails.

Health workers need to be the staff going to families.

In FCP now, health worker role does not include weighing and measuring children.

Problem with FCP has been to collect data adequately – need to prove to ensure continued funding.

Urban Aboriginal people do not access as readily, perhaps community controlled services should be delivers of the program. It's not clear what would be best. If both services deliver, need to work together. Need to be careful not to duplicate services, and to monitor progress adequately with data.

WuChopperen not actively involved at outset as no funds were being offered for provision of workers.

Boundaries – different tribe/culture

Health education vital – to ensure responsibility – community based focus – employ local community members.

Good to reach the population as antenates, however as this may not be possible education should start early (i.e. primary school – Hopevale have had a project, primary school – early intervention)

9.3.4 Yvonne Cadet-James, Mary Whiteside (Workshop follow-up interview 8 Dec 2001, Cairns)

Issues

Problem – repeating issues – health workers voicing concerns. The most appropriate method of addressing these concerns is to provide feedback. Once feedback starts, the community appears to be happier with the process.

Defining health - When working with Indigenous communities it is important not to have a Western model of health. An appropriate model needs to incorporate Indigenous people in the development, implementation and evaluation. Health workers can get frustrated when definition of health is not incorporated into roles i.e. welfare assistance etc.

Community consultation is happening, but not partnerships

Training – needs commitment of Queensland Health

Family Care Program - Possibly incorporate Komla's Family Wellbeing into the FCP manual. Can't run one week training without follow-up.

Health worker – problems with kinship protocols, communication etc. Cultural boundaries. There is an assumption that it's (the roles) are being done, however may not necessarily, therefore health team need to recognize and work with this. Reason why multi…

Structure

Cairns District Health Service have an Indigenous Reference Group

2 Indigenous reps on the District Health Service Research Committee

Education and training networks and linkages have been established – Wendy Sexton, Aileen Addo, Karen West (Mt Isa), district managers etc

In Cairns – Indigenous and non-Indigenous communities are working together.

9.3.5 Daphne Naden and Helen Myles (Workshop follow-up interview 8 Dec 2001, Cairns)
Apunipima Cape York Health Council

Issues

Still some sensitivity of people entering homes

Trust – When establishing trust – non-Indigenous and Indigenous work together

Violence - when talking about violence in the Indigenous community, mainly in regards to physical violence rather than financial violence

Networks - Unsure of support networks in urban location

Uncertain of communications between parents and young children re: issues

When comparing traditional versus modern, most roles are overlapping except for caring.

Due to stolen generation – miss out on love of mother and parenting skills. Didn't receive information about women's health (personal experience). Learnt information from schools.

Important to outline that each child is different.

Confidentiality - confidentiality is an issue with Indigenous health workers in communities. Biggest job for Cape workers will be obtaining the confidence of the community.

Communication - Talk to women in groups in community i.e. gambling. Informal consultation provides the opportunity for more information to be received. Communities have responded more to people going around the community rather than setting up meetings – community members don't go to meetings. Problems with communication can be a result of cultural boundaries between families/clans. Some individuals may not be able to talk in the presence of family members, therefore need to have a number of individuals to coordinate programs.

Need to have 2 health workers.

These issues make it difficult to run workshops

Delivery of service/ program

In urban location young parents are open to visitation.

Health Education - In urban get good information from school programs

Aboriginal young men don't talk about sexual health. Male and female sexuality separated – difficulty to discuss parenting. In regards to caring for babies, males won't care for baby girls

Network/links - Important to keep links between service providers and pass on information. It is important to pass on information and link young women with older women. Often the older women have been taught information, however they have not been followed-up.

Family Care Program Structure – Rather than using the title of counselors, it would be more appropriate to classify this role as mentors to parents.

Family Care Program - Interested in approach for Cape York.

Future

Future Programs – Programs focusing on fair relationships and parenting. Need to involve males.

9.3.6 Audrey Deemal (Workshop follow-up interview 8 Dec 2001, Cairns)

Services - Lack of services for young Indigenous women. Lack of quality of services.

Training - Life Promotion Workers have been put into positions, however not qualified.

Confidentiality - Women may not use services due to concern with confidentiality.

"People are placed into positions within Indigenous community health services without qualifications, support and appropriate training. Therefore are often found out or find it hard to motivate themselves to efficiently and sustain effective work ethics".

Number of people I know are put into position that have no experience, during my research into community health services some of the comments from participants were that: "In mental health issues, people who work in those areas and who are in those positions are the ones needing the therapy the most – then again I suppose they are the best candidate as they speak from experience only".

9.4 Consultations with key stakeholders in health service delivery
(See also Section 6)

9.4.1 Meeting with Adrian Carson
Consultation Process for Better Practices Project
2nd May 2001
16th Floor, Queensland Health

Role of the Principal and Indigenous Health Coordinators within the Central Zone
The roles of Principal Indigenous Health Coordinator (PIHC) and Indigenous Health Coordinator (IHC) are primarily concerned with the planning of health services to Aboriginal and Torres Strait Islander communities and implementation of policy within the Zone. The PIHC functions at a strategic level and works across all sixteen (16) Health Service Districts. IHC function more at a local level, providing support to a number of designated Districts and facilitating the establishment of Aboriginal and Torres Strait Islander Health Forums and the development of local (District) Indigenous Health Plans. The Zone employs one (1) PIHC and three (3) IHC.

Central Zone
The Central Zone comprises16 District Health Services and an Aboriginal and Torres Strait Islander population of some 22,991 (ABS, 1996). Compared to both Southern and Northern Zones, the Central Zone employs a limited number of Indigenous Health Workers.

While Bidgerdii (Rockhampton) is currently the only Community Controlled Health Service (CCHS) within the Zone, another is currently being established in Cherbourg. Resources available to the Zone are therefore a reflection (also) of limited Commonwealth funding to the region.

The Central Zone Indigenous Operational Services Statement is currently being endorsed. This document will provide an overview of existing operational arrangements concerning the provision of health services to Aboriginal and Torres Strait Islander communities within the Central Zone. It will also identify issues and options for service enhancement which may be further considered and developed within the context of a Zonal Indigenous Services Development Plan.

In relation to partnerships between CCHS and DHS it was noted that a Memorandum of Understanding exists between the Gehgre CCHS and the Gladstone District Health Service which sets out arrangements for co-location and clinical supervision of staff employed by Gehgre. It was understood that similar arrangements exist in Cunnamulla (Southern Zone).

Priority Areas within the Zone
An example of programs/services specifically targeting Aboriginal and Torres Strait Islander child health within the Zone is the ear/hearing health program, which targets those aged 0-5 years. It was understood that a number of Districts within the Zone provided comprehensive and potentially best practice child health services as part of a broader Indigenous Health Program (ie. Rockhampton, South Burnett and The Prince Charles Hospital and District Health Service). Details of these services were to be provided at a later date.

It was noted that effective roll-out of programs are often hampered by poor communication/planning between the State and Commonwealth.

There is a need to focus on the range of issues which impact on the health of Aboriginal and Torres Strait Islander children. It is also important for Aboriginal and Torres Strait Islander communities to be involved in the identification of these issues/priorities and decision making processes concerning the planning, development and provision of health services to their communities. When identifying these areas it is also important that State and CCHS work in partnership, as both services would have the same issues.

It was acknowledged that relationships between the many different organisations/providers involved on the provision of health services to Aboriginal and Torres Strait Islander peoples in the Zone are often difficult to build. The Zone will therefore be pursuing Memorandums of Understanding (MOU) and/or similar arrangements within CCHS and other mainstream providers which will seek to clearly identify respective roles and responsibilities and commit the parties to working in partnership to improve health outcomes for Aboriginal and Torres Strait Islander peoples.

Principles of Service Delivery
The principles underpinning the Zone's approach to improving health outcomes for Aboriginal and Torres Strait Islander peoples are in line with those identified in the Aboriginal and Torres Strait Islander Health Policy (1994):
- Community control of primary health care services;
- Participation;
- Culturally appropriate health service provision;
- Needs-based criteria for service provision and resource allocation;
- Workforce planning and development;
- Information, monitoring and evaluation; and
- Across government approach to the provision of key social and infrastructure service to the Aboriginal and Torres Strait Islander population.

Indigenous identification within a number Health Service Districts has been reported to be at low as 30%, compared to approximately 80% in the Northern Zone, and as such there is a need to improve existing data, particularly the identification of Indigenous people. Data is collected through hospital and primary health care services, however a lot of data collection is paper based. It is understood that identification of Aboriginal and Torres Strait Islander peoples is particularly poor in regions within smaller Indigenous populations (ie. western areas of the Zone).

Implementation of Programs
Programs need to support local activity currently underway within the particular community, district etc, and therefore need to build into local existing programs. To ensure that the program can adequately be undertaken the workforce of the community, district etc, needs to be reviewed.

Initially when establishing programs, consultation with communities is necessary to ensure that the community identify priority areas, and therefore identify a need for the development of a particular program/service. The involvement of the community in consultation is important as in most instances, failure of programs within communities will be identified by community members, rather than health service staff or staff of the particular program. Aboriginal and Torres Strait Islander Health Forums and Health Action Groups are essential to enabling and supporting effective participation of Indigenous peoples in local decision making processes concerning the planning, development and provision of health services to their communities.

The success of visiting specialists is determined by the extent to which these services are integrated with local primary health care services. While these services are often seen to take a "fly in- fly out" approach, it is important that visiting services seek to identify and build skills within the community.

Health Workers
With the original ratio of health workers to Indigenous population at 1:150, the Indigenous workforce within the Central Zone, in comparison to the Northern and Southern Zones, is limited. There are approximately 40 health workers across the Central Zone, with 5/6 hospital liaison officers being included in this workforce.

There is a perception that the retention of Indigenous staff in Queensland is better than other states/territories, in regards to professional support and supervision, however the reality of this is uncertain. In retaining staff, particularly health workers, it is important that opportunities to debrief are available and health workers are provided with the ability to network with other health workers and professionals.

Although it is important to focus on increasing the recruitment of the Indigenous population, there is a primary need to focus on the current skills/issues of staff. There are a number of expectations/demands placed upon health workers within the community.

Barriers in regards to families
- Lack of appropriate services – to address family issues
- Isolation – geographical isolation
- Mental health – there is no focus on particular issues
- Access to drug and alcohol services. Current services are not designed for families
- Services aren't properly coordinated
- Environment not fixed – only for individual. Services for the indigenous community need to be holistic rather than individually-focused
- GP's not bulk billing, therefore Indigenous community members may use accident and emergency. Alternately, some community members are noted to not go to some GP's who do bulk bill if they are unfriendly
- Men need to be involved in the delivery of health services
- Research around models of service has been lacking.
- Need priorities to be clear. By initially integrating services on a small scale, services will eventually filter to become implemented on a holistic scale.
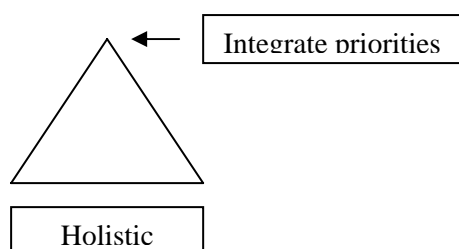
Priorities for the Central Zone
- Community/regional/Zonal planning
- The establishment of Aboriginal and Torres Strait Islander Health Forums and Health Action Groups
- Partnerships with CCHS
- The roll-out of Cultural Awareness and other cultural security strategies
- Implementation of Queensland Health Indigenous Workforce Management Strategy 1999
- Improving information systems
- Addressing identified health issues, including: chronic disease prevention and management; eye health; ear/hearing health; sexual health; women's health; child health; men's health; mental health and broader emotional and social well-being; and substance misuse.

9.4.2 Meeting with Cleveland Fagan
        Consultation Process for Better Practices Project
        5th June 2001
        Telephone link-up from Brisbane (Indigenous Health Program) to Cairns

Principles
The Northern Zone works across the 7 principles outlined in the Aboriginal and Torres Strait Islander 1994 Health Policy. All of the principles are interlocked (i.e. workforce is linked to cross cultural training to ensure that non-indigenous staff have knowledge of patients working with and also knowledge of needs-based planning. Service delivery problems identified in the Northern Zone related to:

- Service planning
- Preventive health
- Workforce

Service planning

Due to the differences that exist between communities, one model of service delivery can't be implemented across all indigenous Queensland communities. Cape communities are different from one another, and also different from communities in the Gulf and other urban and rural areas. In developing a model, there is a need to develop a generic model that can be adapted by local communities.

Commonwealth money is prioritised against 10 communities of interest outlined in the Partnerships Agreement. Many of the communities of interest are located in the Northern Zone (i.e. Cape, Torres, Gulf, Mt Isa, Hughenden/Richmond, Atherton/Croydon), and while these communities have undertaken or are currently undertaking regional planning, the identification of communities of interest fails to recognise other communities which have a high concentration of indigenous people and also have needs (i.e. Palm Island, and Yarrabah). As these communities are not identified, as a priority area, they are not a high priority in terms of accessing commonwealth funds into Queensland.

In the Cape, discussions are being held with Apunipima Cape York Health Council for joint regional planning. The planning process should identify how Queensland Health and other services can deliver programs, which the community has identified. Once complete, the planning has been completed, it will be forwarded to the Partnership for their endorsement. The plan will then be submitted to OATSIH to consider program funding to implement the strategies identified in the plan

The only area that has undertaken planning in the Zone is the Atherton/Croydon and Torres Strait Community of Interest. Discussions for Regional planning in the Gulf area has been undertaken with the Karboyick Larkinjar, with an outcome being a regional workshop held in the Gulf and Mt Isa communities to look at the issue of regional planning for the Gulf areas.

In developing an Indigenous Plan for the Northern Zone, the Principal Indigenous Health Coordinator and the Indigenous Health Coordinators are currently identifying what community planning which focuses on health has been undertaken.

Health Action Groups are in some communities. While communities have the final decision as to whether or not they would like a Health Action Group. The Health Action Groups should have input into program design, identify strategies for delivering services to communities and outlining mechanisms to work with Queensland Health. the Health Action Groups concentrate on improving indigenous health in conjunction with Queensland Health.

Preventive health

The Apunipima Health Council has developed a program titled 'River of Life' which targets the future generation and is being rolled out in the Cape. The aim of the

program is to increase the health of the future generation, with the target group of the program being school children and mothers with children. Information on nutrition, exercise, drugs and alcohol is delivered in the program, which has the family as the role model, thus aiming to change family behaviour.

Queensland Health is looking at how the River of Life will link into the Enhanced Model of Primary Health Care/Chronic Disease Strategy to improve the health of indigenous peoples in the Cape.

Enhanced Model of Primary Health Care/Chronic Disease Strategy
Enhanced Model of Primary Health Care has been developed in the Northern Zone for the Cairns, Cape, Torres and Mt Isa Districts. The strategy is part of an enhanced model of primary health care. There are 3 components of the model, these being:
1) Identification of health needs - work in conjunction with communities to identify health needs. Identification can possibly be undertaken through regional planning, Health Action Groups or other health related planning which has been undertaken in the community
2) Workforce and information systems – ensuring there are adequate indigenous staff. This component of the model is linked to workforce policy and training. In developing and maintaining this component, it has been important to set national standards with which to work by, particularly when working in a clinical setting. The technology used in the delivery of the model incorporated a computer and/or paper based patient recall system for identification of people with chronic diseases.
3) Evidence-based programs to measure health outcomes such as the Chronic Disease Strategy.

The Chronic Disease Strategy, has the following components:
- Education/promotion – consulting with adults and others about sexual health, mental health, alcohol and drugs and other programs. It has been more appropriate for community organisations to deliver prevention programs.
- Early detection – health workers undertake opportunistic screening during visits, even though they may not be clinically focused (i.e. family and social issues). During the consultation, the health worker may provide brief intervention, and if a chronic disease is identified, referrals are made to the appropriate specialist service (i.e. ENT, eye health, child health, women's health).
- Management – monitor health issue to halt progression. A health management plan is established for the client, to ensure that the health problem doesn't worsen. Monitoring and management of the problem will eventually reduce the burden of care on hospitals.

Primary Clinical Care Manual (revised) outlines the national standards which doctors, nurses and health workers (clinical staff) need to meet.

Reporting on indicators
The Torres has been trialling FERRET, with an evaluation being undertaken to look at the success of the implementation of FERRET. If the evaluation is found to be suitable, it will be implemented across the Cape, Cairns and Mt Isa districts. Information generated from FERRET will enable measurement of the impact the chronic disease strategy has had on the chronic disease problem in Torres communities. A program similar to the chronic disease strategy was focused on diabetes in the Torres. The program evaluated the effectiveness of a patient recall system. Of diabetic patients who were on the recall system, there was a reasonably large decline of diabetes compared to patients who were not involved in the patient recall system.

As a lot of community members only access doctors when unwell, the patient recall system is useful in developing a plan which outlines when clients should visit service providers for monitoring of their health problem, thereby establishing how the client is managing the health problem.

Workforce
The role of health workers employed by Queensland Health is both clinical and preventive. When delivering preventive services and information, it is important that health workers get into the community and talk about various health issues. In the Cape a lot of preventive work was directed at health workers getting into the schools, thus linking the Indigenous Workforce Strategy and part of the implementation of the Enhanced Model of Primary Health Care. From these two strategies the Rural and Remote Workforce Plan has been developed.

There is a need to build alliances between Queensland Health and Education Queensland and other sectors to increase community and individual interest about employment in the health sector. However, there is also a need to build and retain the professional development of the current health workforce, so as to provide better service to communities.

Implementation of Primary Health Care

Within the Northern Zone, it has been identified that a specific child health component needs to be developed, with antenatal care being provided within the system. Currently specialist services travel to communities in the Cape every 6-8 weeks. Also, a child and women's health specialist service travels to communities from Cairns. There is some uncertainty as to what specialist services are available in Mt Isa.

In urban areas, community-controlled services deliver a lot of clinical, preventative and specialist clinics, whereas Queensland Health deliver preventive services. In the Northern Zone, there is a focus to build links between Queensland Health and community-controlled services to ensure better communication and delivery of services. When accessing specialist services in Cairns, remote community members access community-controlled services rather than accessing the 24hour medical service or Cairns Base Hospital. It is therefore important that linkages between service providers are developed. An example of such linkages are identified in the Townsville Synergy, which involves linkages between AMS's, Queensland Health and other related organisations. From current discussions it is anticipated that other synergy's or similar arrangements will be developed in Cairns, Mt Isa and Mackay. The synergy's will aim to address the duplication of services which result in inefficient utilisation of resources and to work collaboratively on improving indigenous health. The synergy's will therefore provide the forum to discuss programs and coordination of services approximately every 1-2 months.

Staff
Although it was anticipated that there would be one Queensland Health health worker for every 150 indigenous population, this is currently not evident in the Northern Zone. In Yarrabah there are 4/5 health workers for a population of 3000. In the Cape there are approximately 3-4 health workers in each community, with 1-2 health workers in the smaller communities. There are also 3-4 health workers in Gulf communities, with the Torres having 1-2 health workers for the outer islands.

In the Cape and Gulf, Queensland Health is the only service provider, with AMS being situated in Cairns, Innisfail, Mareeba, Townsville and Mackay.

Although there can never be too many health workers, Cairns and other urban areas (Cairns, Atherton, Mareeba, Townsville, Mackay) have a lot of health workers. Some are based in community health, but a lot are aligned to programs (ie sexual health, mental health, oral

health). It is therefore difficult to estimate how many health workers are present in the urban areas, and whether they deliver clinical or primary health care work.

Barriers to service delivery

Workforce

Although health workers provide the link between other health professionals (i.e. nurses, doctors) and the indigenous community, inequity is evident following non-recognition of health worker training, whether a certificate or diploma. While doctors and nurses have more clinical experience, health workers need to be recognised and respected for their ability to effectively deliver health information to community members in a culturally appropriate manner. It is however difficult to break down barriers between doctors, nurses and health workers, as leave, study entitlements, housing and other entitlements currently serves to create inequity between health workers and other health professionals.

In the Northern Zone, it is difficult to get health workers and other health professionals to work in remote communities, while also trying to attract quality staff to work in these locations. The main barrier focuses on the lack of incentives. The Zone is therefore trying to utilise community members, who would have a vested interest to stay in their community, to get training and return to their community to work.

Resources

In the Northern Zone, resources will always be a problem due to the geography of the Zone. The cost of travelling within the Zone and the time taken to travel are primary resource problems. Coupled with this is the difficulty in attracting quality staff to various locations and employment positions in rural and remote area.

Salary

AMS have Health Union Services awards which differ from that offered in Queensland Health, however entitlements between Queensland Health and AMS are relatively the same. Salary barriers related to service delivery arise as health workers receive minimal salaries compared to those received by doctors and nurses, although the role of health workers in the delivery of services is equally as important.

9.4.3 Meeting with Mick Adams
       Consultation Process for Better Practices Project
       20th June 2001
       QAIHF

QAIHF
QAIHF operates as a broker between organisations, identifying the need to take time as a collective group and discuss issues.

Issues
Workforce
Misconceptions about using indigenous staff in the delivery of services can arise. In particular, although health workers may have undertaken clinical skills training, practical skills may not be evident. It is important that health workers have a combination of practical and clinical skills. Subsequently, health workers could educate non-indigenous staff about appropriate delivery of services to indigenous clients.

Conflicts (tensions) have and continue to exist between non-indigenous and indigenous health professionals, and arise due to non-recognition of health worker skills (i.e. a nurse with tertiary qualification doesn't recognise skills of health workers). As a result, indigenous staff may find it difficult to work with non-indigenous staff. In responding to this problem, the role statements of both professionals needs to be devised and clearly outlined. Mechanisms with which indigenous and non-indigenous health professionals can work together without conflicting their positions and status within their respective communities also needs to be devised.

Health workers and nurses need to work together to get positive outcomes with clients. When working together, both health professionals need to recognise that they're constantly learning from each other and their environment. Such recognition will avoid restriction of their skills and abilities when delivering services.

Health professionals need to be skilled in dealing with domestic violence situations and behaviour modification. In particular they need to look at the reason for the problem, working broadly rather than focusing on the particular situation. It is important that health professionals also incorporate alternative methods in response to the problem.

The incorporation of a broader focus would allow health professionals to look at contributing factors and past history rather than looking only at the presenting illness. Utilisation of this process would require that consultations provided time to form relationships with clients.

While cross-cultural training is currently active within the health workforce, there is a need to also include the training in medical schools, so as to inform future health professionals of the indigenous culture, prior to their entrance in the workforce.

Delivery of Programs
When delivering programs to the indigenous community, there is an identified need to also provide education about particular interventions. The community needs to be provided with education, which will serve to empower community members about the particular health issue. The skills of community members also needs to be included in the delivery of programs. Although there may be a particular focus on a health issue, it is important that the delivery of services/programs incorporates a broader focus. The indigenous community has a diverse range of skills (i.e. horse handling and gardening), and wherever possible these should be included. However, the community also needs to learn new skills and as such they would benefit from being taught administration skills. The adoption of these would enable communities to utilise current skills and work towards a self-sustainable community.

In identifying emergent health issues, doctors have the capacity to monitor these and devise programs accordingly. Through successful monitoring by doctors and other health professionals, problems in the community will be alleviated.

FERRET was indicated as a useful patient recall system, which enabled the monitoring of health check-ups. The only problem with the system was that it focused on the presenting issue rather than the underlying health problem. Therefore, there is the need to have a thorough history, so that doctors don't presume the cause of the presenting problem. A recall system such as FERRET also has the capacity to monitor the management of health issues, which is a particular need within the indigenous community.

Empower mothers

When delivering services, there is an underlying need to empower mothers. Empowerment which focuses on parenting, would deliver information to enhance mothers' current knowledge base regarding health issues. Following this, mother's confidence levels would be increased, enabling mothers to confidently access hospitals and other medical services and discuss health issues with doctors and nurses, requesting clarification when needed.

Mothers need to be able to provide health professionals with health information about their child, while also receiving health information from health professionals. As mothers have the most knowledge about their child, it is important that their knowledge is included in the consultation process. Such empowerment would also enable mothers to actively access after hours medical attention, thereby reducing the delay in accessing medical care because of a lack of confidence and knowledge of a particular health issue.

During visitations, there is a need to determine what information is delivered to clients, and what procedures are undertaken. Delivery of information would include interacting with mothers, outlining details of the procedure being undertaken. It is important that the process of information delivery is not demeaning, and recognises the social situations that exist in the community (i.e. financial). An approach such as this would provide reassurance to the mother about parenting practices.

While in the position of CEO (AICHS), Mick facilitated workshops to identify how AICHS provides services to the community and how the service can empower women. Subsequently a process involving the doctor, nurse and health workers was established and run for a short period of time. The process aimed to:
- monitor what happens between visits
- measure effectiveness of the service
- measure mother's interpretation of messages delivered
- measure if mother's follow taught practices between visits

Parenting

The parental influence is extremely important in the upbringing of a child. If a child witnesses domestic violence in the household, there is a higher possibility that the child will mirror the practices. As children mirror relationships of their parents, it is therefore important to establish positive partnerships. In addressing parenting issues, men and women (fathers/partners and mothers) need to know their roles within the household. From working in partnership, the responsibility displayed by both partners will be evident to the child, subsequently the child will adapt to these roles in later life.

In indigenous traditional society, there was a clear designation of roles (i.e. a male child would be raised be women until a particular age when men in the family would take over the raising role). This group influence also implied that nephews and nieces were classified as sons and daughters, with family providing support and help with their upbringing. Such practices are still evident in modern indigenous families, highlighting the importance of passing on practices. Addressing health issues within the indigenous community needs to acknowledge the positive strength outside of services, incorporating the extended family.

Such an approach incorporates a two-way learning process, whereby the health service and family provide information to each other.

The role of the extended family in the raising of children highlights the importance of utilising them as role models in the delivery of information, rather than professional sports people. The practices of some professional sports players outside of their particular sports field, is far from the positive model which they portray when playing their sport. As such, utilisation of some sporting personalities may result in negative replicating of their actions by young people. Utilisation of family members in delivering health information may be more successful due to the personal connection which would enable young people to relate to their family members more than sporting personalities.

Within indigenous households, a number of issues may be present which require counselling or another form of intervention. Within the community, males and females as young as 12 years of age may become parents. As a result of their age, these parents tend to have not been shown the responsibility of taking care of a child and may live apart from each other. It is important that although the father may not be able to provide financial support, that he provides emotional support to his child and the mother.

In addressing the age at which males and females are becoming parents, it is important that work is undertaken with each partner to restore the roles of responsibility. In working with the parents, information focusing on health education/promotion materials would also be delivered.

While traditionally antenatal classes have focused on women, there is a current move to include men in classes, ensuring they are also provided with the knowledge of the antenatal procedure and what to expect postnatally. Mick indicated his interest in men's groups and indicated the importance of creating classes for men to become fathers.

Education of children
Delivery of health information to children has tended to be medical. More effective delivery of information would include a focus on the environment and physical location of where children are being taught and the content of information being delivered.

Partnerships Agreement
In regards to the Partnerships Agreement, the Department of Health and Aged Care provide resources in response to action in identified communities of interest. There is however a need to look at the processes (i.e. cultural barriers, protocols, confidentiality) involved in the delivery of services rather than the outcomes of the service. A focus on processes involved would also require adequate monitoring and reporting on the processes used.

9.4.4 Meeting with Amy Lester and Ellen McDonald
Consultation Process for Better Practices Project
25th June 2001
Telephone link-up from Brisbane (Indigenous Health Program) to Bidgerdii (Rockhampton)

Bidgerdii Community Controlled service
The Bidgerdii Community Controlled Health Service cover the area between the Capricorn Coast, Northern Territory border, Windorah and Hervey Bay. The service is the only AMS from Mackay to Brisbane, and links up with other AMS (i.e. Dalby, Mackay, Townsville).

Service delivery
Biderdii provide a full medical service and is currently focused on diabetes and weight-reduction programs. There is no current focus on nutrition, however as a lot of patients are diabetic, this is an area to be targeted. While the clientele who access Bidgerdii are diverse, a large proportion have a low income, which limits their ability to access nutritional foods, and therefore warrants a nutrition program. Four to five months previous to this interview the service did have a nutrition program, however the position that coordinates the program is currently vacant due to the previous staff member leaving for another position.

The service provides counselling and eye health to Rockhampton and areas outside of Rockhampton. While it is difficult to provide services to areas outside of these areas, the service manages to alleviate some of the pressure. Locations that Bidgerdii has been able to provide services to (i.e. Fluvax for adults), have included locations that have Queensland Health hospitals. When providing Fluvax, the service mainly work in conjunction with St Vincent's or the Ambulance, rather than Queensland Health. This is as each service provides services to various areas within the region, ensuring that they 'don't stand on each others toes'. Bidgerdii have indicated that they would like a Queensland Health health worker to become involved in delivering particular programs and interventions.

The eye health coordinator, targets adults and children at school. A positive outcome of the eye health program has been parents taking children to have their eyes checked.

Bidgerdii have had a few instances where staff have received criticism from Queensland Health staff when undertaking outreach services to various communities. Criticisms have focused on the operations of the particular program/service, however Bidgerdii maintain that the program/service being delivered is at the request of the community, therefore the community should be the judge of the program/service being delivered.

Bidgerdii currently have cramped working conditions and are in the process of moving to another location which will be easier for community members to access as it is closer to public transport.

Due to relationships between the indigenous and non-indigenous community, Bidgerdii provides services to non-indigenous partners of indigenous community members. Recognition of the ethnicity of clients who access the service is built into the planning process when delivering services.

Immunisation program
The immunisation program is currently organised through Queensland Health, community health, Aboriginal Health and St Vincent's. It has been identified that as the community don't readily access the doctor for immunisation, if a Bidgerdii staff member wasn't available in the community, the service would not have the high immunisation response rate.

Approximately 5500 clients access Bidgerdii, with a small percentage of clients accessing the service from outside of Rockhampton (i.e. Biloela, Mt Morgan, Blackwater, Gladstone). Those that access the service from other locations, appear to access the service when they are

'really sick'. Such practices have resulted from discrimination from health service providers within their communities and subsequently health service providers not addressing their needs. These clients indicate that they like the continuity of care that they receive from the service, and as such the service note that they continue to access the programs/ services of Bidgerdii.

When delivering and developing programs, community consultation is undertaken as a mechanism to establish what the issues are within the community. Development and delivery of programs also requires that Bidgerdii maintain cultural appropriateness of the service, therefore staff have been committed to ensuring that the service delivered is Aboriginal controlled and is 'for the people, by the people'.

Data is collected from various sources - ABS, ATSIC and Bidgerdii records – and it has been identified that discrepancies exist between Bidgerdii's data collection and official statistics (ABS). The discrepancy arises as indigenous people don't like to indicate their name or ethnicity for fear that Government is watching and will therefore identify if someone isn't on the electoral role or not paying taxes. While official statistics for the Rockhampton indigenous community can be doubled to provide an indication of the indigenous population, Bidgerdii have recognised that more community people are starting to identify as Aboriginal and Torres Strait Islander.

Monthly statistics, necessary for Service Activity Reporting are collected by the service. Such collection of data is paper and computer based. The FERRET system is not currently utilised by the service, however once the service is moved to a new building, the system will be incorporated into operations.

Although the sexual health worker undertakes home visits, other services provided by Bidgerdii do little home visiting. The service offers a transport service, therefore brings patients into the service.

The service predominantly has a clinical service delivery role, with less attention being focused on preventive services. If resources were available for another 2-3 health workers who would be able to provide back-fill in the clinic, the service would be able to offer more of a preventive role.

Bidgerdii have been approached by the Woorabinda Council to screen for Strongyloides in the community, and the service is currently writing a submission to address this. The Woorabinda Council and Hospital would be involved with the project, with stool samples being sent to Westmead. Bidgerdii offer counselling and eye health programs to Woorabinda and are currently undertaking negotiations with an Opthamologist to offer a service from Woorabinda once a fortnight, rather than the community accessing the service from another location. An approach such as this would decrease the possibility of losing clients in the system.

In partnership with a number of organisations across the region, Bidgerdii will be commencing the Regional Training Centre for Social and Emotional Well-being. The Centre currently has a trainer, coordinator and administration, with a psychologist joining the personnel. In establishing the Centre, Bidgerdii staff travelled to various locations (Armidale, Adelaide, New South Wales, Alice Springs and Melbourne) to identify how other Training Centres were operating. It is anticipated that community will have ownership of the Training Centre.

Cross-cultural training is not currently offered to doctors and other health professionals through Bidgerdii, however this would be an area of training the service would like to pursue, particularly with the establishment of the Regional Training Centre.

Future delivery of services
In the near future Bidgerdii will be establishing a Memorandum of Understanding with the Rockhampton Queensland Health Service – Phillips Street. The Memorandum of Understanding will establish what services and programs each health service is able to deliver. Currently Phillips Street don't have a doctor, however have more health workers than Bidgerdii. Both services refer clients to each other, however the Memorandum of Understanding would enable utilisation of services across the board, as currently there is a duplication of services. As both services are targeting the one population, the memorandum will enable better coordination of available services.

Nutrition, hearing health and diabetes education are problems currently within the community and the service would like to be able to target these areas, particularly through the employment of appropriate workers. The service also anticipates that staff be multi-skilled.

The service is currently submitting a proposal to the Commonwealth for a Stronger Families project. The project aims to have a family focus and identify mechanisms of how knowledge, skills and practices are passed on. The service will find out from the community what they need and be able to follow through with addressing the identified issue. If successful, it is anticipated that the project will be ongoing.

Child health programs
While Bidgerdii is currently delivering a full medical service that is delivered in medical practices, the service is not currently targeting child health. The service do however undertake antenatal and postnatal (2-10 days) visits, in consultation with the hospital. Postnatal visits include sending referral letters, undertaking immunisation and basic measurements (head, legs, weight). Immunisation is also undertaken at the service, with more children being identified as coming to the service for comprehensive immunisation. The service does not have funding for a child health nurse and health worker to provide services outside of Rockhampton and areas within a close vicinity. It is therefore difficult to provide services to these areas.

The Queensland Health service (Phillips Street) have child health programs and a paediatrician available once every fortnight, whom Bidgerdii refers clients to.

Workforce
With the resources available, Bidgerdii currently has three health workers, one eye health coordinator and counsellor, one registered nurse and two doctors. Health workers currently have a rotational system within the service. (Note – as of November 2001, Bidgerdii only had one health worker).

The service indicated frustrations as staff who receive training may leave the service for positions which offer a larger salary and other incentives. In attracting staff, the service has had interest from people 'down South' seeking job opportunities, however these individuals seem to approach Bidgerdii when a position has been filled. Overall, the ability to attract staff varies. Most of the staff are mothers of young children who come from Rockhampton. Staff members who have young children find it difficult to undertake training outside of Rockhampton, particularly for 2-3 week periods, as they don't like to leave their children.

Bidgerdii are supportive of training staff wish to undertake, however recognise that a barrier to focusing on maternal and child health results from Queensland Health providing trained Registered Nurses. The service therefore can be limited to go to small geographical areas that have small hospitals, a process which can take some negotiation with the particular location. In addressing this, through additional resources the service would like to establish a position for a child health nurse. There is also the hope of having a health worker focused on child health. Furthermore with coordination between Phillips St and Bidgerdii, the service would be able to pick up more children.

Bidgerdii indicated that doctors didn't recognise and respect training received by health workers. Subsequently, health workers can feel that they're in positions as a 'token person'.

Framework Agreement
The Central Highlands has been outlined as a community of interest in the Framework Agreement. Subsequently, Bidgerdii has recently completed regional planning and are waiting for the Minister to sign off on this. In undertaking the regional planning, Bidgerdii recruited a consultant and was involved in a number of trips to the Central Highlands where interviews were undertaken with communities within the region. Most of the regional planning process involved writing and feeding information back to the participating communities. From the interviews, it was hoped that an outreach service would be established at Blackwater, with funding being provided for another 1.5 health workers.

The Blackwater community have not had a Health Action Group, however it is anticipated that this will be established. Individuals and organisations involved in the planning process in Blackwater included the Queensland Health District Manger, Director of Nursing (Blackwater Hospital), Duaringa Shire Council, Anglicare, Domestic Violence Program in Emerald and local people from Dingo, Blackwater and Bluff. The planning process also was to involve the doctor from Blackwater, however the doctor was away during the process. Planning consultations involved two one-day meetings – one with service providers and the other with community members.

Barriers to service delivery
A number of barriers within the region were indicated including discrimination, number and training of health workers, and gender of health professionals.

Discrimination
Within the region, community and health workers have encountered discrimination. Subsequently it has been identified that community members outside of Rockhampton, who were ill would access services in Rockhampton rather than accessing the local doctor. In addressing health workers who have experienced discrimination within their working environment, there is a need to support these staff and provide other health workers in the event that back-filling of staff is required.

Number and training of health workers
The number of health workers Bidgerdii is able to employ with available resources does not allow the service to provide the services it would like to provide. In particular, the service would like to provide programs which address nutrition and child health.

While adequate training of health workers does not appear to be a problem, the geographical location of training facilities (Brisbane, Carins etc), creates burdens if staff need to go away for training, as most staff members have children.

Gender of health professionals
Bidgerdii previously only had one doctor, who was a non-indigenous male. Gender created barriers to female clients who indicated that they would prefer a female doctor. The service has recently been provided with the services of a female doctor. Her presence within the service reduces the amount of women who access Family Planning.

9.4.5 Meeting with Andrea Kerslake
            Consultation Process for Better Practices Project
            26ᵗʰ June 2001
            Kambu Medical Service, Ipswich

Kambu Medical Service
Kambu is a community-controlled medical service which has been in operation for the past 25 years. The service provides clinical and preventive services to the indigenous population of the West Moreton district. According to the ABS, the indigenous population within the district is 4200, however Kambu estimate that the population is more likely to be about 8500.

Service delivery
In recognition of mixed relations (indigenous and non-indigenous) which exist between clientele, Kambu also provides services to the non-indigenous community if they choose to access the service.

The need to link in with other services is paramount to the delivery of services, and in response Kambu is currently trying to network with doctors at Lowood. Currently the service is willing to follow-up patients and provide transportation of clients if needing to go to the hospital.

It is important that doctors and other health providers within the West Moreton district are aware of the services provided by Kambu. General practitioners generally don't refer clients to the AMS. As a result of the lack of knowledge of the service, Kambu are trying to establish a system with the hospital which would provide clients who identify as indigenous with information about the services provided at Kambu. There is a belief in the indigenous community that Kambu is just a clinic and doesn't provide other health services and programs.

Doctors who provide services from Kambu are not based within the service. Due to the time taken to develop and maintain trust with clients, it is important that the service is able to maintain doctors, thereby providing a service which clients will access more readily.

Community Health located in Ipswich currently don't have indigenous staff, however do refer clients to Kambu.

The recall system (Rx Medical) used by the service is computer based. It is often difficult to locate clients, due to the population being transient and moving with family to and from various locations including Cherbourg, south of the Queensland-New South Wales border and North Queensland. However, of clients which the service is able to locate, the main method of recall is through a letter.

The delivery of the programs provided by the service are identified as being flexible, with change occurring to suit the needs of the population receiving services at a particular time. Program change can also occur with the recruitment of new staff in program positions.

Feedback about delivery of programs and services is verbally acquired from clients of Kambu. Therefore clients are involved in the development of programs and services provided, as they indicate to staff what programs and services they would like.

When establishing programs, Kambu currently have an informal consultation process with the indigenous community. Such consultation will be formalised following completion of Quality Assurance, a process currently being undertaken by the service.

The process to access ENT specialists was identified as being a lengthy process with the waiting list being approximately 3-6 months.

Kambu provide weekly hearing clinics, with support being provided by Australian Hearing once a month. In providing hearing services, Kambu has an established relationship with Australian Hearing, which is located in Ipswich. Workers from Australian Hearing work with health workers, providing the opportunity to have an audiologist supporting health workers.

Kambu participates in a lot of case conferencing for young people. The case-conferencing process with other agencies is useful for the service, as three or four agencies may be providing similar services for clients. The process therefore ensures that services don't double-up on service provision. While case-conferencing has not been associated with the antenatal and postnatal programs, it is anticipated that this will eventuate.

Programs for young people
In delivering health promotion and education to schools, Kambu mainly focus on primary school. The service experiences difficulties in accessing high schools, as these currently have specific program areas which are outlined in the standard curriculum. Delivery of health promotion and education to youth is delivered through Teen Care, a drop-in centre for indigenous youth, particularly street kids and borders. Kambu also work with the Goodna Hostel, by running various health sessions and undertaking a sexual health program. The service did try to run a sexual health clinic, however it was evident that a successful approach was to access youth through parks and other locations used by youth, and provide information verbally.

Barriers to service delivery
A barrier to service delivery has been that some of the indigenous community are unaware of Kambu and/or the services that are provided.

Workforce
While the positions held by health workers at Kambu are identified roles, the service strives to have multi-skilled staff. While the below positions are currently held by health workers, Kambu also aims to have another staff member who is trained in the particular area that can do screening for the particular health issue when clients present at the clinics. All health workers normally commence in a clinical role within the service, prior to moving into a program role. Health worker roles within Kambu are:
- Clinic
- Community – home visits, dressings, nursing homes, follow-up with pill boxes, support for patients if going at hospitals and services such as x-ray
- Nutrition and diabetes (look after diabetic patients, Healthy Lifestyle program)
- Antenatal/postnatal program
- Community care (n=2) - housing and welfare, food vouchers etc
- Hearing health
- Sexual health
- Health promotion

The service identified difficulty in locating trained staff for maternal and child health program, and subsequently would like to focus on training to provide services for babies and young people. While staff had acquired antenatal skills through various training facilities (i.e. JCU, ATSICHET), difficulties arose from the acquisition of little or no child health skills.

When focusing on training of health workers, Kambu is supportive of staff persuing training in areas of specific interest. The service also recognises that information is constantly changing, and therefore provide support when staff need to update training and information previously received. Health workers have identified that they like the training received, however some training can be too detailed.

While people acquire knowledge differently (i.e. lectures vs. books), the most appropriate mode of training delivery indicated was in block release (one week at a time). Should

training in child health be available, support for this method was indicated by Kambu. The block release mode enables workers to implement acquired theory into practical experience in the clinical environment, thus reinforcing information acquired during training. The block release mode is also accessible to health workers, particularly as a lot of the workers have children and wish to stay employed while training. The opportunity to go to a different environment, meet with health workers and discuss various work methods was also provided with block release training.

Currently facilities can be provided to Kambu to do training (i.e. hearing), and another possible training mode indicated was classes that would be operated from the workplace.

The non-recognition and respect of health worker training by doctors, was an area that requires attention. In particular, awareness of the skills and abilities of health workers needs to be raised within the workforce. Increasing awareness of the training health workers receive would serve as a mechanism to advocate for health workers to perform procedures taught during training. An example of a procedure health workers aren't able to perform was immunisation. Although urban health workers were capable of the procedure, only remote health workers could perform immunisation in their workplace.
The indigenous community places a great deal of expectation upon health workers, however appropriate recognition of training received would be able to clarify within the health service and community what expectations should be placed upon health workers.

Antenatal and postnatal program
When a woman's pregnancy is confirmed in the main clinic, she is referred to the antenatal and postnatal program, which looks after the woman until delivery and 2 years postnatally.

The antenatal and postnatal program has been in operation for 7 years, and was established in response to community women not accessing the hospital for antenatal care. Rather than undertaking antenatal classes, the program provides women with one-on-one education about their pregnancy prior to delivery. The service has identified that delivery of health information is more effective if delivered individually than to a group. Depending on the patient's needs, the program can be delivered either in the home or clinic. The program is flexible according to the level of need of clients and can be delivered once per week or once per month.

At any one time, there can be up to 30 pregnant women accessing Kambu, however the antenatal and postnatal program does not seek to target women who attend antenatal classes, as it is recognised that these women do not need the program as they have greater education about their pregnancy and child raising. The antenatal program attempts to get mothers to have at least one scan before delivery.

The antenatal and postnatal clinic is run by a female doctor each Monday. A midwife (child health nurse) and health worker work in the program. Although some women may not access the hospital for antenatal care, of those who do Kambu has identified the need to provide a shared-care role with the hospital. Unless the service is involved in the antenatal paperwork with the hospital, the service may not find out about the expectant mother. The shared-care role therefore provides the opportunity for patients to be referred to the Kambu postnatal program following discharge from hospital. The shared-care role enables contact to be made with a mother and child, which may not have been made until immunisation, therefore allowing appropriate information and interventions to be undertaken if necessary.

The antenatal and postnatal program incorporates a breastfeeding focus and subsequently breastfeeding resources have been developed. The program identifies that mothers can only be encouraged to breastfeed. The community tends to go through periods of increased breastfeeding. The mother's age and family have been identified as influential predictors of whether women breastfeed. While family may influence the mother to feed the child

sunshine milk, the family and other feeding influences need to be respected when delivering information to mothers about feeding choices.

Other child health programs
Nutrition program
The nutrition program is focused on children aged 2-5 years. Run by a health worker, the program picks children up once they have finished the postnatal program. The program undertakes growth and developmental checks of children (i.e. weighing) and aims to create awareness that development changes may be different in the indigenous population, therefore there is a need to create awareness of what is appropriate in an indigenous child. What may be viewed as 'failure to thrive' in the non-indigenous community, may be 'normal' in the indigenous community.

Compared to other services in Ipswich, Kambu have good immunisation statistics. The midwife is currently getting endorsement to undertake immunisations in the home.

In the future, Kambu is aiming to focus on behaviour issues of children aged over 2 years. In addressing this, a group of mothers will be consulted to identify what issues are in the community. However, due to the difficulties in talking to a group of mothers, consultation with mothers is best on Mondays when mothers are accessing either the standard or postnatal clinic.

Patients accessing the standard or postnatal clinic, which are conducted on Mondays, book-in either in the morning or afternoon. Screening for the hearing program is also undertaken on Mondays. The hearing program (baby vigilance) focuses on children aged 0-5 years. The approach taken acknowledges the need to get children at a young age, particularly before they commence school.

The hearing program incorporates screening twice a year, however if concerns are raised or if a child has had an ear infection, screening will be undertaken every 3 months, or as required. As some children are not screened in the program, school screening is also undertaken. Within the schools, Kambu screens both indigenous children and other children which the school has concerns about. The difficulty faced with screening in schools results from children moving to and from schools, therefore a child may miss out on screening in grades one and six. However, by establishing the program with younger children, problems will be detected earlier.

Kambu do not screen children at Amaroo Kindergarten, as screening is undertaken by Queensland Health, however other health promotion programs are undertaken by the service within the Kindergarten.

Kambu have a good working relationship with the Queensland Health District Health Service, and undertake consultation with Queensland Health at various times. The service is currently in the process of negotiating a paediatric clinic, to be held one morning per month. Following a trial of the clinic, an evaluation of the need for the clinic will be undertaken, with the clinic progressing accordingly. In establishing the clinic, the District Health Service would fund the paediatrician who would operate from Kambu. The clinic would focus on clients with the greatest need. It is anticipated that the clinic will aim to overcome the waiting times experienced at the hospital and address the issue of mothers not readily accessing the hospital paediatric service.

As a result of historical events, Kambu don't work a lot with Family Services. Work is however undertaken with Kids Care, a child care agency (used to be titled ACA at AICHS). Kids Care is a community organisation which assist and provide support to indigenous families.

9.5   Meeting with Dr Paul Torzillo
         Consultation Process for Better Practices Project
         6th September 2001
         Telephone link-up

RACP have a committee on Aboriginal health, of which Paul is the Chair. Paul has extensive experience in Aboriginal health, having been long-term Medical director of Nganampana Health Services (remote Central Australian community controlled organisation).He stated that for the interview he was not specifically representing the RACP Committee on Aboriginal Health, but was giving a personal view.

Specialist Services
Specialist services tend to have a consumer end-focus. In establishing specialist service requirements, in general there is a need to consider the role of the specialist. The role of the specialist varies according to regional factors (i.e. urban and remote) and the area of specialty (i.e. orthopaedic are needed in base hospitals, but not communities; need ENT visiting communities if service not normally provided in communities).

Identification of services that visit communities would reduce extensive travel for clients and avoid clients having to go to a hospital or base centre for specialist attention. As such, there is a need to identify what is available within regions and what needs to be made available.

The benefit of a super-speciality service over an existing specialist service (i.e. super specialist visiting areas that already have general physicians or general paediatrician visiting them), resides on 3 issues:
• Content
• Training
• Sustainability

Content
Are there some assessment skills, investigation, service delivery procedures that will be delivered by the specialists that aren't delivered by the visiting specialists?

In regard to public utility delivery to indigenous communities, there is a need to initially discuss content of the service prior to discussing the process of service delivery. The view to initially discuss content is generally unpopular, however by undertaking this procedure, issues to be discussed would include what service is being delivered, who is delivering the service, sustainability of the service, and general content of the service.

An integrated approach in the delivery of child health services is beneficial, however in regards to incorporating a specialist approach, there will need to be a focus on what the big needs within the community are. This approach would therefore initially be content-based, rather than process-based.

Training
Training issues will vary depending on where services are located. In a number of locations, the visiting paediatrician may know staff very well, they might have a firm understanding of the knowledge base and abilities of staff, and as such they may be able to indicate that staff in a particular area might be the most appropriate people to be delivering on-site training. In other locations, staff may be busy and not the most appropriate trainers, therefore having a super-specialty service visit may have benefits for local staff in regards to training.

Sustainability
Most existing general services tend to be funded by health departments, therefore the ability of the service to be sustainable can be reduced. General paediatric visiting services operating in Far North Queensland and Perth were identified as the 2 best services operating in Australia.   Generally these services still lack resources and aren't as common as they need to

be, however they have been operating for a while and are generally sustainable. The Commonwealth funded super-specialty programs are one-off programs, which focus on particular research, making them difficult to sustain within indigenous communities.

If a community wants to look at a particular disease or group of problems, a short-term program with specific objectives might be appropriate. Having super-specialists visit for a couple of years might provide research data or training that could be sustained by existing services rather than the super-specialists.

Building on the content-based approach, before delivering a specialist service to a community, the program will need to identify what staff within the community (or those servicing the community) do, the content of what is currently delivered, what children are seen, what conditions are treated, current knowledge and resources available. This approach can identify what services can be provided by specialists. There might be a differing mode of service delivery in different regions. Essentially this method looks at what is available at the local level, and integrates services where they are needed.

Sources of funding for different types of specialised visits
The rural health section (unsure of the Department), of the Commonwealth Government has provided specialist service money. This money (approx $49 million) is to be expended by each of the States and Territories over the next 5 years. In each of the States and Territories, committees have been established to identify how the funds will be provided. The committees represent an area of vested interest groups (including the Division of GP's), therefore there are a multitude of factors to determine how the funds are expended. There is uncertainty as to whether or not there is a political component in regards to marginal seat supplementation. Some of the funds potentially could be funding specialist services that might go to Aboriginal communities. An example of the funding can be demonstrated in the Northern Territory where two community physician positions (one in Darwin and one in Alice Springs) are being funded from the money. These are clinical positions.

In general, trying to raise funds to deliver services to Aboriginal communities alone is not a sensible long-term strategy, therefore part of the strategy should incorporate linking into general services. Such a strategy would incorporate the move towards more services being provided to rural and remote locations in general and try to ensure there is an Aboriginal service component. The disadvantage with this method is strategically there is uncertainty as whether there will be enough dedicated resources for specialist services for rural and remote Aboriginal communities.

Evaluation
There are many factors about child health that have been known for 100 years, and having to prove they're worthwhile is time consuming. When focusing on Aboriginal communities, there are a number of denominator problems evident – these are small communities, you have to measure things over short time frames, and have to be careful not to evaluate according to methodology which is likely not to show a benefit even if one exists. So that evaluation doesn't become larger than necessary, one should think about sentinel site evaluation of programs. There might be a small number communities (2-3) where particular work is being undertaken, enabling information to be collected from the site. Collection would be practical rather than ideological, and could include information collected by service providers within the site which looks at changes within illness patterns.

In regards to state-wide evaluation, hospital-based indicators should be used, however it should be acknowledged that the impact of a program on these indicators will be slow, therefore there should not be a strong focus on these indicators.

There is a current focus on the need to justify each component of basic health care delivery. Health professionals and communities already have an understanding of the basic necessary components which include the need to have a confident, accessible, 24 hour clinic or service

available to look after sick children, and the need for basic programs which focus on immunisation and growth. The challenge with service delivery is getting these basic components competently delivered.

Geographical differences pose difficulties with service delivery. While there are some principles of service delivery which apply in all geographical locations, there will be geographical differences in regards to the prevalence of certain diseases, the resources the community has available outside the health sector and the competence of the primary health care service that's available within the sector. If the primary health care service is poor, than delivering specialist services in a sustainable manner is difficult as the service may not have anybody to interact with, therefore the primary health care service can't effectively utilise the specialist service. The type of specialist service delivered will vary, therefore different processes will be needed for different regions. While it is obvious that there will be huge differences between urban and remote regions, it is important to highlight the variations which exist.

Roles of Health Workers and value of having Health Workers with specialised roles
The discussion about the roles of Health Workers is dominated by rhetoric, rather than assessing what the skills of Health Workers are. The roles of Health Workers varies enormously across the country. There are locations where Health Workers have high levels of education, are skilled, manage health centres and are important health care providers. A lot of these locations are in Queensland. Within other locations there are a number of Health Workers who are illiterate and don't have appropriate skills, therefore making it difficult to establish a role.

The evidence identified within the past 30 years does not support the automatic assumption that having an Aboriginal Health Worker involved in the delivery of health care will improve the health of the Aboriginal population. Sometimes it is beneficial to have this role, however at other times the presence of an Aboriginal Health Worker doesn't make any difference to the health situation.

In locations where there are Health Workers with skills and real jobs, intensive resources should be provided that would enable workers to be supported on a long-term basis. Support provided would include regular training, technology to allow communication, and appropriate pay scales. This support however would not be available in locations where Health Workers did not have appropriate skills.

Currently the health workforce within rural and remote communities is limited, therefore while the principle of having a specialist Health Worker role is appealing, the reality is it would be more beneficial to the community to employ a generalist Health Worker who would do a number of jobs, rather than focusing on one health area. The benefits of having specialist roles is that some Health Workers are only interested in certain areas, therefore in a specialist role, Health Workers may do the work more enthusiastically, they may do it better and they may be keener to learn about the job. In addressing whether or not to have specialist Health Worker roles, there is a need to identify the current workforce within regions and the health requirements of the region. Therefore in some regions a vertical program or specific issue training might be helpful.

An example of specialist Health Worker roles is identified in an STD and HIV program. The role of the Health Worker within the program was successful, resulting from the program being delivered in the context of a focused, developed and successful STD and HIV controlled program. The program was well integrated into the health service, has involved a lot of work, runs well, is structured and is successful, therefore it provides a supportive environment as there are defined roles enabling the incorporation of an Aboriginal Health Worker with a specific disease or program focus. The Health Workers involved in the program are resident in a couple of communities, however travel to other communities is required.

9.6   Final Project Workshop with Queensland Health Corporate Stakeholders
Better Practices for Child Health Service Delivery to Indigenous Communities Project
Minutes of Meeting
30th November 2001
Queensland Health, Corporate Office

Present:
Dr Sue Vlack; Dr Neil Wigg; Ms Gerry Cleary; Ms Helen Luyendyk; Ms Amanda Croker; Dr Richard Roylance; A/Prof Cindy Shannon.
Apologies:
Prof Paul Colditz; Dr Paul Woodgate; Dr Kenneth Armstrong; Ms Marilyn Chew; Ms Indrani Ganguly; Mr Stanley Nangala; Dr John Aloysis; Mr Tom Kairupan; Dr Beres Wenck; Dr Brent Masters; Mrs Louise Sanderson
Minutes:
Mrs Louise Sanderson and Mr Michael Meehan

1.   Background to the Project
Sue Vlack discussed the background to the project, outlining that the Indigenous Health Program (IHP), University of Queensland, undertook the project for the Indigenous Health Policy Unit. The proposal was initiated following IHP's involvement in a number of child health projects. Those involved in the current Better Practices project include the Indigenous Health Program, the Perinatal Research Centre (University of Queensland), the Family CARE Program, and Department of Respiratory Medicine (Royal Children's Hospital).

The project aimed to:
- Document the existing delivery models, and the relationship of the models to local service providers, the Indigenous community, and workforce development strategies. The report would document processes for measuring health outcomes, and levels of community satisfaction, as well as the knowledge changes that occur as a result of education and health promotion initiatives.
- Produce a detailed plan for an integrated model of paediatric care to be implemented in a variety of Indigenous health settings, including urban community-controlled and Queensland Health settings, as well as rural and remote communities. The plan will include a coordinated program of neonatal, respiratory, growth and development clinical services, as well as community based home care programs. It will also include the implementation of the Health Worker training package in child health, and address the overall community health promotion needs.

The project focuses on the 0-5 year age group. This group was identified as important as long term health outcomes are laid out during these years. Also, the 0-5 year age group proves to be a positive time to work with families. The needs of young children differ from those of older children, and different strategies may be required to extend the proposed model.

Programs delivered which initiated the Better Practices project, were delivered in urban, rural and remote settings. Programs delivered were of different styles – health education program, specialist service and home visiting program. These programs were documented, eliciting elements and principles of service delivery required for an integrated model of service delivery. Amanda Croker requested a copy of each project report.

The SIDS/ Baby Help Project
This project aimed to develop health education and awareness resources for carers of Indigenous children aged 0-2 years. Specifically, the project developed a SIDS resource to convey the "Reducing the Risks of SIDS" public health message. The project also developed a resource to assist carers in detecting serious illness, and providing an indication of when medical attention should be sought. In developing the resources, data was collected regarding

the knowledge, attitudes and practices of carers of Indigenous children aged 0-2 years. Information collected informed the development of resources.

Paediatric Respiratory Outreach Program

This program serviced the Torres Strait and Western Queensland Indigenous communities. The program was a visiting super-specialist service, with a paediatric respiratory team visiting communities to supplement work of local paediatricians. The service went directly to communities, providing detailed and reliable assessments of children in regard to asthma and lung disease. The program also designed an education program for parents of asthmatic children. Components of the visits included community consultation to establish the clinic and to inform appropriate styles of service delivery, providing clinical services and educating parents. The respiratory team consisted of an expanded team (i.e. physiotherapist) to ensure that clients received the best treatment and management for their condition. Attendance was high, with the program being well received within the participating communities.

Within the meeting, concerns were raised regarding the role of the specialist group - given that community control of asthma is a broad aspect of public health managed by GP's. There are current management programs that are available to GPs.

The emphasis on the provision of the "specialist team" within the project is defined as finite in that it's purpose is more in the context of the establishment of a model of awareness raising in the community, and professional development of local staff. This is particularly relevant regarding career structure issues and a shift towards specialist health workers and the capacity for health workers to be involved in services, education and training

* Note – The Better Practices project is not promoting respiratory outreach as an important element of the proposed program, rather identifying the model of specialist service delivery.

Family CARE Project

A case study was undertaken by the Better Practices project personnel within Cairns. The case study looked at the community health team who was delivering the Family CARE Program (FCP) for approximately 18 months.

The FCP incorporates Indigenous health workers, with the primary care focus being home visit support. The program has measurable outcomes which are monitored regularly and fed-back. A training package is also included, with central staff delivering the training to workers in the field.

Neil Wigg advised that the local Indigenous Family Care Project conducted by Dr Ken Armstrong is working in conjunction with the North Brisbane Indigenous Health Service. Specifically, there is a focus on the applicability of the model. To date, the model has been identified as being very successful in that families have been identified and a structured system of family home visits and initial care of family has been undertaken. There has been a high level of acceptance among families towards the program. Initial visiting by a combination of medical, nursing staff and indigenous workers at home visits has been identified as working well.

It is noted that the structured program is not running as it was 12 months ago, with withdrawal of some personnel. Evaluation of the program is yet to be presented. The Indigenous Health Program requested a copy of the report and evaluation.

Concerns were raised regarding the FCP in relation to wide acceptance by the Indigenous community. It was discussed whether there was a need for more money to be spent per client head to engage indigenous clients for the initial visit to the program. There may be a need for costing of programs to reflect cultural considerations such as the itinerant nature of individual indigenous persons and family units. There is a need to be mindful of over-representation of expectations of success to the Health Minister.

(At this point discussion became more animated and interactive, and is largely presented as a group effort rather than assigned to individuals.)

2 Documentation of a model of service delivery and a proposed model of child health service delivery

Given fragmented problems identified in child health delivery, the Better Practices project is not regionally restrictive. This project aimed to bring together the principles and elements of the models now operating and identify how they can each add value and become more effective, thereby operating in an integrated and comprehensive manner. The program has been based on relationships with Indigenous communities, rather than being based on community locality.

The respiratory project identified the need for services in the post-natal period especially in remote Indigenous communities. A lot of the mothers were from remote communities. Considering the rate of low birth weight and prematurity, there was no identified post-natal follow-up of babies in the target communities.

Amanda Croker identified that there was some overlap of the clinical pathways for preterm babies project, undertaken by Prof Paul Colditz. Currently planning to trial the project in Townsville.

If clients attend both community controlled health services and Queensland Health services, there is a need for collaboration between the services. As such identification is needed regarding the current links between services, particularly in regards to information sharing processes. An example of the Townsville Aboriginal and Islander Health Service, which is collaborating with the Queensland Health for the antenatal, postnatal care, was discussed. In regards to the FCP, a collaborative approach would be beneficial, particularly if clients are accessing the Aboriginal community controlled health service antenatally, and if this is their usual service for health care. When discussing collaborative approaches, barriers between health services need to be recognised.

In regard to the best model of service delivery, it was suggested that there may be a need for a method of official status recognition of volunteer health workers within projects. Such recognition will assist audit purposes whilst empowering community volunteers. A formal approach should not be viewed as a means to over-burden individuals with more work, nor should it be viewed as restrictive. There are difficulties in providing resources to people who don't have any official status (i.e. grandmothers and other carers of children). Support and acknowledgement of volunteers within the community is needed. Such acknowledgement is often a powerful motivator. However, the notion of getting volunteers to deliver child health services may receive strong opposition.

Community education is a large component of what the projects recommend. Included in community education is the recognition and role of certain people in households.

The current Health Promotion project being undertaken by the Indigenous Health Program is mapping community capacity building and awareness raising programs. The mapping exercise seeks to identify those individuals working in a voluntary capacity.

The main focus of the proposed model of care that can be implemented in a variety of settings, includes neo-natal growth; the development of clinical services; community based home care, a community health worker training package and child education package.

The Better Practices methodology used included the employment of project officers, a review of literature, documentation of program models, development of a questionnaire guideline and interviews with program personnel and others involved in programs.

Findings identified 14 critical success factors, these being:
1. **Community consultation** before and during the life of the project/service;
2. **Community involvement** in the delivery of the project/service;
3. **Empowerment** of clients and community service providers within the project/service via embeddedness in community development model;
4. Effectively documenting the context and **monitoring** progress of the project/service;
5. **Research** which contributes to scientific and community understanding of the health problem and advances knowledge of intervention effectiveness;
6. Targeted enhancement of **workforce development** and community skills in relation to program delivery;
7. Development of **culturally secure resources**;
8. **Culturally** secure and **locally appropriate service provision**;
9. **Continuity of Care**
10. **Role delineation with multi-disciplinary** teams improves team functioning
11. **Integration of services** in the current method of service delivery to ensure sustainability and access to a wide range of services;
12. **Holistic approach** ensures that client needs are addressed
13. **Population health approach**
14. **Partnerships** developed with health services and other providers within communities

It was identified that the geographic and demographic base of a community needs to be understood in order to develop a model of care. In response to this, Sue indicated that the model needs to be locally planned, however will need to have an overview, so that there is an understanding of where to start. One of the challenges may be that there isn't a sense of community. There is a constant assumption that access isn't an issue and that services are available. There is a need to identify a sense of community, rather than establishing and delivering a model that does not recognise the involvement and ability available within the community.

The model would attempt to reach those individuals and families that currently are not accessing services. A range of services that people can access needs to be available.

The practical method in which to deliver the service needs to be focused on families. When focusing on families, particular attention should highlight cultural and local issues. Community would therefore advise the program. Health workers would be a part of the team. Promoting network of referrals. Specialist service needs to be integrated with a primary health care service. Integration ensures that there isn't a parallel medical file and two health professionals aren't working without communicating with each other, moving issues forward rather than duplicating efforts.

In delivering the proposed model, a series of steps were identified:
1. Establish a local forum for children's health issues
2. Engage current service providers
3. Establish partnerships between service providers and community organisations
4. Build on current service delivery by establishing specialist Indigenous Health Worker positions in Maternal and Child Health in organisational locations best able to utilise and support the workers
5. Increase access to services by presenting identifiable, culturally appropriate services with specific care objectives for Indigenous children
6. Provide appropriate and empowering health education resources to families in relation to children 0 to 5 years
7. Monitor healthy processes and health outcomes in children 0 to 5 years
8. Feedback evaluation of processes and outcomes to managers and the children's issues forum for the purpose of quality improvement

In regard to step 1, discussion queried who is responsible for ensuring that a local forum is established? Helen Luyendyk informed of the children's intersectoral group at the Southside

Zonal Public Health. While this group hasn't focused on Indigenous child health, they have focused on a lot of other issues in regards to changes. Those involved in the group include the Dept of Education, pharmacists, Dept of Families, and the Division of General Practice.

In regard to step 3, part of QAIHF's role is to increase the number of Memorandums of Understanding. When establishing partnerships, it should be recognised that in two of the three zones there are zonal paediatric networks (Southern and Central zone). These networks may be a useful link, although they may need to establish a sub-committee concerned with Indigenous child health. In integrating community controlled services, the paediatric networks may be able to link in the CEOs of community controlled services, as well as the Indigenous Coordinators.

When implementing the model of service delivery, there is a need to work with the District Manager. It was recommended among those attending that District Managers drive the model within regions, whether at a primary, secondary or tertiary level. It is also noted that the appointed Principle Indigenous Coordinators in each zone and Indigenous Coordinators who represent various districts, have varying degrees of influence throughout the geographical regions and would be key activators.

The need for service accountability and responsibility to be clearly defined within the model framework was discussed. Concerns were raised over the levels of accountability of District Managers and Indigenous Coordinators, especially in regards children attending an Indigenous health service and the delineation of responsibility/accountability for that child between the District Manager and the Indigenous service. As the model needs a clear pattern of accountabilities, it was recommended that the level of accountability needs to be written into the District Managers contract. The level of accountability also needs to be identified in the indicators, therefore reporting on indicators will be at a district level. District managers need to be provided with the number of Indigenous children in their locality, and the proportion of Indigenous children according to the total population.

Richard Roylance indicated that those involved in the meeting may wish to meet with Dr John Youngman to identify formal accountability processes. Richard outlined that Dr Youngman believes that service contracts are weakened if they have too much detail and subsequently there has been some resistance to this.

The group queried whether it was possible to have some type of contract with the Indigenous Health service and the District Manager.

A whole of government approach would be useful, so that other departments are reporting against areas that need addressing (Disability, child protection, Putting Families First). With the complexities of getting a whole of government approach, may need to have parallel processes.

Queensland Health indicated that the investment and approach outlined in the Better Practices draft report were in line with the new child health policy. Furthermore, Queensland Health will be focusing on developing the Indigenous child health plan in 2002. It was advocated that this is a 12 month process, which will need to pull together a reference group and key people. If the Better Practices report is endorsed, information could be drawn upon when establishing the policy.

In regard to step 5 (increasing access to services), it was discussed that staff from North and South Burnett Health Service Districts, for example will outline that they don't currently have the services to increase access. Districts therefore need to build services that are culturally appropriate.

When looking at the values which underpin the model, discussion highlighted the debate regarding whether there focus should be on services being culturally relevant and community

driven, and therefore a medium to longer term aim to enhance the capacity and capability of the Indigenous health workforce, or whether Indigenous families should be provided with the best technical service available, regardless of who is delivering the service. Therefore, should the service focus on cultural relevance or specialist expertise. Answers can only be generated from the communities and services themselves as to what is needed, desired and workable. The Better Practices model may want to emphasis the development of the capacity of the Indigenous health workforce as a medium to longer term strategy, or training the existing health workforce to be more culturally sensitive and appropriate - a multi-strategy approach. Guidance about this issue will be needed. At the end, the indigenous community need to determine whether or not they are comfortable using the generalist services or whether they want to have services that they identify with culturally and socially. Need to give recognition to the Indigenous health workforce. The role delineation of indigenous health workers in a team (increasing power and support) is probably more important than increasing awareness among health personnel about cultural appropriateness.

Need strategies for improving access and appropriateness of existing services and developing some strategies of triaging people into Aboriginal medical service or generic services (forums etc to get pathways across). Understanding of how access to medical records from aboriginal medical service to generic service occurs needs to be sought.

In regards to promoting an integrated activity with a range of service providers, it was recommended that further discussion with other key people (Queensland Health's Organisational Development Unit) was needed before completion of the Better Practices report. Those involved in the Indigenous workforce strategy should provide some opinion about his issue as a recommendation.

Example of a successful model – Townsville's mums and babies' service (Townsville Aboriginal and Islander Health Service). Rio Tinto has provided funds for the service that provides a culturally appropriate service and uses Queensland Health expertise. The Townsville health service has indicated that they can release staff two-three days per week to participate in the program.

Amanda indicated that further meetings may need to be arranged to discuss some of the training issues. Ken and staff of Amanda's unit are working on the concept of 'Train the Trainer'. There was uncertainty as to the status of specific indigenous health worker training.

In regards to the capacity for specialist health worker positions, the national competencies are about to be re-written, therefore there may be a possibility to provide input into the child health area if specialist child health positions were to evolve.

The specialised health worker role needs to be available across the geographical location. These positions will need to indicate how they will link into current service delivery, and whom they will be accountable to (i.e. Indigenous Coordinator or Director of Community Health). Currently the school based youth health nurses receive training and professional supervision from zonal coordinators, with administrative support being provided by their line manager. Queensland Health could purchase non-govt services for professional development.

Have difficulties with expecting people of different levels of training to do the same work I.e. Paying health worker to do home visiting, and also paying Level 2 nurse to do same work. Therefore will need to develop certification, so that they get paid for what they do. The Commonwealth strategic framework for indigenous health workforce that is being distributed for comment reiterates this issue.

Noel tried to encourage Indigenous registered nurses to finish training (Brisbane South funding child health training course through ACU – district meets cost of course). The model will need to include a few options to promote within locations. Each district/ zone would identify what is most suitable.

3.   Finalising the Report

In regard to the critical success factor of a population health approach, it was discussed whether or not project personnel were going to make comment in the final report about the need to emphasise community development. A cross-reference to the child and youth health policy should be made, thereby highlighting that the model does not simply focus on providing services, rather also aims to link into public health.

Useful to look at other models that have/haven't worked in regard to training and workforce issues

In regard to the report, should be providing options of what could happen within the existing workforce. A number of child health positions could be identified.

Need to identify the level of child health skill, the general health worker should have.

Also think about National Performance areas in regard to developing system and health workforce.

Seek guidance regarding workforce issues:

- Training across the board for child health staff regarding indigenous child health – specific issues
- Identification of the Indigenous health worker workforce for child health, plus particular training
- Indigenous nursing workforce being targeted and trained in indigenous child health
- Creation of positions that are additional to all of the above
- Developing the workforce through funding that becomes available through the targeted area

Clarification is needed throughout the model when discussing Indigenous health care. There is uncertainty about the identification of every indigenous person. Is this identified within a specific area, or rather refers to only those that utilise available Indigenous health services? It was discussed that when developing a model of care there is a need for some sort of matrix whereby in some locations more emphasis will be placed on integrating general services.

Need for establishment of service delivery indicators in line with performance indicators.

Could identify an Indigenous child health coordinator in each of the zones. Would be an additional role on a current role, rather than creating a new position.

Accountabilities and responsibilities within the framework need to be defined.

Incorporation of a whole-of-government approach.

It was recommended that IHP write to each Zonal Manager in early 2002, advising of the Better Practices project objectives. IHP should also commence preliminary discussion and advisory processes with Odette Pagan and Terry Meehan to flag the model's progress. Other key players will also need to be notified, and it was recommended that copies of the report be forwarded with a covering letter.