Remote Service Provision in the Northern Territory

June 2014
About

The Centre for Applied Disability Research exists to improve the wellbeing of people living with disability by gathering insights, building understanding and sharing knowledge.

The Centre for Applied Disability Research is an initiative of National Disability Services.

NDS gratefully acknowledges the service providers operating in the Katherine Region who contributed to the information presented in this report. Their assistance has provided an invaluable opportunity for NDS to explore existing data and reports and to test that information against the realities of remote service provision in the Northern Territory.
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APPENDIX A – KATHERINE REGION MAP PROJECT: NDIS IMPLICATIONS FOR REMOTE INDIGENOUS SERVICE PROVISION IN THE NORTHERN TERRITORY ... 24
1. INTRODUCTION

The purpose of this research was to identify the issues specific to delivering disability services in the remote Northern Territory environment, with particular consideration to Aboriginal people with disability (‘clients’) and in the context of the planning and future direction of the National Disability Insurance Scheme (NDIS).

2. TERMINOLOGY

Throughout this report, the term Aboriginal has been used in preference to Indigenous except where quoting from other sources. The term Aboriginal includes Aboriginal and Torres Strait Islander Australians.

3. METHODOLOGY

A literature review was conducted on the subject of remote health service delivery as a whole, not specific to disability services or the Northern Territory. Interviews were conducted with 36 representatives from service providers (i.e. staff/managers) from 22 organisations working in the Katherine Region to obtain their views on remote Aboriginal service provision. The Project Officer visited a remote community to gain a firsthand insight into remote Aboriginal service delivery.

Service providers interviewed included managers based in urban settings; managers delivering services in remote settings; frontline staff/health care workers delivering services in urban settings; and frontline staff/health care workers delivering services in remote settings. Their views have been collated within eight themes (Climate, Geography, Culture, Language, Process, Coordination and Relationships, Workforce, and Safety and Social Issues) and evidence supporting these views was obtained where possible.

The Katherine Region was selected as a pilot site and case study for Northern Territory service delivery for this project and encompasses Katherine Municipality, Roper Gulf Shire and Victoria-Daly Shire (see Appendix A: Katherine Region Map). The town of Katherine (Katherine Municipality) receives clients from, and delivers services to, outlying remote communities in the Roper Gulf and Victoria-Daly Shires.

The Aboriginal population represents approximately 57% of the population\(^1\) in the Katherine Region. Statistics indicated that ‘after correcting for differences in age structure, Indigenous Australians have a profound or severe core activity limitation at around 2.2 times the rate of non-indigenous Australians.’\(^2\)

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\(^1\) 2011 Census of Population and Housing, Basic Community Profile, Katherine (T) (LGA72200), Roper Gulf Shire (LGA) (LGA73600) and Victoria–Daly Shire (LGA) (LGA74500).

There are limitations to data sets for Aboriginal populations and there may be instances of under-representation and over-representation of Aboriginal populations in statistics quoted in this document. Statistics therefore should be used with care to summarise particular issues, as they may not reflect the true state of affairs.

The Productivity Commission’s Inquiry Report on Disability Care and Support extensively outlines difficulties in obtaining accurate data around Indigenous disability, including non-response rates and a varied concept of disability in Aboriginal communities.3

4.1 Under-representation

Under-representation is often the result of people choosing not to identify themselves as Aboriginal and Torres Strait Islander (for various reasons) or where their Indigenous status is ‘not stated’. The estimated undercount in the 2011 Census was 17.2% for Indigenous Australians.4 Census statistical data is estimated for Aboriginal and Torres Strait Islander population because of its volatility:

‘Estimated resident Aboriginal and Torres Strait Islander population

The estimated resident Aboriginal and Torres Strait Islander population is based on the Census count and adjusted for instances in which Indigenous status is unknown and for net undercount. These adjustments are necessary because of the volatility of counts of the Aboriginal and Torres Strait Islander population between censuses. The estimated resident Aboriginal and Torres Strait Islander population is compiled for 30 June each census year, and is not updated between censuses. However, experimental Aboriginal and Torres Strait Islander population estimates have been produced for the period 1986 to 2006 and experimental Aboriginal and Torres Strait Islander population projections for the period 2007 to 2021.

Importantly, for disability statistics, the First Peoples Disability Network also suggested that ‘in traditional language there was no comparable word to disability which suggests that disability may have been accepted as part of the human experience...’6 and therefore is not identified as ‘disability’.

4.2 Over-representation

Over-representation can happen for various reasons, as noted by the AIHW:

‘There are a number of factors that may contribute to over-counting, including repeat HACC clients providing different names or birth date information to different HACC agencies, resulting in individuals being counted more than once; service users being more likely to identify as Indigenous in the HACC MDS compared with the 2006 ABS Census; and the over-estimation of the age of HACC service users resulting in higher age-specific usage rates among older clients (ABS & AIHW

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5 4704.0 - The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples, Oct 2010, Latest Issue, Released at 11:30 AM (Canberra Time) 29/10/2010, Glossary.
5. CLIMATE

The Northern Territory encompasses two areas known as the Central Desert area and the Top End. The Top End has two commonly recognised seasons – wet season and dry season, although Aboriginal calendars frequently recognise more seasons with more specific attributes. Wet season can include monsoons and tropical cyclones in coastal areas.

Due to heavy rain, communities accessed by river crossings can be inaccessible by road for up to six months of the year. Depending on weather conditions and the level of maintenance done on airstrips, they will be accessible by light aircraft.

For example, the community of Ngukurr (about 320km or 3.5 hours from Katherine and 640km or 7 hours from Darwin) is frequently cut off from Katherine throughout the wet season. To charter a flight in a single-engine aircraft costs about $1,200 return.8

The impact of unpredictable climate related, seasonal factors affects the capacity of the disability service system in a number of ways – here are some examples:

• the town experiences an influx of people who usually reside in remote communities and who do not want to be cut off from the town and its services;
• the disability service system experiences an influx of clients. There is insufficient emergency housing in Katherine town and people may have to ‘sleep rough’ (outdoors) or in overcrowded housing. If they enter the service system, clients may be able to access accommodation;
• service providers are less able to reach clients in communities;
• some clients cannot be transported to or from a community in light aircraft due to their medical requirements; and
• some clients can be transported in light aircraft but may not be able to bring their special equipment. This means they may use inappropriate equipment or are bedridden when they arrive in town until their equipment can be brought in by road or alternative equipment is sourced.

Katherine disability service providers work within, and plan for, the seasonal restrictions where possible.

6. GEOGRAPHY

6.1 Katherine as a satellite town

The town of Katherine is 320km or about 3.5 hours’ drive from Darwin. In the 2011 Census, there were 9,187 people in Katherine (T) (Local Government Area). Aboriginal and Torres Strait Islander people made up 25.5% of the population; 12.2% of the population work in Defence at the RAAF base near Katherine.9

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7 Australian Government, Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Identification in community services data collections, User rates by age group and jurisdiction, Page 78.

8 Price quoted by Katherine Aviation current at 14 January 2013.

9 2011 Census of Population and Housing, Basic Community Profile, Katherine (T) (LGA72200)
The whole of the Katherine Region, incorporating the three LGAs of Katherine Municipality (9,187), Roper Gulf Shire (6,121) and Victoria-Daly Shire (5,924) has an estimated total population of 21,232.\textsuperscript{10} While not all of the people from outlying communities receive services from the town of Katherine, anecdotally the service population of the town is about 35,000. This could be due to tourists transiting through the town and an undercount of the population (see section 4.1, ‘Under-representation’).

This is a particular problem for Katherine Town Council’s delivery of services, as their rate-paying population is significantly lower than the number of service users. The implication of this trend is that spending on services in this area may seem disproportionate to the perceived service population size.

\begin{center}
\begin{tikzpicture}
\node[align=center,draw,circle,minimum size=2.5cm] (A) at (0,0) {Victoria–Daly Shire \hspace*{1cm} Town of Katherine \hspace*{1cm} Roper Gulf Shire} ;
\node[align=center,draw,circle,minimum size=1cm,above of=A] (B) at (0,1.5) {5,924 \hspace{3cm} 9,187 \hspace{3cm} 6,121} ;
\end{tikzpicture}
\end{center}

6.2 Services to or from remote communities

Geography plays a role in accessing services for Aboriginal people in remote areas. As Table 1 below shows the main impediments cited by Indigenous Australians aged 15 years and over relating to access to Health services.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|}
\hline
Access issues raised by Indigenous Australians aged 15 and over & Non-Remote & Remote \\
\hline
Waiting time too long/not available when needed & 55.0 & 33.2 \\
No services in the area & 27.3 & 50.9 \\
Not enough services in the area & 34.0 & 47.1 \\
Transport/distance & 24.7 & 45.8 \\
Cost of service & 37.5 & 16.5 \\
Don’t trust services & 7.3 & 5.6 \\
Services not culturally appropriate & 5.5 & 4.7 \\
\hline
\end{tabular}
\caption{Types of problems faced by Indigenous Australians aged 15 years and over seeking health services, 2008}
\end{table}

Source: ABS and AIHW (2008).\textsuperscript{11}

As discussed in section 5 (‘Climate’), delivering services to communities can be complicated by weather as well as distance. Road maintenance is largely dependent on who is responsible for the roads and anecdotally, the communities that lie within mining areas generally have better road maintenance due to the mining vehicle access requirements. Roads can be unsealed gravel or dirt with varying degrees of corrugations and/or potholes.

Some of the issues raised by participants that are associated with geography/distance are outlined in Table 2.

\textsuperscript{10} 2011 Census Community Profiles, Katherine (T) (LGA) Code LGA72200, Roper Gulf (S) (LGA) Code LGA73600 and Victoria-Daly (S) (LGA) Code LGA74500.

<table>
<thead>
<tr>
<th>Table 2: Delivery issues raised by service users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issue</strong></td>
</tr>
<tr>
<td>Diagnosis delay</td>
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<tr>
<td></td>
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<tr>
<td>Review delay</td>
</tr>
<tr>
<td>Equipment delay</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Travel times and expense</td>
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<td>Availability of appropriate services</td>
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<tr>
<td>Additional service costs</td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>In-community access limited</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
At times, clients and service providers are forced to use taxi services between Katherine and communities. As a typical example, a fare from Katherine to Urapunga (a distance of approximately 300km) would cost about $630 each way.\(^\text{12}\)

### 7. CULTURE

Aboriginal culture has many ramifications for service delivery and rates of access. Aboriginal populations as a percentage of the total population according to the 2011 Census are:

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katherine Town</td>
<td>2,344 of 9,187</td>
<td>26%</td>
</tr>
<tr>
<td>Victoria-Daly Shire</td>
<td>4,692 of 5,924</td>
<td>79%</td>
</tr>
<tr>
<td>Roper Gulf Shire</td>
<td>5,008 of 6,121</td>
<td>82%</td>
</tr>
<tr>
<td><strong>TOTAL KATHERINE REGION</strong></td>
<td><strong>12,004 of 21,232</strong></td>
<td><strong>57%</strong></td>
</tr>
<tr>
<td>Total Northern Territory</td>
<td>56,776 of 211,945</td>
<td>27%</td>
</tr>
<tr>
<td>Total Australia</td>
<td>548,368 of 21,507,717</td>
<td>3%</td>
</tr>
</tbody>
</table>

While these statistics should be used as an indication only (see section 4, ‘Important note about statistical data’), it should be noted that a significant proportion of the population of Northern Territory regions are of Aboriginal descent.

#### 7.1 Particular Aboriginal cultural nuances

The following list is a compilation of service providers’ observations of possible cultural nuances which may be encountered in Aboriginal service delivery:

- Aboriginal family can be reluctant to visit family members at a care facility. This could be because of:
  - feeling intimidated by the facility;
  - associating facilities with being a place of dying;
  - disliking service provider staff observing interactions between family members; or
  - limitations on the association between family or ‘skin’ groups where members of different families are staying at the same facility.

- The practice of ‘sorry business’ or ‘sorry time’. When a person passes away, the whole community may be shut down at little or no notice. Sometimes no business is conducted when this ceremony is being undertaken, and people may not be allowed to enter or leave the community.

- Clients are sometimes absent from a community when service providers visit.

- Aboriginal clients may not seek supports or identify themselves to service providers until they need immediate help or removal from communities. This may be because:
  - they are unaware of what supports (including entitlements) exist (see section 13, ‘Language’, and section 9, ‘Process’);
  - they do not trust service providers; or
  - the health issue may not be seen as a priority.

Other factors, which relate more to how services and staff relate to aboriginal individuals and communities and the ability of systems and processes to accommodate aboriginal cultural nuances include:

- High staff turnover in clinics may result in a lack of continuity in the awareness of what services

\(^{12}\) Price is for 300kms calculated on Katherine Taxi Fare Card (viewed 2/02/2013) example trip Katherine to Urapunga not including booking fee. [http://www.taxiautofare.com/au/taxi-fare-card/Katherine-Taxi-fare](http://www.taxiautofare.com/au/taxi-fare-card/Katherine-Taxi-fare).
or programs are available (see section 11, ‘Workforce’ and section 10, ‘Coordination and relationships’)

- Aboriginal clients may have numerous profiles in health systems such as eHealth or the National Diabetes Scheme, due to having several names (skin names or family names) or dates of birth (often because the actual date of birth is unknown and no birth certificate exists). Often there is no need for a person to have a driver’s license in community or it may be difficult to obtain for a variety of reasons.
- A staff member may need to be of a particular gender or of a particular family group or a certain relation to be able to speak with a client about health matters, or undertake personal care tasks.
- Views of money management and accountability may be different from views of a funding body or service provider.
- Views of care and family obligations may be different from views of a funding body or service provider.

### 7.2 Service–client interaction and communication

As outlined at section 11.1 (‘Workforce shortage and high staff turnover’), service providers experience a high degree of staff turnover. Working successfully with Aboriginal clients can often rely on relationship-building over a long period.

> ‘In working with remote Indigenous communities, it needs to be reinforced; there are no short cuts to building relationships and trust. One of the by-products of high numbers of ‘visitors’ (whether they be government employees, tourists, mining companies, researchers etc) taking short cuts in this regard is that [an] environment of low trust is created, resulting in an aggressive state of passive resistance to the latest person rolling through town with a story and a deal. There are no short cuts to ethical engagement with communities.’

Frequent changes to government programs and high turnover of service provider staff can result in apathy in engaging with any new program. Perpetual changes can be disorienting and unsettling for staff and clients or just cause a state of distrust or angst.

Additionally where personalities clash or where expectations of services are not managed, there can be damaged relationships.

> ‘Numerous participants ... noted that negative experiences within communities and with government agencies or service providers can make Indigenous Australians with a disability reluctant to seek support.’

Alarmingly, service providers noted that where there may not be a long-term relationship with a client, or where a service provider does not take the time required with a client, it can result in the client indicating they agree to a course of action, or that they understand something, when in fact they may just be giving the expected acquiescence. This can be very serious for Aboriginal clients who, for example, don’t understand the necessity to take medication or to continue a course of treatment. Aboriginal clients may also not be making informed choices about their health because they don’t understand clearly what is being discussed.

> ‘…This story, and many others like it, indicates the immense communication problem that exists between the medical professionals and their clients. In my experience alone, a large number of Yolnu have found that they have been involved in operations they knew nothing about, or in which

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13 Local Matters, Local Matter, Relationships and trust is the golden egg, Page 6.
15 Trudgen, R., ‘Why Warriors lie down and die’, Chapter 4 – The essence of human interaction – communication, p. 73.
what they thought would happen was completely different from what did happen. There are many legal and moral ramifications here.15

7.3 Leaving a community

For cultural reasons, there may be resistance to certain family members leaving a community. For example, if a person is an elder in the community, the community may do everything to try to keep that person there. This may have consequences for the person’s health and wellbeing if they are not receiving the care or services they need.

Additionally, there can be fear associated with children leaving a community, even for respite because:

- the person taking the child is unknown to the family;
- the family may not fully understand the process; or
- there may be historical-based fears about children being taken away permanently.

There can be a great deal of culture shock for Aboriginal clients coming from a remote living scenario to an urban living environment. This can be detrimental to mental health and wellbeing.

7.4 Person with disability and family/community dynamic

The relationship between a person with a disability and their community can also complicate service provision. This may include anything from abuse and neglect, to the appropriation of equipment and funding provided to a person with disability. For example, resources can be used by other community members or the intended recipient may be expected through familial obligations to provide money or food (a practice colloquially known as ‘humbugging’).16 The National Disability Insurance Scheme Act 2013 has provisions for situations where a person is seen to be at risk,17 as this was one of the most common concerns of service providers in discussions on the rollout of

8. LANGUAGE

Census data for 2011 shows the percentage of the population where there is ‘English only spoken at home’ and ‘Households where two or more languages are spoken’.

<table>
<thead>
<tr>
<th>Languages spoken at home</th>
<th>Percent of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katherine LGA</td>
<td>90</td>
</tr>
<tr>
<td>Roper LGA</td>
<td>85</td>
</tr>
<tr>
<td>Gulf LGA</td>
<td>75</td>
</tr>
<tr>
<td>Victoria Daly LGA</td>
<td>65</td>
</tr>
<tr>
<td>Katherine Region combined</td>
<td>95</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>80</td>
</tr>
<tr>
<td>Australia</td>
<td>70</td>
</tr>
</tbody>
</table>


17 The Parliament of the Commonwealth of Australia, National Disability Insurance Scheme Act 2013, Act No.20 of 2013, An act to establish the National Disability Insurance Scheme, and for related purposes, Chapter 3, Part 2, Division 3 – Managing the funding for supports under participants’ plans, 44 Circumstances in which participant must not manage plan to specified extent, p. 46.
The top languages spoken at home as a percentage of the total population of that Local Government Area (LGA) for the three LGAs defined in the Katherine Region are shown in Table 3.

Table 3: Most frequently spoken languages as percentage of Katherine Region LGAs

<table>
<thead>
<tr>
<th>Language</th>
<th>Katherine LGA</th>
<th>Roper Gulf LGA</th>
<th>Victoria Daly LGA</th>
<th>Northern Territory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kriol</td>
<td>3.3% (303)</td>
<td>48.8% (2,991)</td>
<td>6.4% (380)</td>
<td>1.9% (3,993)</td>
</tr>
<tr>
<td>Warlpiri</td>
<td>0.9% (82)</td>
<td>-</td>
<td>-</td>
<td>1.1% (2,409)</td>
</tr>
<tr>
<td>Murrinh Patha</td>
<td>-</td>
<td>-</td>
<td>39.1% (2,315)</td>
<td>1.1% (2,373)</td>
</tr>
<tr>
<td>Tagalog</td>
<td>0.9% (79)</td>
<td>-</td>
<td>-</td>
<td>0.8% (1,764)</td>
</tr>
<tr>
<td>Anindilyakwa</td>
<td>-</td>
<td>1.2% (75)</td>
<td>-</td>
<td>0.7% (1,489)</td>
</tr>
<tr>
<td>Filipino</td>
<td>0.7% (68)</td>
<td>-</td>
<td>-</td>
<td>0.6% (1,267)</td>
</tr>
<tr>
<td>Gurindji</td>
<td>0.5% (46)</td>
<td>-</td>
<td>7.5% (445)</td>
<td>0.2% (525)</td>
</tr>
<tr>
<td>Ngarinyman</td>
<td>-</td>
<td>-</td>
<td>4.4% (262)</td>
<td>0.1% (275)</td>
</tr>
<tr>
<td>Nunggubuyu</td>
<td>-</td>
<td>3.8% (231)</td>
<td>-</td>
<td>0.1% (241)</td>
</tr>
<tr>
<td>Ngan’gikurunggurr</td>
<td>-</td>
<td>-</td>
<td>1.5% (87)</td>
<td>0.0% (98)</td>
</tr>
<tr>
<td>Yanyuwa</td>
<td>-</td>
<td>1.1% (67)</td>
<td>-</td>
<td>0.0% (72)</td>
</tr>
<tr>
<td>Garrwa</td>
<td>-</td>
<td>0.9% (55)</td>
<td>-</td>
<td>0.0% (72)</td>
</tr>
</tbody>
</table>

While these 2011 Census statistics should be used as an indication only (see section 4, ‘Important note about statistical data’), it should be noted that a significant proportion of the population of these Northern Territory regions may speak a language other than English as their first language and is an important consideration in service delivery. There are 195 confirmed languages in the Northern Territory.\(^\text{18}\)

Service providers indicated that it can be difficult to obtain appropriate translators because translators:

- may need to be a specific gender;
- may need to be unrelated to, or have certain family connections to, the client;
- may need to be proficient in a number of languages or dialects;
- must be booked 24 hours in advance\(^\text{19}\); or
- may not be familiar with the medical system, terminology or concepts.

There are few health promotion materials produced in language. The research found some resources that had been translated into Kriol and some ‘talking posters’ that require a person to touch a symbol for English or Kriol to hear the message in that language.

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\(^{19}\) Aboriginal Interpreter Service Booking fees and conditions, viewed February 2013.
The Northern Territory Government Department of Health’s Draft Health Promotion Strategic Framework for 2011-2015 identifies the need for health information and social marketing to be provided in a range of languages and explains the factors for determining health can be compounded by other issues such as remoteness and/or social isolation and language barriers.

8.1 Literacy

In the Northern Territory, 15% of Year 7 children living in very remote Indigenous communities and 45% of children living in remote Indigenous communities could read at the accepted minimum standard in 2005.

‘...For many Indigenous students, particularly those from remote communities, English is a second, third or even fourth language. In some communities the only places standard Australian English is spoken and read are at the school and the health clinic.’

9. PROCESS

The National Indigenous Access Framework determines that Indigenous Australians experience almost double the rate of disability of other Australians and that Indigenous Australians are under-represented in the take-up of disability services.

Data detailing clients receiving services in the Northern Territory, and specifically at local government area (LGA) level, was not available for this project. The Report on Government Services (ROGS) 2012 states that the potential population using Commonwealth State Territory Disability Agreement (CSTDA) services in 2009-10 was 10,077 or 16.6% of the population for the Northern Territory.

The 2009 Disability, Ageing and Carers, Australia: State tables for Northern Territory advise ‘All with disability’ at 26,700.

9.1 Unmet need

This project originally considered the option of mapping the unmet service need of people with disability. It quickly became apparent that this would not be possible. Service providers noted that new Aboriginal clients are regularly introduced to the system, not having previously identified themselves to services for a variety of reasons – including the cultural and language reasons outlined in previous sections.

Anecdotally and statistically there seems to be an under-representation of Aboriginal people with disability accessing services. Some of the responsibility for poor access rates lies with a service

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26 Australian Bureau of Statistics, Disability, Ageing and Carers, Australia: State tables for Northern Territory, Released at 11:30am (Canberra time) Fri 12 Aug 2011.
system that relies on processes and procedures that are impractical to the realities of a remote Aboriginal lifestyle, or are difficult to navigate for Aboriginal people with disability due to language and other reasons. There are probably many contributing factors to this trend that could be explored by identifying process issues from a service provider and client perspective, and collaborating to find solutions.

10. COORDINATION AND RELATIONSHIPS

Service provision in a remote community is largely reliant on the relationships proactively developed and maintained between service providers. There can be numerous parties involved in service provision in communities, and relationships between services can be varied and based on personal relationships – to the benefit or detriment of service provision. In some instances there can be poor or no communication between services on the ground and visiting services.

Some of the impacts include:

- lack of clarity for service providers and clients about what services are available and from where;
- relationships on the ground can be impacted by relationships between organisations;
- some factions within an organisation would like to separate from an organisation because of politics; and
- there may be service duplications or gaps.

‘With the fragmentation of Aboriginal funding into hundreds of discrete programs and the duplication of programs at single locations, it is obvious that it is a long path forward for government to improve its own ability to coordinate and integrate common policy and program objectives. On Groote Eylandt there are seven separate activities being funded by DEEWR focussing on school/community engagement all at the same location, undertaken by multiple providers and none of which are integrated.’

Initiatives such as Government Business Managers (GBMs) have been implemented into 72 of the 73 prescribed communities across the Northern Territory (22 communities in the Katherine Region), to attempt to address service fragmentation issues. Their role is:

- ‘providing the key liaison and consultation point in communities, including communicating the NTER (Northern Territory Emergency Response) measures at a local level, engaging with elders and working collaboratively with other government representatives, including at the Territory and local levels;
- managing and coordinating the day-to-day activities of staff from different Australian Government agencies based in the community; and
- providing feedback on progress and local issues and concerns to government and to the NTER Operations Centre. Their knowledge and information guides coordinated government action and decision making tailored to the particular needs of a community’.

In remote communities, where the population is usually 2,000 or lower, the nature of the relationship between people changes from that of an urban working relationship. A community-based disability service worker potentially could work daily with other service providers, be neighbours with them, see them at any meetings or social events and see them at the community shop. Anecdotally,

there have been instances where individuals’ personality-driven agendas have contributed to high staff turnover in services, with a resultant breakdown in relationships between their service, other services and clients.

11. WORKFORCE

The Productivity Commission’s report on Disability Care and Support, which was the impetus for the Australian Government’s implementation of a National Disability Insurance Scheme, identifies a number of workforce issues, most of which were identified in the Katherine service provider interviews.

As part of the Geographic Information System component of this project, service providers were asked to define the capacity of their service. Providers advised their services were working to full capacity, with the exception of services funded for a very specific client group that may not have been identified at that time to fill that space – for example, a client of a certain age from a particular background.

11.1 Workforce shortage and high staff turnover

Some service providers advised that they would be keen to expand their service’s capacity but one of the impediments to this was the difficulty in obtaining and/or retaining staff to fill available positions. Providers noted contributory factors including:

- a lack of available or suitable housing for employees;
- the inability to offer longer-term contracts;
- overseas or interstate staff only working on short-term secondment to get the remote experience;
- poor cultural awareness or ‘culture shock’; and
- perceived inadequate wages.

Service providers also identified employee safety as a possible deterrent to working in remote communities or a possible contributing factor to poor staff retention rates. Some Aboriginal communities experience high levels of disruption and sometimes large-scale violence (see section 12, ‘Safety and social issues’).

Workforce shortages and high turnover are a disability workforce-wide issue as outlined in the Productivity Commission’s report, and this is particularly so for the Northern Territory. Figures show the turnover rate of nurses and midwives employed in Remote Health in the Northern Territory in 2006-2007 was approximately 57% per annum.\(^{30}\) For GPs between 2001-2006 there was a turnover of 60% in the Northern Territory.\(^{31}\)

The total annual cost of nursing workforce turnover for the Department of Health and Families in the Northern Territory is estimated at over $6.8 million, with the average cost per turnover for a nurse estimated at about $10,000.\(^{32}\)

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\(^{30}\) Attracting and Keeping Nursing Professionalism in an Environment of Chronic Labour Shortage, A Study of Mobility Among Nurses and Midwives in the Northern Territory of Australia, Charles Darwin University Press 2008, Table 2.4 Turnover rate in nurses/midwives employed by the Northern Territory Department of Health and Families, 2006-2007, page 32.


\(^{32}\) Culture shock and healthcare workers in remote indigenous communities of Australia; what do we know and how can we measure it?, Page 4, Centre for Remote Health, Flinders University and Charles Darwin University, Alice Springs (quoting data from Attracting and Keeping Nursing Professionals in an Environment of Chronic Labour Shortage: A Study of Mobility Among Nurses and Midwives in the Northern Territory of Australia.
With difficulties in obtaining and retaining a disability workforce, services struggle to work to capacity, resulting in decreased availability or quality of services provided to people with disability. Limited service capacity directly affects remote service access rates (see section 6.2, ‘Services to or from remote communities’).

11.1.1 Housing

The estimated housing shortage at June 2011 for the Northern Territory was 14.6% of estimated underlying demand. Housing shortages are consistently raised in the media in the Northern Territory.

In the town of Katherine, the rental vacancy rate officially hit zero in December 2012. A Katherine Accommodation Action Group has been formed to address the issue of housing shortages.

Several service providers advised that their employees were forced to stay in holiday or other temporary accommodation for a period of their employment. The service providers found it difficult to retain staff due to unavailability of housing and may be hesitant to recruit further for this reason.

In remote communities, there are varied options for staff housing and visiting service providers. Some housing is adequate, although often in short supply, while some housing is very basic and may not be regularly cleaned or serviced by a caretaker. The Australian Government has committed $7 million for the provision of better temporary staff accommodation for government personnel currently residing in cyclone prone coastal and inland communities.

Casual accommodation, if it can be found, for housing permanent staff can cost about $84 per night in the town of Katherine or about $60-150 per night in a community.

11.1.2 Funding cycles and short-term contracts

NDS NT’s members receive the majority of their funding from Northern Territory Government (NTG) Department of Health (DoH) and from Australian Government funding. Government funding cycles for non-government organisations (NGOs) are generally three-year contracts or six months to a year for specific term contracts. There is no assurance that funding will be renewed in the next cycle. With no guarantee of ongoing funding, employment contracts are often reviewed during funding negotiations.

One service provider who routinely receives Commonwealth funding advised that projects could ultimately be ineffective or less effective because of the time it takes to recruit someone to a position for the project, and then the time required for that person to build a relationship with project participants or stakeholders. This means that the project work only truly commences after a year or more.

The implementation of the NDIS in the Northern Territory is likely have a profound effect on employment contracts, as client funding will be predominantly individualised and paid in arrears. Service providers will be required to make financial provisions for meeting workplace legislation requirements under the NDIS.

11.1.3 Overseas and interstate workforce on short-term secondments

Overseas and interstate health professionals are recruited for short-term placements in remote communities in the Northern Territory. Medical students can also undertake 2-8 week placements.

34 ‘Under $300 a rental rarity’, NT News, Nicole Mills, 7 January 2013
36 Average Wotif.com price at 13 March 2013.
in remote communities in the Northern Territory. Most often it is not the intention of these health professionals to remain in the community for a longer period. There is a cost associated with the transport, housing and wages of these professionals.

11.1.4 Culture shock

Service providers suggested culture shock may be a contributing factor to staff turnover.

‘The phenomenon of culture shock has been linked to poor retention rates of remote area healthcare professionals and to the quality of health care in remote communities.’

The service providers in this project who were questioned on the issue of cultural proficiency training as part of their interview noted that they either:

- did not put their staff through any cultural proficiency training; or
- put their staff through cultural proficiency training but it was inadequate to prepare them for their working conditions.

Few felt that their practices were sufficient to prepare their workforce for remote Aboriginal service delivery. This is a particular issue for interstate and international workers:

‘Not only is the culture in their new workplace different, but they also have to adapt to living in a very remote area, where both medical and other resources are limited. Training, orientation and support programs are often limited or non-existent, and generally fail to adequately prepare the healthcare professional for their new role in the community.’

The particular stresses of remote placement are not unique to the remote Northern Territory and the requirements to undertake work there could be compared to other remote environments.

‘It is mandatory for anyone wishing to work in Antarctica to undergo physical and psychological assessment to establish whether they will stand up to the stresses of isolation, the extreme environment and the intense proximity to other people. All the same factors exist in remote Aboriginal communities, along with confronting cross-cultural conditions.’

11.1.5 Wages

The SACS Award Equal Remuneration Order case and the evidence given on behalf of the social and community services sector has highlighted the need for wage increases.

During the period of this research, Jobs Australia, ACOSS and NDS ran training sessions for providers on IR matters and the modern SCHADS Award. During that engagement the conditions under the Northern Territory Award for Social and Community Services were proven to be largely

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37 Culture shock and healthcare workers in remote indigenous communities of Australia; what do we know and how can we measure it?, Page 2, Centre for Remote Health, Flinders University and Charles Darwin University, Alice Springs (referencing from Why Warriors Lay Down and Die: Towards an understanding of why the Aboriginal people of Arnhem Land face the greatest crisis in health and education since European contact.

38 Culture shock and healthcare workers in remote indigenous communities of Australia; what do we know and how can we measure it?, Page 4, Centre for Remote Health, Flinders University and Charles Darwin University, Alice Springs (referencing from Overseas-trained doctors in Indigenous rural health services: negotiating professional relationships across cultural domains AND Settling in: overseas trained GPs and their spouses in rural Western Australia.

39 Kartiya are like Toyotas, White workers on Australia’s cultural frontier, Kim Manhood, Page 2

40 Fair Work Act 2009, s.302 Equal remuneration order, Equal Remuneration Case, Australian Municipal, Administrative, Clerical and Services Union and others (C2010/3131), Social, Community, Home Care and Disability Services Industry Award 2010.
above or on a par with the new SCHADS Award. Wage rates were lower than the new award rates, but indications were that most Northern Territory disability sector employers were already paying above the NT award rate to attract and retain staff. 41

However, with the higher cost of living in the Northern Territory, higher wages are seen to be a trade-off for the loss of big city conveniences.

No wage loading is available to Northern Territory Government employees in the town of Katherine as it is not considered remote. 42 They are paid at the same rate as Darwin-based employees. However, NTG employees do receive allowances for travel and placement in remote communities. No enquiries were made of non-government services’ practices in relation to remote allowances.

**11.2 Employing an Aboriginal workforce**

There is considerable work being done to increase the Aboriginal workforce Australia-wide and specifically in the Northern Territory, largely because of the identified higher rates of unemployment. 43

‘While there are economic opportunities in remote Australia, communities there still have high unemployment rates and limited access to the services on the ground.’ 44

However, service providers identified a number of issues that prevent or delay their employing some Aboriginal employees, such as:

- legal and/or contractual requirements for employees to have a driving licence, Ochre Card (a working with children check) or other certification that can take time to obtain and requires visits to town; and
- cultural issues determining with or for whom the employee can and cannot work. These are explored further in section 7, ‘Culture’.

In the community visited, the local Aboriginal workforce included:

- aged care centre workers;
- maintenance workers;
- community store staff;
- art centre and tourism venture staff; and
- women’s crisis centre staff.

Encouragingly, the Shires and Health Boards in the Katherine Region indicated that they employ about an 80% local Aboriginal workforce. As with all working relationships, those between Aboriginal employees and their employers vary, and the additional factors of language and culture contribute to those dynamics.

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41 National SACS Education and Information Program 2012, Comparison of SACS (NT) and the SCHCADS Modern Award.
42 Public Sector Employment and Management Act, Determination No. 2 of 2003, Item 1 ‘A remote location is defined as a town, place, community or locality outside the environs of Darwin, Katherine and Alice Springs, where access to health, education, social, financial, emergency, communication and professional support services are limited.’
43 Australian Government, Remote Jobs and Communities Program, Jobs and stronger communities for people in remote Australia, May 2012, Why change is needed.
44 Australian Government, Remote Jobs and Communities Program, Jobs and stronger communities for people in remote Australia, May 2012, Why change is needed.
11.3 Ageing workforce

The Productivity Commission’s report states ‘… the disability workforce has relatively few young workers and a more middle-aged profile than does the Australian female workforce overall’. This was identified as reflecting the Katherine disability workforce, and as an area of concern for Katherine service providers.

12. SAFETY AND SOCIAL ISSUES

12.1 Safety

A number of safety issues unique to the NT context were identified by service providers and are regularly reported through local media.

In the Northern Territory, crocodiles are a threat in most waterways (four deaths in 2010\(^{45}\)) meaning there is little or no safe access to swimming and fishing in communities.

Wild dogs are costing the cattle industry $80 million per year, according to the Northern Territory Cattlemen’s Association\(^ {46}\), and ‘there are growing concerns about human health and safety issues following recent reports of dog attacks on people camping in national parks’\(^ {47}\). Anecdotally, camp dog, wild dog or community dog attacks regularly cause injury to other animals and people.

Buffalo, pigs or other animals in communities can also contribute to property damage and be dangerous to people in vehicles and on foot.

These situations were identified by service providers and are regularly reported through local media.

12.2 Social issues

Social issues that affect clients and any providers delivering services in a community have a basis in Aboriginal disadvantage and have prompted action from Governments, including the Northern Territory and Australian Government intervention. Key social issues and some of the government programs to address them are shown in Table 4.

Table 4: Key areas of disadvantage and government programs addressing them\(^ {48}\)

| Substance abuse (alcohol, drugs and sniffing) | Restrictions in place in some communities. Only Opal fuels available in some communities. |
| Gambling and pornography | Restrictions in place in some communities. |
| Money management | Basics card and store cards restricting where money can be spent. |
| Child abuse/neglect | Mobile child protection units. |
| Domestic violence | Women’s Safe Houses. |
| Rioting/traditional fighting or payback/anti-social or violent behaviour | Increased police presence in some communities. |
| Nutrition | Community stores to provide fresh produce. |

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\(^{45}\) Australian Bureau of Statistics, 3303.0 Causes of Death, Australia, 2010 Table 8.1 Underlying cause of death, All causes, Northern Territory, 2010.


\(^{48}\) FaHCSIA, Stronger Futures in the Northern Territory, a ten year commitment to Aboriginal people in the Northern Territory July 2012 and anecdotal discussions with service providers.
13. FINDINGS

13.1 Numerous complex service delivery considerations in the Northern Territory combine to create a service delivery environment unlike that of most other jurisdictions in Australia

Many of the issues identified in this report reflect national considerations for delivering disability services and are not unique to the Northern Territory. However, the cumulative effect of additional factors create a very challenging environment for service providers delivering services to Aboriginal clients in remote environments. Distance, climate, culture and language demonstrably affect the quality, frequency, certainty and cost of service delivery, and are therefore factors that potentially frustrate the achievement of positive outcomes for people living with disability.

13.2 Relationships and communication have a profound impact on the way services are delivered in the Northern Territory

Good client–service relations and professional working relationships are particularly important in the disability sector. The success of these relationships in remote settings has a profound impact on the quality of service delivery. Poor relationships between services and clients can have particularly severe consequences in regional and remote areas where services; and clients’ choice and ability to seek alternative services, are limited. The consequences of disengagement from services through negative interactions can include adverse health and wellbeing outcomes.

Methods of service delivery that involve fly-in/fly-out or drive-in/drive-out to achieve service delivery can also impede positive outcomes. These practices, combined with high staff turnover, can create a ‘revolving door’ of staff and may prevent service providers from forming anything other than superficial relationships within communities. Building trust and relationships within communities takes time and is a strong enabler for culturally aware, person centred service delivery.

The quality of communication between service providers, both community based and visiting, impacts on successful coordination of service delivery in remote environments. In the absence of central systems across organisations and agencies that enable service interactions with clients to be recorded, it is impossible to avoid the ‘gaps, cracks and overlaps’ that characterise remote service delivery. Effective (consistent, open/transparency, regular) communication between agencies can mitigate the risks associated with the common features of remote service delivery directly implicated here. Moreover, the NDIS trials present an opportunity for services, both government and non-government, to review their service obligations and identify service gaps and unnecessary service duplications, in light of shared commitments and guiding principles including those most clearly articulated in the National Disability Strategy and COAG principles to determine the responsibilities of the NDIS and other service systems.

13.3 Service provider practices should be improved to allow for better interactions with Aboriginal clients and cross-cultural understanding. Cultural awareness inductions are often too basic in disability services and do not adequately prepare service providers and their employees for the complex challenges in their working environment

Cultural awareness is a core competency. Service providers must embed cultural awareness into every level of their organisation, its practices, policies and procedures. The evidence cited in this report, suggests that poor cultural interactions are a contributing factor causing workforce turnover and potentially serious health and wellbeing consequences for clients.

Service providers need to review their practices in using interpreters to ensure appropriate delivery of services. At the very least, it is critical that people with disability and their families understand interactions relating to their health and wellbeing. The NDIS takes a very strong and clear stance on the rights of people with disability in communicating their decisions in a culturally appropriate way:
‘People with disability should be supported in all their dealings and communications with the [National Disability Insurance] Agency so that their capacity to exercise choice and control is maximised in a way that is appropriate to their circumstances and cultural needs.’\(^{49}\)

Improved cross-cultural communication can only benefit service providers and clients through increased understanding and engagement on both sides.

Consequently strategies and actions that build the cultural awareness of service providers is an essential component of any comprehensive strategy to ensure that the right services are available at the right time and place for the right price, for aboriginal people living with disability in remote areas.

### 14. CONCLUSION

While the physical environment of the remote Northern Territory unquestionably alters the way in which services can be provided to people with disability, there is a real opportunity to increase the capacity of service providers operating in rural and remote areas to meet current and future challenges.

The implementation of the National Disability Insurance Scheme across Australia aims to give people with disability more choice and control over their lives. The Council of Australian Governments’ (COAG’s) Principles to Determine the Responsibilities of the NDIS and Other Service Systems\(^{50}\) clearly indicate that, although clients in remote areas may not have as much choice as in urban environments, all Australians with disability ‘have the same right of access to services’.\(^{51}\) COAG acknowledges that this will require ‘flexibility and innovation in the way the NDIS funds and/or delivers these activities’.\(^{52}\)

The COAG Principles also provide Applied Principles, a framework for the development of a cohesive system of support for people with disability with all agencies working in the areas of health, mental health, early childhood development, child protection and family support, school education, higher education and Vocational Education and Training (VET), employment, housing and community infrastructure, transport, justice and aged care. These agencies must have clearly defined responsibilities supplemented by the National Disability Insurance Scheme supports. Within this framework there are real opportunities to strengthen communication, coordination and collaboration between government and non-government service providers to build a more sustainable service system for people with disability, particularly in rural and remote regions. A component of this NDS NT project included the development of a Geographic Information System. This could have some practical applications for assisting service coordination and improving general awareness of the services operating in each area by mapping service user groups and the reach and types of existing services.

Cultural awareness sits at the heart of delivering high-quality services to people with disability, and the knowledge that leads to Aboriginal cultural awareness can only be gained through working closely with Aboriginal organisations and Aboriginal people. It is also important to note that the depth of knowledge required to truly engage with Aboriginal people with disability and their families

\(^{49}\) National Disability Insurance Scheme Act 2013, No. 20, 2013, Chapter 1, Part 2, Section 4, 4
\(^{50}\) Council of Australian Governments (COAG), Principles to Determine the Responsibilities of the NDIS and Other Services, 19 April 2013.
\(^{51}\) Council of Australian Governments (COAG), Principles to Determine the Responsibilities of the NDIS and Other Services, Principle 1, 19 April 2013.
\(^{52}\) Council of Australian Governments (COAG), Principles to Determine the Responsibilities of the NDIS and Other Services, Principle 4, 19 April 2013.
means that a ‘one size fits all’ approach to cultural proficiency cannot meet the objectives of true cultural awareness. Rather, service providers need to engage with local Aboriginal people and develop an understanding of local history, culture and current issues. This will help them to effectively provide services that meet the needs of the individual, their families and their support system, often within the context of community expectations. The NDS NSW programs of Aboriginal Resources and Pathways and Aboriginal Jobs Together could be developed to suit the Northern Territory service environment and assist in promoting better collaboration between Aboriginal and non-Aboriginal partners to deliver disability service excellence.

Service providers with the requirement for cultural awareness incorporated at every level of their organisation – in their mission, strategic plans, training, induction processes and service delivery practice – will be better prepared to meet the requirements of the NDIS by providing improved choice and control for people with disability, their families and carers. In addition, organisations that embrace cultural awareness have the potential to lower staff turnover\(^\text{53}\), reduce the incidence of communication breakdown with people with disability\(^\text{54}\), families and other agencies, and to increase demand for their services from existing and new clients.\(^\text{55}\)

In summary, a service environment built on the principles of putting the person with a disability at the centre of the service system (person-centredness); supporting the establishment of a framework that ensures collaboration between all agencies (COAG principles); and building the capacity of service providers to ensure cultural awareness is embedded into every practice will go some way to providing a positive industry response to the guiding tenets of the NDIS.

\(^{53}\) Refer 11.1.4 Culture shock
\(^{54}\) Refer 7.2 Service–client interaction and communication
\(^{55}\) Refer 9 Process
Appendix A – Katherine Region Map

Encompassing Victoria-Daly Shire, Katherine Municipality and Roper Gulf Shire

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