Katherine Regional Health and Related Services (KRAHRS) Allied Health Services

Margaret Massey, Katherine Regional Aboriginal Health and Related Services Allied Health

Katherine Regional Aboriginal Health and Related Services (KRAHRS) Allied Health Services is a multi-disciplinary team which sits within the three Katherine Aboriginal controlled health boards of Sunrise Health Services, Katherine West Health Board and Wurli Wurlinjang. The team is based in Katherine, Northern Territory, 320 kilometres south east of Darwin.

Katherine is the administrative base of the Katherine Region and has a population of about 10 000 people and another 10 000 people living in small towns, Indigenous communities and properties. Approximately 40% of the overall population of the region are Aboriginal people.

The Northern Territory Government’s Katherine region extends to a larger area than the area serviced by KRAHRS Allied Health to include Borroloola and Pine Creek. The region is approximately the size of Victoria, bordered by Arnhem Land, Kakadu National Park, the Western Australian border, The Tanami Desert, The Barkley region and the Gulf of Carpentaria. A number of the communities are a full day’s drive from Katherine.

The allied health project is a multi-disciplinary team that operates under the principles of primary health care and community development. The aim of the KRAHRS Allied Health project is to increase the accessibility of allied health professional services to the remote communities of the Katherine region.

The Northern Territory Government’s allied health mandate is to provide acute care and a case management role for the frail aged and people with disabilities. The KRAHRS Allied Health team is funded to work in communities with populations less than 5000 people. KRAHRS Allied Health offers additional services to those provided by Northern Territory Government. This is done in two different ways Intensive individual therapy and project work.

When working with clients on remote communities things take a long time. Rain, rising rivers, floods, some communities can be inaccessible for up to 6 months. Deaths, funerals and Sorry Business where communities close down to the outside world for a period of time. Competing priorities eg accessing shops in town when there is no shop on the community, the round trip in a taxi from the closest community to Katherine costs $400.

Intensive individual therapy

Intensive individual therapy involves our multi-disciplinary team providing longer term intensive therapy to clients with complex needs. There are agreed defined goals with sustainable outcomes. It is longer term intensive therapy which is time limited. with a holistic, client centred approach.

The team has been working with a 21 year old woman with cerebral palsy living on a remote Indigenous community who was still in a push chair. This young woman is cared for by her mother who is chronically ill and at times is too ill to be able to push this chair.

The KRAHRS team last year consisted of occupational therapist, speech therapist, physiotherapist, podiatrist and social worker. This team along with the Sunrise Health Service nutritionist and GP and the Northern Territory Government’s Aged and Disability team worked with a 21 year old woman and her mother over a 12 month period.
The following was achieved by the KRAHRS team:

- equipment assessment and prescription, wheelchair refurbishment, specialised seating
- input into the family’s new house design eg width of doorways and assistance with home modifications eg ramp and rails
- training in use of the electric wheelchair, hoist and transfers
- exercise program designed and carer trained
- foot examination, assessment for shoes and information on foot care provided
- assistance in accessing Centrelink payments
- application to the Guardianship Board
- assisted with family issues and advocacy
- feeding and swallowing
- communication device trials and assistance with the introduction of an electronic device
- story book created

The Sunrise Health Service nutritionist assisted in extending her menu and provided assistance to the family with food preparation. The Sunrise Health Service GP prepared a Care Plan and arranged for a woman’s wellness check.

Northern Territory Government provided the modified electric wheelchair and other equipment eg hoist, home modification equipment, respite care and patient travel.

Projects

Projects are identified from a number of different sources and use the particular skills, experience and interests of the allied health team members. Work undertaken is sustainable, empowers the recipients and results in improved quality of life. Sometimes intervention in processes and structures to facilitate access to services is required. It involves collaboration between services, improved co-ordination of services with an integrated response, changes in systems and creative solutions to opportunities presented.

Following are some examples of project work undertaken by the Team since mid 2006. Projects are in varying stages of completion.

Child development referral screen

The occupational therapist in conjunction with the speech pathologist and physiotherapist has been modifying an existing milestone referral screen in order to improve referral processes for Aboriginal children with potential developmental delay and provide earlier detection for children most at risk. Current processes between remote clinics and allied health teams in the Katherine region were identified in 2005 as haphazard and inconsistent. Children in need of assessment were only identified if nursing staff flagged them as being potentially delayed due to other factors such as failure to thrive and stunted growth.

Development has included work with Katherine West Health Board who indicated their need to include developmental milestone screening into their existing child health processes. The modified referral screening tool will be trialled in their communities for a 3 month period, to check the cultural appropriateness and sensitivity of the screen.
A review of similar remote health services in both WA and QLD indicated no existence of either referral screens or assessment tools for developmental delay in the aboriginal population. It is hoped if the trial is successful that a useful non-standardised child development milestone referral screen will be available for other teams to trial in their regions.

This tool can be used by all remote Aboriginal health services for early identification, early referral leading to early intervention for developmental delay in young children. It will also provide a consistent referral screening process, something which is currently lacking.

**Speech pathology in an Aboriginal context**

In 2004, a working party of NT speech pathologists formed and proposed a project to develop a shared frame of reference and resources for clinicians working with Aboriginal people in rural and remote areas in Northern Territory. The Speech Pathology Association provided some funding for this project which commenced in July 2006.

This project is aimed at speech pathologists new to Northern Territory, speech pathologists currently working with Aboriginal people in the rural and remote areas of the Northern Territory and Western Australia and for speech pathologists with an interest in this unique area of practice. This project developed practice guidelines, frames of reference, research and essential contacts for speech pathologists.

This project is the beginning of a body of work that will contribute towards improving the quality of work provided by speech pathologists working with Aboriginal people and will contribute to reducing the barriers to services that Aboriginal people experience. It is also expected to improve retention rates of speech pathologists.

**Cleft Lip and Palate Project**

In the Katherine region there are a number of young children who have cleft lip and/or palate living in remote Aboriginal communities. The main service delivery for these individuals is the Cleft Lip and Palate Clinic at Royal Darwin Hospital. This is a multi-disciplinary clinic that occurs four times a year usually involving a visiting plastic surgeon, paediatrician, speech pathologist, audiologist and orthodontist. All individuals in the Top End of the Northern Territory with cleft lip and palate are referred to this clinic where they are monitored and reviewed typically on a six or twelve month basis after their initial surgeries are complete. From here clients are referred out to their local services for follow up and treatment by paediatricians, ear nose and throat specialists, audiologists, speech pathologists and orthodontists. These local services are typically visiting services to Katherine with some visiting outreach services provided to large remote communities by speech pathology and audiology. To access these local visiting services in Katherine clients need to travel for up to 7 hours one way.

For the families in the Katherine region the difficulties associated with cleft lip and palates are significantly compounded by living in a remote Aboriginal community. They encounter many difficulties including; frequent travel over long distances to Darwin (up to 11 hours one way), long periods away from home and family in an unfamiliar and often hostile environment, challenges balancing community, family and health priorities, poor access to medical and allied health services and inappropriate styles of service delivery for Aboriginal people.

As there is no single case manager there is no central co-ordination of these services. This is left to the individual service providers and health clinic staff who have high case loads and travel demands. The consequence of this is a demanding and complicated schedule of appointments in Darwin and Katherine with some occasional visits to the community by the audiologist or speech pathologist.

As a result of these circumstances non-compliance in attending appointments or following medical/health advice among this group is very high. They may go years in between appointments, miss important surgery or treatment, suffer ongoing hearing loss, experience significant delays in communication, and endure exceptionally poor speech quality as well as the social and emotional effects of these disabilities.
This project requires a number of different strategies to overcome this multi-faceted issue. These include assisting the service providers to become more accessible through better transport, improved cultural safety for Aboriginal people and enhancing co-operation and co-ordination between service providers and empowering clients and their families through appropriate accessible education. The outcome of this project will allow Aboriginal children with cleft lip and/or palate and their families to be empowered through knowledge and education reduce the burden of travel and high demands of multiple appointments and make their experience within the health care system more comfortable increasing their opportunity to participate fully and secure better health outcomes. It is hoped that this project will be able to identify the children who have not been attending the clinic for a few years and reconnect them with services.

**Hospital Project**

A gap within services was recognised by a number of key service providers who have worked within this field for a number of years, which identified that there were certain system barriers and process which were having a long term impact upon the health of new mothers and their babies (and extended family) from remote communities.

There are a number of issues which impact adversely on mothers and infants, especially first time mothers in the Katherine region. Individually these women are not able to change processes, however, service providers are able to impact on the current systems through an integrated response and creative solutions to opportunities presented.

Within the Katherine Region, pregnant women are transported from their remote community home into Katherine towards the end of their pregnancy. This usually occurs at approx 38 weeks gestation (unless there are medical complications and they are transported into town earlier). Once in Katherine, the women are usually accommodated at the Aboriginal Hostel in the grounds of the Katherine Hospital.

Once the women have their babies, return transport back home is arranged by Patient Travel and sometimes this can happen very quickly and the mother may only receive short notice about her return trip. Necessary paper work needs to be completed (Centrelink, Birth Registration, open a bank account etc) in a short time frame. Centrelink payments are not granted within this timeframe (and can take up to 3 or 4 weeks if the mother already has the necessary identification and paper work to lodge forms). Usually this results in the mothers returning to their home community with either little or nothing for themselves and their babies. Statistics from Katherine Hospital, December 2005 to December 2006 identified 195 babies as Aboriginal.

The social worker is collaborating with Sunrise Health Service, Katherine West Health Board, Wurli Wurlinjarg, Katherine Hospital, Katherine Hospital, local midwives, Aboriginal Hostel, Mission Australia, Centrelink, local supermarket and banks. This has lead to the identification of a number of projects to be undertaken in collaboration with other service providers to assist new mothers and their babies.

While our target group are women from the remote communities, the programs will be open to all women. Some of the projects being developed are:

- **Education on the communities:** The social worker liaised with the local midwives group and Mission Australia to develop a package where assistance is provided to remote community mothers in applying for necessary documents prior to the birth of their babies. This includes applications for a birth certificate, tax file number, Medicare card and other necessary identification to apply for Centrelink payments and a bank account. This will assist in breaking down barriers which prevent women from accessing services and payments.

- **Education in Katherine:** There is an opportunity presented with the community women residing in town for 2 weeks prior to the birth of their baby. Services located in town provide information sessions and practical assistance. Money Business (Mission Australia) assist with financial issues including opening bank accounts, the health services provide hands on information regarding
nutrition, child development, play, domestic violence etc. A community based worker will be employed to work with these new mothers. Centrelink have commenced a visiting service to the hostel which include the Centrelink social worker. Centrelink is exploring the possibilities of providing at the hospital a fax and phone that is a direct access to the Indigenous Call Centre in Darwin.

- Baby Bundles: A local supermarket will provide Baby Bundles and payment will be arranged through Centrelink’s Centrepay. The Bundle is standardised and contains essential requirements for a new baby eg nappies, creams, singlets, soap, maternity pads etc. The mothers will receive the Bundle before leaving hospital and will be transported with them back to their communities.

These projects will assist in improving the maternal and child health outcomes in remote communities. They continue to grow and more projects will be developed around maternal and infant health.

**Presenter**

**Margaret Massey** is currently the manager of the Katherine Regional Aboriginal Health and Related Services (KRAHRS) Allied Health team, which has been delivering allied health services to remote Indigenous communities around Katherine for over four years. Throughout her working life Margaret has been involved in community development projects as well as direct service delivery. Many of the projects she has developed with communities are still thriving.